

Distribution Agreement

In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature:

Rebecca M. Wheeler

Date

Internationally Educated Nurses' Perceptions of Agency:
Implications for Patient Care and Nurse Retention

By

Rebecca M. Wheeler
Doctor of Philosophy

Nursing

Kenneth W. Hepburn, Ph.D.
Advisor

Ron Barrett, Ph.D.
Committee Member

Jennifer W. Foster, RN, Ph.D., FACNM
Committee Member

Martha F. Rogers, MD.
Committee Member

Accepted:

Lisa A. Tedesco, Ph.D.
Dean of the James T. Laney School of Graduate Studies

Date

Internationally Educated Nurses' Perceptions of Agency:
Implications for Patient Care and Nurse Retention

By

Rebecca M. Wheeler
M.A., Columbia University, 1995
B.S.N., Emory University, 2006

Advisor: Kenneth W. Hepburn, Ph.D.

An abstract of
A dissertation submitted to the Faculty of the
James T. Laney School of Graduate Studies of Emory University
in partial fulfillment of the requirements for the degree of
Doctor of Philosophy
in Nursing
2012

Abstract

Internationally Educated Nurses' Perceptions of Agency: Implications for Patient Care and Nurse Retention

By Rebecca M. Wheeler

Purpose: The purpose of this study was to explore the perspectives of internationally educated nurses (IENs) in comparison to those of U.S. nurses about their ability to exercise agency in the context of health care in U.S. hospitals. Specifically, the aims were to explore the relationship between agency and retention and quality of care with regard to pursuit of nursing education and participation in governance.

Background: The nursing workforce in urban hospitals may consist of a significant percentage of IENs. Nurse migration to the United States increased as hospitals sought IENs to maintain staffing levels in the face of a national nursing shortage. It is important to understand how the perspectives of these nurses regarding their agency may influence patient care.

Method: This exploratory, qualitative study framed by structuration theory consisted of two phases of semi-structured interviews. In the first, 82 nurses were recruited from two urban hospitals in the Southeastern United States: 21 IENs from each hospital and 20 U.S. RNs. In the second, 40 nurses, 11 IENs from each hospital and 9 U.S. RNs, were re-interviewed about themes discovered during the first phase. Data were collected and analyzed in an iterative process.

Findings: Most IENs plan to remain in nursing in the United States until they retire. Most initially received associate degrees in nursing, and many obtained bachelor degrees in the United States. Few obtained graduate degrees. Like U.S. RNs, most do not perceive work on hospital governance committees to be relevant to their roles as nurses, nor do they tend to seek promotions. Both IENs and U.S. RNs experienced discrimination in the workplace.

Discussion: IENs may share perspectives similar to those of U.S. RNs because they have adapted to the U.S. hospital environment, reproducing what they observe in the U.S. RNs. In general, nurses may not pursue further nursing education or participate in hospital governance because they value the individual empowerment they have providing direct patient care. They may not see the value of collective empowerment and/or may not feel they have the knowledge, training and support for roles that do not involve direct patient care.

Internationally Educated Nurses' Perceptions of Agency:
Implications for Patient Care and Nurse Retention

By

Rebecca M. Wheeler
M.A., Columbia University, 1995
B.S.N., Emory University, 2006

Advisor: Kenneth W. Hepburn, Ph.D.

A dissertation submitted to the Faculty of the
James T. Laney School of Graduate Studies of Emory University
in partial fulfillment of the requirements for the degree of
Doctor of Philosophy
in Nursing
2012

ACKNOWLEDGEMENTS

This dissertation would not have been possible without the guidance and support of my Dissertation Committee Chair, Dr. Kenneth Hepburn, and the members of my Dissertation Committee: Dr. Ron Barrett, Dr. Jennifer Foster, and Dr. Martha Rogers. I am also eternally grateful to my friends and family, who kept me going and supported me along the way.

Table of Contents

Introductory Chapter	1
Manuscript for Publication 1	76
Experiences of Internationally Educated Nurses in the Southeastern United States	
Manuscript for Publication 2	99
Pursuit of Further Education in Nursing: Internationally Educated Nurses and US RNs Compared	
Manuscript for Publication 3	123
Governance and Professional Advancement: Issues of Empowerment among Hospital Nurses	
Manuscript for Publication 4	140
Discrimination Experienced by Internationally Educated Nurses and U.S. Nurses in Hospitals	
Conclusion	165

List of Tables

Introduction

Table 1. Sample of Participants	46
---------------------------------	----

Manuscript for Publication 1: Experiences of Internationally Educated Nurses in the Southeastern United States

Table 1. Characteristics of All Participants	83
--	----

Table 2. Characteristics of IENs	84
----------------------------------	----

Table 3. IEN Country of Origin, Year of Migration to the United States, and Initial Level of Education	85
--	----

Manuscript for Publication 2: Pursuit of Further Education in Nursing: Internationally Educated Nurses and US RNs Compared

Table 1. Characteristics of IENs and US RNs	106
---	-----

Table 2. Participants' Educational Attainment and Educational Plans	107
---	-----

Manuscript for Publication 3: Governance and Professional Advancement: Issues of Empowerment among Hospital Nurses

Table 1. IEN and US RN Characteristics	128
--	-----

Manuscript for Publication 4: Discrimination Experienced by Internationally Educated Nurses and U.S. Nurses in Hospitals

Table 1. IEN and US RN Age and Years of Nursing Experience	147
--	-----

Table 2. Participants' Race and Region of Origin	147
--	-----

Conclusion

Table 1. IEN Nationalities According to Interview Phase	167
---	-----

Running Head: IENS' PERCEPTIONS OF AGENCY

Internationally Educated Nurses' Perceptions of Agency:
Implications for Patient Care and Nurse Retention

Rebecca M. Wheeler

Emory University

Introductory Chapter

Introduction

The quality of patient care is an overriding concern in the United States.

Internationally educated nurses (IENs) play a key role in U.S. efforts to improve patient care because many U.S. health care systems have resorted to recruiting IENs from overseas to increase staffing levels. These IENs make up a considerable portion of the nursing workforce, especially where they are concentrated in facilities in urban areas (Aiken, 2007). However, quality patient care is not only about the number of working nurses, and IENs' impact is not limited to filling vacant nursing positions in healthcare facilities. There are other important ways in which nurses affect quality care, including their participation in hospital governance and their pursuit of further nursing education (Aiken, Clarke, Cheung, Sloane, & Silber, 2003; Aiken, Sochalski, & Lake, 1997; Armstrong, Laschinger, & Wong, 2009; Buerhaus, Needleman, Mattke, & Stewart, 2002; Institute of Medicine, 2003; Kendall-Gallagher, Aiken, Sloane, & Cimiotti, 2011; Kutney-Lee & Aiken, 2008; Laschinger, Almost, & Tuer-Hodes, 2003). No research has focused on IENs in the U.S. nursing workforce with regard to their agency (the ability to act on the decisions they make) involving remaining in their positions (or in nursing, or in the United States), continuing their education, and participating in hospital governance.

The United States is one of many higher-income countries that recruit IENs.

International secondary data analyses have provided general demographic information about IENs (Aiken, 2007; Brush, 2008; Buchan, Parkin, & Sochalski, 2003; Crawford, 2004; Polsky, Ross, Brush, & Sochalski, 2007; Schumacher, 2011; Xu & Kwak, 2005, 2007; Xu, Zaikina-Montgomery, & Shen, 2010). Some qualitative studies have looked at

adjustment barriers they face in the hospitals (Allen & Larsen, 2003; Beechinor & Fitzpatrick, 2008; Diccico-Bloom, 2004; Hardill & MacDonald, 2000; Hawthorne, 2001; Jose, 2010; Likupe, 2006; Liou & Grobe, 2008; Magnusdottir, 2005; Matiti & Taylor, 2005; Omeri & Atkins, 2002; Pittman, Aiken, & Buchan, 2007; Yi & Jezewski, 2000). No research has taken a broad perspective about IENs' agency as it relates to nursing in the United States, especially given their experiences as foreign, often non-white women who may not speak English as their first language. These issues have an impact on patient care and are of concern to those who formulate and implement health care policy from the local to the international level.

Statement of the Problem

Nurses have pivotal roles in the provision of quality patient care in the United States because they are the healthcare professionals who work at the bedside, in constant contact with patients. There are high expectations of nurses in terms of education, training and knowledge to manage increasingly complex patient care needs and health care environments. It is important to understand how IENs compare to U.S. nurses (US RNs) because they are a significant subgroup of the U.S. nursing workforce. As they are shaped by U.S. expectations of nurses, so they may also shape U.S. nursing by virtue of their experiences as women raised and trained in other countries.

Retention, participation in hospital governance and continuing education in nursing are the focus of this study because they are key factors in the provision of quality patient care, they are of high importance to the nursing profession, and they have not been studied among IENs working in the United States. Many studies have shown that lower nurse-patient ratios improve patient outcomes (Aiken et al., 2011; Aiken, Clarke,

Sloane, Lake, & Cheney, 2008; Buerhaus et al., 2002; Friese, Lake, Aiken, Silber, & Sochalski, 2008; Kutney-Lee & Aiken, 2008; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002) and hospitals have recruited IENs during U.S. nursing shortages to maintain appropriate staffing levels commensurate with researchers' recommendations. The retention of nurses is equally important to maintaining lower nurse-patient ratios and hinges on job satisfaction. Work dissatisfaction leads to increased nurse turnover and vacancy rates (Black, Spetz, & Harrington, 2010; Gullatte & Jirasakhiran, 2005; MacKusick & Minick, 2010; Steinbrook, 2002). High attrition rates mean increased workload and burnout rates as the remaining nurses in the facility continually train new hires and/or manage higher patient loads due to unfilled positions (Baernholdt & Mark, 2009; Jones, 2008). When there is a shortage of nurses, as there has been to varying degrees in the United States since the 1960s (Brush & Berger, 2002), it is easier for nurses to find new jobs so nurses are more likely to leave when dissatisfied.

Research that has examined nurses' role in promoting quality care has found that nurse participation in workplace governance is an important factor in nurses' provision of quality care because it increases nurses' sense of control over their practice (Aiken et al., 1997; Armstrong et al., 2009; Kramer & Schmalenberg, 2003; Lake, 2002; Laschinger et al., 2003). Another important factor is advanced nursing education because studies have found that nurses who continue their education are more current in their knowledge as well as more confident and empowered (Aiken et al., 2003; Buerhaus et al., 2002; Coleman et al., 2009; Institute of Medicine, 2003; Kendall-Gallagher et al., 2011; Kutney-Lee & Aiken, 2008; Skees, 2010; Wade, 2009). Both of these factors lead to improved patient care because nurses feel valued and supported and therefore more

capable of managing threats to patient safety. Both factors also lead to improved job satisfaction and decreased job turnover. The importance of these factors is highlighted by the recent Institute of Medicine report *The Future of Nursing: Leading Change, Advancing Health* (2010) which advocates higher nursing educational levels and more nurse participation in hospital decision-making and leadership to improve patient care. It is also reflected by the values of the Magnet Recognition Program® (American Nurses Credentialing Center, 2012) that hospitals achieve when they demonstrate excellence in nursing, which is measured in part by nurses' educational attainment and nurse participation in hospital/unit governance.

International nurse migration to the United States has increased during the last few decades because of a shortage of nurses and the need to maintain appropriate staffing to provide quality care. In 2008, there were approximately 2,596,599 registered nurses working in nursing positions in the United States (U.S. Department of Health and Human Services, 2010). Before the recession that began in 2007, the United States was facing a severe shortage of nurses that was predicted to worsen with estimates ranging from 500,000 in 2015 (Ahmad, 2005) to 800,000 in 2020 (Aiken, Buchan, Sochalski, Nichols, & Powell, 2004; Brush, Sochalski, & Berger, 2004). These estimates have been revised downward to 260,000 in 2025 but are still considered significant (Buerhaus, Auerbach, & Stalger, 2009). Since nurse staffing levels have been shown to be a key factor affecting quality of care and patient outcomes (Aiken et al., 2008; Friese et al., 2008; Needleman et al., 2002; Needleman, Buerhaus, Stewart, Zelevinsky, & Mattke, 2006), hospitals and other healthcare facilities spend millions of dollars to recruit IENs to fill vacancies. The United States is one of the largest importers of nurses, with IENs making up 13% of the

newly-licensed nurses in 2008 (Schumacher, 2011). The concentration of IENs is probably higher in urban hospitals (Aiken, 2007).

IENs are also valuable because they can be sources of culturally appropriate information for patients who share their nationality. Immigrant populations in the southeastern United States, for example, have increased markedly since 1999 with their numbers in some metropolitan areas growing by as much as 77% between 2000 and 2007 (Singer, 2009). Cultural competence is defined as “a quantifiable set of individual attitudes and communication and practice skills that enables the nurse to work effectively within the cultural context of individuals and families from diverse backgrounds” (Gustafson, 2005, p. 2). It has been identified as one of the competencies needed by nurses to provide quality patient care in U.S. health care systems (Cronenwett et al., 2007; Institute of Medicine, 2004; Maier-Lorentz, 2008). IENs tend to work in urban hospitals, where they would be likely to provide care for these new immigrants and may share their nationalities. They can also provide valuable insight to others who work with patients from other cultures. IENs can therefore be doubly valuable to improving access to health care; they help mitigate the nursing shortage and provide alternative and perhaps more culturally understandable sources of health information for underserved minority patient populations, including immigrant populations, as well as other healthcare providers.

Relatively little is known about IENs or their experiences in the United States. The international nursing literature focuses primarily on the barriers to adjustment faced by IENs (Allen & Larsen, 2003; Hawthorne, 2001; Magnusdottir, 2005). Social science literature has studied unskilled foreign women, for example, domestic workers or sex

workers (Ehrenreich & Hochschild, 2002; Parrenas, 2001), but generally there is little focus on professional female migrants like nurses. Yet demographic information from general surveys in the United States implies that IENs have a significant impact on the U.S. patient population and the health care systems in which they work. IENs tend to provide direct patient care; 76.1% of them are employed as staff nurses (Xu et al., 2010). IENs are more likely to be employed full time (81.5% compared to 70.9% of US RNs) and work more hours per week (36.25 hours compared to 31.73 for US RNs) (Xu et al., 2010). IENs tend to work in hospitals (70.3% compared to 58.8% of US RNs) (Xu et al., 2010), often in urban areas treating the underserved (Aiken, 2007). Despite their status as professionals, there is evidence that some employers have taken advantage of IENs, compelling them to work the least desirable shifts and perform duties inappropriate to their positions, and paying them less than their U.S. or United Kingdom counterparts (Allen & Larsen, 2003; Diccico-Bloom, 2004; Likupe, 2006; Pittman, Folsom, Bass, & Leonhardy, 2007).

Little is known about attrition rates of IENs. Individual hospitals may collect data about the nurses who leave, but there are no aggregate figures specifically for IENs. Nor is there information about IENs who leave the profession. For US RNs, turnover figures and costs can be very high. It is estimated that it can cost \$80,000 or more to replace a nurse (Gullatte & Jirasakhiran, 2005; Jones, 2008). Estimates vary widely in the United States regarding how many newly-graduated nurses leave their jobs within the first year, ranging from 30% to 75% (Booth, 2011; MacKusick & Minick, 2010; Welding, 2011). This reflects the difficulty of quantifying the problem and at the same time clearly demonstrates its importance. Nursing schools do not have the faculty to train enough new

nurses to fill the gaps despite increased applications to schools (Aiken, 2008; Arends-Kuenning, 2006; Buerhaus, Staiger, & Auerbach, 2003). Theories of migration postulate that individuals who migrate once are more likely to migrate again and studies of nurses seem to support that finding (Dovlo, 2007; Kingma, 2007; Lee, 1966; Massey et al., 1994). It is important to know more about IENs' professional plans given the cost to recruit and train them as well as the importance of maintaining lower nurse-patient ratios to provide better quality care.

IENs' pursuit of further education in the United States has only been studied via the National Sample Survey of Registered Nurses (NSSRN) that is sent out every four years. The most recent analysis of the NSSRN (conducted in 2004) found that 10.3% of IENs had completed an advanced degree in nursing, (although it is not clear if they did that in the United States) and 7.2% of IENs were currently enrolled in educational programs (compared to 10.3% and 7.7% respectively of US RNs) (Xu et al., 2010). The opportunity to pursue graduate education in nursing is considered an important reason why nurses decide to migrate (Aiken et al., 2004; Kingma, 2007; Pearson & Peels, 2001), yet there are no U.S. data that correlate migration with attainment of advanced degrees.

IENs' participation in hospital governance has not been studied in the United States, but international studies suggest it is valued by nurses in other countries. Studies have shown that nurses in other countries value participation in unit and hospital decision-making to the extent that it increases their job satisfaction and intent to stay (Aiken et al., 2001; Mrayyan, 2009; Ridley, Wilson, Harwood, & Laschinger, 2009; Salmon, Yan, Hewitt, & Guisinger, 2007). Participation in hospital governance is associated with control over practice, so nurse autonomy can be considered a proxy

measure, and some studies have shown that nurses in other countries value autonomy (Aiken, 2007; Takase, Mause, & Manias, 2005).

IENs are valued workers because they are professional registered nurses with licenses to practice who can take advantage of legal migration routes to the United States. They are expected to function in the United States on the same high level as their American counterparts, yet their work will be affected by many factors. Their migration is framed by expectations of life and work in the destination country and their home countries' definitions and valuation of nursing as a profession, which may be different from those in the United States. IENs' class, gender, race and cultural characteristics, as well as their personal characteristics like age and nursing experience, have implications for their expression of agency (e.g. their actions) at home and in their chosen destination countries. IENs' positions in their home societies, in terms of class, gender, race and culture, may be very different from their positions in the United States. IENs are in potentially vulnerable positions as they transition to nursing in a new country because they are migrants, generally female, often non-white, and some do not speak English as their first language. IENs' actions, given other agents and structures in the United States, will affect the provision of quality patient care and their own plans for the future.

Theoretical Framework

This research will employ the key concepts of agent and structure from the social theory of structuration (Giddens, 1984) to examine the relationship between nurses and the health care systems that frame their work. This theory has not been used in this way in the nursing literature. Registered nurses are agents whose actions impact quality patient care in unit and hospital structures through participation in governance, obtaining further

education, and remaining at their jobs or in their profession. Structures are the surrounding rules and resources that the agents use to act, and these exist at multiple levels ranging from the family to the workplace to society at large. According to Giddens, agents and structures affect each other. Agents use their differing understandings of structures to attain their goals, and "through individual and collective actions ... these structures are reproduced and transformed" (Goss & Lindquist, 1995, p. 331). At the same time the structures exert "enabling or constraining features" that direct the interactions of individuals (Hardcastle, Usher, & Holmes, 2005, p. 223). Other social theories prioritize either the individual or the structure, but structuration theory seeks to resolve this tension by proposing a "duality" of agency and structure in which neither is prioritized over the other, although this does not mean that agency and structure are necessarily balanced. This duality also emphasizes that structuration is a dynamic process in which structures and agency are mutually constitutive. (Giddens does not describe his theory diagrammatically: for the researcher's diagrammatic interpretation, see Appendix A.)

Concepts from structuration theory that will be referred to, but not emphasized, in this study are time and space. According to Giddens there are three levels of time: *durée* (repetitive daily life), *dasein* (the life span of the individual) and *longue durée* (institutional time spanning generations). Daily interactions in *durée* move individuals through the life span, and the life span contributes to the *longue durée* of institutions (Giddens, 1984). Spatially, interactions take place both in the same geographical location as well as across space, especially where technology has facilitated interactions among people in separate geographical locales (via, for example, the telephone and internet). As

localized practices are reproduced and expand across time and space, they form social systems that are virtual instead of physical. The focus of this study is to compare how the agents (the nurses) interact with other agents and structures (nursing in the U.S. hospital environment). This study is primarily centered in only one time (*durée*) and one space (Atlanta, Georgia). However, it is impossible to divorce this study completely from other spaces and levels of time given its international nature and focus on health care. An analysis involving the broader concepts of time and space should be included in future research.

Agency

This research will employ Giddens' concept that agency is action, both intentional and unintentional (Giddens, 1984). For Giddens, every individual possesses agency because everyone has three levels of knowledge that inform their actions: the unconscious, practical consciousness, and discursive consciousness. The unconscious level involves motivations that cannot be verbally expressed. Practical consciousness refers to the knowledge involved in routine activity that is mostly automatic, needing little thought. For nurses, practical consciousness is the knowledge that allows them to perform many of the technical skills of their work, for example, giving an injection or hanging a bag of intravenous fluids. Discursive consciousness is the level at which individuals are able to explain or describe their knowledge. Giddens believes people have a greater capacity to exercise agency the more they reflect on the structures around them in their discursive consciousness (Hardcastle et al., 2005). When a nurse questions another healthcare provider's instructions for the care of a patient, she brings her technical knowledge from the practical consciousness to the discursive consciousness in

order to explain why she believes there is a problem. By bringing the interplay between agency and structure to the discursive consciousness level, individuals or collectives can intentionally change the structure. This research focuses on discursive consciousness because interview questions were designed to have nurses describe, explain and reflect upon their understandings of various aspects of their work.

According to Giddens, action occurs through three processes: motivation, rationalization, and reflexive monitoring. He proposes that individuals are motivated by their search for ontological security, which occurs primarily on an unconscious level. Giddens defines ontological security as “[c]onfidence or trust that the natural and social worlds are as they appear to be, including the basic existential parameters of self and social identity” (Giddens, 1984, p. 375). Predictable routines and predictable social interactions help build both trust and social identity. Rationalization concerns individuals’ understanding of the motivations for their actions, although they may not always be able to articulate them. When individuals engage in reflexive monitoring, they “monitor continuously the flow of their activities...[and] routinely monitor aspects, social and physical, of the contexts in which they move” including the conduct of others (Giddens, 1984, p. 5). It is through reflexive monitoring that individuals can “discursively account for and justify action” (Goss & Lindquist, 1995, p. 332). Reflexive monitoring may bring activities occurring at the level of practical consciousness to the level of discursive consciousness, and this process can reveal problems, allowing for the possibility of change. For example, a nurse who is used to being obeyed unquestioningly by her patients educates a patient based on this unconscious assumption of how the social interaction works. When a patient counters this assumption by opposing her suggestions,

the nurse may rationalize that her explanations were appropriate because she understands the underlying illness. She may then reflexively monitor her actions and realize that in this particular context the education she gave her patient was incorrect because the patient was from a cultural background that was incompatible with her teachings. This could lead to a change in how patients are educated on the unit. It is also possible that the questions posed to nurses in the process of this study will bring knowledge to the discursive level. As participants reflect on this knowledge, they may decide to make changes in the structures around them. Thus the three processes and the three levels of knowledge work together to produce action.

Structure

This study focuses primarily on registered nurses as agents, and it is important to understand the structures affecting them. According to structuration theory, structures consist of resources and rules that people use to create social systems, which are then continuously re-created through formal procedures and habits either consciously or unconsciously (Hardcastle et al., 2005). Resources are what individuals use to act, and they can enable or constrain individual action. There are two kinds of resources: allocative (material goods, like money and property) and authoritative (human resources, like knowledge and skills) (Sewell Jr, 1992). In a hospital, agents have access to allocative resources like equipment (e.g., syringes, bandages, beds), medications and technology (e.g. electronic medical records, computer terminals). Agents also have access to people with expertise to perform certain activities (authoritative resources), like various healthcare providers (e.g. physicians, nurses, therapists), supportive personnel (e.g. technicians, food service, cleaning service), and administrators.

Giddens recognizes that access to these resources is uneven, meaning that although everyone is capable of action, not everyone has the same resources available to them. For example, IENs may not have the same access to all resources as US RNs because, having been trained outside the system, they may not know the rules involved in accessing them (see next paragraph). For example, when seeking promotions, nurses must know which individuals (authoritative resources) are involved in the process and the roles they play. IENs may not have the training to access certain resources, like those involving technology. Depending on where they are from, they may not know that some resources even exist, like certified nurses' aides. However, it is also true that US RNs may experience similar issues depending on where they were trained and where they have worked.

Rules are “techniques or generalizable procedures applied in the enactment/reproduction of social practices” (Giddens, 1984, p. 21). Individuals use rules to inform their actions. There are three kinds of rules: rules of domination (rules involving both the allocation of resources and the authorization of their use), of signification (semantic rules for how individuals interpret the world around them), and of legitimation (moral rules regarding behavior norms). Individuals do not always strictly conform to rules and resources but may exert their own influence to change the rules and resources in minor or major ways.

Rules of domination are often explicit in the policies set by hospital administration. These include, for example, who has access to certain allocative resources (like medications of different types), what certain healthcare providers' responsibilities are (e.g. a charge nurse), and who controls budgets. Rules of legitimation and

signification are not generally enumerated clearly in policies, but rather are implicit in both hospital culture and broader society. Rules of legitimation include the professional norms of different healthcare providers and the wider social norms in which individuals were raised that dictate how healthcare providers interact with each other and with patients. Rules of signification involve the language used by agents to communicate. IENs may have difficulties with some of these rules because they have been trained and have worked outside the United States where these rules may have been different. However, it is also possible that these rules vary for US RNs depending on where they grew up and were initially trained in the United States. Again, time and space are underlying factors because agents from different places bring knowledge and practices that can change resources and rules over a period of time.

Understanding these rules will affect nurses' ability to access resources and obtain positive patient outcomes either by direct action (advocating for the patient) or indirect action (participating in hospital governance or obtaining further education). For example, in a hospital a physician will order a medicine (allocative resource) be given to a patient. The nurse is the authoritative resource who gives the medication because of her role in the structure (at least in the United States). If the nurse misunderstands the physician's order (rule of signification), or does not feel she should communicate her doubts about an order with the physician (rule of legitimation), or believes she can delegate the administration of the medication to an aide (rule of domination), this could have serious consequences to the health and safety of the patient.

It is important to clarify how structure, social systems and institutions differ according to Giddens. Interactions between individuals and rules and resources shape

both the individuals and the rules and resources in certain ways. These interactions are structures. These structures involve properties that allow the interactions to be repeated in the same ways in different places, making them “systematic” (Giddens, 1984, p. 17).

Institutions are these systematized structures. Institutions that utilize certain structural properties, such that the institutions become “reinforced and sedimented over the longer term,” form the social system (Goss & Lindquist, 1995, p. 332). Social systems, then, consist of many “institutionalized” structural properties (Kaspersen, 2000, p. 44). Time and space influence all of these because agents from different places perform actions in *durée* that affect structures. Over time (*dasein* or even *longue durée*), they can shape the larger institutions and social systems, which in turn may expand geographically.

Hospitals are examples of social systems containing many institutions involving interactions (structures) among healthcare personnel, patients and families conforming to rules and resources that shape the delivery of health care.

Giddens' concept of agency is “a positive, empowering one” (Greener, 2008, p. 278). According to Giddens, “agency implies power” because “[a]gency concerns events of which an individual is the perpetrator, in the sense that the individual could...have acted differently” (Giddens, 1984, p. 9). Even though the rules and resources of the structures shape individuals' actions, Giddens claims (as quoted in Goss and Lindquist, 1995, p. 333) “[even] the most seemingly ‘powerless’ individuals are able to mobilize resources whereby they carve out ‘spaces of control’.” However, as previously mentioned, Giddens admits that individuals are “positioned” differently in terms of their access and control over resources, therefore although everyone has access and control over *some* resources, they do not necessarily have the same *degree* of access and control

or the same resources available (Giddens, 1984; Goss & Lindquist, 1995; Ogden & Rose, 2005; Sewell Jr, 1992).

The focus of this research is on nurses' agency. IENs, nurses who were raised, educated and trained in other countries, are compared to US RNs to explore how the nurses act given other agents, rules and resources. Nurses' agency is reflected by actions nurses take (or do not take) that impact their patients' care but do not involve the technical actions required of their work, because technical actions reflect knowledge in nurses' practical consciousness (Hanks, 2008). That is, giving a patient an injection is not considered a reflection of nurses' agency, but calling a physician to discuss a patient's pain management is. Giving an injection is a technical skill known in practical consciousness that is performed on a rational level. Agency is reflected by the actions nurses take by staying or leaving a job, pursuing another degree and participating in hospital governance because these actions all involve discursive consciousness and reflexive monitoring. The goal of the study is to explore the nurses' perceptions of what enables and constrains their actions, and how these perceptions impact their decisions involving education, governance, or their intentions to stay in their jobs, in nursing, or even in the United States.

Application of the Theory

Structuration theory has been used to examine a wide range of social issues, including race, gender, health and immigration, as well as the organization of institutions, such as health care. Theoretical discussions of how structuration theory can be used to understand an issue predominate, while practical applications of the theory are somewhat limited (the latter are discussed in the literature review section). This is perhaps because

some consider it a second-order theory and that, as such, it “is sited at a higher level of abstraction than the events or contingencies of particular periods and places which constitute the domain of empirical enquiry” (Gregson, 1987, p. 80).

Goss and Lindquist (1995) applied structuration theory to international labor migration because they believe it frames the complexities of migration better than other approaches (e.g. functionalist and structuralist), and that the concept of migrant institutions is more appropriate than the concepts of households or social networks from other theories. They propose that migrants act knowledgeably and strategically, “but the capacity for such action is differentially distributed according to knowledge of rules and access to resources, which in turn may be partially determined by their position within other institutions” (Goss & Lindquist, 1995, p. 345). They use migration from the Philippines since the 1970s as a macro-level case study to illustrate how recent increases in the number and diversity of migrants is a result of “the complex of international and national institutions that transcend the boundaries of states and locales, linking employers in the developed or rapidly developing economies with individuals in the furthest peripheries of the Third World.” (Goss & Lindquist, 1995, p. 335). They describe how social systems of *longue durée*, like those involved in the global economy, have shaped demand for international labor. Institutions of recruitment, consisting of individuals who act as gatekeepers (examples of agents), control rules and resources as well as who has access to them and how they can be accessed. Yet the institutions are also subject to rules and resources controlled by other structures, including legal, political and financial structures. Successful return migrants (another example of agents) also provide resources, often in the form of social networks in both the home country (that will facilitate the

potential migrant's exit) and in the destination country (that will facilitate the potential migrant's arrival). Migration is "institutionalized" as different agents' goals are articulated and routinized in social processes. These processes shape interactions and rules and resources as well as access to them. Thus Goss and Lindquist use structuration theory to conceptualize the complicated network of agents, institutions and structures, and rules and resources that constitute international labor migration.

Structuration theory will guide this study by framing both IENs' and US RNs' actions in the specific context of two urban hospitals. Immigrants must learn the rules and resources of the structures around them in order to improve their position and increase their agentive power (Healey, 2006). IENs' effectiveness and ability to function in the healthcare workplace depends on their understandings of the rules and resources particular to the structures of that environment. IENs may not be prepared to exercise agency, or exercise it the way U.S. nurses do, due to their cultural, educational and professional backgrounds. For example, professional hierarchy might be more pronounced in some cultures, inhibiting nurses from confronting physicians if they see a problem with patient care. IENs may also be constrained by the health care system and how they are perceived as foreign, often non-white, women. For example, IENs may be perceived as inferior to US RNs because of their accents, color or nationality, causing their opinions to be disregarded and putting patients' health at risk. This interplay between nurses' perception of their agency and the health care structures will also have consequences for their decisions about remaining in their jobs and/or in the profession as well as their decision to participate in hospital governance and/or pursue further education. If nurses lack sufficient knowledge about the rules and resources of the

structure around them to inform their behavior, then nurses may become dissatisfied or unhappy, leaving their jobs and actively deciding not to engage in governance or education activities. Alternatively, in an environment where nurses understand the rules and resources, and feel their ideas and opinions are valued, nurses may be more willing to participate to find ways to improve patient care. By understanding the relationship between agency and structure, opportunities for change can be identified and addressed in order to prevent maladaptive outcomes and promote positive outcomes, especially for nurses and their patients.

Purpose and Specific Aims

The purpose of this research is to explore IENs' perceptions about their ability to exercise agency in the context of health care in U.S. hospitals considering the structures that frame their practice in the United States may be different from those of their home countries. More specifically, this study will examine the relationships between agency and the retention of IENs in the nursing workforce, their participation in hospital governance and their pursuit of further education in nursing.

The specific aims are to:

1. Explore the differences between IENs' and US RNs' perceptions of agency.
2. Explore the relationship between agency and retention.
3. Explore the relationship between agency and quality of care with regard to participation in hospital governance and continuing nursing education.

This study will use qualitative methods to examine the experiences and perspectives of IENs and U.S. nurses in the U.S. healthcare system as they relate to agency. The study will examine the relationship between agency and retention and

quality of care by employing concepts from structuration theory to frame interview questions and interpret findings. Results of this exploratory study will be used to inform future research to guide interventions involving retention of IENs and their provision of quality patient care.

There are several broad objectives of this research. First, this research will provide a better understanding of barriers IENs face in the transition from nursing in their home countries to nursing in the United States at a broader and deeper level than what has been studied thus far. It will also provide more information about IENs' backgrounds, their reasons for migrating and the process they went through to obtain work in the United States. Findings from the interviews may reveal other issues besides retention, governance and continuing education that impact IENs' agency and thus their ability to provide quality patient care. Findings will help guide future research about this population of nurses. This has implications for the U.S. nursing profession and health care system in terms of policies that may need to be changed or implemented in order to ensure retention of IENs and encourage their participation in hospital/unit governance and their pursuit of further nursing education to improve quality patient care.

Background and Significance

IENs in the United States are part of a global phenomenon that has generated considerable debate. The increase of international nurse migration reflects the intersection of the broader trend of international migration of skilled women and the availability of nursing jobs in higher-income countries. Therefore it is necessary to provide some background to understand the global context of international nurse migration and then present what is known about IENs specifically in the United States.

Gendered and Skilled Migration

In the last 40 years international migration has become increasingly feminized and involves more skilled workers (with tertiary education) (Kingma, 2008). Nurse migration is an important part of this trend because the majority of nurses are female and registered nurse licensure requires education at the tertiary level in most countries. Women consist of almost half of all international emigrants, and more and more of them are migrating alone (Timur, 2002). According to the migration literature, there are several reasons for gender-selective migration and these are related to access to resources in social structures. When low-income groups are displaced as rural economies change in low-income countries, women are marginalized because they have more wage-earning potential, and thus more status, in agricultural economies (Chant, 1992; Pedraza, 1991). In both urban and rural areas, the jobs available to women are often low-paying and of low status, therefore their access to local labor markets is restricted. This, combined with social marginalization, increases the attraction of out-migration for women (Chant, 1992). Social networks in other countries facilitate migration of women because they are an extension of the private, domestic sphere of women at home (World Health Organization, 2005). Education is another important resource because women who have attained higher educational levels, like nurses with baccalaureate degrees, are more likely to be mobile (Chant, 1992).

Factors in destination countries can both enable and constrain the migration of skilled workers, and sometimes specifically female skilled workers. The expansion of certain segments of the labor market in high-income countries, for example the health care industry, has provided new opportunities for women who were traditionally

employed in the service sector as domestic servants or in child care (Brush & Vasupuram, 2006). Immigration policies that address national employment sectors experiencing critical shortages, like nursing, foment skilled migration (Brush & Berger, 2002; Davis & Nichols, 2002; Lowell & Gerova, 2004).

There are also factors in home countries that affect skilled migration, and sometimes specifically female skilled migration. The political situation can push skilled workers out. For example, skilled professionals were targeted because their education and socioeconomic status made them threats to repressive regimes in Argentina, leading to a mass exodus of educated workers until the end of the military dictatorship in 1983 (Pellegrino, 2002). The restructuring required by Structural Adjustment Programmes (SAPs) (designed by the World Bank and International Monetary Fund) imposed financial restrictions as conditions of loans, which caused many governments to freeze the hiring of skilled workers in certain sectors (Dovlo, 2007), leading to their unemployment. The SAPs often affected women more than men as cuts were made in education, health care, and housing (Van Eyck, 2004), pushing women to look for work elsewhere to help sustain their families. However, costly visa applications, recruitment fees, tests and exams can inhibit potential migration, especially for women (Iredale, 2005).

Structural rules and resources must be taken into consideration when studying migration. Factors that enable and constrain migration will vary from country to country, affecting where migrants come from, the countries they choose for their destinations, and whether they stay or migrate on. The gender and educational level of the migrants will impact who can leave and where they can go. At the same time, work opportunities

available in other countries may influence the profession women choose, especially if there is an established migration trend (see Choy (2003) for the example of the Philippines). The expectations involved in migration and the resources available to move may also be heavily influenced by individuals' families. Yet migration ultimately rests on the individual migrants' agency, exercised when they make their decision and actually leave. This represents a tension of power between structural factors that have the power to control migratory movement and individual-level agency. It is the interaction between these two levels of power that influences migratory movement, and has yet to be studied as it applies to any forms of skilled female migration, like the migration of nurses.

International Nurse Migration

The shortage of nurses in higher-income countries is considered to be the cause of the increase in international nurse migration because these countries have the ability to attract nurses from lower-income countries, either directly via recruitment agencies or indirectly via social networks. Prior to the 2007 recession, predictions about the shortage of nurses in the United States ranged from 275,000 in 2010 (Aiken et al., 2004) to 500,000 by 2015 (Ahmad, 2005) to 800,000 by 2020 (Brush et al., 2004). These predictions have now been revised downward to 260,000 by 2025, yet this number is still double the size of any nursing shortage since the 1960s (Buerhaus et al., 2009), so it is expected that migration will continue. Other English-speaking, higher-income countries have also experienced significant nurse shortages. Before the recession it was predicted that Australia, the United Kingdom, and Canada would face shortages between 40,000 and 78,000 by 2011 (Aiken et al., 2004). These countries try to reduce the shortage by recruiting from certain developing countries, usually ones with which they share a

common language, similar educational curriculum, and colonial relationship (Buchan, 2001; Ferrinho, Antunes, Silva, Dal Poz, & Gilles, 2007). Nurses may migrate to these countries indirectly, for example nurses in Africa often migrate to other countries in the region, then perhaps to South Africa, then to the United Kingdom and then even to the United States (Connell, Zurn, Stilwell, Awases, & Braichet, 2007; Dovlo, 2007).

Geographical proximity also plays an important role. In Peru, for example, 57% of out-migrating nurses have gone to Italy but more Central American nurses choose the United States (Malvarez & Castrillon Agudelo, 2005).

Retention of Nurses

International studies about the retention of nurses generally focus on issues of work satisfaction because job dissatisfaction is one of the main reasons that nurses leave the profession in higher-income countries, and is often the reason why nurses in lower-income countries migrate. Structural factors in the healthcare system that constrain nurses' agency are significant causes of job dissatisfaction, affecting their intent to stay. Several studies of nurses in hospitals in high- and low-income countries have found that nurses are dissatisfied when there are not enough staff to provide quality patient care, when nurses are not included in organizational decision-making, and when nurses have limited opportunities for advancement and further education (Aiken et al., 2001; Buchan, Kingma, & Lorenzo, 2005; Siantz & Malvarez, 2008; Van Eyck, 2004). Nurses' ability to exercise agency (e.g. act) influences their satisfaction with their jobs and profession, and ultimately nurse retention.

U.S. studies show similar findings, which suggests that U.S. nurses share similar values in their work. In the United States, nurses are dissatisfied with the workload,

staffing levels, decreased amount of time providing direct patient care, and a lack of control over their work environment (Goodin, 2003; Steinbrook, 2002). Poor interpersonal relationships with other healthcare professionals and poorly coordinated care cause nurses to become dissatisfied and mentally exhausted, so they leave the profession (MacKusick & Minick, 2010).

Ethical Issues

There are many ethical issues involved in international nurse migration that cause intense debate. Ethical discussions generally focus on the loss of nurses in lower-income countries and the treatment of nurses once they arrive in the destination countries. Few deny that individuals have the right to choose where they want to live and work, but some take issue with the “poaching” (Ahmad, 2004, 2005) of nurses by wealthier nations when they aggressively recruit nurses from poorer nations that cannot afford to lose them. Lower-income countries lose skilled professionals in whom they have invested financially by providing training, meaning that, essentially, poorer countries are subsidizing wealthier ones (Connell et al., 2007). In addition, the reduced number of nurses limits citizens’ access to health services and limits the success of public health initiatives (Anderson & Isaacs, 2007). Often the nurses who decide to leave are the more experienced and better-trained nurses, causing a leadership void that impacts the infrastructure of the health care system in sending countries (Choo, 2003; Ferrinho et al., 2007; Gross et al., 2011).

The other key ethical issue is IENs’ vulnerability to mistreatment, even exploitation, throughout the migration process. Because recruiting agencies are not regulated, nurses have been cheated by disreputable operations that misrepresent the

situation the IENs will have in the destination country or who take their fees but never help the nurse leave at all (Kingma, 2006). They may not end up working in positions that correspond to their level of experience and qualifications because of discrimination or a lack of recognition of their qualifications, resulting in an inefficient use of skilled personnel or a “skill loss” (Connell et al., 2007; Martineau, Decker, & Bundred, 2004). Hospitals may fail to prepare the IENs for their new lives, both professionally and personally, providing them with little or no support during their transition (Beechinor & Fitzpatrick, 2008; Yi & Jezewski, 2000). The sense is that, given the global need for nurses, destination countries have a duty to protect nurses who migrate. Yet little research, especially in the United States, has focused on IENs' perspectives of their migration process.

Factors Involved in Out-migration

In order to try to understand why nurses are migrating, the literature is replete with hypothesized “push” factors (influencing nurses to leave their countries) and “pull” factors (attracting them to other countries) (Ahmad, 2005; Buchan, 2006; Campbell, 2006; Connell et al., 2007; Kline, 2003). These factors are shaped by various factors at both national or community levels and specific workplace and family levels, sometimes described as “external factors” (those outside of the IEN's control) and “internal factors” (those that the IEN can control) (Kawi & Xu, 2009, p. 181). They are perhaps best categorized as economic, political, social and professional (Chikanda, 2005). Economic factors include remuneration, the ability to save money, and national economic stability. Political factors involve community-level violence, conflict and/or war while social factors include living conditions and quality of life issues (e.g. education, health care,

retirement) for either the individual or the family. Professional factors involve working conditions (e.g. workload, schedule, safety) as well as opportunities for advancement and further education. Factors also can overlap. Problems with the national infrastructure, for example in the healthcare system or the educational system, are economic, political and social in nature. Professional advancement generally leads to higher wages, making it both a professional and an economic factor.

Regardless of how migration factors are classified, the nurses' desire to improve their lives pushes them to act by migrating, and it is primarily the situation in the home country that will determine the kind of improvement in life that the IENs seek. Although higher pay is often thought to be the main reason why nurses emigrate, that is not true for all nurses. For example, a 2006 study that analyzed the characteristics of internationally-recruited nurses in London (Buchan, Jobanputra, Gough, & Hutt, 2006) found several different profiles of migrating nurses. One is of younger (under age 35), adventure-seeking nurses from Australia, New Zealand or the United States. Another is of those seeking to improve their economic situations and that of their families, often from the Philippines. A third is of nurses seeking professional development opportunities, often from South Africa.

The question arises, then, whether IENs demonstrate different degrees of agency depending upon how voluntary their migration is. For example, it is arguable that adventure-seeking nurses are highly agentic because their decision to migrate is entirely based on personal desire. In contrast, it can be argued that nurses migrating from a country experiencing armed conflict or a collapsed economy are less agentic because they feel forced to leave in order to survive. However, this idea must be rejected if using

Giddens' definition of agency. The conditions that cause individuals to make the decision to act do not constitute agency. Agency is rather the ability to make a decision and act upon it. Individuals act by taking advantage of rules and resources in order to change (and presumably improve) their lives. In the case of this research, migration is an example of agency.

IENs in the United States

Demographic characteristics

In the United States, research that focuses on the IEN population generally attempts to describe demographic characteristics of IENs, with secondary data analyses, or describe the barriers they face in US hospitals, with qualitative studies. Data sources for secondary data analyses include; the National Council of State Boards of Nursing's (NCSBN) Practice and Professional Issues survey (PPI) of winter 2003 (Crawford, 2004), the U.S. government's National Sample of Registered Nurses (NSSRN) survey (conducted every four years since 1977) (Schumacher, 2011; Xu & Kwak, 2005, 2007; Xu et al., 2010), the U.S. Census (Aiken, 2007; Polsky et al., 2007), applications for licensure (Buchan, Parkin, & Sochalski, 2003), and nursing exam pass rates (Aiken, 2007; Brush, 2008). These studies conclude that IENs generally (1) are older than nurses educated in the United States (US RNs) (2) are married, (3) were initially educated at the baccalaureate level, (4) have more years of work experience than US RNs, (5) work primarily in urban areas in hospitals as staff nurses in intensive care units (ICUs) or medical-surgical units (secondarily as staff nurses in long-term care facilities), and (6) work full time, more hours annually, and for more years than US RNs. There is nothing in the data about the populations IENs serve, but there is an underlying assumption that

the patient population in urban hospitals tends to be more diverse and underserved. There are no data about retention or attrition rates for IENs.

There are many data issues involved in analyzing the U.S. IEN population, ranging from the types of sources used to presentations of findings. One significant issue is how researchers determine IENs' countries of origin. The problem is complicated because different researchers use different data sources and different time frames in their analyses. For example, Aiken (2007) presents one table that lists the country/region of origin of all IENs currently in the United States in 2000 using data from the U.S. Census of that year. In another table, Aiken lists the countries with the largest numbers of nurses who passed the NCLEX-RN exam in 2005, but it is not known if those who took the exam actually migrated. (For actual charts, see Aiken, 2007, pages 1306-1307.) Brush (2008) compiled a list of countries of origin based on the number of nurses who passed the qualifying exam administered by the Commission on Graduates of Foreign Nursing Schools (CGFNS) as part of a pre-certification process done prior to taking the NCLEX-RN exam. Again, it is not known if these nurses actually took the NCLEX-RN exam or migrated. Another issue with her table is that the number of years differs in each time frame: 1990-1995, 1996-2000, and 2000-2006 (Brush, 2008). Buchan, Parkin and Sochalski (2003) compiled a list of countries of origin from applications for US RN licensure from 1997-2000. These nurses applied to take the NCLEX-RN exam, but it is unclear whether they took the exam and *passed* it. The different data sources and time frames make it difficult to draw definitive conclusions about IENs' countries of origin.

Presentation of the data can also be confusing. Some researchers do not report specific numbers, choosing to present percentages instead. For example Xu and Kwak,

using data from the NSSRN from 1984 to 2000, found that the proportions of IENs coming from Canada and the U.K. have decreased (from 30.6% and 17.9% to 17.5% and 8.9% respectively) while they have increased for those coming from the Philippines and India (from 36.4% and 9.1% to 38.9% and 10.9% respectively) (Xu & Kwak, 2006). Yet without specific numbers, it is difficult to appreciate the actual impact of these changes.

These data issues are also evident in studies about where IENs go in the United States. Few researchers focus on this and none of the researchers examine where specific nationalities of IENs tend to go. Aiken (2007), again using the data from the U.S. Census of 2000, found that California and Florida have the highest proportion of IENs, 29% and 24% respectively, but she does not report percentages for other states. Instead she presents a map of states shaded according to six categories of the proportions of IENs (0-1%, 2-3%, 3-5%, 5-8%, 8-14%, and 15-29%), a rationale for these categories is not given. Xu and Kwak (2007) used the NSSRN surveys from 1977-2000 to determine changes in geographical concentration of IENs, but they only report the percent changes for regions without providing base numbers or specific state data. Therefore, the fact that the largest gain (12.1%) was experienced by the region consisting of Louisiana, Arkansas, Oklahoma and Texas and the largest decrease (9.64%) was experienced by the region with Illinois, Indiana, Michigan, Ohio and Wisconsin, is of limited utility. Polsky et al. (2007) used the U.S. Census from 1990 and 2000 to conclude that there was a “dramatic shift [of IENs] from the Mid-Atlantic and Pacific census divisions to the South and Mid-West census divisions” (Polsky et al., 2007, p. 896), but because they report their findings using percentages in a bar graph, it is impossible to determine the actual percent changes in these regions.

These studies do not reveal much about where the IEN population is in the United States. Because IENs tend to work in urban hospitals, it is possible that cities in different states have the same proportion of IENs even though the overall proportion of IENs in the states differs. The amount and type of data collected varies according to city and state, for example there is no city-level or hospital-level data available about the IEN population in Atlanta, Georgia. The researcher communicated with the head of human resources at Grady Memorial Hospital and the Chief Nursing Officer at Emory University Hospital, and in both cases the individuals consulted could only report anecdotally on characteristics of their IENs. Nor does the Georgia Nurses Association or the Georgia State Board of Nursing have any data regarding IENs. However, Mississippi, like many states that have centers dedicated to collecting data specifically about nursing (which Georgia does not), has more data about its nursing workforce, including information about IENs.

There are other problems with the data regarding IENs. There are gaps in the kind of data collected, for example nothing is known about the attrition rates of these nurses at the institutional level or the professional level. That is, there are no data about IENs who leave their jobs or the profession. The data sources used in the U.S. research did not necessarily specifically target IENs, meaning researchers interpreted the available information, and researchers may not have interpreted information in the same ways. For example, it is difficult to know how "IEN" was defined. The Census does not ask where nurses received their training, only where respondents were born. Therefore Aiken defined IENs as those nurses born outside the United States who migrated after age 22, assuming that those who migrated younger were not trained in their home countries

(Aiken, 2007). Other researchers do not address how they defined who IENs were. There are also potential problems with voluntary surveys that target IENs. Samples may be skewed; for example, only nurses who are completely comfortable with written English (and survey language) may choose to respond to surveys. Respondents' answers may be unreliable. As foreigners, they may be unaccustomed to surveys and may distrust how the surveys will be used. They may fear repercussions if they give certain responses. More information of a qualitative nature is needed about IENs in order to help interpret the available survey data.

Barriers to adjustment

The other main focus of research about IENs involves the barriers they face in the workplace. The United Kingdom has led the way in this research, and studies from other European countries, the United States, Australia, New Zealand, and Canada show that IENs have similar experiences. These studies demonstrate that IENs' initial experiences are the most significant (Allen & Larsen, 2003; Beechinor & Fitzpatrick, 2008; Hardill & MacDonald, 2000; Magnusdottir, 2005; Matiti & Taylor, 2005; Omeri & Atkins, 2002; Yi & Jezewski, 2000). Negative initial experiences, especially professionally, can harm the IENs' productivity, the quality of the care they provide, and increase the risk that they will leave (Allen & Larsen, 2003).

The studies generally agree that IENs face barriers in their new countries that inhibit adjustment and thus their "mastery of new roles and responsibilities" (Beechinor & Fitzpatrick, 2008, p. 178), but in the workplace the impact of the barriers can be mitigated by making changes in the structures. The three main barriers IENs face are; communication, isolation, and exploitation. The communication barrier reflects IENs'

lack of language resources. Not being a native speaker of the national language makes the adjustment process more difficult, but body language, slang, and medical jargon can be very different even when the IEN speaks the national language (Allen & Larsen, 2003; Hardill & MacDonald, 2000; Hawthorne, 2001; Kawi & Xu, 2009; Magnusdottir, 2005; Xu, 2007). Communication barriers can make IENs afraid to ask questions or express opinions, affecting teamwork and leading to confusion and misunderstandings (Ea, 2007). IENs may understand the national language well, but speaking it with a strong accent may create barriers with other healthcare workers and patients and their families (Xu, 2007).

A second barrier is isolation, both professional and personal (Allen & Larsen, 2003; Beechinor & Fitzpatrick, 2008; Diccico-Bloom, 2004; Magnusdottir, 2005). This barrier reflects a lack of resources for IENs to help them in their transition and structural rules that constrain their work. Homesickness and feeling cut off from one's culture and family contribute to personal isolation (Dicicco-Bloom, 2004) as does a lack of social support and feeling unaccepted in the new culture (Beechinor & Fitzpatrick, 2008). The lack of recognition of qualifications and the negative attitudes of co-workers and patients regarding IENs' experiences and abilities is another facet of professional isolation. (Hawthorne, 2001; Likupe, 2006). IENs may be required to work for a period of time in low-skill positions, perhaps under the supervision of people with fewer qualifications than the IENs, causing them to lose their confidence as they feel devalued (Allen & Larsen, 2003). Racism and/or discrimination from co-workers or patients are important causes of professional and personal demoralization (Dicicco-Bloom, 2004; Likupe, 2006).

IENs can be exploited in many ways, reflecting issues with resources for IENs as well as structural rules. IENs may be asked to work undesirable shifts, more frequent shifts, or perform tasks that are not appropriate to their position of employment (Allen & Larsen, 2003; Diccico-Bloom, 2004; Likupe, 2006). Employers may hold their passports or green cards, or threaten to go to immigration in order to ensure IENs comply with work demands (Pittman, Folsom, et al., 2007). They may delay payment to IENs or pay less than the IENs' U.S. counterparts or not pay for all the hours worked (Pittman, Folsom, et al., 2007). Employers may not provide sufficient orientation for the IENs (Pittman, Folsom, et al., 2007).

Not as much research about IENs' barriers to adjustment has been done in the United States, but the studies that have been done reflect the same issues. Typically these studies focus on nurses from specific countries, for example Canada (Beechinor & Fitzpatrick, 2008), India (Dicicco-Bloom, 2004; Jose, 2010), the Philippines (Beechinor & Fitzpatrick, 2008; Jose, 2010), Nigeria (Jose, 2010) and Korea (Yi & Jezewski, 2000). Two studies (Beechinor & Fitzpatrick, 2008; Liou & Grobe, 2008) employed surveys, while the rest employed interviews. The sample sizes for the surveys were 35 (Liou & Grobe, 2008) and 73 (Beechinor & Fitzpatrick, 2008), while the samples in the qualitative studies ranged from ten to 20 IENs. Like studies performed in other countries, the U.S. studies found that IENs experienced issues with language and isolation. Only DiCicco-Bloom's study (2004) found issues of exploitation and in her study these were framed in terms of discrimination.

Issues of race and culture

The United States, especially the South, has a long history of institutionalized racist practices that had a direct impact on African American U.S. nurses and may now contribute to racism impacting IENs. Segregation existed that either implicitly or explicitly blocked African Americans from entering nurse training programs or gaining experience in hospitals. Atlanta, along with Nashville and New Orleans, became southern centers for African-American-only schools and hospitals because existing schools and hospitals were not integrated (Hine, 1989). Nor did state nursing associations allow African American nurses to join. Thus, Hine (1989) argues that African American nurses achieved agency through the development and advocacy efforts of their own National Association of Colored Graduate Nurses. Some would also argue that the fight African American nurses waged against white people's assumptions that they were inferior, incapable, and inadequately trained has not ended (Hine, 1989). Although this may no longer be true for African American nurses, the aforementioned studies show that immigrants may face many similar negative stereotypes. Wilson (2003) argues that African American nurses are doubly oppressed because they are both nurses and African American and that this leads to "their sense of invisibility and voicelessness" (Wilson, 2003, p. 64). Racism and discrimination are rooted in structural rules individuals use to inform their actions and are particularly important to address with the IEN population, especially given the increasing diversity of sending countries.

One important gap in the literature involves IENs' specific cultural backgrounds. Different cultures value different behaviors, meaning IENs' practice is shaped by different structures. Flynn and Aiken (2002) broadly address culture, proposing a theory of cultural variability that categorizes countries as either individualistic or collectivistic

(see also Liou & Grobe, 2008). The United States is an example of an individualistic country because organizations tend to emphasize individualism and egalitarianism above teamwork and uniformity. South American and Caribbean countries, for example, are categorized as collectivistic because their organizational cultures value teamwork, hierarchical structures, and uniformity in practice. This can impact the workplace as nurses from collectivistic countries tend to be more subservient in relationships with physicians, more passive, and less interested in cost-effectiveness (Flynn & Aiken, 2002). Transitioning to structures with different values can affect patient care and the stress experienced by IENs, especially if the IENs' home culture is very dissimilar, requiring them to acquire different paradigms of patient care.

Nor have differences regarding the scopes of nursing practice been studied. Although professional scopes of practice are regulatory in nature, countries have differing regulations due to their cultures. IENs were trained under the scopes of practice in their home countries and therefore IENs may be unprepared for certain tasks they are expected to perform in the destination countries. This can cause role confusion, which affects patient care and retention. For example, in some cultures the patient's family helps with feeding and hygiene, so IENs from these cultures are unaccustomed to having these responsibilities as part of their practice. U.S. nurses are expected to be advocates for their patients, which involves critical thinking and assertive action. An IEN may come from a country where this is not an expectation of a nurse. IENs may come from countries where women do not tend to pursue advanced degrees. Thus more research is needed that explores cultural differences, both social and professional, between IENs and their U.S. counterparts.

In the social science literature, there are only two major studies involving foreign nurses in the United States; one focuses on Filipina nurses (Choy, 2003) and the other on Indian nurses (George, 2005). Choy suggests the high migration rates of Filipina nurses is a result of U.S. colonial imperialism, imposed in the early 1900s, that created a system that “prepared Filipino women to work as nurses in the United States as opposed to the Philippines” (Choy, 2003, p. 5). George focuses on the ramifications of the migration of Indian female nurses as the primary migrants, examining the socio-cultural impact of the nurse-wives’ increased status and earning ability on their families, especially their husbands. Both studies demonstrate how structures constrain nurses. In Choy’s study, political and economic factors control nurses’ movements. In George’s study, socio-cultural factors mitigate nurses’ increased professional status. Yet neither looks at the impact of nursing work on these women. It is important to examine nurses’ professional experiences, especially if, as these works suggest, these women are unique because they are the primary migrants and therefore are empowered to some degree to make decisions about their lives.

Studies Using Structuration Theory

Giddens suggests two methodological approaches for using structuration theory in practice: “strategic conduct analysis” to examine the agents and “institutional analysis” to examine the structures (Giddens, 1984, p. 288) but this does not mean that they are completely separable (Goss & Lindquist, 1995; St-Pierre, Reinharz, & Gauthier, 2006). However, in practice, empirical use of structuration theory tends to separate these approaches to focus on either structures or individuals. Structuration theory has been used in both qualitative and quantitative studies in a wide range of fields, including urban

planning, migration, health/healthcare, and the adoption of technology. The majority of these studies examine how structural properties constrain and enable individuals rather than on how individuals choose to use (or not use) the rules and resources available. They also focus on the potential for policy change. This section will review the migration and healthcare studies that have used structuration theory because of their applicability to the proposed research. Research performed in other countries will be incorporated because structuration theory has not been used frequently in the United States in these fields.

Immigration studies employing structuration theory vary in scope, population and issues studied. Some focus on refugees (Healey, 2006; Korac, 2003; Lamba, 2003) while others focus on voluntary migrants (Benítez, 2006; Masso, 2009). Some focus on immigrants' experiences in general (Healey, 2006; Korac, 2003), while others look at their experiences finding work (Lamba, 2003) or using communication technology (Benítez, 2006). In general, these studies tend to employ qualitative methods interviewing immigrants. Structuration theory is used to inform their analyses, and at issue is the constraining/enabling of agency by rules and resources. All of the studies conclude that immigrants need more support at the national policy level.

The findings from immigration studies have implications for this study. The ability to understand and manage the rules in a new country affects immigrants' ontological security, increasing it if experiences are positive and decreasing it if they are negative (Healey, 2006; Korac, 2003). Individual coping strategies at both the level of practical consciousness (for example turning towards religion) and discursive consciousness (for example actively seeking education) can increase ontological security when immigrants lack structural resources to manage rules (Healey, 2006; Korac, 2003).

Rules of domination and legitimation in the form of discrimination and recognition of credentials pose the most difficult challenges for immigrants (Healey, 2006; Korac, 2003; Lamba, 2003). Social networks are of debatable aid for coping with rules because rules corresponding to social structures in the country of origin may be reproduced in the destination country in ways that inhibit immigrants' coping (Benítez, 2006; Lamba, 2003).

Studies using structuration theory in the healthcare context focus on the impact of the structure (usually the hospital) on providers' behavior (Beringer, Fletcher, & Taket, 2006; Geneau, Lehoux, Pineault, & Lamarche, 2008; Hyde & Brady, 2002; Lehoux, Sicotte, Denis, Berg, & Lacroix, 2002). These studies also tend to be qualitative. Two studies found the search for ontological security shapes physicians' practice as they seek to decrease uncertainty in their daily interactions with patients (Geneau et al., 2008; Lehoux et al., 2002). The two studies that included nurses found that although the hospital environment is highly structured, rules regarding the nurse's position in patient care coordination (Beringer et al., 2006) or clinical teaching of nursing students (Hyde & Brady, 2002) needed to be more explicit to avoid role confusion. Creating opportunities for targeted discussion about rules and resources brings them to a discursive level, where solutions can be found to improve patient care.

From these studies it is evident that an individual's ability to understand rules and access personal or structural resources will affect his or her ontological security and thus the action he or she takes. This research focuses on nurses as agents to examine their actions and how rules and resources direct their actions around staying in their jobs, participation in hospital/unit governance, and the pursuit of further education in nursing.

By comparing US RNs and IENs, the research will focus on how agency may differ depending on where nurses are from, their experiences, and their understandings of the rules and recourses around them.

Significance

IENs exemplify the growing migration trend of skilled women. They are able to migrate legally because of both structural factors and their own ability to exercise agency. The macro-level political, economic and cultural factors in combination with personal factors, acculturation experiences, and job satisfaction are all part of a much larger phenomenon that reflects issues of structural power and individual agency. Therefore, attempts to describe this population or find “solutions” to international nurses migration will inevitably be insufficient because they fail to take into account the impact of these factors on individual empowerment.

This study attempts to understand what happens to IENs when they transition to life in the United States, especially to professional nursing in U.S. hospitals. The study compares IENs and US RNs in terms of their experiences in the practice environment and their understandings of hospital rules and resources as they relate to nurses' decisions to participate in hospital/unit governance and pursue further education, as well as their plans for the future. The information obtained will help us gain an understanding of how IENs, as nurses educated and trained outside the United States, fit in with the expectations of U.S. nursing, especially in terms of providing quality patient care. It will also help us identify where similarities and differences may lie, and what these may mean to nursing and patient care in the United States.

Methods

Research Design

This study seeks to broaden our understanding about IENs' experiences in order to explore nurses' perceptions of their ability to exercise agency after transitioning to nursing in the United States. Further, this research examines how nurses' perceptions of their ability to exercise agency affect their ability to provide quality care and their plans for the future, particularly their plans to stay in their jobs. This study employed in-depth interviews in a nested research design. First, 82 nurses were recruited for brief structured interviews: 41 nurses from each of two hospitals. In each hospital, 21 of the 41 nurses consisted of IENs, and the other 20 consisted of U.S. nurses in order to provide a basis for comparison to determine which factors are specific to IENs. Subsequently, 40 nurses were chosen (20 from each hospital: 9 US RNs and 11 IENs) for more in-depth, semi-structured interviews. This research design allowed the researcher to obtain broad data and then concentrate and deepen the data as she intensified her focus.

Qualitative methods are appropriate for this study because they are often used to “validate, explain, illuminate, or reinterpret *quantitative data*” (Miles & Huberman, 1994). Factors involved in international, high-skilled migration, especially of nurses, have been studied primarily using demographic statistics and surveys, but few studies have employed qualitative methods. The individual who migrates is influenced by a wide range of factors at both the micro level (personal and professional factors), and the macro level (national and international factors) (de Haan, 1999; Pedraza, 1991). These factors and the experiences of the IEN in the destination country directly impact the nurse's future plans and ability to provide quality care. Qualitative methods are suited to examining the wide range of experiences of IENs. The qualitative data will provide a

better understanding of the quantitative data that are being relied upon to make national and international policy decisions about nurse migration.

Research Setting and Sample

This research was conducted in Atlanta, Georgia. Atlanta is the second largest metropolitan area in the southeast (behind Miami). It has experienced tremendous population growth in the last two decades, including its immigrant population. This has had an impact on the healthcare system, requiring expanded capacity for a larger and more diverse patient population while health care facilities face a nursing shortage. The history of segregation in Atlanta still affects race relations and access to services. Health care services demonstrate this continued informal segregation since those without health insurance tend to be non-white and therefore have decreased access to quality care (National Research Council, 2003). To ameliorate these problems, some Atlanta area hospitals have expanded recruitment efforts overseas, increasing the pool of IENs in the area. Yet IENs are informally segregated as well because they tend to work where U.S. (white) nurses will not: in facilities with fewer resources in terms of both personnel and finances.

Two hospitals, Emory University Hospital (EUH) and Grady Memorial Hospital (Grady), were selected for this research because of their location (within five miles of downtown Atlanta) and the patient population they serve. Preliminary anecdotal accounts suggested that working conditions and morale are different in these facilities. EUH is a 579-bed, private, high-end tertiary care facility. Its patient population usually has health insurance. Grady is a 953-bed, publicly funded hospital that primarily treats the underserved. It is also important to note that Grady was a segregated hospital during the

first half of the 20th century. Anecdotally, Grady is a less desirable place to work for U.S. nurses because of its lower prestige, patient population, and reliance on public funding. Therefore it may employ a higher number of international nurses whose experiences may be different from those working at EUH.

Female nurses were chosen as the population for this study for three equally important reasons. First, the social science literature holds that gender is a significant differentiating factor in society. Specifically, the reasons for migration and the experiences of female migrants are different from those of male migrants (Chant & Radcliffe, 1992; Iredale, 2005; Momsen, 1992; Pedraza, 1991). Second, the migration of professional women, like registered nurses, is understudied. Third, nursing is a female-dominated profession in most countries. As a consequence, the majority of IENs are female. One survey in 2008 determined that 92.2% of IENs in the United States are female (Xu et al., 2010).

The 82 nurses for this study were drawn from both night and day shifts. The cultures of these shifts are considered to be different, thus the nurses who choose to work each shift may have different perspectives and experiences. For example, the night shift is typically considered a stressful shift because at night staff levels are lower. Yet at the same time less interaction is required of nurses (especially with patients' families and other healthcare providers) during this shift. IENs may be assigned to this shift because U.S. nurses are less willing to work at these hours (Pittman, Folsom, et al., 2007). However, some nurses choose this shift because it provides higher remuneration. Some prefer the day shift because it coincides with the schedules of family members and allows for maximum professional and social interactions. In this study, approximately 40% of

IENs and 32.5% of US RNs worked at night. They chose to do so because of child care needs or because they considered themselves “night people”. There was no appreciable difference between perspectives of night and day shift nurses regarding education, governance, or their plans for the future.

One of the goals of the study was to explore the impact of agency on the ability to provide quality patient care. Therefore the participants had to have experience working at the bedside providing direct patient care, not in a laboratory or a specialized department caring for patients briefly, such as the operating room. According to secondary data analyses, most IENs work in medical-surgical units or intensive care units, but in this study they were recruited from other units as well. Since this was an exploratory study, it was appropriate to recruit participants from a variety of practice milieus.

There are four samples of nurses; two samples from each hospital. Two samples of 21 from each hospital consist of nurses who were born and received their initial nursing training (leading to nursing licensure) plus at least one year of practice in other countries. In addition, IEN participants practiced hospital bedside nursing in the United States for at least one year so that they have had enough experience to compare nursing practice in the United States with that in their home countries.

The other two samples, 20 from each hospital, consist of nurses born and trained in the United States. They too completed at least one year of practice at the bedside in hospitals in order to have enough experience to provide appropriate perspective on their work as nurses. They also were registered nurses like their international counterparts. These nurses provide a baseline to which the IENs can be compared. Interviewing these nurses helped differentiate what is specific to IENs and what is perhaps more

characteristic of the nursing profession in general. U.S. participants were matched, as much as is possible, to the IENs based on the parameters of the type of unit where they work and years of experience. Once the IEN was chosen, convenience sampling was used to identify a U.S. nurse for interviewing.

Recruitment

Purposive sampling was used to find IEN participants from different backgrounds who provide a range of experiences (Creswell, 2003; Schreiber & Stern, 2001). This was achieved by chain-referral sampling in which the researcher asked initial participants for referrals to others who fill the inclusion criteria and would be willing to participate (Bernard, 2006; Lofland, Snow, Anderson, & Lofland, 2006). This kind of sampling is used for populations that are hard to find and small in number (Bernard, 2006), and should ensure that participants meet the inclusion criteria (Lofland et al., 2006). The researcher also posted recruitment materials in areas of the hospitals that are frequented by nurses (e.g. break rooms and locker rooms). Nurses were selected for the more in-depth interviews according to their willingness to participate and meeting the goal of obtaining the widest variety of experiences. Because there was less variation among US RNs, slightly more IENs were selected to participate in this phase (e.g. 9 US RNs and 11 IENs, for a total of twenty per hospital) (see Table 1). In qualitative research the sample size is driven by saturation, meaning participants are recruited until interviews provide no further new information regarding the research themes (Charmaz, 2006). Eighty-two participants is a reasonable target given that many studies reach saturation with smaller samples.

Table 1

Sample of Participants

Brief Interviews		In-depth Interviews	
Grady	21 IENs 20 US RNs	11 IENs 9 US RNs	20 total
EUH	21 IENs 20 US RNs	11 IENs 9 US RNs	20 total

Data collection

Prior to all data collection, approval was obtained from Emory University's investigational review board (IRB), which governs human subjects' protection in research for both hospitals. This ensured appropriate consent forms were developed to protect the participants.

Semi-structured interview schedules guided both the initial and the in-depth interviews (see Appendices B and C; note that this is a comprehensive list of potential questions, not all were necessarily asked and in many cases they were altered). The initial interviews were designed to obtain baseline data and guide selection of participants for the in-depth interviews. The researcher asked both IENs and U.S. nurses questions focusing on how they chose nursing and their current place of employment, concrete descriptions of their initial work experiences and how they compared to their expectations, factors that make nursing enjoyable, factors that make nursing unpleasant, if the nurse plans to stay, and if not, then what the nurse's future plans are. The researcher asked IENs additional questions regarding their migration process and initial experiences as nurses in the United States. Initial interviews lasted anywhere from 15 to 60 minutes.

Questions in the in-depth interviews elicited concrete examples to clarify and expand upon themes from the initial interviews while obtaining more information about the nurse herself. The goal was to obtain a deeper understanding of each nurse's situation by encouraging the participant to respond freely, with minimal influence by the interviewer (Bernard, 2006; Weiss, 1994). The researcher also sought information illuminating the relationship between these themes and their ability to provide quality patient care. At the end of each interview, participants had the opportunity to ask questions of the researcher. In-depth interviews lasted anywhere from 30 to 120 minutes.

As previously mentioned, structuration theory holds that by bringing issues to the discursive level through discussion, the opportunity for changes can be made. Initially, the semi-structured interview questions were chosen based on issues raised in the literature and may have prompted participants to reflect on experiences in ways they had not previously done. As interviews progressed, the recursive nature of the data analysis and data collection meant that questions changed as the researcher obtained more information. This process may have caused participants to focus on issues on a discursive level.

All interviews were recorded using a digital voice recorder. They were conducted wherever it was most convenient for the participants, which was usually on the unit in a conference room or break room, although some of the second interviews were held in participants' homes or neutral places (like a coffee shop). Participants were given a small incentive (in the form of a gift card) upon completion of the second interview in appreciation of their time. Field notes were taken immediately following each interview, recording the researcher's general impressions, potential revisions to the interview guide,

and new questions or concepts that arose. Both structured and semi-structured interview guides were pilot tested with two US RNs and two IENs to verify that appropriate information would be obtained.

Confidentiality

The recordings of the interviews were uploaded onto a password-protected computer server. The interviews were transcribed by professional transcriptionists and checked by the researcher for accuracy. All transcripts were edited to remove any personal identifiers or altered such that the identity of the participant remained confidential. The participants were assigned a code to identify all data.

Data Analysis

Data analysis followed the constant comparative method. The constant comparative method is systematic, using three different and interrelated modes of coding: open coding, axial coding and selective coding (Creswell, 1998). Interviews and field notes were openly coded using concrete, descriptive codes in order to create an inventory of the data. In the next iteration of the process, new interviews were conducted and open codes from prior interviews were modified. New codes were added and existing codes were altered or deleted. Axial coding of prior interviews occurred simultaneously as new interviews were conducted. In axial coding, the researcher examined the open codes, looking for relationships and themes. This process of interviewing, open coding and axial coding continued throughout the research process. Finally, the researcher employed selective coding to draw conclusions from the data about what has been discovered (Creswell, 1998). Selective coding was performed looking at all sources of data, comparing and contrasting codes in search of major themes and issues.

The following four sections of this paper are manuscripts written for submission to professional journals. The first reports general findings from the study. It provides an overview of the characteristics of the participants and the general results of the study, including a focus on the study's first aim: nurse retention. The second manuscript presents findings about nurses' education, which is part of the study's third aim. It includes a description of nurses' educational attainment levels and future plans as well as nurses' thoughts about them. The third manuscript addresses the other part of the study's third aim: nurses' participation in hospital governance. It also examines their pursuit of promotions in the hospital. The fourth manuscript discusses a fourth theme related to nurses' agency that arose from the data: discrimination faced by nurses and their coping strategies. The paper ends with a concluding section that discusses the study as a whole.

References

- Ahmad, O. B. (2004). Brain drain: the flight of human capital. *Bull World Health Organ*, 82(10), 797-798.
- Ahmad, O. B. (2005). Managing medical migration from poor countries. *British Medical Journal*, 331(7507), 43-45. doi: 10.1136/bmj.332.7507.43
- Aiken, L. H. (2007). US nurse labor market dynamics are key to global nurse sufficiency. *Health Services Research*, 42(3 Pt 2), 1299-1320. doi: 10.1111/j.1475-6773.2007.00714.x
- Aiken, L. H. (2008). Economics of nursing. *Policy, Politics & Nursing Practice*, 9(2), 73-79.
- Aiken, L. H., Buchan, J., Sochalski, J., Nichols, B., & Powell, M. (2004). Trends in international nurse migration. *Health Affairs (Millwood)*, 23(3), 69-77. doi: 10.1377/hlthaff.23.3.69
- Aiken, L. H., Cimiotti, J. P., Sloane, D. M., Smith, H. L., Flynn, L., & Neff, D. F. (2011). Effects of nurse staffing and nurse education on patient deaths in hospitals with different nurse work environments. *Medical Care*, 49(12), 1047-1053.
- Aiken, L. H., Clarke, S. P., Cheung, R. B., Sloane, D. M., & Silber, J. H. (2003). Educational Levels of Hospital Nurses and Surgical Patient Mortality. *JAMA*, 290(12), 1617-1623. doi: doi:10.1001/jama.290.12.1617
- Aiken, L. H., Clarke, S. P., Sloane, D. M., Lake, E. T., & Cheney, T. (2008). Effects of Hospital Care Environment on Patient Mortality and Nurse Outcomes. *Journal of Nursing Administration*, 38(5), 223-229. doi: DOI: 10.1097/01.NNA.0000312773.42352.d7

- Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J. A., Busse, R., Clarke, H., . . . Shamian, J. (2001). Nurses' reports on hospital care in five countries. *Health Affairs (Millwood)*, 20(3), 43-53.
- Aiken, L. H., Sochalski, J., & Lake, E. T. (1997). Studying Outcomes of Organizational Change in Health Services. *Medical Care*, 35(11), NS6-NS18.
- Allen, H., & Larsen, J. A. (2003). "We need respect": experiences of internationally recruited nurses in the UK. Surrey: European Institute of Health and Medical Sciences.
- American Nurses Credentialing Center. (2012). Announcing a new model for ANCC's Magnet Recognition Program Retrieved January 10, 2012, from <http://www.nursecredentialing.org/MagnetModel.aspx>
- Anderson, B. A., & Isaacs, A. A. (2007). Simply not there: the impact of international migration of nurses and midwives--perspectives from Guyana. *J Midwifery Womens Health*, 52(4), 392-397. doi: 10.1016/j.jmwh.2007.02.021
- Arends-Kuenning, M. (2006). The balance of care: Trends in the wages and employment of immigrant nurses in the US between 1990 and 2000. *Globalizations*, 3(3), 333-348. doi: 10.1080/14747730600870100
- Armstrong, K., Laschinger, H. K. S., & Wong, C. (2009). Workplace Empowerment and Magnet Hospital Characteristics as Predictors of Patient Safety Climate. . *Journal of Nursing Care Quality*, 24(1), 55-62.
- Baernholdt, M., & Mark, B. A. (2009). The nurse work environment, job satisfaction and turnover rates in rural and urban nursing units. *Journal of Nursing Management*, 17, 994-1001.

- Beechinor, L. A., & Fitzpatrick, J. J. (2008). Demands of immigration among nurses from Canada and the Philippines. [Journal Article]. *International Journal of Nursing Practice, 14*(2), 178-187.
- Benítez, J. L. (2006). Transnational dimensions of the digital divide among Salvadoran immigrants in the Washington DC metropolitan area. *Global Networks, 6*(2), 181-199.
- Beringer, A. J., Fletcher, M. E., & Taket, A. R. (2006). Rules and resources: a structuration approach to understanding the coordination of children's inpatient health care. *Journal of Advanced Nursing, 56*(3), 325-335. doi: 10.1111/j.1365-2648.2006.04023.x
- Bernard, H. R. (2006). *Research Methods in Anthropology: Qualitative and Quantitative Approaches* (4 ed.). Oxford: AltaMira Press.
- Black, L., Spetz, J., & Harrington, C. (2010). Nurses Who Do Not Nurse: Factors That Predict Non-Nursing Work in the U.S. Registered Nursing Labor Market. *Nursing Economic\$, 28*(4), 245-254.
- Booth, B. E. (2011). Alarming rise of new graduate nurse attrition. *Journal of Practical Nursing, 61*(1), 3-5.
- Brush, B. L. (2008). Global nurse migration today. *J Nurs Scholarsh, 40*(1), 20-25.
- Brush, B. L., & Berger, A. M. (2002). Sending for nurses: Foreign nurse migration, 1965-2002. *Nursing and Health Policy Review, 1*(2), 103-115.
- Brush, B. L., Sochalski, J., & Berger, A. M. (2004). Imported care: recruiting foreign nurses to U.S. health care facilities. *Health Aff (Millwood), 23*(3), 78-87. doi: 10.1377/hlthaff.23.3.78

- Brush, B. L., & Vasupuram, R. (2006). Nurses, nannies and caring work: importation, visibility and marketability. *Nursing Inquiry*, 13(3), 181-185.
- Buchan, J. (2001). Nurses moving across borders: 'brain drain' or freedom of movement? *Int Nurs Rev*, 48(2), 65-67. doi: 10.1046/j.1466-7657.2001.00073.x
- Buchan, J. (2006). The impact of global nursing migration on health services delivery. *Policy, Politics, & Nursing Practice*, 7(3 Suppl), 16S-25S.
- Buchan, J., Jobanputra, R., Gough, P., & Hutt, R. (2006). Internationally recruited nurses in London: a survey of career paths and plans. *Human Resources for Health*, 4(14). doi: 10.1186/1478-4491-4-14
- Buchan, J., Kingma, M., & Lorenzo, F. M. (2005). Issue Paper 5 International migration of nurses: trends and policy implications *The Global Nursing Review Initiative*. Geneva: International Council of Nurses.
- Buchan, J., Parkin, T., & Sochalski, J. (2003). International nurse mobility: Trends and policy implications. Geneva: World Health Organization.
- Buerhaus, P. I., Auerbach, D. I., & Stalger, D. O. (2009). The Recent Surge In Nurse Employment: Causes And Implications. [Article]. *Health Affairs*, 28(4), w657-w668.
- Buerhaus, P. I., Needleman, J., Mattke, S., & Stewart, M. (2002). Strengthening hospital nursing. *Health Affairs (Millwood)*, 21(5), 123-132.
- Buerhaus, P. I., Staiger, D. O., & Auerbach, D. I. (2003). Is the current shortage of hospital nurses ending? *Health Aff (Millwood)*, 22(6), 191-198.
- Campbell, S. (2006). Addressing nursing shortages in sub-Saharan Africa. *Nursing Standard*, 20(51), 46-50.

- Chant, S. (1992). Conclusion: towards a framework for the analysis of gender-selective migration. In S. Chant (Ed.), *Gender and Migration in Developing Countries* (pp. 197-206). New York: Bellhaven Press.
- Chant, S., & Radcliffe, S. A. (1992). Migration and development: the importance of gender. In S. Chant (Ed.), *Gender and Migration in Developing Countries* (pp. 1-29). New York: Bellhaven Press.
- Charmaz, K. (2006). *Constructing Grounded Theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage.
- Chikanda, A. (2005). Nurse migration from Zimbabwe: analysis of recent trends and impacts. *Nursing Inquiry*, 12(3), 162-174.
- Choo, V. (2003). Philippines losing its nurses, and now maybe its doctors. *Lancet*, 361(9366), 1356. doi: 10.1016/S0140-6736(03)13094-2
- Choy, C. C. (2003). *Empire of Care: Nursing and Migration in Filipino American History*. Durham, N.C.: Duke University Press.
- Coleman, E. A., Coon, S. K., Lockhart, K., Kennedy, R. L., Montgomery, R., Copeland, N., . . . Stewart, C. (2009). Effect of Certification in Oncology Nursing on Nursing-Sensitive Outcomes. [Article]. *Clinical Journal of Oncology Nursing*, 13(2), 165-172.
- Connell, J., Zurn, P., Stilwell, B., Awases, M., & Braichet, J. M. (2007). Sub-Saharan Africa: beyond the health worker migration crisis? *Soc Sci Med*, 64(9), 1876-1891. doi: 10.1016/j.socscimed.2006.12.013
- Crawford, L. (2004). Nurses educated in other countries: coming to America. *JONA's Healthcare Law, Ethics & Regulation*, 6(3), 66-68.

- Creswell, J. W. (1998). *Qualitative Inquiry and Research Design: Choosing Among Five Traditions*. Thousand Oaks, CA: Sage Publications, Inc.
- Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (2 ed.). Thousand Oaks: Sage Publications, Inc.
- Cronenwett, L., Sherwood, G., Barnsteiner, J., Disch, J., Johnson, J., Mitchell, P., . . . Warren, J. (2007). Quality and safety education for nurses. *Nursing Outlook*, 55(3), 122-131.
- Davis, C. R., & Nichols, B. L. (2002). Foreign-Educated Nurses and the Changing U.S. Nursing Workforce. *Nursing Administration Quarterly*, 26(2), 43.
- de Haan, A. (1999). Livelihoods and Poverty: The Role of Migration--A Critical Review of the Migration Literature. *Journal of Development Studies*, 36(2), 1.
- Dicicco-Bloom, B. (2004). The Racial and Gendered Experiences of Immigrant Nurses from Kerala, India. *Journal of Transcultural Nursing*, 15(1), 26-33. doi: 10.1177/1043659603260029
- Dovlo, D. (2007). Migration of nurses from sub-Saharan Africa: a review of issues and challenges. *Health Serv Res*, 42(3 Pt 2), 1373-1388. doi: 10.1111/j.1475-6773.2007.00712.x
- Ea, E. E. (2007). Facilitating acculturation of foreign-educated nurses. *The Online Journal of Issues in Nursing*, 13(1).
- Ehrenreich, B., & Hochschild, A. R. (2002). *Global Woman: Nannies, Maids and Sex Workers in the New Economy*. New York: Henry Holt and Company.

- Ferrinho, P., Antunes, A. R., Silva, A. P., Dal Poz, M. R., & Gilles, D. (2007). The Portuguese contribution to the brain drain from Portuguese speaking African countries. *Cah Sociol Demogr Med*, 47(3), 377-391.
- Flynn, L., & Aiken, L. H. (2002). Does international nurse recruitment influence practice values in U.S. hospitals? *Journal of Nursing Scholarship*, First quarter, 67-73.
- Friese, C. R., Lake, E. T., Aiken, L. H., Silber, J. H., & Sochalski, J. (2008). Hospital Nurse Practice Environments and Outcomes for Surgical Oncology Patients. *Health Services Research*, 43(4), 1145-1162.
- Geneau, R., Lehoux, P., Pineault, R., & Lamarche, P. (2008). Understanding the work of general practitioners: a social science perspective on the context of medical decision making in primary care. *BMC Family Practice*, 9(1), 12.
- George, S. M. (2005). *When Women Come First: Gender and Class in Transnational Migration*. Berkeley: University of California Press.
- Giddens, A. (1984). *The Constitution of Society: Outline of the Theory of Structuration*. Berkeley: University of California Press.
- Goodin, H. J. (2003). The nursing shortage in the United States of America: an integrative review of the literature. *Journal of Advanced Nursing*, 43(4), 335-350.
- Goss, J., & Lindquist, B. (1995). Conceptualizing International Labor Migration: A Structuration Perspective. *International Migration Review*, 29(2), 317-351.
- Greener, I. A. N. (2008). Expert Patients and Human Agency: Long-term Conditions and Giddens' Structuration Theory. *Social Theory & Health*, 6(4), 273-290.
- Gregson, N. (1987). Structuration theory: some thoughts on the possibilities for empirical research. *Environment and Planning D: Society and Space*, 5, 73-91.

- Gross, J. M., Rogers, M. F., Teplinskiy, I., Oywer, E. O., Wambua, D., Kamenju, A., . . .
 Waudu, A. N. (2011). The impact of out-migration on the nursing workforce in
 Kenya. *Health Services Research, 46*(4), 1300-1318. doi: 10.1111/j.1475-
 6773.2011.01251.x
- Gullatte, M. M., & Jirasakhiran, E. Q. (2005). Retention and recruitment: reversing the
 order... From *Nursing Management: Principles and Practice* (pp. 217-233), edited
 by Mary Magee Gullatte, RN, MN, ANP, AOCN, FAAMA, 2005, Pittsburgh, PA:
 Oncology Nursing Society. Reprinted with permission. *Clinical Journal of
 Oncology Nursing, 9*(5), 597-604.
- Gustafson, D. L. (2005). Transcultural nursing theory from a critical cultural perspective.
Advances in nursing science, 28(1), 2-16.
- Hanks, R. G. (2008). The lived experience of nursing advocacy. *Nursing Ethics, 15*(4),
 468-477.
- Hardcastle, M. R., Usher, K. J., & Holmes, C. A. (2005). An overview of structuration
 theory and its usefulness for nursing research. *Nursing Philosophy, 6*, 223-234.
- Hardill, I., & MacDonald, S. (2000). Skilled International Migration: The Experience of
 Nurses in the UK. *Regional Studies, 34*(7), 681-692.
- Hawthorne, L. (2001). The globalisation of the nursing workforce: barriers confronting
 overseas qualified nurses in Australia. *Nursing Inquiry, 8*(4), 213-229.
- Healey, R. L. (2006). Asylum-Seekers and Refugees: A Structuration Theory Analysis of
 their Experiences in the UK. *Population Space & Place, 12*(4), 257-271.
- Hine, D. C. (1989). *Black Women in White: Racial Conflict and Cooperation in the
 Nursing Profession, 1890-1950*. Bloomington: Indiana University Press.

- Hyde, A., & Brady, D. (2002). Staff nurses' perceptions of supernumerary status compared with rostered service for Diploma in Nursing students. *Journal of Advanced Nursing, 38*(6), 624-632.
- Institute of Medicine. (2003). Keeping patients safe: Transforming the work environment of nurses. In T. N. A. Press (Ed.). Washington, D.C.: Institute of Medicine.
- Institute of Medicine. (2004). In the nation's compelling interest: Ensuring diversity in the health care workforce. In T. N. A. Press (Ed.). Washington, D.C.: Institute of Medicine.
- Iredale, R. (2005). Gender, immigration policies and accreditation: valuing the skills of professional women migrants. *Geoforum, 36*(2), 155-166.
- Jones, C. B. (2008). Revisiting nurse turnover costs: Adjusting for inflation. *Journal of Nursing Administration, 38*(1), 11-18. doi: 10.1097/01.NNA.0000295636.03216.6f
- Jose, M. M. (2010). Lived experiences of internationally educated nurses in hospitals in the United States of *International Nursing Review, 58*, 123-129.
- Kaspersen, L. B. (2000). *Anthony Giddens: An introduction to a social theorist* (S. Sampson, Trans.). Malden, MA: Blackwell Publishers Inc.
- Kawi, J., & Xu, Y. (2009). Facilitators and barriers to adjustment of international nurses: an integrative review. *International Nursing Review, 56*(2), 174-183. doi: 10.1111/j.1466-7657.2008.00705.x
- Kendall-Gallagher, D., Aiken, L. H., Sloane, D. M., & Cimiotti, J. P. (2011). Nurse Specialty Certification, Inpatient Mortality, and Failure to Rescue. *Journal of Nursing Scholarship, 42*(2), 188-194.

- Kingma, M. (2006). *Nurses on the Move: Migration and the Global Health Care Economy*. Ithaca: ILR Press.
- Kingma, M. (2007). Nurses on the move: a global overview. *Health Services Research*, 42(3 Pt 2), 1281-1298. doi: 10.1111/j.1475-6773.2007.00711.x
- Kingma, M. (2008). Nurses on the move: Historical perspective and current issues. *Online Journal of Issues in Nursing*, 13(2).
- Kline, D. S. (2003). Push and pull factors in international nurse migration. *Journal of Nursing Scholarship*, 35(2), 107-111.
- Korac, M. (2003). The Lack of Integration Policy and Experiences of Settlement: A Case Study of Refugees in Rome. *Journal of Refugee Studies*, 16(4), 398-421.
- Kramer, M., & Schmalenberg, C. E. (2003). Magnet hospital nurses describe control over nursing practice. *Western Journal of Nursing Research*, 25(4), 434-452.
- Kutney-Lee, A., & Aiken, L. H. (2008). Effect of nurse staffing and education on the outcomes of surgical patients with comorbid serious mental illness. *Psychiatric Services*, 59(12), 1466-1469.
- Lake, E. T. (2002). Development of the practice environment scale of the Nursing Work Index. *Research in Nursing and Health*, 25(3), 176-188.
- Lamba, N. K. (2003). The Employment Experiences of Canadian Refugees: Measuring the Impact of Human Social Capital on Quality of Employment*. *Canadian Review of Sociology & Anthropology*, 40(1), 45-64.
- Laschinger, H. K. S., Almost, J., & Tuer-Hodes, D. (2003). Workplace Empowerment and Magnet Hospital Characteristics: Making the Link. [Article]. *Journal of Nursing Administration*, 33(7), 410-422.

- Lee, E. S. (1966). A Theory of Migration. *Demography*, 3(1), 47-57.
- Lehoux, P., Sicotte, C., Denis, J. L., Berg, M., & Lacroix, A. (2002). The theory of use behind telemedicine: : how compatible with physicians' clinical routines? *Social Science & Medicine*, 54(6), 889-904.
- Likupe, G. (2006). Experiences of African nurses in the UK National Health Service: a literature review. *Journal of Clinical Nursing*, 15(10), 1213-1220.
- Liou, S., & Grobe, S. (2008). Perception of Practice Environment, Organizational Commitment, and Intention to Leave Among Asian Nurses Working in U.S. Hospitals. *Journal for Nurses in Staff Development*, 24(6), 276-282. doi: 10.1097/01.NND.0000342235.12871.ba
- Lofland, J., Snow, D., Anderson, L., & Lofland, L. H. (2006). *Analyzing social settings: A guide to qualitative observation and analysis* (4 ed.). Belmont: Wadsworth Thompson Learning.
- Lowell, B. L., & Gerova, S. G. (2004). Immigrants and the Healthcare Workforce: Profiles and Shortages. *Work and Occupations*, 31(4), 474-498. doi: 10.1177/0730888404268916
- MacKusick, C. I., & Minick, P. (2010). Why are nurses leaving? Findings from an initial qualitative study on nursing attrition. *Medsurg Nursing*, 19(6), 335-340.
- Magnusdottir, H. (2005). Overcoming strangeness and communication barriers: a phenomenological study of becoming a foreign nurse. *International Nursing Review*, 52(4), 263-269.
- Maier-Lorentz, M. M. (2008). Transcultural nursing: its importance in nursing practice. *Journal of Cultural Diversity*, 15(1), 37-43.

- Malvarez, S., & Castrillon Agudelo, M. C. (2005). Overview of the nursing workforce in Latin America *The Global Nursing Review Initiative*. Washington, D.C.: Pan American Health Organization.
- Martineau, T., Decker, K., & Bundred, P. (2004). "Brain drain" of health professionals: from rhetoric to responsible action. *Health Policy*, 70(1), 1-10. doi: 10.1016/j.healthpol.2005.04.012
- Massey, D. S., Arango, J., Hugo, G., Kouaouci, A., Pellegrino, A., & Taylor, J. E. (1994). An evaluation of international migration: The North American case. *Population and Development Review*, 20(4), 699-751.
- Masso, A. (2009). A Readiness to Accept Immigrants in Europe? Individual and Country-Level Characteristics. *Journal of Ethnic & Migration Studies*, 35(2), 251-270.
- Matiti, M. R., & Taylor, D. (2005). The cultural lived experience of interationally recruited nurses: a phenomenological study. *Diversity in Health and Social Care*, 2, 7-15.
- Miles, M. B., & Huberman, A. M. (1994). *An expanded sourcebook: Qualitative data analysis* (2 ed.). Thousand Oaks: Sage Publications.
- Momsen, J. H. (1992). Gender selectivity in Caribbean migration. In S. Chant (Ed.), *Gender and Migration in Developing Countries* (pp. 73-90). New York: Bellhaven Press.
- Mrayyan, M. T. (2009). Differences of hospitals' organisational climates and nurses' intent to stay: Nurses' perspectives. *Journal of Research in Nursing*, 14(5), 465-477.

- National Research Council. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, D.C.: The National Academies Press.
- Needleman, J., Buerhaus, P., Mattke, S., Stewart, M., & Zelevinsky, K. (2002). Nurse-staffing levels and the quality of care in hospitals. *N Engl J Med*, *346*(22), 1715-1722.
- Needleman, J., Buerhaus, P. I., Stewart, M., Zelevinsky, K., & Mattke, S. (2006). Nurse Staffing In Hospitals: Is There A Business Case For Quality? [Article]. *Health Affairs*, *25*(1), 204-211. doi: 10.3777/hlthaff.25.1.204
- Ogden, D., & Rose, R. A. (2005). Using Giddens's Structuration Theory to Examine the Waning Participation of African Americans in Baseball. *Journal of Black Studies*, *35*(4), 225-245. doi: 10.1177/0021934704266091
- Omeri, A., & Atkins, K. (2002). Lived experiences of immigrant nurses in New South Wales, Australia: searching for meaning. *International Journal of Nursing Studies*, *39*(5), 495-505.
- Parrenas, R. S. (2001). *Servants of Globalization: Women, Migration and Domestic Work*. Palo Alto, CA: Stanford University Press.
- Pearson, A., & Peels, S. (2001). A global view of nursing in the new millennium. Part 5: problems faced by nurses. *Int J Nurs Pract*, *7*(5), S21-25.
- Pedraza, S. (1991). Women and Migration: The social consequences of gender. *Annual Review of Sociology*, *17*, 303-325.
- Pellegrino, A. (2002). Skilled Labour Migration from Developing Countries: Study on Argentina and Uruguay. In I. M. Programme (Ed.), *International Migration Papers*. Geneva: International Labour Office.

- Pittman, P., Aiken, L. H., & Buchan, J. (2007). International migration of nurses: introduction. *Health Serv Res, 42*(3 Pt 2), 1275-1280. doi: 10.1111/j.1475-6773.2007.00713.x
- Pittman, P., Folsom, A., Bass, E., & Leonhardy, K. (2007). U.S.-Based international nurse recruitment: Structure and practices of a burgeoning industry. Washington, DC: AcademyHealth.
- Polsky, D., Ross, S. J., Brush, B. L., & Sochalski, J. (2007). Trends in characteristics and country of origin among foreign-trained nurses in the United States, 1990 and 2000. *American Journal of Public Health, 97*(5), 895-899. doi: 10.2105/AJPH.2005.072330
- Ridley, J., Wilson, B., Harwood, L., & Laschinger, H. K. (2009). Work environment, health outcomes and magnet hospital traits in the Canadian nephrology nursing scene. *The Canadian Association of Nephrology Nurses and Technologists Journal, 19*(1).
- Salmon, M. E., Yan, J., Hewitt, H., & Guisinger, V. (2007). Managed migration: the Caribbean approach to addressing nursing services capacity. *Health Serv Res, 42*(3 Pt 2), 1354-1372. doi: 10.1111/j.1475-6773.2007.00708.x
- Schreiber, R. S., & Stern, P. N. (Eds.). (2001). *Using Grounded Theory in Nursing*. New York: Springer Publishing Company.
- Schumacher, E. J. (2011). Foreign-born nurses in the US labor market. *Health Economics, 20*(3), 362-378. doi: 10.1002/hec.1595
- Sewell Jr, W. H. (1992). A Theory of Structure: Duality, Agency, and Transformation. *American Journal of Sociology, 98*(1), 1.

- Siantz, d. L. M. L., & Malvarez, S. (2008). Migration of nurses: A Latin American perspective. *Online Journal of Issues in Nursing, 13*(2).
- Singer, A. (2009). The New Geography of United States Immigration *Brookings Immigration Series* (Vol. 3, pp. 8). Washinton, D.C.: The Brookings Institute.
- Skees, J. (2010). Continuing education: a bridge to excellence in critical care nursing. *Critical Care Nursing Quarterly, 33*(2), 104-116. doi: 10.1097/CNQ.0b013e3181d913a1
- St-Pierre, M., Reinhartz, D., & Gauthier, J. (2006). Organizing the public health-clinical health interface: Theoretical bases. *Medicine, Health Care and Philosophy, 9*, 97-106. doi: 10.1007/s11019-005-3602-8
- Steinbrook, R. (2002). Nursing in the Crossfire. *N Engl J Med, 346*(22), 1757-1766. doi: 10.1056/nejm200205303462225
- Takase, M., Mause, P., & Manias, E. (2005). Explaining nurses' work behaviour from their perception of the environment and work values. *International Journal of Nursing Studies, 42*, 889-898. doi: 10.1016/j.ijnurstu.2004.12.008
- Timur, S. (2002). Changing Trends and Major Issues in International Migration: An Overview of UNESCO Programmes. *International Social Science Journal, 52*(165), 255-268.
- U.S. Department of Health and Human Services, H. R. a. S. A. (2010). The Registered Nurse Population: Initial Findings from the 2008 National Sample Survey of Registered Nurses.
- Van Eyck, K. (2004). Women and International Migration in the Health Sector: Public Services International.

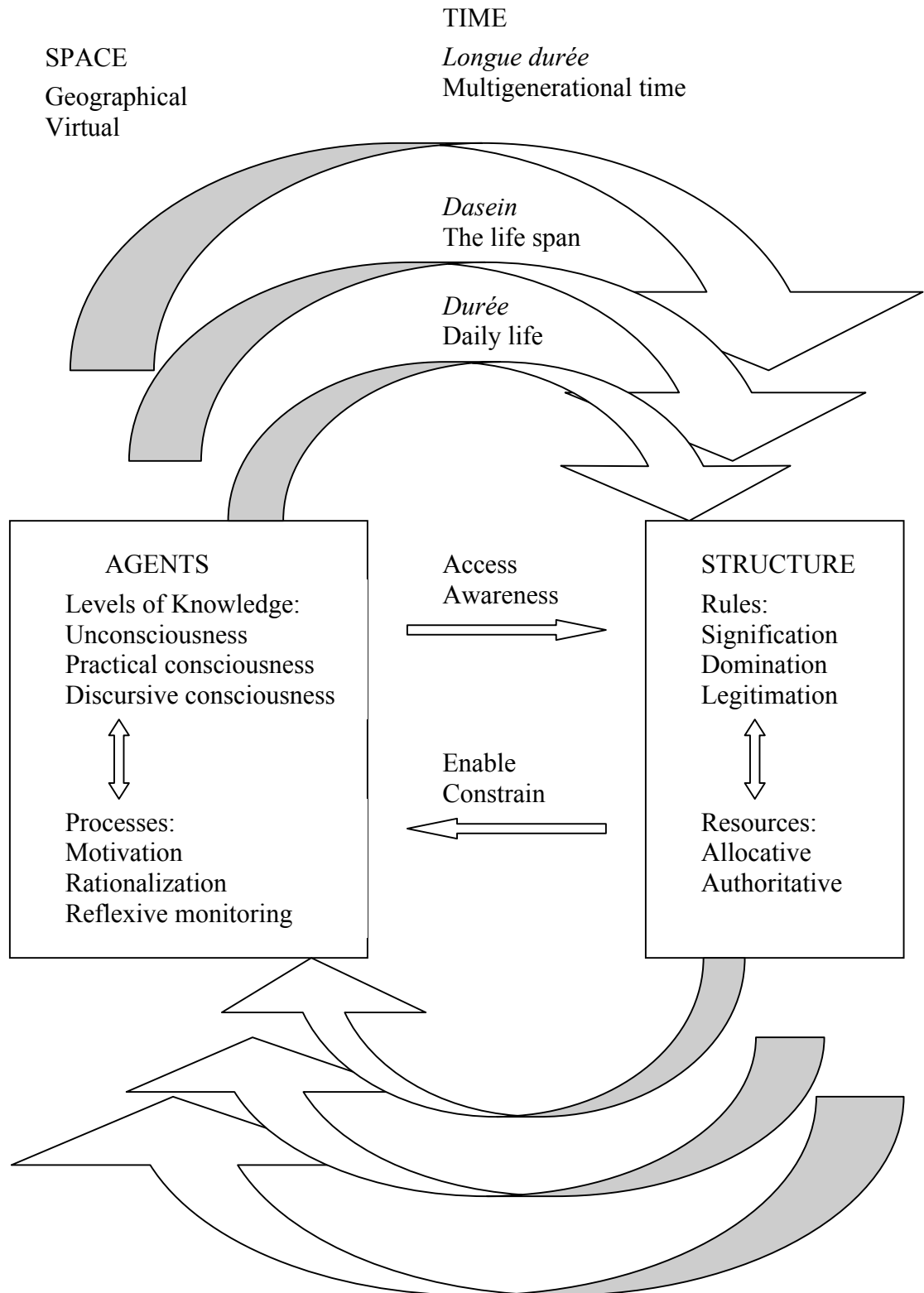
- Wade, C. H. (2009). Perceived effects of specialty nurse certification: a review of the literature. *AORN Journal*, 89(1), 183-192.
- Weiss, R. S. (1994). *Learning from Strangers: The art and method of qualitative interview studies*. New York: The Free Press.
- Welding, N. M. (2011). Creating a Nursing Residency: Decrease Turnover and Increase Clinical Competence. *Medsurg Nursing*, 20(1), 37-40.
- Wilson, D. W. (2003). Conceptualizing African American registered nurses as a vulnerable population. *Journal of Multicultural Nursing & Health (JMCNH)*, 9(1), 61-67.
- World Health Organization. (2005). *Migration of health personnel*. Paper presented at the Meeting of Ministers of Health for the Pacific Island Countries, Samoa.
- Xu, Y. (2007). Strangers in strange lands: A metasynthesis of lived experiences of immigrant Asian nurses working in Western countries. *Advances in nursing science*, 30(3), 246-265. doi: 10.1097/01.ANS.0000286623.84763.e0
- Xu, Y., & Kwak, C. (2005). Characteristics of internationally educated nurses in the United States. *Nursing Economics*, 23(5), 233-238.
- Xu, Y., & Kwak, C. (2006). International perspectives. Trended profile of internationally educated nurses in the United States: implications for the nurse shortage and beyond. *Journal of Nursing Administration*, 36(11), 522-525.
- Xu, Y., & Kwak, C. (2007). Comparative trend analysis of characteristics of internationally educated nurses and U.S. educated nurses in the United States. *International Nursing Review*, 54(1), 78-84.

Xu, Y., Zaikina-Montgomery, H., & Shen, J. J. (2010). Characteristics of internationally educated nurses in the United States: an update from the 2004 National Sample Survey of Registered Nurses. *Nursing Economic\$, 28*(1), 19.

Yi, M., & Jezewski, M. A. (2000). Korean nurses' adjustment to hospitals in the United States of America. *Journal of Advanced Nursing, 32*(3), 721-729.

Appendix A

Diagrammatic Interpretation of Structuration Theory



Appendix B

Brief, Structured Interview Guide

Questions for IENs

I. Demographic Questions

1. Name
2. Age
3. Degree(s) obtained in home country
4. Years of nursing experience in home country
5. Year left home country
6. Year started work at current hospital
7. Position(s) held in current hospital

II. Work-related questions

1. Why did you choose to become a nurse?
2. What were your expectations about nursing before you began working in your own country?
3. What were your expectations about nursing before you began working in the U.S.?
4. What do you enjoy about nursing in the U.S.?
5. What is the downside about nursing in the U.S.?
6. What are your future plans regarding nursing?

Questions for U.S. Nurses

I. Demographic Questions

1. Name

2. Age
3. Degree(s) obtained
4. Years of nursing experience
5. Year started work at current hospital
6. Position(s) held in current hospital

II. Work-related questions

1. Why did you choose to become a nurse?
2. What were your expectations about nursing before you began working?
3. What do you enjoy about nursing?
4. What is the downside about nursing?
5. What are your future plans regarding nursing?

Appendix C

In-Depth, Semi-Structured Interview Guide

Questions for IENs

I. Introductory question: Tell me briefly about your life here.

1. Your work
2. Your family
3. Your social life

II. Tell me about how you decided to leave your home.

1. When did you begin to consider leaving?
2. What made you want to leave?/Most important reasons for leaving?
 - a. What things connected with work?
 - b. What things connected with home?
 - c. Outside influence? (individual, agency...)
3. What made you want to stay home?/Most important reasons for staying?
 - a. What things connected with work?
 - b. What things connected with home?
4. Who helped you with the decision?
5. How did you feel about your job?

III. How did you decide where to go?

1. What were your options?
2. Did you have the job before you left or find it here?
3. Who helped you?
4. What did you know about your destination and the work?

5. How did you know it?

IV. Describe your initial experiences in the U.S.

1. What were your experiences at work like?

- a. Other nurses?
- b. Physicians?
- c. Patients?
- d. Work activities?
- e. Physical environment?

2. How did these experiences compare to your expectations?

- a. What was different?
- b. What was the same?

3. How did you come to have these expectations?

4. What has helped you provide quality patient care?

- a. Describe a situation in which you felt you provided quality care.
- b. What enabled you to do so?
- c. What would make it easier to provide quality care?

5. What has inhibited you from providing quality patient care?

- a. Describe a situation in which you felt you were unable to provide quality care.
- b. What inhibited you from doing so?
- c. What needs to change to enable you to provide quality care?

6. If you had to do it over, would you do it again?

- a. Why or why not?

7. What would you do differently?
- V. What are your plans for the future?
1. Regarding work?
 2. Regarding your education?
 3. Regarding where you want to live?
 4. Have your plans changed since you left your home country? Why?
 5. What would convince you to return home? To stay here?
- VI. Final questions.
1. Is there anything else I should ask?
 2. Is there anything else you'd like to add?
 3. Would it be ok if I contacted you with any questions or if I need clarification?

Questions for U.S. nurses

- I. Introductory question: Tell me briefly about your life.
1. Your work
 2. Your family
 3. Your social life
- II. How did you decide where to work?
1. How did you find the job?
 2. Who helped you?
 3. What did you know about your place of employment and the work?
 4. How did you know it?
- III. Describe your initial experiences in nursing.
1. What were your experiences at work like?

- a. Other nurses?
 - b. Physicians?
 - c. Patients?
 - d. Work activities?
 - e. Physical environment?
2. How did these experiences compare to your expectations?
 - a. What was different?
 - b. What was the same?
 3. How did you come to have these expectations?
 4. What has helped you provide quality patient care?
 - a. Describe a situation in which you felt you provided quality care.
 - b. What enabled you to do so?
 - c. What would make it easier to provide quality care?
 5. What has inhibited you from providing quality patient care?
 - a. Describe a situation in which you felt you were unable to provide quality care.
 - b. What inhibited you from doing so?
 - c. What needs to change to enable you to provide quality care?
 6. If you had to do it over, would you do it again?
 - a. Why or why not?
 7. What would you do differently?
- IV. What are your plans for the future?
1. Regarding work?

2. Regarding your education?
3. Regarding where you want to live?
4. Have your plans changed since you started nursing? Why?
5. What would convince you to leave nursing? To stay?

V. Final questions.

1. Is there anything else I should ask?
2. Is there anything else you'd like to add?
3. Would it be ok if I contacted you with any questions or if I need clarification?

Running Head: IENS' EXPERIENCES

Manuscript 1

Experiences of Internationally Educated Nurses:

A Qualitative Study in the Southeastern United States

Rebecca M. Wheeler

Emory University

Abstract

Aim: The aim of this study was to gain a deeper understanding about the experiences of internationally educated nurses (IENs) and how IENs differ from US RNs in two urban hospitals in the Southeastern United States.

Background: US healthcare facilities have addressed nursing shortages in part by recruiting IENs. In the United States, qualitative studies of IENs generally focus on small samples of IENs of specific nationalities while quantitative research relies on surveys that do not specifically target IENs. More research focused on IENs is needed, especially since studies suggest they may make up significant percentages of the nursing workforce in urban hospitals.

Methods: This study involved two rounds of semi-structured interviews of 82 IENs and US RNs. Interviews focused on themes relating to education, barriers to practice, intent to stay in nursing and IENs' migration experiences.

Findings and discussion: Most IENs interviewed for this study migrated independently to the United States after 1990 to join family and do not plan to return to their home countries to practice. Most IENs initially received ADN degrees and many have obtained their BSN in the United States. IENs faced challenges adjusting to the attitudes of US patients, the perceived lack of respect for nurses, and delivering total patient care.

Conclusions: IENs would benefit from orientation to help them with cultural differences, but in other ways they are similar to US RNs and hospital policies could target both groups.

Keywords: Internationally Educated Nurses, United States, Migration, Barriers, Qualitative Research

Introduction

International nurse migration to the United States increased in the last few decades due to the shortage of nurses and the need to maintain appropriate staffing to provide quality care. Internationally educated nurses (IENs) made up an estimated 13% of the newly-licensed nurses in the United States in 2008 (Schumacher, 2011). They tend to work in urban hospitals and have positions providing direct patient care (Aiken, 2007; Xu, Zaikina-Montgomery, & Shen, 2010), yet little is known about this group of nurses in the United States.

Background and significance

During the last few decades, higher-income countries like the United States experienced shortages of nurses that increased the number of IENs migrating from lower-income countries. Prior to the 2007 recession, predictions about the shortage of nurses in the United States ranged from 275,000 in 2010 (Aiken, Buchan, Sochalski, Nichols, & Powell, 2004) to 500,000 by 2015 (Ahmad, 2005) to 800,000 by 2020 (Brush, Sochalski, & Berger, 2004). These predictions have now been revised downward to 260,000 by 2025, yet this number is still double the size of any nursing shortage since the 1960s (Buerhaus, Auerbach, & Stalger, 2009) and migration is expected to continue.

There is much debate about the ethics of international nurse migration. Economic, political, social and professional “push” (influencing nurses to leave their countries) and “pull” factors (attracting them to other countries) (Ahmad, 2005; Buchan, 2006; Campbell, 2006; Chikanda, 2005; Connell, Zurn, Stilwell, Awases, & Braichet, 2007; Kline, 2003) influence nurses' decisions to migrate, but the nurses may be exploited in the process. Recruitment companies are key players in facilitating nurse migration.

Because recruitment companies are not regulated, nurses have been exploited by disreputable operations that misrepresent the job in the destination country or that take fees but never help the nurses leave their home countries (Kingma, 2006). Once in the United States, healthcare facilities may fail to prepare the IENs for their new lives, both professionally and personally, providing them with little or no support during their transition (Beechinor & Fitzpatrick, 2008; Yi & Jezewski, 2000). They may discriminate or fail to recognize IENs' credentials, giving them positions beneath their qualifications and experience, resulting in an inefficient use of skilled personnel (Chikanda, 2005; Connell et al., 2007; Martineau, Decker, & Bundred, 2004). The sense is that, given the global need for nurses, destination countries have a duty to protect IENs, ensuring not only that they are treated well, but also that they are able to maximize their professional potential.

In the United States, information about IENs comes from general surveys providing demographic information or small qualitative studies that describe the barriers IENs face in US hospitals. Survey data generally conclude that IENs (1) are older than nurses educated in the United States (US RNs) (2) are married, (3) were initially educated at the baccalaureate level, (4) have more years of work experience than US RNs, (5) work primarily in urban areas in hospitals as staff nurses in intensive care units (ICUs) or medical-surgical units (secondarily as staff nurses in long-term care facilities), and (6) work full time, more hours annually, and for more years than US RNs (Aiken, 2007; Brush, 2008; Buchan, Parkin, & Sochalski, 2003; Crawford, 2004; Xu & Kwak, 2005; Xu et al., 2010). There are no data for the number of IENs that are recruited by recruitment companies or directly by hospitals. Nor are there data about retention or

attrition rates for IENs. Survey findings show that the largest number of IENs migrating to the United States is from the Philippines. Other countries whose nurses are migrating in large numbers are India, Nigeria and China (Aiken, 2007; Brush, 2008). However, it is difficult to know specific numbers because information from surveys must be interpreted since none directly target IENs.

The three main barriers IENs face adjusting to nursing in the United States are; communication, exploitation, and isolation. Language differences interfere with communication as does body language, slang, and medical jargon even when the IEN speaks the national language fluently (Allen & Larsen, 2003; Hardill & MacDonald, 2000; Hawthorne, 2001; Jose, 2010; Kawi & Xu, 2009; Magnusdottir, 2005; Xu, 2007; Yi & Jezewski, 2000). Communication barriers can make IENs afraid to ask questions or express opinions, affecting teamwork and leading to confusion and misunderstandings (Ea, 2007). If IENs speak with strong accents it may create barriers with other healthcare workers and patients (Xu, 2007). IENs are exploited when they are asked to work undesirable shifts, more frequent shifts, or perform tasks that are not appropriate to their position of employment (Allen & Larsen, 2003; Diccico-Bloom, 2004; Likupe, 2006). Employers may hold their passports or green cards, or threaten to go to immigration in order to ensure IENs comply with work demands (Pittman, Folsom, Bass, & Leonhardy, 2007). They may delay payment to IENs or pay less than the IENs' US counterparts or not pay for all the hours worked (Pittman et al., 2007). Factors involved in the isolation IENs experience include: feeling cut off from one's culture (Dicicco-Bloom, 2004), feeling unaccepted and lacking support (Beechinor & Fitzpatrick, 2008), the lack of recognition of qualifications, the negative attitudes of co-workers and patients regarding

IENs' experiences and abilities (Hawthorne, 2001; Likupe, 2006), and racism and/or discrimination from co-workers or patients (Dicicco-Bloom, 2004; Likupe, 2006).

The primary objective of this exploratory qualitative study was to gain a deeper understanding about the experiences and perspectives of IENs in a Southeastern urban center and compare them to those of their US colleagues (US RNs). Since there are no local or regional data about IENs, it is important to understand their migration experiences, barriers they face(d) adjusting to US nursing, and their future plans regarding nursing and staying in the United States.

Methods

This study employed two phases of interviews. First, 82 female registered nurses were recruited for brief semi-structured interviews (lasting from 15 to 60 minutes or more). Forty-one nurses, 21 IENs and 20 US RNs, were recruited from each of two hospitals in a Southeastern urban center. US nurses were recruited to provide a basis for comparison. The data were collected and analyzed in an iterative process using the constant comparative method (Creswell, 2003). As themes became evident, questions were incorporated in subsequent interviews to explore them. In the second phase, 40 nurses were chosen (20 from each hospital: 9 US RNs and 11 IENs) for more in-depth interviews (lasting from 15 minutes to over 2 hours) focusing on themes derived from the initial interviews. Nurses were selected for the more in-depth interviews according to their willingness to participate and meeting the goal of obtaining the widest variety of experiences. Because there was less variation in data from US RNs, slightly more IENs were selected to participate in this phase. Demographic information was also collected. To be included in the study, IENs must have been raised, received their initial nursing

training (leading to nursing licensure), and had at least one year of practice in their home countries. Both IENs and US RNs completed at least one year of practice at the bedside in US hospitals in order to have appropriate perspective about their experiences.

Purposive sampling was used to find IEN participants from different backgrounds who provided a range of experiences (Creswell, 2003; Schreiber & Stern, 2001). This was achieved by chain-referral sampling in which the researcher asked initial participants for referrals to others who fill the inclusion criteria and would be willing to participate (Bernard, 2006; Lofland, Snow, Anderson, & Lofland, 2006). This kind of sampling is used for populations that are hard to find and small in number (Bernard, 2006), like IENs from certain countries or regions. The researcher also posted recruitment materials and went from unit to unit to recruit participants from day, night and weekend shifts. An effort was made to recruit US RNs from the same units and shifts as the IENs.

Prior to all data collection, approval was obtained from the investigational review board (IRB) at the researcher's affiliated university following expedited review. Participation was voluntary and verbal informed consent was required from all participants at the time of each interview. In order to protect nurses' confidentiality, data were coded and transcripts were edited for any information that could lead to the identification of the participant. Codes and transcripts were stored on a password-protected computer, accessible only by the researcher. Individual nurses are identified by code and IENs are identified by region instead of country.

Study Findings

Table 1 presents characteristics of all study participants. Tables 2 and 3 present information specific to IENs. Participants ranged in age from 24 to 70 years, with IENs

approximately six years older on average than US RNs (see Table 1). The youngest IENs on average were from Southwest Asia (average age approximately 38 years) and the oldest were from sub-Saharan Africa and East Asia (average age 49 and 51 years respectively). (Age calculations are approximate because some participants refused to give their age or gave an age range.) IENs also had more years of nursing experience on average (see Table 1) and have held more jobs in nursing than US RNs. The sub-Saharan IENs in this study generally worked more years than any other group before migrating to the United States. Thirteen IENs (30%) worked in countries other than their home countries prior to migrating to the United States. Of these, almost 50% were from Southwest Asia and 25% were from sub-Saharan Africa.

Table 1

Characteristics of all Participants

	Mean age (years) (Age range)	Mean years nursing experience (range)	Initial nursing degree received (ADN= associate, BSN=bachelor)	Other degree (completed, in process)
US RNs (n=40)	39 (24-58)	12 (1-40)	5 LPN* 13 ADN 22 BSN	4 ADN 5 BSN 10 MSN
IENs (n=42)	45 (30-70)	21 (7-46)	28 ADN 14 BSN	14 BSN 2 MSN
		in USA: 12		

(1-30)

* The licensed practical nurse is a credential that only exists in the United States.

Table 2

Characteristics of IENs

Region of origin	Number	Number of nurses who worked in other countries before USA	Number Recruited
Oceania	1	1	0
Pacific	1	0	1
East Asia	6	1	0
Southwest Asia	12	6	5
Africa (sub-Saharan)	13	2	2
European Union	2	1	0
Caribbean	7	2	3

The majority of the IENs in this study migrated to the United States after 1990 (see Table 3). Almost half migrated between 2001 and 2010. Half of these nurses came from Southwest Asia and over a quarter came from sub-Saharan Africa. The previous decade, when 33% of the IENs came to the United States, only 14% were from Southwest Asia and 14% were from sub-Saharan Africa.

The first nursing degree for more IENs was equivalent to the US associate degree (ADN) while the first nursing degree for more US RNs was a bachelor degree (BSN) (see

Table 1). Five US RNs began as licensed practical nurses, compared to none of the IENs. Of those who initially had ADN degrees, a similar percentage of IENs and US RNs have gone on to obtain (or are in the process of obtaining) a BSN. Comments from both groups indicate they value education and recognize the BSN is integral for them to stay competitive in nursing. More US RNs have obtained (or are in the process of obtaining) graduate degrees compared to IENs.

Table 3

Country of Origin, Year of Migration to the United States and Initial Level of Education

	1971	1976	1981	1986	1991	1996	2001	2006	Total
	-1975	-1980	-1985	-1990	-1996	-2000	-2005	-2010	
Total IENs	2	2	0	4	9	5	13	7	42
Oceania	0	0	0	0	1	0	0	0	1
Pacific	1	0	0	0	0	0	0	0	1
East Asia	1	1	0	0	3	0	0	1	6
SW Asia	0	0	0	0	1	2	5	4	12
Africa	0	1	0	3	1	2	4	2	13
Europe	0	0	0	0	1	0	1	0	2
Caribbean	0	0	0	1	2	1	3	0	7
Recruited	1	0	0	0	1	1	6	2	11
ADN	2	2	0	4	5	4	5	6	28
BSN	0	0	0	0	4	1	8	1	14

Reasons for Migration

Twenty-three IENs came to join family or came with a husband (either for his education or his work). This was true for three-quarters of the IENs from sub-Saharan Africa and half of the nurses from Southwest Asia. Approximately a quarter of the IENs came to the United States via recruitment companies (see Table 3). These nurses were from sub-Saharan Africa, Southwest Asia, the Pacific or the Caribbean. Other reasons IENs came were: to study (n=2), for adventure (n=2), because she won the visa lottery in her country (n=1), and for a different job (n=1).

Barriers to Practice in the United States

The most common initial difficulty IENs faced when they began working in the United States was feeling overwhelmed because they had to learn to provide total patient care (in which a single nurse is completely responsible for the care of a certain number of patients) when they were accustomed to team nursing (in which several nurses, each with a specific role, share responsibilities for a certain number of patients). This was not specific to IENs from any country or region. Because total patient care carries so much individual nurse responsibility, IENs found it challenging initially to manage their time appropriately to provide all the necessary care during their shifts.

IENs reported feeling isolated in two ways. Several IENs held their first nursing jobs in small towns where people were unfamiliar with their particular cultures, so they experienced cultural isolation. Some nurses were initially overwhelmed by the fast pace of their shifts, especially those unaccustomed to total patient care, which meant they did not have the time to establish relationships with other nurses, leaving them professionally isolated.

These IENs mentioned two other barriers; being treated with a lack of respect and concern about litigation. IENs perceived that nurses are treated with less respect in the United States than in their home countries, particularly by patients and their families. IENs mentioned feeling unappreciated and even disrespected. Many IENs find patients and their families “difficult” and feel patients do not take responsibility for their health and do not listen to the physicians or nurses. Finally, IENs mentioned an underlying concern about litigation in the United States. Several IENs described situations in which they behaved in a certain way in order to protect their nursing licenses. For some, these fears are compounded by heavy patient loads due to lack of staff.

Only IENs from Asian countries mentioned language as a difficulty when they began to work in the United States. However, some US RNs mentioned having difficulty understanding IENs, and both IENs and US RNs mentioned that patients sometimes rejected IENs when unable to understand their accented English.

IENs did not find it difficult to adjust to the technical aspects of nursing in the United States. As one nurse stated “your head will still be the head...biology is the same thing, anatomy is the same thing” (Nurse AR, Africa), reflecting that technical aspects of nursing work are perceived to be the same no matter where the nurses practice. Some IENs mentioned that technology was different in the United States, but some US RNs also mentioned they encountered technological differences when moving from one hospital to another. None found these differences challenging because they said they were adequately trained by the hospitals to use the equipment.

None of the IENs in this study reported any exploitation during the migration process (e.g. by recruitment companies). One IEN (from the Caribbean) reported that her

first employer would not pay her according to years of experience outside the United States. A few IENs reported working in places where they were given heavier workloads than US RNs, however several US RNs also reported being given heavier workloads than their colleagues.

Future Plans

Most IENs plan to stay in nursing in the United States until they retire. Only three mentioned they would like to work in nursing in their home country; one would like to teach nursing, one would like to be an administrator in a hospital, and one would like to open a clinic. Nineteen IENs said they would be interested in continuing their education or specializing in an area of nursing (compared to 22 US RNs), and twelve specifically mentioned pursuing a graduate level degree (compared to 16 US RNs). Only one IEN expressed an interest in administration, all the others want to remain at the bedside in some capacity. US RNs also expressed more interest in continuing to provide direct patient care and a disinclination to rise in the hospital administrative hierarchy. Half of the IENs plan to stay in the United States after retirement and eight plan to retire to their home countries. The remainder is undecided. The main reason most plan to stay is because their children are growing up in the United States.

Discussion

In this study, the two largest groups of IENs were from Southwest Asia and sub-Saharan Africa. This may reflect national findings that migration from Southwest Asia and sub-Saharan Africa to the United States has increased in the last decade (Aiken, 2007; Brush, 2008; Xu et al., 2010). These nurses also seem to have different characteristics; the IENs from sub-Saharan Africa were older and had more years of

experience, and more IENs from Southwest Asia were recruited. It could be beneficial for future studies to examine different national groups of IENs to gain a deeper understanding of the factors involve in their migration.

IENs who used recruitment companies came from Southwest Asia and sub-Saharan Africa as well as the Pacific and the Caribbean, suggesting that recruitment companies focus their work on these regions (Pittman, Folsom, & Bass, 2010) and they are a factor in facilitating IEN migration. However, many nurses used family networks to facilitate their migration, reflecting the continuation of migration flows established by previous generations. This finding has implications for hospital recruitment practices. It may be more cost-effective to focus recruitment procedures on international populations within the United States. Recruitment materials could reflect the value the employers place on diversity and IENs in order to attract IENs who come via family networks.

This study found most IENs were initially educated at the ADN level and most US RNs were initially educated at the BSN level. In the United States, there has been increased emphasis on the value of baccalaureate-level education in nursing because of the research into quality patient care in the last few decades (Aiken, Clarke, Cheung, Sloane, & Silber, 2003; Kendall-Gallagher, Aiken, Sloane, & Cimiotti, 2011). In addition, nursing schools have been trying to increase capacity to help ameliorate the nursing shortage. Surveys from the American Association of Colleges of Nursing (AACN) have shown increased enrolment in BSN programs every year since 2001 (American Association of Colleges of Nursing, 2011). The US RNs in this study are somewhat younger than the IENs and many US RNs earned their nursing degrees later in

life. This suggests these US RNs may have been educated relatively recently, which could explain why more US RNs initially obtained BSN degrees.

The finding that more IENs in this study have ADN degrees may reflect the increased number of nurses from countries where education at the ADN level is more common, like India and countries in sub-Saharan Africa. It also may reflect the lack of availability of BSN programs in certain countries at the time when these nurses were educated. None of the IENs who came to the United States before 1991 were educated at the BSN level; one nurse noted that there were few BSN programs in her country when she went to nursing school several decades ago. The increase in migration of IENs with BSN degrees after 1991 may indicate the increased availability and popularity of the BSN degree in their home countries. It is also possible that US recruitment practices or immigration policies have changed in ways that affect IENs with different degrees.

None of the nurses in this study said they came to the United States in order to obtain an advanced degree in nursing, but more ADN-educated IENs in this sample have gone on to obtain BSNs than ADN-educated US RNs. Both IENs and US RNs realize a BSN degree would help them stay competitive in nursing, and both also said they enjoy school; many said they did the BSN for their own benefit. IENs may be more motivated to obtain their BSN because they have already invested much time and effort in becoming nurses in the United States so they want to protect this investment by being as competitive as possible.

Some findings from this study did not support others in terms of barriers encountered by IENs. Language was not mentioned as a problem, except by Asian nurses. This could be because the majority of the IENs came from countries in Southwest

Asia and sub-Saharan Africa where English is at least one of the official languages. However, that some US RNs have difficulty understanding their IEN colleagues and that some patients reject IENs when unable to understand their accented English supports other study findings (Xu, 2007) and has implications for hospital management. Although IENs may not perceive they need it for themselves, assistance with English may be beneficial for many IENs in their interactions with patients and other healthcare workers.

Exploitation was not reported by the nurses in this study. Because so many IENs used family networks to migrate, they were not subject to abuses during recruitment processes or contracted work in unfamiliar patient care facilities. IENs with family in the United States found their own jobs based on what they heard from people they knew, who were often family members already living in the area, so they may have been familiar with the reputation of the health care facilities when they applied. These social networks may protect IENs from exploitation as a result of the information they provide.

IENs did report feeling isolated at work because of increased individual responsibility given the system of providing total patient care. This system reflects the value US culture places on individualism, yet most of the IENs come from collectivistic countries, where teamwork is valued (Flynn & Aiken, 2002). This cultural difference could cause IENs to feel isolated. Staff shortages and charting responsibilities increase nurses' workloads further, giving them even less time to get to know each other and develop camaraderie and a support network. IENs may also be more overwhelmed because of their concern about threats to their licenses, perhaps because they went through so much to obtain them. IENs may work and chart more carefully to ensure they protect themselves from litigation. It is worth noting that litigation can also be a concern

of US RNs who move to a different state where laws governing nurse practice may be different. IENs also find some US patients and their families to be demanding and disrespectful towards nurses, which would inhibit rapport. IENs need assistance in understanding and managing these cultural differences to reduce their stress and help with interpersonal interactions. Despite feelings of isolation, IENs generally felt they could ask colleagues questions and for help, and many have come to enjoy the autonomy they have under the total patient care system. However, IENs seem to want, and would benefit from, increased teamwork and collaboration among nurses on the units.

In terms of retention, the majority of the IENs interviewed for this study plan to stay in the United States and keep working in direct patient care. If they do plan to return to their home countries, generally it is to retire. The main reason they plan to stay is because of their children, most of whom are growing up in the United States. However, IENs seem to change jobs as much as US RNs. This may be because they have held several positions in their careers and are therefore aware that there are other employment opportunities if they are dissatisfied or need to accommodate family needs. This is important for employers as it implies that specific jobs do not tie IENs to the United States: their family situations do. If US RNs and IENs are dissatisfied by the same things, and IENs adopt the values of US nursing, then US employers' recruitment and retention plans should be able to target IENs and US RNs in similar ways.

This study had several limitations. Many of these interviews were conducted in the hospitals where the nurses worked. Although every effort was made to find a private space, participants may have felt uncomfortable discussing certain topics. Participants may also have believed the interviewer was affiliated with hospital management, despite

reassurances to the contrary. Nurses could have been reluctant to share personal information with a stranger. Results cannot be generalized, as this was a qualitative study.

Conclusion

The findings of this study may have many implications for employers of IENs. Given that IENs may make up a large portion of the workforce in certain hospitals, units, or shifts, and that they are valuable additions to the workforce in terms of nursing experience and cultural knowledge, it is in the best interests of US employers to ensure that their IENs are satisfied especially considering IENs are more likely to work full-time at the bedside than their US counterparts (Xu et al., 2010). Although IENs do not plan to leave the workforce or the country, they have had experience working for different employers and may leave their jobs for the same reasons US RNs do. These findings also show that some of the issues IENs face adjusting to US nursing practice may be similar to those encountered by new US RNs (Kovner, Brewer, Greene, & Fairchild, 2009). This suggests orientation programs and retention strategies could be designed to incorporate both groups. Both IENs and US RNs seem to continue their education at similar rates and share similar motivations to return to school, suggesting they might respond to comparable continuing education initiatives. However, IENs' relationships with other providers and patients would clearly benefit from some assistance with language and education about US patient culture, as well as a more collaborative and supportive work environment.

References

- Ahmad, O. B. (2005). Managing medical migration from poor countries. *British Medical Journal*, 331(7507), 43-45. doi: 10.1136/bmj.332.7507.43
- Aiken, L. H. (2007). US nurse labor market dynamics are key to global nurse sufficiency. *Health Services Research*, 42(3 Pt 2), 1299-1320. doi: 10.1111/j.1475-6773.2007.00714.x
- Aiken, L. H., Buchan, J., Sochalski, J., Nichols, B., & Powell, M. (2004). Trends in international nurse migration. *Health Affairs (Millwood)*, 23(3), 69-77. doi: 10.1377/hlthaff.23.3.69
- Aiken, L. H., Clarke, S. P., Cheung, R. B., Sloane, D. M., & Silber, J. H. (2003). Educational Levels of Hospital Nurses and Surgical Patient Mortality. *JAMA*, 290(12), 1617-1623. doi: doi:10.1001/jama.290.12.1617
- Allen, H., & Larsen, J. A. (2003). "We need respect": experiences of internationally recruited nurses in the UK. Surrey: European Institute of Health and Medical Sciences.
- American Association of Colleges of Nursing. (2011). New AACN Data on Nursing Enrollments and Employment of BSN Graduates. Washington, D.C.: American Association of Colleges of Nursing.
- Beechinor, L. A., & Fitzpatrick, J. J. (2008). Demands of immigration among nurses from Canada and the Philippines. [Journal Article]. *International Journal of Nursing Practice*, 14(2), 178-187.
- Bernard, H. R. (2006). *Research Methods in Anthropology: Qualitative and Quantitative Approaches* (4 ed.). Oxford: AltaMira Press.

- Brush, B. L. (2008). Global nurse migration today. *J Nurs Scholarsh*, 40(1), 20-25.
- Brush, B. L., Sochalski, J., & Berger, A. M. (2004). Imported care: recruiting foreign nurses to U.S. health care facilities. *Health Aff (Millwood)*, 23(3), 78-87. doi: 10.1377/hlthaff.23.3.78
- Buchan, J. (2006). The impact of global nursing migration on health services delivery. *Policy, Politics, & Nursing Practice*, 7(3 Suppl), 16S-25S.
- Buchan, J., Parkin, T., & Sochalski, J. (2003). International nurse mobility: Trends and policy implications. Geneva: World Health Organization.
- Buerhaus, P. I., Auerbach, D. I., & Stalger, D. O. (2009). The Recent Surge In Nurse Employment: Causes And Implications. [Article]. *Health Affairs*, 28(4), w657-w668.
- Campbell, S. (2006). Addressing nursing shortages in sub-Saharan Africa. *Nursing Standard*, 20(51), 46-50.
- Chikanda, A. (2005). Nurse migration from Zimbabwe: analysis of recent trends and impacts. *Nursing Inquiry*, 12(3), 162-174.
- Connell, J., Zurn, P., Stilwell, B., Awases, M., & Braichet, J. M. (2007). Sub-Saharan Africa: beyond the health worker migration crisis? *Soc Sci Med*, 64(9), 1876-1891. doi: 10.1016/j.socscimed.2006.12.013
- Crawford, L. (2004). Nurses educated in other countries: coming to America. *JONA's Healthcare Law, Ethics & Regulation*, 6(3), 66-68.
- Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (2 ed.). Thousand Oaks: Sage Publications, Inc.

- Dicicco-Bloom, B. (2004). The Racial and Gendered Experiences of Immigrant Nurses from Kerala, India. *Journal of Transcultural Nursing, 15*(1), 26-33. doi: 10.1177/1043659603260029
- Ea, E. E. (2007). Facilitating acculturation of foreign-educated nurses. *The Online Journal of Issues in Nursing, 13*(1).
- Flynn, L., & Aiken, L. H. (2002). Does international nurse recruitment influence practice values in U.S. hospitals? *Journal of Nursing Scholarship, First quarter*, 67-73.
- Hardill, I., & MacDonald, S. (2000). Skilled International Migration: The Experience of Nurses in the UK. *Regional Studies, 34*(7), 681-692.
- Hawthorne, L. (2001). The globalisation of the nursing workforce: barriers confronting overseas qualified nurses in Australia. *Nursing Inquiry, 8*(4), 213-229.
- Jose, M. M. (2010). Lived experiences of internationally educated nurses in hospitals in the United States of *International Nursing Review, 58*, 123-129.
- Kawi, J., & Xu, Y. (2009). Facilitators and barriers to adjustment of international nurses: an integrative review. *International Nursing Review, 56*(2), 174-183. doi: 10.1111/j.1466-7657.2008.00705.x
- Kendall-Gallagher, D., Aiken, L. H., Sloane, D. M., & Cimiotti, J. P. (2011). Nurse Specialty Certification, Inpatient Mortality, and Failure to Rescue. *Journal of Nursing Scholarship, 42*(2), 188-194.
- Kingma, M. (2006). *Nurses on the Move: Migration and the Global Health Care Economy*. Ithaca: ILR Press.
- Kline, D. S. (2003). Push and pull factors in international nurse migration. *Journal of Nursing Scholarship, 35*(2), 107-111.

- Kovner, C. T., Brewer, C. S., Greene, W., & Fairchild, S. (2009). Understanding new registered nurses' intent to stay at their jobs. *Nursing Economic\$, 27(2)*, 81-98.
- Likupe, G. (2006). Experiences of African nurses in the UK National Health Service: a literature review. *Journal of Clinical Nursing, 15(10)*, 1213-1220.
- Lofland, J., Snow, D., Anderson, L., & Lofland, L. H. (2006). *Analyzing social settings: A guide to qualitative observation and analysis* (4 ed.). Belmont: Wadsworth Thompson Learning.
- Magnusdottir, H. (2005). Overcoming strangeness and communication barriers: a phenomenological study of becoming a foreign nurse. *International Nursing Review, 52(4)*, 263-269.
- Martineau, T., Decker, K., & Bundred, P. (2004). "Brain drain" of health professionals: from rhetoric to responsible action. *Health Policy, 70(1)*, 1-10. doi: 10.1016/j.healthpol.2005.04.012
- Pittman, P., Folsom, A., & Bass, E. (2010). U.S.-based recruitment of foreign-educated nurses: implications of an emerging industry. *American Journal of Nursing, 110(6)*, 38-48.
- Pittman, P., Folsom, A., Bass, E., & Leonhardy, K. (2007). U.S.-Based international nurse recruitment: Structure and practices of a burgeoning industry. Washington, DC: AcademyHealth.
- Schreiber, R. S., & Stern, P. N. (Eds.). (2001). *Using Grounded Theory in Nursing*. New York: Springer Publishing Company.
- Schumacher, E. J. (2011). Foreign-born nurses in the US labor market. *Health Economics, 20(3)*, 362-378. doi: 10.1002/hec.1595

- Xu, Y. (2007). Strangers in strange lands: A metasynthesis of lived experiences of immigrant Asian nurses working in Western countries. *Advances in nursing science*, 30(3), 246-265. doi: 10.1097/01.ANS.0000286623.84763.e0
- Xu, Y., & Kwak, C. (2005). Characteristics of internationally educated nurses in the United States. *Nursing Economics*, 23(5), 233-238.
- Xu, Y., Zaikina-Montgomery, H., & Shen, J. J. (2010). Characteristics of internationally educated nurses in the United States: an update from the 2004 National Sample Survey of Registered Nurses. *Nursing Economic\$, 28(1)*, 19.
- Yi, M., & Jezewski, M. A. (2000). Korean nurses' adjustment to hospitals in the United States of America. *Journal of Advanced Nursing*, 32(3), 721-729.

Running Head: NURSES' PURSUIT OF FURTHER EDUCATION

Manuscript 2

Pursuit of Further Education in Nursing:

Internationally Educated Nurses and US RNs Compared

Rebecca M. Wheeler

Emory University

Abstract

Purpose: The United States has placed increasing emphasis on nurses continuing their education because research suggests that it positively affects patient outcomes.

Internationally educated nurses (IENs) make up a significant portion of the U.S. nursing workforce. No research focuses on their educational plans especially in comparison to their U.S. counterparts. The purpose of this study was to understand the perspectives of IENs and U.S. nurses regarding continuing their nursing education.

Method: This qualitative study used the theoretical framework of structuration.

Semi-structured interviews were conducted with 82 nurses from two urban hospitals in the southeastern United States.

Results: IENs and US RNs share similar perspectives about continuing their education and face similar barriers.

Conclusion: More efforts are needed to increase the professional value of pursuing further education in nursing, especially at the graduate level. In particular, more resources of time and money would be beneficial.

Keywords: Internationally educated nurses, education, structuration, qualitative methods

The quality of patient care is an overriding concern in the United States. Shortages of nurses threaten care quality, leading to the recruitment of many internationally educated nurses (IENs) over the years to maintain staffing levels. However, IENs' impact on care quality is not limited to filling vacant nursing positions in healthcare facilities. Research has identified other important ways in which nurses affect care quality, one of which includes their pursuit of further nursing education (Aiken, Clarke, Cheung, Sloane, & Silber, 2003; Aiken, Sochalski, & Lake, 1997; Armstrong, Laschinger, & Wong, 2009; Buerhaus, Needleman, Mattke, & Stewart, 2002; Institute of Medicine, 2003; Kendall-Gallagher, Aiken, Sloane, & Cimiotti, 2011; Kutney-Lee & Aiken, 2008; Laschinger, Almost, & Tuer-Hodes, 2003). The purpose of this study was to compare perspectives of IENs and U.S.-trained registered nurses (US RNs) about continuing their nursing education. The theory of structuration (Giddens, 1984) provided a framework to help guide interview questions and interpret the data.

Literature Review

In the United States, nurses are increasingly being called upon to take leadership roles to help improve health care and they need education to prepare them to assume responsibilities associated with these roles. Reports by the Institute of Medicine (IOM) recognize the importance of nurses in patient care (Institute of Medicine, 2003) and recommend higher levels of education for nursing (Institute of Medicine, 2010). Continuing education benefits patient care by helping nurses improve their knowledge and expertise in current techniques and research (Cheesman, 2009; Richards & Potgieter, 2010; Skees, 2010; Wade, 2009; Zulkowski, Ayello, & Wexler, 2007). This enhances nurses' performance through increased confidence and sense of empowerment and

provides more autonomy over practice (Cary, 2001; Fleischman, Meyer, & Watson, 2011; Krapohl, Manojlovich, Redman, & Zhang, 2010; Niebuhr & Biel, 2007; Piazza, Donahue, Dykes, Griffin, & Fitzpatrick, 2006; Sechrist, Valentine, & Berlin, 2006; Wade, 2009).

Research studies support the importance of nurses' education preparation, demonstrating that higher educational levels improve patient outcomes. Hospitals with more BSN-prepared nurses and lower nurse-patient ratios had lower patient mortality rates among patients suffering from a variety of illnesses (Aiken et al., 2011; Aiken et al., 2003; Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Eastabrooks, Midodzi, Cummings, Ricker, & Giovanetti, 2005; Friese, Lake, Aiken, Silber, & Sochalski, 2008; Kutney-Lee & Aiken, 2008). Graduate nursing education (degrees at the master's level and beyond) has been shown to enhance nursing leadership, innovation, and evidence-based practice (Clement-O'Brien, Polit, & Fitzpatrick, 2011; Quinn, 2001; Weeks, Starck, Liehr, & LaFontaine, 1996).

The U.S. nursing profession encourages nurses to continue their education. A key piece of the American Nurses Credentialing Center's Magnet Recognition Program® is nurses' continuing education because it contributes to the goals of improved patient care and an engaged nursing workforce that can advance nursing practice (American Nurses Credentialing Center, 2012). Many state nursing associations promote a BSN-educated workforce. An exemplar bill is currently before the New York state legislature that mandates new nurses obtain a BSN within ten years of graduating from their ADN programs (Gormley, 2011).

International nurse migration to the United States has increased in the last decade because of a shortage of nurses and the need to maintain appropriate staffing to provide quality care. The United States is one of the largest importers of nurses, with IENs making up 13% of nurses newly licensed in 2008 (Schumacher, 2011). Demographic information from general surveys in the United States suggests that IENs have a significant impact on the U.S. patient population. IENs tend to provide direct patient care; 76.1% of them are employed as staff nurses (Xu, Zaikina-Montgomery, & Shen, 2010). IENs are more likely to be employed full time (81.5% compared to 70.9% of US RNs) and work more hours per week (36.25 hours compared to 31.73 for US RNs) (Xu et al., 2010). IENs generally work in hospitals (70.3% compared to 58.8% of US RNs) (Xu et al., 2010), often in urban areas treating the underserved (Aiken, 2007).

One key reason IENs decide to migrate is for the opportunity to pursue further education in nursing (Aiken, Buchan, Sochalski, Nichols, & Powell, 2004; Kingma, 2007; Pearson & Peels, 2001). However, IENs' pursuit of further education in the United States has only been studied via the quadrennial National Sample Survey of Registered Nurses (NSSRN). The most recent analysis of the 2004 NSSRN found that 10.3% of IENs and US RNs had completed "an advanced nursing educational program" and that 7.2% of IENs and 7.7% of US RNs were currently enrolled in educational programs (Xu et al., 2010, p. 21). Yet no definition of "advanced nursing educational program" is given, so it is unclear if this refers to graduate degree-earning programs. Nor is it clear whether IENs attended the educational programs in the United States. It is not known if nurses who are currently enrolled are in nursing programs or graduate programs. More information is needed about IENs' perspectives on education, especially in comparison to

their U.S. colleagues, to gain an understanding of how they fit in to U.S. nursing with respect to continuing their education.

Theoretical Framework

Structuration theory (Giddens, 1984) holds that agents and structures have a dynamic relationship in which each affects the other. Interactions among agents are shaped by agents' understandings of structural rules and access to resources, but agents also have the ability to change these rules and resources and thus shape the structures. IENs, as nurses born, educated and trained outside the United States, may not have the same understandings as US RNs of the rules and resources of U.S. hospital nursing. This may affect their perceptions and experiences, and consequently their actions, regarding nursing education.

Methods

In order to explore IEN and US RNs' perspectives on nursing education, qualitative methods were used to obtain rich data from a variety of experiences. Two phases of semi-structured interviews were conducted with female registered nurses who worked at the bedside at two urban hospitals in the Southeastern United States. In the first phase, 82 were recruited: 41 nurses from each hospital, of which 21 were IENs and 20 were US RNs. In the second phase, 40 of the original 82 nurses were re-interviewed according to themes derived from the first phase. There were 20 nurses from each hospital: 11 IENs and 9 US RNs. Participant characteristics are presented in Table 1.

Participants were purposively recruited from both day and night shifts. After an IEN was interviewed, an effort was made to recruit a US RN from the same unit and shift. Inclusion criteria for IENs were that they were raised, educated (leading to nursing

licensure), and employed for at least one year in nursing (at the bedside) in their home countries. IENs also had to have worked in nursing at the bedside for at least one year in the United States. US RNs were included if they were raised, educated (leading to nursing licensure), and employed for at least one year in nursing (at the bedside) in the United States.

Data collection and analysis were performed following the constant comparative method (Creswell, 2003). Data were coded, categorized, compared and conceptualized in an iterative process during the data collection process. During initial interviews, nurses were asked about their educational preparation and future educational plans as well as their perspectives and experiences involving nursing education. In the second phase, nurses were asked to expand on their comments regarding nursing education and explain why they did or did not want to pursue further degrees in nursing. The investigational review board (IRB) affiliated with the researcher's university approved the research before any data were collected. All nurses provided verbal consent prior to each interview. The researcher informed them that their participation was voluntary and that they could refuse to participate at any time. They were also assured that the data would be confidential, and are identified here by code and region of origin to protect their identities. All research material was stored on a password-protected laptop, accessible only by the researcher.

Results

More of the IENs in this study were initially trained at the associate degree (ADN) level while more US RNs were initially trained at the baccalaureate (BSN) level. (Table 1 presents general characteristics of participants and Table 2 presents information

about educational attainment and plans.) A higher percentage of ADN-prepared IENs has obtained a BSN or is enrolled in a BSN program than US RNs. A higher percentage of BSN-prepared US RNs has obtained a graduate degree or is enrolled in a graduate nursing program than IENs. Overall, a higher percentage of BSN-prepared nurses has obtained a graduate degree or is enrolled in a graduate nursing programs than ADN-prepared nurses. Yet both groups had similar perspectives about the value of more nursing education and faced similar barriers pursuing nursing degrees.

Table 1

Characteristics of IENs and US RNs

Country of Origin	Number	Mean age* (years) (Age range)	Mean years* experience (Range)
US RNs total	40	39 (24-58)	12 (1-40)
IENs total	42	45 (30-70)	21 (7-46)
Caribbean	7	43 (35-49)	20 (14-28)
European Union	2	-	-
Africa (sub-Saharan)	13	49 (35-62)	25 (8-46)
Southwest Asia	12	38 (30-56)	16 (8-34)
East Asia	6	51 (38-70)	24 (7-34)
Pacific	1	-	-
Oceania	1	-	-

* Approximations. Some participants preferred to give an age range instead of their exact age. Some nurses were not employed in nursing periodically, making calculations of years of experience approximate.

Table 2

Participants' Educational Attainment and Plans

	US RNs n=40	IENs n=42
Initial nursing degree: LPN	5 (12.5%)	-
LPN-prepared nurses who earned an ADN degree	5 (100%)	-
LPN-prepared nurses who earned a BSN degree	2 (40%)	-
LPN-prepared nurses who want a BSN in the future	1 (20%)	-
LPN-prepared nurses who earned an MSN degree	0	-
LPN-prepared nurses who want a graduate degree in the future	3 (60%)	-
Initial nursing degree: Associate (ADN)	13 (32.5%)	28 (66.6%)
ADN-prepared nurses who earned a BSN degree	3 (23.1%)	7 (25%)
ADN-prepared nurses currently enrolled in a BSN program	2 (15.4%)	7 (25%)
ADN-prepared nurses who want a BSN in the future*	3 (37.5%)	3 (21.4%)
ADN-prepared nurses who earned a graduate degree	1 (7.7%)	2 (7.1%)
ADN-prepared nurses currently enrolled in a graduate program	1 (7.7%)	1 (3.6%)
ADN-prepared nurses who want a graduate degree in the future*	5 (45.5%)	7 (28%)
Initial nursing degree: Bachelor (BSN)	22 (55%)	14 (33.3%)
BSN-prepared nurses who earned a graduate degree	5 (22.7%)	1 (7.1%)
BSN-prepared nurses currently enrolled in a graduate program	4 (18.2%)	1 (7.1%)

BSN-prepared nurses who want a graduate degree in the future* 7 (53.8%) 6 (50%)

* Calculations are based on the number of nurses educated at that level who have not already attained (or are in the process of attaining) the particular degree

The Value of Pursuing More Nursing Education

Many IENs and US RNs mentioned that continuing their education would increase their earning potential and/or their career options. Nurse BT (Africa) wants to pursue her BSN and a graduate degree because “I can aspire to any level I want to in my life. I don’t want to just sit at this level. If I go get my BSN, my masters, I can get to a better place than where I am.” Nurse LB (US) wants to be a midwife because “I want to make more money and do better things.” Nurse RA (US) is going for her BSN “because it seems to be the only route to kind of move up as far as hierarchy.” Some nurses recognize they will need career options when the 12-hour shifts in bedside nursing become too physically demanding. Nurse DF (Africa) said, “with age, the running around is getting on me, so I’m thinking maybe if I do improve my education, I might get higher up in the career.” Nurse KQ (US) said, “I love what I do, but frankly, it is hard work...I do not know if I can keep doing this physical labor.”

Some nurses have broader plans that influence their decision to pursue further education. Nurse AI (US) obtained a graduate degree because “I didn’t like nursing at the baccalaureate level, so I thought at the masters level I could help change nursing.” Nurse KN (US) wants to become a nurse practitioner because she wants to be one of those to meet a growing need in nursing; “going forward, our profession is going to need a lot more practitioners.” For some IENs, more education would help them achieve goals in

their home countries. With a graduate degree, nurse TT (Asia) could teach, nurse AK (Africa) could help run a hospital, and nurse BM (Africa) could set up a clinic.

For many IENs and US RNs, plans to pursue further education are based on their personal values. Nurse AO (Asia) said, "whenever [there's] any chance at education, I'm trying to attend...I love the learning." Nurse TO (Pacific) set three goals for herself when she came to the United States, one of which was to complete her BSN and obtain an MSN, which she achieved. Nurse ON (US) said, "I have always been striving to improve myself. I love schooling." Nurse KN (US) is obtaining her BSN because "I want to be able to keep up...to stay on the cutting edge of things and feel like I'm a part of things." Nurse TC (US) wants to be a nurse practitioner because "it's being able to just do it on your own and having the autonomy."

In this study, because both hospitals are pursuing Magnet recognition, there are implicit or explicit expectations that nurses continue their education to at least the BSN level. Some nurses feel pressured to obtain BSN degrees in order to protect their jobs. Nurse RC (US) believes "you pretty much have to [get a BSN], they're going to phase it [the ADN] out." Nurse TQ (US) reported that "the rumor went around over the weekend that if you do not have your bachelor's by 2015, you cannot work in any hospital anywhere as a registered nurse." Nurse NA (Asia) said, "they [the hospital administrators] want certification. They want you to continue education. They want you to have everything...now I have more pressure." These hospitals may provide some degree of resources for education in the form of bonuses, tuition reimbursement, and/or schedule accommodation to attend classes, and some nurses take advantage of them.

Barriers to Continuing Education

Some nurses do not pursue further education despite their interest because they lack time due to family circumstances. Many nurses are waiting to return to school until their children get older. Nurse NK (Asia) said, "I am waiting for my children to be of an age where they can manage on their own and I do not have to worry about them" before going back to school. Nurse TP (Asia) said, "I have a small baby, that's why maybe after two years I'm going back to school." Nurse EB (US) has observed her colleagues and noted, "I'm single, I don't have any kids...for a lot of the other girls that may have families, husbands, and several kids, it's just hard to get away and go to school because it does take a lot of study time."

Nurses commented that hospitals may not provide resources of time and money. Hospitals do not always follow through with reimbursement or bonuses or provide time for studies in the form of shift accommodations or time off. According to nurse RR (Caribbean) "we're told that we will be given some kind of bonus or whatever it is and the managers don't want to pay for that." Nurse LL (Europe) echoed her; "they sort of encourage it [further education] because they say they'll pay toward your education, but then they want you to work the same hours...come on, now. Be realistic." Nurse TQ (US) said in her hospital:

They are not paying and reimbursing like they used to, so that has been a real problem and a lot of people have complained about [it] who are in school now...they will not give you the time off, they will not pay for the education...[even though] they are pushing very hard because of Magnet.

IENs face an additional barrier to enrolling in college or university programs because transcripts of their original nursing education from home are required to enter

BSN and graduate programs. Nurse AN (Africa) would like to go back to school, but “I left school in 1985, so to get my transcripts and everything here is a lot of headache.”

Nurse AB (Africa) has been trying to enroll in school but “my transcript...they said something was not complete” so she is in the process of finding out what she needs to do.

Nurse DF (Africa) had to re-educate herself starting as a licensed practical nurse (LPN) in the United States “because our hospital was also involved in that war business, so our papers were torn up and I could not bring any of my transcripts.”

Online educational programs use technology as the primary means of communication, which is a barrier for some nurses because they feel they lack computer skills. Nurse BT (Africa) mentioned a colleague who told her “I don’t even know how to use computer, how will I go to online school?”

Nurses may decide that the personal or professional value in obtaining another degree is not high enough considering the time and financial resources needed. Nurse TQ (US) is undecided about pursuing her BSN “because I do not know what the personal advantage would be to me if I want to continue to do bedside nursing.” Older nurses in particular may not believe that more education will benefit them enough to make it worth the investment in time and finances. Nurse TK (Asia) said, “I started online...one course then I stop (sic) because the fees are very high and I’m 56 and thinking ‘What will I gain?’” Nurse JN (Europe) believes “I think once you get out... especially the older you get, they don’t feel like going back to school.” On the other hand, nurse NA (Asia) said, “I got my certification...I have to make [sic] the next step: or go back to school or learn something new...but another thing is I’m really too old, but I look around and I’m not too old. Here people go back to school at 50, 53” but she does not think she will do the same.

Nurse UN (US) thinks that some older nurses may not go back to school for graduate degrees because “they sometimes make more than what a beginning APRN [advanced practice registered nurse] would make. It doesn't make sense for them to go back to school.”

Discussion

The findings of this study show that IENs and US RNs have made similar decisions and have similar perspectives about nursing education. This could mean both groups of nurses understand and react to structural rules and resources related to education in similar ways. A comparable percentage of IENs and US RNs who began with ADN degrees continued on to obtain BSN degrees, suggesting both groups place similar value on the importance of continuing their undergraduate education to the BSN level. Their comments demonstrate they have similar personal goals regarding education and they have similar understandings of the potential benefits of a BSN degree, including job security as their places of employment pursue Magnet recognition and the ability to pursue graduate education in the future. Both IENs and US RNs also face similar barriers to continuing their education and are less likely to pursue graduate degrees.

Although some nurses seem to recognize that graduate education would give them access to higher salaries, more autonomy, and more influence over nursing practice, fewer seem to be motivated to pursue education at this level. This was particularly true for nurses initially educated at the LPN and ADN levels in this study. While this may involve socioeconomic issues, it is also possible that the curriculum or the culture of LPN or ADN nursing programs may not succeed in inspiring nurses to pursue education beyond the BSN. A few IENs believe the importance of continuing their education was

instilled in them during their nursing programs in their home countries. These nurses could serve as resources for nursing leadership and help develop new ways of encouraging further education. Another option is to make streamlined programs more available and/or appealing, such as ADN to MSN programs. The most recent report from the IOM (Institute of Medicine, 2010) advocates these kinds of programs, yet only one nurse (an IEN) obtained her MSN this way.

Education provides knowledge and skills that lead to higher self-esteem and therefore it is viewed as a route to individual empowerment, especially for women (Smith & Troutner, 2004; Stromquist, 2002). It is possible that nurses value undergraduate degrees more than graduate degrees because these degrees prepare them to provide direct patient care, which empowers individual nurses. Hospital nursing emphasizes individual empowerment with its total patient care model of care delivery, in which a single nurse is primarily responsible for the care of a certain number of patients. Nurses value nurse practitioner degrees because they also prepare nurses to provide direct patient care, which is why it was the graduate degree most often mentioned by those interested in continuing their education.

Other graduate degrees, including doctoral degrees, do not focus on individual empowerment of nurses at the bedside but rather prepare nurses for roles as researchers, educators and administrators: roles which distance nurses from their role at the bedside and require nurses to work collectively to enact changes that affect nursing and patient care on broader levels. This suggests nurses may be disinclined to seek education that will prepare them for roles away from the bedside. Only a few nurses expressed specific

interest in graduate degrees for positions that would give them more influence over nursing practice and health care.

In this study, nurses' comments suggest the hospital and colleagues are the most important purveyors of the value of a BSN. It may be communicated explicitly, by hospital leadership and written policies, as one of the expectations of nurses in a Magnet facility. It can also be communicated by colleagues, as can be seen in nurse TQ's (US) comment about the rumor that nurses without BSN degrees will be unable to find jobs in the future. It is communicated implicitly as nurses watch other nurses in education programs or observe what nurses with different degrees do. For example, a few nurses said they went back to school after seeing a colleague manage it successfully. This suggests efforts to encourage further education may be more successful if enacted in the workplace, yet they need to be developed carefully to ensure nurses see value in their time and money spent.

Only some nurses were motivated to continue their education by professional behavior norms to help improve the profession and health care: many more nurses expressed interest in pursuing education to achieve their personal goals. This suggests that nursing needs to make further education a stronger norm for the profession in general. This could be achieved through legislative processes, like the New York bill that ADN-prepared nurses must earn a BSN. This might also be achieved through closer partnerships among schools, employers and nursing organizations. In this way, resources and ideas could be shared to encourage further education and facilitate the process. Closer partnerships between health care facilities and academic institutions would also

help ameliorate issues of disconnect between practice and education, exemplified in the case of a coworker who told nurse TQ (US):

So far I have learned nothing that I did not know already... Why am I paying money and the time with four kids to get this [degree] if I am learning stuff I already know and they [the hospital] are not going to compensate me a lot more?

Nurses mentioned that the strongest barrier to continuing education was a personal lack of time due to nurses' family responsibilities, but they were constrained further by the perceived inflexibility of their work schedules. Nurses did not specifically mention limited personal financial resources, although that may be implied in their comments about caring for children. Nurses seem to expect hospitals to provide some resources, especially given the emphasis placed on continuing education as hospitals seek Magnet recognition. Financial resources from the hospital facilitated returning to school when they were available, but they inhibited it when they were not. The decreased availability of hospital resources for education may reflect limitations in finances and staffing caused by current economic conditions in the United States.

If a majority of nurses is to pursue further education, resources need to be improved. Health care institutions need to provide enough money and schedule flexibility to add to personal resources, decreasing the barriers to returning to school and demonstrating the hospitals' commitment to supporting nurses who continue their education and thus benefit the organization and patient care. More educational programs need to accommodate nurses' work and family responsibilities. Online educational programs were popular among these nurses because of the flexibility of their time commitment. IENs would benefit from changes in schools' policies for admission. Other

means of evaluating nurses' prior educational attainment besides transcripts, which may be difficult to obtain, should be developed. Training in computer skills would also be beneficial.

The results of this study need to be interpreted cautiously. All interviews were conducted by a doctoral student. Her pursuit of an advanced degree may have made some participants reluctant to admit a lack of interest in pursuing further education or made them exaggerate their interest. Participants may also have perceived the interviewer to have an affiliation with hospital management, which may also have caused participants to express more interest in education than they truly felt, especially given the hospitals' pursuit of Magnet recognition. In addition, nurses may have been reluctant to share personal information, especially about their personal financial resources.

Conclusion

It is encouraging that IENs and US RNs have similar perspectives regarding further education in nursing because it means potential solutions can target both groups. Both IENs and US RNs are equally likely to return to school for more degrees in nursing, and both are more likely to continue their education to obtain BSN degrees than graduate degrees. They seem to have a similar understanding of the value of continuing their education and they face similar barriers involving resources. Their disinclination to pursue graduate education, excluding nurse practitioner degrees, may reflect an underlying preference for individual empowerment in roles providing direct patient care. In order to encourage nurses to pursue further education, more value needs to be placed on graduate education in nursing by preparing nurses in practices and strategies of collective empowerment. Efforts should be made to strategically align key stakeholders

and nurses' pursuit of further education should be supported by more resources in the hospitals. In this way, when nurses are deciding whether they should pursue further education, the perceived value of the degree will be higher than the perceived barriers of attendance. A more educated nursing workforce benefits health care, the nursing profession, and over all, the patients.

References

- Aiken, L. H. (2007). US nurse labor market dynamics are key to global nurse sufficiency. *Health Services Research, 42*(3 Pt 2), 1299-1320. doi: 10.1111/j.1475-6773.2007.00714.x
- Aiken, L. H., Buchan, J., Sochalski, J., Nichols, B., & Powell, M. (2004). Trends in international nurse migration. *Health Affairs (Millwood), 23*(3), 69-77. doi: 10.1377/hlthaff.23.3.69
- Aiken, L. H., Cimiotti, J. P., Sloane, D. M., Smith, H. L., Flynn, L., & Neff, D. F. (2011). Effects of nurse staffing and nurse education on patient deaths in hospitals with different nurse work environments. *Medical Care, 49*(12), 1047-1053.
- Aiken, L. H., Clarke, S. P., Cheung, R. B., Sloane, D. M., & Silber, J. H. (2003). Educational Levels of Hospital Nurses and Surgical Patient Mortality. *JAMA, 290*(12), 1617-1623. doi: doi:10.1001/jama.290.12.1617
- Aiken, L. H., Clarke, S. P., Sloane, D. M., Lake, E. T., & Cheney, T. (2008). Effects of Hospital Care Environment on Patient Mortality and Nurse Outcomes. *Journal of Nursing Administration, 38*(5), 223-229. doi: DOI: 10.1097/01.NNA.0000312773.42352.d7
- Aiken, L. H., Sochalski, J., & Lake, E. T. (1997). Studying Outcomes of Organizational Change in Health Services. *Medical Care, 35*(11), NS6-NS18.
- American Nurses Credentialing Center. (2012). Program overview Retrieved January 10, 2012, from <http://www.nursecredentialing.org/Magnet/ProgramOverview.aspx>

- Armstrong, K., Laschinger, H. K. S., & Wong, C. (2009). Workplace Empowerment and Magnet Hospital Characteristics as Predictors of Patient Safety Climate. . *Journal of Nursing Care Quality, 24*(1), 55-62.
- Buerhaus, P. I., Needleman, J., Mattke, S., & Stewart, M. (2002). Strengthening hospital nursing. *Health Affairs (Millwood), 21*(5), 123-132.
- Cary, A. (2001). Certified registered nurse: results of the study of the certified workforce. *American Journal of Nursing, 101*(1), 44-52.
- Cheesman, S. D. (2009). Administrative angles. The "connection" between continuing education and quality. *Journal of Continuing Education in Nursing, 40*(8), 340-341. doi: 10.3928/00220124-20090723-08
- Clement-O'brien, K., Polit, D. F., & Fitzpatrick, J. J. (2011). Innovativeness of nurse leaders. *Journal of Nursing Management, 19*(4), 431-438. doi: 10.1111/j.1365-2834.2010.01199.x
- Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (2 ed.). Thousand Oaks: Sage Publications, Inc.
- Eastabrooks, C. A., Midodzi, W. K., Cummings, G. G., Ricker, K. L., & Giovanetti, P. (2005). The impact of hospital nursing characteristics on 30-day mortality. *Nursing Research, 54*(2), 74-84.
- Fleischman, R. K., Meyer, L., & Watson, C. (2011). Best practices in creating a culture of certification. *AACN Advanced Critical Care, 22*(1), 33-49. doi: 10.1097/NCI.0b013e3182062c4e

- Friese, C. R., Lake, E. T., Aiken, L. H., Silber, J. H., & Sochalski, J. (2008). Hospital Nurse Practice Environments and Outcomes for Surgical Oncology Patients. *Health Services Research, 43*(4), 1145-1162.
- Giddens, A. (1984). *The Constitution of Society: Outline of the Theory of Structuration*. Berkeley: University of California Press.
- Gormley, M. (2011, December 30). NY Bill Would Require Bachelor's Degrees For RNs, *The Atlanta Journal Constitution*.
- Institute of Medicine. (2003). Keeping patients safe: Transforming the work environment of nurses. In T. N. A. Press (Ed.). Washington, D.C.: Institute of Medicine.
- Institute of Medicine. (2010). The future of nursing: Leading change, advancing health. In T. N. A. Press (Ed.). Washington, D.C.: Institute of Medicine.
- Kendall-Gallagher, D., Aiken, L. H., Sloane, D. M., & Cimiotti, J. P. (2011). Nurse Specialty Certification, Inpatient Mortality, and Failure to Rescue. *Journal of Nursing Scholarship, 42*(2), 188-194.
- Kingma, M. (2007). Nurses on the move: a global overview. *Health Services Research, 42*(3 Pt 2), 1281-1298. doi: 10.1111/j.1475-6773.2007.00711.x
- Krapohl, G., Manojlovich, M., Redman, R., & Zhang, L. (2010). Nursing specialty certification and nursing-sensitive patient outcomes in the intensive care unit. *American Journal of Critical Care, 19*(6), 490-499. doi: 10.4037/ajcc2010406
- Kutney-Lee, A., & Aiken, L. H. (2008). Effect of nurse staffing and education on the outcomes of surgical patients with comorbid serious mental illness. *Psychiatric Services, 59*(12), 1466-1469.

- Laschinger, H. K. S., Almost, J., & Tuer-Hodes, D. (2003). Workplace Empowerment and Magnet Hospital Characteristics: Making the Link. [Article]. *Journal of Nursing Administration*, 33(7), 410-422.
- Niebuhr, B., & Biel, M. (2007). The value of specialty nursing certification. *Nursing Outlook*, 55(4), 176-181.
- Pearson, A., & Peels, S. (2001). A global view of nursing in the new millennium. Part 5: problems faced by nurses. *Int J Nurs Pract*, 7(5), S21-25.
- Piazza, I. M., Donahue, M., Dykes, P. C., Griffin, M. Q., & Fitzpatrick, J. J. (2006). Differences in perceptions of empowerment among nationally certified and noncertified nurses. *Journal of Nursing Administration*, 36(5), 277-283.
- Quinn, C. (2001). Research utilization: a challenge for nursing graduate education to improve patient care. *Journal of Nursing Education*, 40(4), 171-173.
- Richards, L., & Potgieter, E. (2010). Perceptions of registered nurses in four state health insitutions on continuing formal education. *Curationis*, 33(2), 41-50.
- Schumacher, E. J. (2011). Foreign-born nurses in the US labor market. *Health Economics*, 20(3), 362-378. doi: 10.1002/hec.1595
- Sechrist, K. R., Valentine, W., & Berlin, L. E. (2006). Perceived value of certification among certified, noncertified, and administrative perioperative nurses. *Journal of Professional Nursing*, 22(4), 242-247.
- Skees, J. (2010). Continuing education: a bridge to excellence in critical care nursing. *Critical Care Nursing Quarterly*, 33(2), 104-116. doi: 10.1097/CNQ.0b013e3181d913a1

- Smith, P. H., & Troutner, J. L. (2004). Empowering Women: Agency, Structure, and Comparative Perspective. In P. H. Smith, J. L. Troutner & C. Hünefeld (Eds.), *Promises of empowerment: women in Asia and Latin America* (pp. 1-34). Plymouth, United Kingdom: Rowman & Littlefield.
- Stromquist, N. P. (2002). Education as a means for empowering women. In J. L. Parpart, S. M. Rai & K. Staudt (Eds.), *Rethinking empowerment: Gender and development in a global/local world*. New York: Routledge.
- Wade, C. H. (2009). Perceived effects of specialty nurse certification: a review of the literature. *AORN Journal*, 89(1), 183-192.
- Weeks, L., Starck, P., Liehr, P., & LaFontaine, K. (1996). Graduate nursing education: what are the benefits and costs to hospitals? *Journal of Nursing Administration*, 26(6), 20-30.
- Xu, Y., Zaikina-Montgomery, H., & Shen, J. J. (2010). Characteristics of internationally educated nurses in the United States: an update from the 2004 National Sample Survey of Registered Nurses. *Nursing Economic\$,* 28(1), 19.
- Zulkowski, K., Ayello, E., & Wexler, S. (2007). Certification and education: do they affect pressure ulcer knowledge in nursing? *Advances in Skin and Wound Care*, 20(1), 34-38.

Running Head: GOVERNANCE AND PROFESSIONAL ADVANCEMENT

Manuscript 3

Governance and Professional Advancement:
Issues of Empowerment among Hospital Nurses

Rebecca M. Wheeler

Emory University

Abstract

Objective: This study compared the perspectives of internationally educated nurses (IENs) and US RNs regarding participation in hospital governance structures and professional advancement.

Background: Nurses' participation in hospital governance is considered a factor in quality patient care. No research has examined how IENs' perceptions about participation in governance compare to those of US RNs.

Methods: Two phases of interviews were conducted with nurses in two urban hospitals in the Southeastern United States. Initially 82 nurses were interviewed; 40 were re-interviewed to follow up on themes around governance and professional advancement.

Results: Both IENs and US RNs found hospital governance structures irrelevant to their work and were disinterested in seeking promotions, demonstrating nurses' individual empowerment but not collective empowerment.

Conclusions: Some short-term strategies might help hospitals encourage nurses to participate in governance and seek promotions. Nursing education and practice need to be adjusted to support nurses' collective empowerment.

Internationally educated nurses (IENs) are important to quality patient care because many U.S. health care systems have recruited IENs to maintain staffing levels during nursing shortages. However, research has shown that nurses also affect quality of care through their participation in hospital governance structures (Aiken, Sochalski, & Lake, 1997; Armstrong, Laschinger, & Wong, 2009; Institute of Medicine, 2003; Laschinger, Almost, & Tuer-Hodes, 2003). IENs' participation in governance has not been studied but has important implications for nursing practice and quality care.

Background

Studies show that nurses feel empowered when they participate in hospital decision-making, increasing satisfaction and improving retention (Barden, Quinn, Donahue, & Fitzpatrick, 2011; Bretschneider, Glenn-West, Green-Smolenski, & Richardson, 2010; Brody, Barnes, Ruble, & Sakowski, 2012; Laschinger et al., 2003; Watters, 2009). Participation in hospital governance structures may help develop leadership (Bretschneider et al., 2010; Brody et al., 2012), bring evidence-based practices to the bedside (Watters, 2009), and improve patient safety as nurses are empowered to practice according to their professional standards (Armstrong & Laschinger, 2006; Armstrong et al., 2009). Hospital environments that give nurses access to information, resources, and support empower nurses' decision-making (Armstrong & Laschinger, 2006; Barden et al., 2011; Bretschneider et al., 2010; Watters, 2009).

In the United States, researchers and organizations advocate nurses' participation in governance. The Institute of Medicine has issued reports describing nurses' impact on positive patient outcomes (Institute of Medicine, 2003) and supporting nurses taking leadership roles (Institute of Medicine, 2010). One important part of the American Nurses

Credentialing Center's Magnet Recognition Program® is nurses' participation in hospital governance because it contributes to the goals of improved patient care and an engaged nursing workforce (American Nurses Credentialing Center, 2012). Further evidence of the importance of nurses' autonomy, decision-making, and job satisfaction is reflected by the fact that data about these are collected by the American Nurses Association's National Database of Nursing Quality Indicators to help hospitals improve quality (American Nurses Association, 2012; Bretschneider et al., 2010).

The United States has recruited IENs to help maintain staffing levels and quality patient care. In 2008, IENs made up an estimated 13% of nurses newly-licensed (Schumacher, 2011) and research shows they may make up a higher percentage of the nursing workforce in urban hospitals where they tend to work (Aiken, 2007). U.S. studies have not examined IENs' perspectives about participation in governance; instead studies have primarily focused on barriers to acculturation (Beechinor & Fitzpatrick, 2008; Diccico-Bloom, 2004; Jose, 2010) or demographic trends (Aiken, 2007; Brush, 2008; Xu, Zaikina-Montgomery, & Shen, 2010). Data from general surveys suggest that IENs are likely to work full time providing direct patient care as staff nurses in hospitals (Aiken, 2007; Xu et al., 2010). The opportunity for professional advancement is one reason why nurses decide to migrate (Aiken, Buchan, Sochalski, Nichols, & Powell, 2004; Kingma, 2007) and international studies have shown that nurses in other countries also value the ability to participate in hospital decision-making (Aiken et al., 2001; Salmon, Yan, Hewitt, & Guisinger, 2007). The purpose of this study was to compare the perspectives of IENs and US RNs about participation in hospital governance to see where differences and similarities lie.

Methods

Two rounds of semi-structured interviews were conducted for this study. Eighty-two female registered nurses were purposefully recruited: 41 nurses from each of two Southeastern urban hospitals. Twenty-one of the 41 nurses from each hospital were IENs, and the other 20 consisted of U.S. nurses. Forty nurses were chosen from the original 82 for a second interview: 11 IENs and 9 US RNs from each hospital. IENs were nurses who were raised, received their initial nursing training (leading to nursing licensure), and had at least one year of practice in their home countries. All nurses completed at least one year of practice at the bedside in U.S. hospitals and were drawn from multiple units and shifts. Efforts were made to recruit IENs and US RNs from the same units and shifts.

The social theory of structuration framed development of interview questions. Structuration posits that agents act according to the rules of a given context, but they also have the power to change the rules (Giddens, 1984). The theory helped frame interview questions about nurses' experiences and understandings of their role in the hospital regarding making decisions and changes beyond the bedside. Data collection and analysis followed the constant comparative method (Creswell, 1998); in this process the researcher conducted interviews and analyzed data in an iterative process. As themes arose from data, new questions were incorporated in subsequent interviews.

Before data collection, approval was obtained from the investigational review board (IRB) affiliated with the researcher's university. Participants were informed that their participation was voluntary and they could terminate interviews at any time. They were assured their information would be kept confidential, and all research materials were stored on a password-protected laptop to which only the researcher had access. Here

they are referred to by code and region to protect their confidentiality. Participant characteristics are presented in Table 1.

Findings

This study did not find meaningful differences between IENs and US RNs' perceptions of participation in governance and promotions. Instead it revealed nurses find participation in governance irrelevant to their work and are disinterested in professional advancement. General characteristics of all participants can be found in Table 1.

Table 1

IEN and US RN Characteristics

Country of Origin	N	Mean age* (years) (Age range)	Mean years* nursing experience (Range)
US RNs total	40	39 (24-58)	12 (1-40)
IENs total	42	45 (30-70)	21 (7-46)
Caribbean	7	43 (35-49)	20 (14-28)
European Union	2	-	-
Africa (sub-Saharan)	13	49 (35-62)	25 (8-46)
Southwest Asia	12	38 (30-56)	16 (8-34)
East Asia	6	51 (38-70)	24 (7-34)
Pacific	1	-	-
Oceania	1	-	-

* Approximations. Some participants preferred to give an age range instead of their exact age. Some nurses were not employed in nursing periodically, making calculations of years of experience approximate.

Irrelevance of Governance

Generally nurses were not actively involved with committees, despite hospital expectations that they participate to help with the Magnet recognition process. Some nurses choose not to participate. Nurse LL (IEN) attended some committee meetings and decided “it wasn’t my thing...You can’t get me on a committee I don’t want to be on.” Nurse NG (US) stated; “I hate that [being on committees]...I’m not going to come. My off days are my off days.” Many nurses were skeptical about the value of their committees. Nurse NK (IEN) admitted; “I don’t know much about it [her committee].” Nurse DS (US) was on a committee “but it never really changed much and as the enthusiasm for it died off, it just became an exercise in futility.” Some nurses accepted their committee responsibility, but reluctantly. When nurse WR (IEN) was asked why she volunteered to be the chair of a committee, she said, “because nobody wants to do it.” Only a few nurses recognize that their participation in governance can improve patient care. For example, nurse EB (US) participates on several committees because “it gives you a more global idea of what’s going on in the system ...and sometimes to give better patient care, we need to know what’s going on on other units.”

Meetings are scheduled inconveniently for nurses; interfering with their patient care or time off. Meetings held during shifts are problematic because they require nurses leave their patients to attend. Nurse KL (US) said, “it causes me much extra stress...when I have patients that are here waiting for me and I’m sitting in a meeting, because the

whole time I'm like 'okay, are my patients okay?'...then that puts you behind for your shift." Nurse EB (US) said, "I don't want to leave my patients, have somebody else look after my patients, so we're just like juggling to go to these meetings." There are other challenges when meetings are held during nurses' time off. Nurse TL (IEN) wants to step down from her committee because "I live one hour away from here and I just didn't want to come for two hours and, you know, it's just so hard" especially since she is also taking classes for her BSN. Night shift nurses find it particularly difficult. Nurse NG (US) said, "I'm supposed to go home, sleep what, four hours? And get up and drive here and, what, sleep in the parking lot until 7 [pm]?" Remuneration is another factor; some nurses do not believe, or do not know if they are compensated for their time attending meetings. Nurses who live far from the hospital shared nurse RR's (Caribbean) concern; "gas prices are higher, you know. So I don't want to leave the house if I don't have to."

Most nurses do not believe Magnet recognition is relevant to their work because they believe it is primarily a strategy to increase the hospitals' status. Nurse NK (IEN) said her institution wants "to be seen as the leading healthcare provider in the south." Nurse DS (US) said, "it's a marketing tool." Nurse EN (US) said, "I'm kind of disappointed, actually, in the whole Magnet thing...I think a lot of it is just status." Some nurses think it is an effort to attract patients of a higher socio-economic status. Nurse RI (IEN) said, "it's a great selling fact...and obviously, if you say you're Magnet...you get more revenue because people want to come more." Nurse AI (US) believes "They [administration] just want to make sure this hospital stays filled with patients...who are going to pay."

Nurses do not believe Magnet recognition will affect their practice because they already provide excellent patient care. Nurse RI (IEN) said, “for me it doesn’t make any difference because you should be doing a good job whether you’re Magnet or not.” Nurse DS (US) said, “I honestly don’t think it [Magnet recognition] means anything because...it doesn’t change your day-to-day taking care of the patient.” Some nurses also feel it causes them more work with no benefit. Nurse TB (IEN) said, “it seems as though we’re doing stuff now to get Magnet, whereas we should be getting Magnet because of stuff we’ve been doing.” Nurse CS (US) said, “we...always did the care, but now you have got to prove that you did the care.”

Disinterest in Professional Advancement

Neither IENs nor US RNs expressed interest in professional advancement generally because they believe it would take them away from the bedside. Nurse BM (IEN) was encouraged to apply for a higher role, but refused; “That’s not my call[ing], bedside nursing is my call[ing].” Nurse AL (IEN) said in her home country nurse managers “still manage the patient care. But here the managers ... manage more office” so she is not interested. Nurse HS (US) does not want to be a manager because “I got into this for the patients and you’re more removed from the patients.” Nurse RC (US) had been a manager at her previous place of employment and when asked if she would be interested in management again she responded, “I’m not a paper-pusher... I’m a people person.” Nurse CV (US) has been in administration for over five years but:

I want to go back to the patient...I miss the constant challenge of your brain to figure out what’s going on, what’s going wrong, and how I can maximize this

patient's life experience and improve their quality of life. And as a manager... I don't have the hands-on that I do when I'm one-on-one with the patient.

Some nurses do not want the extra responsibility. Nurse TG (IEN) was a manager in her country but "here it's different... it's too much responsibility." Nurse NA (IEN) said, "I do not want a promotion... every time I do the charge nurse, it makes me headache [sic]... I just want a peaceful life; come to work and go home." Nurse NG (US) has been encouraged annually to apply for promotions, but "it's just too stressful... I was an advanced nurse clinician and actually I cut back because I had to be in charge every time I'm here and that is just too much... you're so stressed out... it's not worth it." Remuneration also plays a role. Nurse HS (US) calculated the salary differential and realized the promotion was not worth it; "You could work a few extra shifts... and have less headache." Nurse EN (US) agreed "I would get another fifty cents an hour, yeah, well, you know what? I can work an extra four shifts and do that." Nurses also said the application process was complicated and involved too much effort.

Some nurses were interested in seeking promotions but were discouraged by a lack of guidance and encouragement from supervisors. Nurse NK (IEN) said:

People who are raised or went to school here [in the United States] or who are the younger set, I find management takes a special interest to keep them under their wing... where when it comes to mid-level nurses like me, nobody is giving me [guidance] and sometimes I feel like I don't know what to do. I wish somebody every once in a while would point it out.

A US RN agreed, "I didn't know what to do to get a promotion... No one told me I had to apply for the position, I thought you just get promoted."

Discussion

Structuration theory focuses, in part, on agents' ability to influence the structures around them through their understandings of rules and resources. This study suggests that both IENs and US RNs understand they have opportunities to make changes in their environments, and for similar reasons they choose not to do so through official governance committees or professional advancement. Ostensibly these reasons are related to scheduling issues, but nurses' lack of participation may be more related to underlying issues of empowerment. Feminist interpretations of empowerment describe individual empowerment as "power within," achieved through attainment of knowledge and expertise, and collective empowerment as "power with," or the ability to work together to effect change (Smith & Troutner, 2004). Bedside nursing both requires and supports the former, while participation in governance is a strategy to achieve the latter. Pursuit of professional advancement is a combination of both as an individual decision that places the individual in a position of working with others to enact broader changes. These roles involve different skills and knowledge.

Although collective empowerment can be facilitated by outsiders, members of a group must believe they have the ability to enact change (Stromquist, 2002). Participation in governance is expected of nurses as these hospitals pursue Magnet recognition and is therefore an externally imposed strategy for collective empowerment. Nurses' views regarding participation as irrelevant to their work therefore suggest they may not see a need for change or they may not perceive committee work as an effective way to enact change. Nurses' belief that they excel in providing patient care suggests they do not see a need for change. Their comments also show they did not see Magnet recognition as

meaningful for them or even for nursing, therefore there is no motivation to spend personal resources of time or money on committee work.

The findings suggest that nurses place higher value on their role at the bedside than on their roles on committees or in advanced positions. Nurses' education and training have prepared them to be experts in patient care, which may explain why they expressed dislike at leaving the bedside either to attend meetings or seek promotions. It is also possible nurses feel they lack the knowledge and skills to successfully navigate these roles.

There are some immediate actions hospitals could take to encourage professional advancement and participation in governance. Hospitals could improve both the content and the manner in which they communicate with nurses about the value of nurses' participation and leadership in governance and how it benefits patients, the hospital, and the nurses themselves. Hospital leadership could actively inform and encourage IENs to seek leadership roles because there may be cultural reasons they choose not to participate in governance or seek advancement. Nurse IP (IEN) said in her culture, people wait to be recognized and promoted, otherwise they are seen as "greedy" so she had to learn to stand up for herself and ask for a promotion. Supervisors play an important role in supporting nurses to seek promotions. Nurse IP (IEN) said, "when this assistant manager position opened...my boss said, 'Oh, you're qualified. You want to apply for this'...it's like the people recognized... my professional [ability] or what I know [and] promoted me." Clarification of policies would help nurses understand remuneration for committee work or how to apply for a promotion. Nurse QR (US) pointed out "a lot of American nurses don't know, probably, about how do I advance to this level? So I think it's just

across the board a knowledge deficit for a lot of nurses.” Higher monetary incentives might encourage nurses to seek promotions and participate on committees.

In the longer term, a review is needed of what is expected of nurses and how this corresponds to nursing education and nursing work. Currently, nursing roles in hospitals are individually empowering, but if nurses are expected to work collectively to enact changes in patient care, then nursing programs need to provide nurses with more knowledge, skills and practice early in nurses’ education about leadership and teamwork. Hospital work needs to provide more opportunities for nurses to work together in a meaningful way. Total patient care, where nurses work individually to provide all of the care for a certain number of patients, may benefit from some modifications to provide more opportunities for nurses to work together.

Conclusion

IENs and US RNs are equally disinclined to participate in governance structures or seek promotions, demonstrating they value individual empowerment over collective empowerment. In the short term, better communication, more individualized encouragement, clear policies, and higher remuneration would help incentivize nurses and demonstrate the organization’s commitment to empowering nurses. In the longer term, nursing education and practice should be examined to see how the collective empowerment of nurses could be embedded in nurses’ professional formation.

References

- Aiken, L. H. (2007). US nurse labor market dynamics are key to global nurse sufficiency. *Health Services Research, 42*(3 Pt 2), 1299-1320. doi: 10.1111/j.1475-6773.2007.00714.x
- Aiken, L. H., Buchan, J., Sochalski, J., Nichols, B., & Powell, M. (2004). Trends in international nurse migration. *Health Affairs (Millwood), 23*(3), 69-77. doi: 10.1377/hlthaff.23.3.69
- Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J. A., Busse, R., Clarke, H., . . . Shamian, J. (2001). Nurses' reports on hospital care in five countries. *Health Affairs (Millwood), 20*(3), 43-53.
- Aiken, L. H., Sochalski, J., & Lake, E. T. (1997). Studying Outcomes of Organizational Change in Health Services. *Medical Care, 35*(11), NS6-NS18.
- American Nurses Association. (2012). NDNQI: National database of nursing quality indicators Retrieved February 16, 2012, from <https://http://www.nursingquality.org/>
- American Nurses Credentialing Center. (2012). Program overview Retrieved January 10, 2012, from <http://www.nursecredentialing.org/Magnet/ProgramOverview.aspx>
- Armstrong, K., & Laschinger, H. K. S. (2006). Structural empowerment, magnet hospital characteristics, and patient safety culture: making the link. *Journal of Nursing Care Quality, 21*(2), 124-132.
- Armstrong, K., Laschinger, H. K. S., & Wong, C. (2009). Workplace Empowerment and Magnet Hospital Characteristics as Predictors of Patient Safety Climate. *Journal of Nursing Care Quality, 24*(1), 55-62.

- Barden, A. M., Quinn, Donahue, M., & Fitzpatrick, J. J. (2011). Shared governance and empowerment in registered nurses working in a hospital setting. *Nursing Administration Quarterly*, 35(3), 212-218.
- Beechinor, L. A., & Fitzpatrick, J. J. (2008). Demands of immigration among nurses from Canada and the Philippines. [Journal Article]. *International Journal of Nursing Practice*, 14(2), 178-187.
- Bretschneider, J., Glenn-West, R., Green-Smolenski, J., & Richardson, C. (2010). Strengthening the voice of the clinical nurse: The design and implementation of a shared governance model. *Nursing Administration Quarterly*, 34(1), 41-48.
- Brody, A. A., Barnes, K., Ruble, C., & Sakowski, J. (2012). Evidence-Based Practice Councils Potential Path to Staff Nurse Empowerment and Leadership Growth. *Journal of Nursing Administration*, 42(1), 28-33. doi: 10.1097/NNA.0b013e31823c17f5
- Brush, B. L. (2008). Global nurse migration today. *J Nurs Scholarsh*, 40(1), 20-25.
- Creswell, J. W. (1998). *Qualitative Inquiry and Research Design: Choosing Among Five Traditions*. Thousand Oaks, CA: Sage Publications, Inc.
- Dicicco-Bloom, B. (2004). The Racial and Gendered Experiences of Immigrant Nurses from Kerala, India. *Journal of Transcultural Nursing*, 15(1), 26-33. doi: 10.1177/1043659603260029
- Giddens, A. (1984). *The Constitution of Society: Outline of the Theory of Structuration*. Berkeley: University of California Press.
- Institute of Medicine. (2003). Keeping patients safe: Transforming the work environment of nurses. In T. N. A. Press (Ed.). Washington, D.C.: Institute of Medicine.

- Institute of Medicine. (2010). *The future of nursing: Leading change, advancing health*. In T. N. A. Press (Ed.). Washington, D.C.: Institute of Medicine.
- Jose, M. M. (2010). Lived experiences of internationally educated nurses in hospitals in the United States of *International Nursing Review*, 58, 123-129.
- Kingma, M. (2007). Nurses on the move: a global overview. *Health Services Research*, 42(3 Pt 2), 1281-1298. doi: 10.1111/j.1475-6773.2007.00711.x
- Laschinger, H. K. S., Almost, J., & Tuer-Hodes, D. (2003). Workplace Empowerment and Magnet Hospital Characteristics: Making the Link. [Article]. *Journal of Nursing Administration*, 33(7), 410-422.
- Salmon, M. E., Yan, J., Hewitt, H., & Guisinger, V. (2007). Managed migration: the Caribbean approach to addressing nursing services capacity. *Health Serv Res*, 42(3 Pt 2), 1354-1372. doi: 10.1111/j.1475-6773.2007.00708.x
- Schumacher, E. J. (2011). Foreign-born nurses in the US labor market. *Health Economics*, 20(3), 362-378. doi: 10.1002/hec.1595
- Smith, P. H., & Troutner, J. L. (2004). Empowering Women: Agency, Structure, and Comparative Perspective. In P. H. Smith, J. L. Troutner & C. Hünefeldt (Eds.), *Promises of empowerment: women in Asia and Latin America* (pp. 1-34). Plymouth, United Kingdom: Rowman & Littlefield.
- Stromquist, N. P. (2002). Education as a means for empowering women. In J. L. Parpart, S. M. Rai & K. Staudt (Eds.), *Rethinking empowerment: Gender and development in a global/local world*. New York: Routledge.
- Watters, S. (2009). Shared leadership. *Journal of Nursing Administration*, 39(1), 26-29.

Xu, Y., Zaikina-Montgomery, H., & Shen, J. J. (2010). Characteristics of internationally educated nurses in the United States: an update from the 2004 National Sample Survey of Registered Nurses. *Nursing Economic\$, 28*(1), 19.

Running Head: DISCRIMINATION EXPERIENCED BY NURSES

Manuscript 4

Discrimination Experienced by

Internationally Educated Nurses and U.S. Nurses in Hospitals

Rebecca M. Wheeler

Emory University

Abstract

Purpose: The purpose of this article is to describe discrimination experienced by U.S. and internationally educated nurses (IENs) in U.S. hospitals.

Design: This qualitative study employed a nested research design.

Method: Semi-structured interviews were conducted with 82 nurses from two urban hospitals in the southeastern United States. A second round of interviews with 40 nurses expanded on themes from initial interviews.

Findings: Nurses experience discrimination from their patients, their nurse colleagues and other hospital personnel. IENs may experience more direct discrimination, but many U.S. nurses also experience discrimination. IENs and U.S. nurses have similar coping strategies.

Conclusions: Discrimination may have serious psychological effects that impact nurse retention and the quality of patient care. More research is needed about discrimination against nurses in the workplace.

Implications for Practice: Healthcare institutions should ensure they have policies to prevent and address discrimination against nurses.

Keywords: Discrimination, coping strategies, internationally educated nurses

Introduction

Internationally educated nurses (IENs) play a key role in U.S. efforts to improve patient care because many U.S. health care systems have resorted to recruiting IENs from overseas to increase staffing levels. These IENs make up a considerable portion of the nursing workforce, especially in facilities in urban areas (Aiken, 2007). International literature has identified barriers faced by IENs that may involve discrimination, but there is a lack of U.S. research. This study found that IENs and both Caucasian and African American nurses observed or had personal experiences of discrimination at work, suggesting some units could be considered hostile workplaces. This has potential implications for nurse retention and the quality of patient care.

Literature Review

International and U.S. studies describe three main barriers IENs face when adjusting to new countries: communication, exploitation, and isolation. When nurses are not native speakers of the national language, verbal communication is compromised, but body language, slang, and medical jargon can be very different even when the IEN does speak the national language (Allen & Larsen, 2003; Hardill & MacDonald, 2000; Hawthorne, 2001; Jose, 2010; Kawi & Xu, 2009; Magnusdottir, 2005; Xu, 2007). Communication barriers can make IENs afraid to ask questions or express opinions, affecting teamwork and leading to confusion and misunderstandings (Ea, 2007). Speaking the national language with a strong accent may create barriers with other healthcare workers and patients (Xu, 2007).

IENs can be exploited by being asked to work undesirable shifts, more frequent shifts, or perform tasks that are not appropriate to their position of employment (Allen &

Larsen, 2003; Diccico-Bloom, 2004; Likupe, 2006). Employers may hold their passports or green cards, or threaten to go to immigration in order to ensure IENs comply with work demands (Pittman, Folsom, Bass, & Leonhardy, 2007). Employers may delay payment to IENs, pay less than the IENs' U.S. counterparts, or not pay for all the hours worked (Pittman et al., 2007). Employers may not provide sufficient orientation for the IENs (Pittman et al., 2007).

IENs may feel isolated from their peers and patients (Allen & Larsen, 2003; Beechinor & Fitzpatrick, 2008; Diccico-Bloom, 2004; Magnúsdóttir, 2005). Co-workers and patients may have negative attitudes regarding IENs' abilities and may not recognize IENs' qualifications (Hawthorne, 2001; Likupe, 2006). IENs may be required to work initially in low-skill positions, perhaps under supervisors with fewer qualifications than the IENs, causing them to feel devalued and lose their confidence (Allen & Larsen, 2003) as well as distancing them from their peers. Discrimination by co-workers or patients are both professionally and personally demoralizing (Dicicco-Bloom, 2004; Likupe, 2006).

The United States, especially the Southeast, has a long history of institutionalized racist practices that have affected African American nurses and may also contribute to discrimination against IENs. Segregation either implicitly or explicitly blocked African Americans from entering nurse training programs or gaining experience in hospitals (Hine, 1989). It was assumed that African American nurses were inferior, incapable, and inadequately trained, and some argue these assumptions still exist (Hine, 1989; Wilson, 2003). Wilson (2003) argues that African American nurses are doubly oppressed and that this leads to "their sense of invisibility and voicelessness" (Wilson, 2003, p. 64). The

studies about IENs indicate they may face similar negative stereotypes as female nurses of color.

Discrimination in the workplace has received little attention in the U.S. nursing literature. One survey about career paths and barriers faced by Caucasian, African American, Filipino, Latino, and Asian Pacific American nurses in California found that all groups, except Caucasian nurses, believed there were opportunities for advancement but that they faced barriers in pursuing these opportunities due to their race/ethnicity (Seago & Spetz, 2008). Studies of Arab American nurses (Kulwicki, Khalifa, & Moore, 2008) and U.S. physicians (Nunez-Smith et al., 2009) found that non-Caucasian participants did not experience overt discrimination (in the form of, for example, threats, termination, or demotion), but many reported being subject to negative comments, being treated with suspicion, and having patients or their families refuse their care.

Discrimination is important to address because it can create a hostile workplace, which affects nurses' performance and psychological health (Kulwicki et al., 2008). Literature from sociology and psychology describes how a hostile work environment "interferes with work performance and negatively affects an individual's employment opportunities" (Shin & Kleiner, 2001, p. 59). It has been proposed that racism used to be based purely on skin color but now is based on culture and is made evident by "attitudes and behaviors...includ[ing] antipathy, avoidance, ignoring, disengagement, rejection, disgust, contempt, scorn, ridicule, and indifference" (Johnstone & Kanitsaki, 2009, p. 67). A racially hostile work environment can have serious psychological consequences including anxiety, fear, insecurity, alienation, a loss of self-esteem, and depression, and it can affect also physical health (Raver & Nishii, 2010; Shin & Kleiner, 2001). For

employers, the consequences can be poor attitudes at work, job dissatisfaction, decreased morale, a lack of trust and increased attrition, all of which weaken the organization (Raver & Nishii, 2010; Shin & Kleiner, 2001).

Methods

This study used qualitative methods in a nested research design. Eighty-two female registered nurses were recruited from two urban hospitals in the Southeastern United States for a round of brief semi-structured interviews. Of the 41 nurses from each hospital, 21 were IENs and the other 20 were U.S. nurses. A second round of interviews was conducted with 40 nurses (20 from each hospital: 9 US RNs and 11 IENs) following up on themes that emerged in the first round. Characteristics of all participants are presented in Table 1.

Purposive sampling was used to recruit participants in order to obtain a wide variety of experiences from nurses multiple units and shifts. The participant population was limited to female RNs because the majority of US RNs and IENs are women (U.S. Department of Health and Human Services, 2010; Xu, Zaikina-Montgomery, & Shen, 2010). After an IEN was recruited, an effort was made to recruit a US RN from the same unit and shift. Inclusion criteria for the IENs were; nurses who were raised, received their initial nursing training (leading to licensure), and had at least one year of practice in their home countries. US RNs were nurses raised and educated (leading to nursing licensure) in the United States. Both IENs and US RNs worked for at least one year at the bedside in U.S. hospitals.

Data collection and analysis employed the constant comparative method (Creswell, 2003). During initial interviews nurses were asked general questions about

what they liked and disliked about nursing. They were also asked to describe their first year of practice as new nurses and IENs were additionally asked to describe their first year practicing in the United States. As data were analyzed, the theme of discrimination became evident. During the second round of interviews, all nurses were asked about personal and observed experiences of discrimination at work.

All interviews were conducted and analyzed by the researcher. Approval was obtained from the investigational review board (IRB) affiliated with the researcher's university prior to collection of any data. All nurses gave verbal consent before each interview and were informed that their participation was voluntary and they could withdraw at any time. Nurses were assured that the data would be confidential, and all identifiers were removed from transcripts. Here nurses are identified by code and region of origin to protect their identities. All research materials were stored on a password-protected laptop that only the researcher could access.

Findings

Experiences of discrimination in the workplace were reported by Caucasian American nurses (identified by a "C"), African American nurses (identified by "AA"), and IENs (identified by the region of the world where they are from). These experiences occurred with patients, supervisors/hospital administrators, and/or fellow staff nurses. Nurses identified experiences as discriminatory when they saw the individual in question consistently behaving differently with nurses of different skin colors or nationalities. These experiences were not limited to one hospital, one state or one geographical region, indicating the pervasiveness of the behavior. Table 1 presents information about

participants' age and years of nursing experience. Table 2 presents information about the race of US RNs and region of origin of IENs.

Table 1

IEN and US RN Age and Years of Nursing Experience

	Number	Mean age* (years) (Age range)	Mean years* experience (Range)
US RNs	40	39 (24-58)	12 (1-40)
IENs	42	45 (30-70)	21 (7-46)

* Approximations. Some participants preferred to give an age range instead of their exact age. Some nurses were not employed in nursing periodically, making calculations of years of experience approximate.

Table 2

Participants' Race and Region of Origin

US RN	Number	IEN	Number
Race		Region of origin	
Caucasian	20	Caribbean	7
African American	20	European Union	2
		Sub-Saharan Africa	13
		Southwest Asia	12
		East Asia	6
		Pacific	1

	Oceania	1
--	---------	---

Total US RN	40	Total IEN	42
-------------	----	-----------	----

Discrimination by Patients

The discriminatory experiences most commonly reported by nurses originate from patients and/or their families. These experiences include derogatory comments and questioning, assumptions made regarding a nurse's role, and rejection of a nurse's care by a patient and/or family members because of the nurse's skin color or accent. Of those nurses who had not experienced this directly, many had seen it happen to their colleagues.

Non-Caucasian nurses are often the subjects of derogatory comments that refer to their skin color. Nurse TB (Caribbean) was told, "What is with all these colored folks out there? I'll lay in my urine before I'll let a colored folk see me." A patient told Nurse DF (Africa) "You don't take a shower – that's why you're so black."

IENs are subject to questioning that US RNs typically are not because their accents identify them as being from outside the United States. IENs reported being asked where they are from, where they went to nursing school, how long they have been nurses, and how long they have been in the United States. These questions were perceived by IENs to be evidence of patients' mistrust in the abilities of IENs. Nurse NA (Asia) said, "white people... first probably they do not trust me, right? They got to ask you more questions." Nurse AA (Africa) said, "once they notice you have an accent, it's like their

care will be compromised, you could be substandard.” Patients also question IENs’ immigration status. Nurse AA (Africa) described one situation:

One [patient] said to me “well, yeah. I need to know whether you are [an] illegal alien.” I said, “Do you think the Board of Nursing in [state] would grant me a license if I’m really an illegal immigrant? Or this hospital would allow me to come into the hospital to work if I’m an illegal immigrant?” He said, “Well, I never know, so I have to find out what you are.” I said, “Ok. You insult me because you and I are on equal standing.” He said, “You are a citizen?” I said, “Yes, and I have just been insulted by you.” And so he apologized.

Often patients make assumptions about the qualifications of the person providing their care based on color or accent. Generally a Caucasian American is assumed to have the highest position (a physician or RN) and a non-Caucasian IEN is assumed to occupy the lowest (a nurse’s aide or cleaning staff). Nurse TF (AA) said, “We’re still in the South and I can go into a patient’s room and it’s not even white [patients]; it’s black [patients] too sometimes, and the first thing they ask you, especially the older ones ‘are you my tech [nurse’s aide]?’” Nurse LL (Europe) said, “somebody told me I was a maid...[when] I was a charge nurse and I ran the third floor.” Nurse SJ (Africa) said, “[patients] think that ‘oh, the one that doesn’t have an accent is the boss.’”

Patients and their families may avoid the nurse who has been assigned to them in favor of another according to skin color or nationality. Nurse NG (AA) described patients who are not receptive to an African American nurse and instead “are looking at the tech, who’s white, and asking her questions that she can’t answer.” Nurse RI (Oceania) has “had some dealings over the years when I’ve given discharge information or whatever

and they [the African American patients] obviously had a mistrust and they have gone to an African American nurse.” Nurse AI (AA) described “we’re sitting at the desk, me and like let’s say two African nurses, and they [patients’ family members] know that they [the African nurses] are their parent’s or their sister’s or whatever’s nurse, but they’ll come to me to ask questions.”

The strongest discriminatory behavior from patients and/or family members is the refusal of a nurse’s care. Nurses have seen Caucasian patients reject African American nurses, African American patients reject Caucasian nurses, and both Caucasian and African American patients reject IENs. Nurse NG (AA) remembered when a Caucasian patient’s fiancée “only wanted the Caucasian nurses, and she was like ‘this one is so sweet, can I have this one?’ and every day she would request and then we saw a pattern.” Nurse DS (C) was assigned a patient because he refused to be cared for by “any nurse that was black” because he was a member of the Ku Klux Klan. “It had to be an American white nurse.” Nurse AR (Africa) said, “because I have an accent...they like to slap my face with it. Some do not even know me at all and they say ‘I do not want you.’” Patients may not overtly reject a nurse’s care, but their preferences are often still clear. Nurse JN (Europe) said, “I think actually black patients like black nurses better.” Nurse CS (C) said:

I find the African American patients treat me a little bit different. They would rather have an African American nurse...they won’t ask to be switched per se but they just tend to treat you more colder (sic), not friendly. Like I found a situation ... one of the techs came in, it was a total personality change within the

patient...asking the tech “Hi, how are you?” And I’m like “Is this the same person?” and then the tech left and I got the cold personality back.

Discrimination by Supervisors or Other Hospital Personnel

Some nurses reported being discriminated against by supervisors and/or other hospital personnel. Nurses reported working with supervisors who favor certain racial groups over others. Nurse TP’s (Asia) supervisor was always watching her as well as another IEN, but “she was really nice with them [US nurses].” She was often given the difficult patients and ultimately she left that job. Nurse DS (C) described working for a supervisor who favored African American nurses:

it was obvious...when you requested time off to this certain person. If you were a part of her posse, no problem. If you weren’t, she wouldn’t look you in the eye when she spoke to you...even if you put [your request] in writing, it would miraculously get lost.

Nurse LL (Europe) discussed working for a supervisor who was an IEN “If you’re actually American she tries to be nicer because she’s scared if you do raise a stink somebody will actually listen. But not if you’re black American [or an IEN].”

Nurses also experience discriminatory treatment as they seek jobs or advanced positions. When nurse NT (AA) went to a job interview “the director did not even call me into her office to interview. She came out to the little waiting room to interview me...and we talked about everything except nursing.” When nurse RA (AA) sought one position, she was told “I didn’t fit the makeup of their clinic” which she understood to refer to her skin color. Nurse LO (AA) believes if she and a Caucasian colleague applied to work at another area hospital “[Caucasians] get in before I would, they’ll probably have a better

chance.” Nurse BO (AA) believes that Caucasian nurses get promoted faster; her African American friends with advanced degrees describe situations where they train a nurse with fewer qualifications and “in six months she will be over [them].” Nurse WR (Africa) noticed in one place where she worked that “the whites [were] always higher – they did things and got away with it. For the African Americans there were things that you didn’t do...and I thought that this was supposed to be somewhere in the past but it’s really here.” Some IENs were discriminated against when their nursing experience was not recognized. Nurse RR (Caribbean) said, “the first thing they told me was ‘you’ve never worked in the U.S. so we can’t pay you for your experience.’” Nurse IP (Asia) said, “I noticed when they hired me ...I was much lower [in rank] than other nurse, even though I have experience. I guess because I was Asian.”

Physicians also discriminate. Nurse NG (AA) described how the physicians who came for early morning rounds asked the recently-arrived day shift Caucasian nurses about how the patients spent the night instead of the non-white night shift nurses: “it just seems like ‘why aren’t you asking us?’ We’ve spent all night with the patients. We know exactly what happened.” She added “there are few [physicians] that get to know us and know us by names and, you know, some never do.” Nurse BO (AA) described how a doctor came to her unit and assumed the Caucasian nurse was a physician, calling her “Doctor.” Nurse TO (Asia) was the only RN on her unit and was the charge nurse, yet one physician would only do patient rounds with one of the Caucasian LPNs.

Supportive supervisors play important roles in diffusing tense situations. Nurse RA (AA) described how her African-American supervisor told a patient:

There's nothing I can do about the color of our skin. The only thing we can do is give you good care and that's what we aim to do here...I know my nurse, I know she's a great nurse...give her a chance to take care of you so that you can have a good outcome and go home happy.

Discrimination by Fellow Nurses

Nurses reported discriminatory treatment by their colleagues. Nurse ON (AA) described how difficult it was to work in facilities where very few RNs were African American and most of the African American employees were nurse's aides or worked in housekeeping. Even though she was an RN, Caucasian LPNs would not listen to her and then would report her to the supervisors for errors they had made. When she finally worked in a setting where the majority of the nurses were African American, she saw the same thing happen when a Caucasian nurse came to work; "they were treating her as I was treated. I stopped it. I was like 'no, you are not going to do that'." When nurse DF (Africa) was working in a hospital among mostly Caucasian nurses, a US RN (C) told her "I feel like you should be sweeping, not be a nurse." Nurse RC (C) described feeling "like I'm the needle in the haystack" working on a unit where she is the only Caucasian nurse. "You do get these little comments every now and then 'that white girl.'" Nurse BT (Africa) had an aide "and she would not help put my patient in bed simply because it was my patient" but the aide would help US RNs. Nurse RI (Oceania) described how when she first began working "everybody here thought I knew nothing, including the doctors." The same thing happened to nurse WR (Africa); "I have this big old accent and so they thought I didn't know how to do anything."

Having the same skin color does not mean IENs are accepted by either Caucasian or African American nurses. Many nurses specifically mentioned conflict between African American nurses and African IENs. Nurse SJ (Africa) believes African American nurses dislike both African nurses and Caucasian US nurses for historical reasons; “they [African American nurses] have told me to my face, they said, ‘well, you guys sold us, the blacks, to the whites.’” Nurse OZ (Africa) confronted two African American nurses who criticized an African nurse, telling them “We are all registered nurses. We come from Africa. It doesn’t mean we didn’t go to school... Nobody got a free pass to practice...it’s the same exam we all take.”

Some US RNs understand these are cultural differences and support their IEN colleagues. Nurse BO (AA) explained:

When they [patients] get an African nurse, they get to complaining. I tell a lot of my patients it’s cultural. I tell the manager a lot of times it’s cultural. And I know they [African nurses] probably don’t see it that way because that’s their culture.

One nurse (TB) (Caribbean) described having to explain the culture of an African nurse to a patient who complained that “her [the African nurse’s] tone of voice, it seems like she’s always arguing”. The nurse responded “well no...that’s just the way she talks”.

Nurse TG (Caribbean) explained “I think you’re having [sic] some cultural awareness of the patient and, you know, we have to do the same with our co-workers too.”

Coping

Nurses cope with discriminatory treatment in five ways. Most frequently they rely on personal values to help them ignore it. They also excuse discriminatory behavior. Sometimes they confront it. They may change units or shifts or even leave their positions

if the situation does not improve. Many nurses work harder to prove themselves to everyone around them.

Personal values

Many nurses say they just “don’t take it personally” and rely on personal values to help them ignore discriminatory treatment. Nurse TL (Asia) tries to ignore any discrimination; “I always think positive...I just do what I have to do, I don’t judge anybody.” Nurse DF (Africa) said her religion helps her to “let it go.” Nurse TG (Caribbean) said, “I always see the good side of people, so I’m like ‘hey, maybe they got something going on bad with them or maybe somebody did do something bad to them, so they’re taking it back all on me.’”

Nurses also rely on their inner confidence and their goals. In one job, nurse WR (Africa) did not let others’ criticism shake her faith that “I knew I was doing the right thing.” Nurse NT (AA) said, “You get to the point where you have to have some self confidence in yourself.” Nurse TG (Caribbean) explained; “I know my goal, why I’m here, and so I don’t let it bother me.” Nurse NA (Asia) is also confident in her abilities “I know exactly what I am doing. I know I am a good nurse.” Nurse AA (Africa) said, “I don’t even give people the opportunity to challenge me.”

Excusing discriminatory treatment

Nurses often excuse patients’ discriminatory behavior as a result of patients’ age and/or background. For example, nurse HS (C) observed that “there are some older people, black and/or white that are sort of country that are not too keen on the foreigner nurses.” Nurse TB (Caribbean) excuses the older patients “they were born in the days when it was black and white were separated and they lived 40 years of that with, you

know, it was this racial thing and so it's hard for them to change." Nurse SJ (Africa) believes some patients are "primitive" and have not had the opportunity to travel or know other ways "so I don't hold anything against them because that's the only thing they know." Regardless of the reason, some nurses are able to blame discrimination on the external world instead of personalizing it. As nurse KL (AA) warned, "you can take it personally, but don't internalize it because it's not about you." Nurse LL (Europe) equates discrimination with a disease "you take on the disease and whatever else because it's like infected people to me [laughs] it's like the minds are infected."

Confronting discriminatory treatment

Some nurses are willing to confront discriminatory treatment by addressing the issue directly with the individuals and/or by officially reporting colleagues to supervisors. Nurse BT (Africa) said, "because you disrespect me...if it comes to the worst, like I did in the past, I just report you to the authority." Nurse OZ (Africa) said, "when I see stuff that is not right, I voice my opinion." Nurse BO (AA) explained "I'm so used to being discriminated against that it don't [sic] even bother me until it's so blatant that I'm like 'this is ridiculous, I'm going to report this.'" In other situations nurses may confront the speaker directly. Nurse NA (Asia) jokes with patients to show their questions are inappropriate. When Nurse TO (Asia) answered a call from a physician who asked to speak to a nurse that did not have an accent, she "looked around and said, 'Well, doctor...[nurse 1] is from New Jersey...[nurse 2] is from Newnan, Georgia, [nurse 3] is from...' I said, 'Everybody has an accent, but I can help you. What can I do for you?'" and so the physician explained what he needed.

Disconnecting and leaving

If discriminatory behavior is pervasive or enduring, nurses may disconnect from or even leave that environment. Nurse ON (AA) described feeling “beaten down” such that she no longer supported the facility; she would only “take a stand” if something affected her patients, otherwise she would just put her “head down,” get through the day and go home. Many of the aforementioned cases of discriminatory treatment by supervisors resulted in nurses leaving. As Nurse RC (C) said, “I deserve better and I’m a better nurse than I’m allowed to be when I work at [hospital].” Nurse SJ (Africa) said, “if ...I’m meeting with difficulty in patient care as a result of racism, I leave.” Nurse HK (Caribbean) felt her colleagues on the night shift did not accept her because she was not from the United States, so she switched to days and was much happier.

Working harder in the face of discriminatory treatment

Many nurses mentioned they work harder to prove they are good, capable nurses to the patients who seem to doubt their abilities. Nurse TB (Caribbean) believes “your work speaks up for more than your color.” Nurses often have strategies for reassuring their patients regarding their care. Nurse NK (Asia) said, “it’s not so much what you say to them that matters than how you take care of them.” Nurse HK (Caribbean) “I try to go over[board] to show them that I am the best thing that you have...I see them calling, so before they call me I’m at their door already...so they see that I am eager to help them.” Nurse ON (AA) tries to “kill them with kindness” to win them over.

Often nurses feel they have to work harder to prove themselves to everyone around them. Nurse IL (Asia) feels she works harder and more carefully so “nobody can put me down.” She also continues to learn and review “my mind is 100 percent intent all the time...make sure I know exactly what I’m doing.” Nurse RC (C) works harder

because “I just always feel like I’m being watched...I want to provide the best that I can for all my patients, but not by having to constantly feel like I have to be looking over my shoulder.” Nurse RA (AA) left one hospital because “you still have to work twice as hard to prove you’re half as good.” Nurse DF (Africa) said, “I’m used to working harder...to make sure I show people that I can do it.”

Discussion

These findings show that female nurses of all races, ethnicities and nationalities can experience discrimination and hostile workplaces. Perpetrators may be patients, colleagues and/or other staff. It can also happen anywhere; many of the experiences these nurses described occurred in facilities that were not in the Southeastern United States. At the heart of discriminatory behavior is an implied mistrust of the abilities of the nurse to provide quality patient care based on her skin color or nationality. As nurse NP (Caribbean) said, “they [patients] appear a bit concerned as to whether or not you [an IEN] can perform.” Nurse NK (Asia) said, “I do see subtle signs of like ‘are you really sure of what you are doing?’”

The nurses in this study have worked in hostile work environments and have experienced many of the discriminatory behaviors described by Johnstone and Kanitsaki (2009) “antipathy, avoidance, ignoring, disengagement, rejection, disgust, contempt, scorn, ridicule, and indifference” (Johnstone & Kanitsaki, 2009, p. 67). They also have experienced many of the psychological consequences of working in a hostile workplace, particularly anxiety, insecurity and alienation. This discrimination has two serious implications for hospitals and, consequently, patients. First, discrimination causes stress and exhaustion, both psychological and physical. Nurses describe the mental effort

involved in working in hostile environments as they constantly scan people to determine how to approach working with them. They describe working harder to prove themselves to patients, their families, colleagues and others in their place of employment. They also describe that as a result of this, they disconnect from both patient and workplace. Nurses who feel discriminated against will not participate in hospital governance, depriving the institution of potentially important perspectives from nurses' experiences, especially cultural and ethnic, that could benefit patient care.

Secondly, nurses will leave institutions that do not support them. This leads to higher turnover, which impacts patient care and the wellbeing of the institution. When nurses leave, the hospital may be short-staffed, causing stress for the remaining nurses and perhaps leading to burnout and even more nurses leaving. High turnover also means constant training of new nurses, which must be done, in part, by other nurses and again may cause increased stress and lead to burnout. Turnover also raises costs for the institutions as they spend more money to recruit and train nurses. It is estimated that it can cost \$80,000 or more to replace a nurse (Gullatte & Jirasakhiran, 2005; Jones, 2008).

It would be beneficial for hospitals to pay attention to the climate of discrimination on the different units and shifts, and in the institution overall. Hospital leadership needs to understand the impact discriminatory treatment can have and foster an open environment for discussion. An effort to develop policies with transparent processes for hiring, awarding promotions, and reporting discriminatory behavior, and that are clear, prominently displayed and consistently followed may help discourage discriminatory treatment. It is evident from this study that supportive supervisors play an important role in diffusing situations involving discrimination. Training in conflict

resolution as well as cultural sensitivity could be part of the requirements for those in supervisory positions. It could also be part of the orientation process for all nurses hired to help them work well with their colleagues. Supervisors and nurses could receive training in how to manage patients and families that exhibit discriminatory behavior. As some of the stories of these nurses demonstrate, patients may realize how insulting their comments or questions are if it is brought to their attention in an appropriate way.

Conclusion

Few professions entail working so closely and for such long periods of time in a one-on-one situation as does hospital nursing. The current health care climate focuses on quality of care and patient safety, the responsibility for which falls on nurses. Nurses are dealing with increased acuity of patients in hospitals, economic pressures that may mean sub-optimal nurse staffing, and additional responsibilities to improve quality care. Discrimination will only impede nurses from meeting these expectations. Hospitals must support their nurses in the face of discrimination; otherwise nurses, patients and the institution may suffer.

References

- Aiken, L. H. (2007). US nurse labor market dynamics are key to global nurse sufficiency. *Health Services Research, 42*(3 Pt 2), 1299-1320. doi: 10.1111/j.1475-6773.2007.00714.x
- Allen, H., & Larsen, J. A. (2003). "We need respect": experiences of internationally recruited nurses in the UK. Surrey: European Institute of Health and Medical Sciences.
- Beechinor, L. A., & Fitzpatrick, J. J. (2008). Demands of immigration among nurses from Canada and the Philippines. [Journal Article]. *International Journal of Nursing Practice, 14*(2), 178-187.
- Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (2 ed.). Thousand Oaks: Sage Publications, Inc.
- Dicicco-Bloom, B. (2004). The Racial and Gendered Experiences of Immigrant Nurses from Kerala, India. *Journal of Transcultural Nursing, 15*(1), 26-33. doi: 10.1177/1043659603260029
- Ea, E. E. (2007). Facilitating acculturation of foreign-educated nurses. *The Online Journal of Issues in Nursing, 13*(1).
- Gullatte, M. M., & Jirasakhiran, E. Q. (2005). Retention and recruitment: reversing the order... From *Nursing Management: Principles and Practice* (pp. 217-233), edited by Mary Magee Gullatte, RN, MN, ANP, AOCN, FAAMA, 2005, Pittsburgh, PA: Oncology Nursing Society. Reprinted with permission. *Clinical Journal of Oncology Nursing, 9*(5), 597-604.

- Hardill, I., & MacDonald, S. (2000). Skilled International Migration: The Experience of Nurses in the UK. *Regional Studies*, 34(7), 681-692.
- Hawthorne, L. (2001). The globalisation of the nursing workforce: barriers confronting overseas qualified nurses in Australia. *Nursing Inquiry*, 8(4), 213-229.
- Hine, D. C. (1989). *Black Women in White: Racial Conflict and Cooperation in the Nursing Profession, 1890-1950*. Bloomington: Indiana University Press.
- Johnstone, M., & Kanitsaki, O. (2009). The spectrum of 'new racism' and discrimination in hospital contexts: a reappraisal. *Collegian*, 16(2), 63-69.
- Jones, C. B. (2008). Revisiting nurse turnover costs: Adjusting for inflation. *Journal of Nursing Administration*, 38(1), 11-18. doi: 10.1097/01.NNA.0000295636.03216.6f
- Jose, M. M. (2010). Lived experiences of internationally educated nurses in hospitals in the United States of *International Nursing Review*, 58, 123-129.
- Kawi, J., & Xu, Y. (2009). Facilitators and barriers to adjustment of international nurses: an integrative review. *International Nursing Review*, 56(2), 174-183. doi: 10.1111/j.1466-7657.2008.00705.x
- Kulwicki, A., Khalifa, R., & Moore, G. (2008). The effects of September 11 on Arab American nurses in metropolitan Detroit. *Journal of Transcultural Nursing*, 19(2), 134-139.
- Likupe, G. (2006). Experiences of African nurses in the UK National Health Service: a literature review. *Journal of Clinical Nursing*, 15(10), 1213-1220.

- Magnusdottir, H. (2005). Overcoming strangeness and communication barriers: a phenomenological study of becoming a foreign nurse. *International Nursing Review*, 52(4), 263-269.
- Nunez-Smith, M., Pilgrim, N., Wynia, M., Desai, M. M., Jones, B. A., Bright, C., . . . Bradley, E. H. (2009). Race/ethnicity and workplace discrimination: Results of a national survey of physicians. *Journal of General Internal Medicine*, 24(11), 1198-1204. doi: 10.1007/s11606-009-1103-9
- Pittman, P., Folsom, A., Bass, E., & Leonhardy, K. (2007). U.S.-Based international nurse recruitment: Structure and practices of a burgeoning industry. Washington, DC: AcademyHealth.
- Raver, J. L., & Nishii, L. H. (2010). Once, twice, or three times as harmful? Ethnic harassment, gender harassment, and generalized workplace harassment. *Journal of Applied Psychology*, 95(2), 236-254. doi: 10.1037/a0018377
- Seago, J. A., & Spetz, J. (2008). Minority nurses' experiences on the job. *Journal of Cultural Diversity*, 15(1), 16-23.
- Shin, S., & Kleiner, B. H. (2001). The Psychological Effects of Working in a Racially Hostile Environment. [Article]. *International Journal of Sociology & Social Policy*, 21(8/9/10), 59-64.
- U.S. Department of Health and Human Services, H. R. a. S. A. (2010). The Registered Nurse Population: Initial Findings from the 2008 National Sample Survey of Registered Nurses.

- Wilson, D. W. (2003). Conceptualizing African American registered nurses as a vulnerable population. *Journal of Multicultural Nursing & Health (JMCNH)*, 9(1), 61-67.
- Xu, Y. (2007). Strangers in strange lands: A metasynthesis of lived experiences of immigrant Asian nurses working in Western countries. *Advances in nursing science*, 30(3), 246-265. doi: 10.1097/01.ANS.0000286623.84763.e0
- Xu, Y., Zaikina-Montgomery, H., & Shen, J. J. (2010). Characteristics of internationally educated nurses in the United States: an update from the 2004 National Sample Survey of Registered Nurses. *Nursing Economic\$,* 28(1), 19.

Running Head: IENS' PERCEPTIONS OF AGENCY

Internationally Educated Nurses' Perceptions of Agency:

Implications for Patient Care and Nurse Retention

Conclusion

Rebecca M. Wheeler

Emory University

Conclusion

Study Summary

The purpose of this study was to explore IENs' perceptions of their ability to exercise agency in U.S. hospitals as foreign women who received their nursing training outside of the United States. The study employed qualitative methods framed by structuration theory. Structuration posits that interactions among agents shape surrounding structures at the same time as structures shape the agents' interactions in a dynamic process (Giddens, 1984). Structures shape agents' behavior through rules and resources, but agents have the power to change the rules and resources and thus shape the structures. This study is unique in that it compared IENs to U.S. RNs in order to see if IENs thought or behaved differently from U.S. RNs in ways that potentially affect quality patient care in terms of nurse retention, nursing education, and participation in hospital governance structures.

The two phases of semi-structured interviews and the constant comparative method of data analysis allowed themes to be developed in an iterative process of coding and memoing as interviews proceeded, giving the researcher the opportunity to further examine themes in subsequent interviews. This process also allowed the researcher to check information and impressions with the original participant or through questions to other participants with similar characteristics and/or experiences (Creswell, 2003).

The participant population was limited to female RNs who had at least one year of experience practicing as bedside nurses in their home countries. IENs also had to have at least one year in the United States in order to be able to compare the two. Participants were purposefully recruited from multiple shifts and units in two urban hospitals, one

public and one private, in order to find IENs from as many different countries as possible to provide a range of experiences. Once an IEN was recruited, an attempt was made to recruit a U.S. RN from the same shift and unit. A total of 86 initial interviews were conducted (45 IENs and 41 U.S. RNs), but four participants did not meet the inclusion criteria and were excluded, leaving a total of 82 (42 IENs and 40 U.S. RNs). Forty nurses (22 IENs and 18 U.S. RNs) were recruited from the original 82 for the second phase of interviews according to their willingness to participate and the experiences that would provide the widest variety of data. Table 1 presents the nationalities of IENs in each interview phase. Recruitment for both phases of interviews ended when fresh data did not provide new perspectives for themes (Charmaz, 2006). The number of participants and range of nationalities recruited for this study is one of its strengths. Qualitative studies performed in the United States, identified by the researcher, recruited 10 to 20 IENs of one or a few nationalities (Dicicco-Bloom, 2004; Jose, 2010; Yi & Jezewski, 2000). Most studies in other countries were limited to less than 25 participants (Alexis, Vydelingum, & Robbins, 2007; Daniel, Chamberlain, & Gordon, 2001; Magnusdottir, 2005; Matiti & Taylor, 2005; Omeri & Atkins, 2002; Turriffin, Hagey, Guruge, Collins, & Mitchell, 2002); having 42 IENs of many nationalities allowed for data from a more diverse group of IENs.

Table 1

IEN Nationalities according to Interview Phase

Region of origin	Interview phase 1	Interview phase 2
Caribbean	7	4
European Union	2	2

Africa (sub-Saharan)	13	6
Southwest Asia	12	6
East Asia	6	3
Pacific	1	0
Oceania	1	1
Total	42	22

Findings

General Findings

Characteristics of the study participants showed that IENs were six years older on average than US RNs. IENs from Southwest Asia were younger while sub-Saharan African and East Asian IENs were older. However, age calculations are approximate because some participants refused to give their age or gave a 5-year age range. IENs had nine more years of nursing experience on average than US RNs.

Information about migration revealed that most of these IENs migrated to the United States in the last 20 years, primarily with or to join family. Most of the IENs who migrated from 2001-2010 were from sub-Saharan Africa and Southwest Asia, and the percentages of IENs migrating from sub-Saharan Africa and Southwest Asia were higher during this last decade than the previous one. More than half of the IENs migrated to the United States to join family or for their husbands' education or work. This was particularly true for the IENs from sub-Saharan Africa and Southwest Asia and East Asia. Recruitment companies were used by IENs from sub-Saharan Africa, Southwest Asia, the

Pacific, and the Caribbean. Other reasons IENs migrated were: to study, for adventure, because she won the visa lottery in her country, and for a job not in nursing.

This study, like others, found IENs faced barriers of professional and personal isolation. IENs experienced personal isolation when they worked in small U.S. towns where people were unfamiliar with their particular cultures. IENs felt professionally isolated by the fast pace of their shifts, which did not give them time to establish relationships with colleagues. IENs who had to learn to provide total patient care (where one nurse is responsible for providing all care for a certain number of patients) when they were accustomed to team nursing (where several nurses have specific roles providing care for a certain number of patients) faced an additional challenge of learning to manage their time appropriately to provide all the necessary care during their shifts. Language as a barrier was mentioned only by IENs from East Asian countries.

This study found IENs faced two barriers not reported in the literature; lack of respect for nurses and fear of litigation. IENs felt U.S. patients fail to take responsibility for their health and do not listen to the nurses, which made IENs feel unappreciated and even disrespected. IENs were concerned about litigation and the possibility of losing their licenses; they described how this concern was an underlying factor in their work and was compounded by heavy patient loads due to insufficient staff.

In terms of retention, most IENs plan to continue working as nurses in the United States until retirement. Half of the IENs plan to remain in the United States after retirement, primarily because their children are growing up in this country, eight plan to retire to their home countries, and the remaining IENs are undecided.

In semi-structured interviews, nurses were asked general questions about their thoughts and experiences in nursing. Some questions focused on the specific aims of exploring nurses' perspectives about education and participation in governance, but as recruitment and analysis progressed, two more themes came to light involving nurses' agency: disinterest in professional advancement and discrimination. These findings have been developed into four manuscripts that will be submitted to scholarly journals. Brief summaries of the findings are presented here.

Nursing Education

Across all nationalities, in this study more IENs' first nursing degree was equivalent to the U.S. associate degree (ADN) while more U.S. RNs' first nursing degree was a bachelor degree (BSN). Of the ADN-prepared nurses, a higher percentage of IENs obtained (or are in the process of obtaining) a BSN than U.S. RNs, but a higher percentage of U.S. RNs obtained (or are in the process of obtaining) graduate degrees than IENs.

Nurses were internally and externally motivated to continue their education. Nurses were internally motivated by the personal value nurses place on education and the increased earning potential and/or career options higher degrees would bring. Because both hospitals in this study are pursuing Magnet recognition, nurses were externally motivated by implicit or explicit hospital expectations that nurses continue their education to at least the BSN level.

For most nurses in this study, barriers to pursuing further education involved lack of time due to family responsibilities, lack of support from the hospitals, and practical issues with attending school. Many nurses have children at home whose needs limit the

time nurses feel they can spend on their own education. Hospitals do not always provide reimbursement, bonuses, shift accommodations, or time off for nurses enrolled in school. IENs must provide transcripts of their original nursing education from home countries to enroll in university programs, and these may be difficult or impossible to obtain. Some nurses feel they lack the computer skills to manage on-line education programs. Older nurses often said that it was not worth obtaining another degree given the time and financial resources needed.

Participation in Governance

Despite hospital expectations that nurses participate in the Magnet recognition process by working on committees, nurses' participation varies due to a general feeling that this work lacks relevance to their role as nurses and takes away from their time providing direct patient care. Both IENS and US RNs in this study attributed their lack of participation to committee meeting schedules, especially night shift nurses. If meetings are held during their time off, nurses are reluctant to attend. Even when committee meetings are held during a shift, nurses find it difficult to take time away from their patients to attend. Some nurses mentioned financial concerns, believing they are not remunerated for their time attending meetings.

Nurses also expressed an underlying disillusion with Magnet recognition. Many believe that hospitals want it in order to increase their prestige and attract patients of higher socio-economic status. Nurses do not seem to believe Magnet recognition affects nursing in a meaningful way. They do not believe it improves the quality of nursing care because they believe they already do their utmost to provide excellent patient care. Some nurses feel it causes them more work without benefitting patient care.

Professional Advancement

In this study, nurses were asked about their perspectives regarding promotions because seeking promotions is voluntary, while committee work is expected. In general, both IENs and U.S. RNs expressed little interest in seeking promotions often because they felt it would keep them from providing direct patient care. Some nurses calculated they could make as much money by working a few extra shifts as staff nurses; they see there was no benefit in making the effort involved in applying for promotions or taking on the extra responsibility a promotion would entail. Supervisors' encouragement played an important role for those who did seek promotions by helping nurses take advantage of opportunities and giving nurses confidence.

Discrimination

Nurses of all backgrounds in this study reported experiences of discrimination in places where they worked across the United States, involving patients, supervisors/hospital administrators, and/or fellow staff nurses. Experiences were considered discriminatory when nurses saw individuals consistently behave differently with nurses of different skin colors or nationalities.

Patients and/or their families were the most commonly mentioned source of discrimination. Nurses perceive that inherent in this behavior is patients' mistrust of their nurses' abilities. Patients made derogatory comments about nurses' nationalities, skin color or accents. They made assumptions about the position of the person providing their care, assuming Caucasian American nurses had the highest positions and non-Caucasian IENs the lowest. Patients also rejected nurses' care based on the RNs' color or nationality.

Nurses in this study described issues with fellow nurses, supervisors, administrators, and physicians who treated nurses differently according to race and/or nationality. Other nurses, especially in facilities where one race predominated in the nursing workforce, would make derogatory comments to colleagues based on skin color or nationality. Supervisors would give some nurses preferential treatment and ignore others. Administrators in charge of hiring nurses would make racial preferences known during job interviews. Physicians would work only with certain nurses based on their skin color or nationality instead of on their qualifications or job titles. However, some nurses and supervisors provide support. Fellow nurses explained cultural differences to patients and co-workers. Supervisors played important roles in diffusing tense situations between patients and/or their families and nurses.

Nurses most frequently seem to cope with discrimination by relying on personal values and inner confidence to help them ignore it. Nurses also cope by excusing discrimination as a result of a patient's age or background. They said some patients are too old to change their ways and some are too limited culturally to understand other races and nationalities. Sometimes nurses cope by confronting discrimination directly or reporting it. If discrimination is pervasive, nurses change units or shifts, leave the hospital, or disconnect from their work. Almost all of the nurses in this study said they cope by working harder to prove themselves to everyone around them.

Discussion

IENs and U.S. RNs in this study express agency in generally similar ways; they obtain BSN degrees, they do not participate in governance or seek promotions, and they have similar experiences with discrimination and coping strategies. Based on

structuration theory, this demonstrates they have similar understandings of the rules and resources around them, and that these rules and resources shape or do not shape the nurses' behaviors in similar ways even though IENs were born, raised and educated outside the United States. This may suggest that agent interactions and rules and resources in the context of hospital nursing are similar across different cultures, at least with respect to issues of education, governance and discrimination.

That IENs behave similarly to U.S. RNs may be reflective of Berry's (1997) concept of socio-cultural adaptation from the field of cross-cultural psychology. According to Berry, adaptation refers to external changes individuals make according to demands of their environments. Sociocultural adaptation specifically refers to "a set of external psychological outcomes that link individuals to their new context" (Berry, 1997, p. 14), which is what this exploration of IENs' agency may reveal. IENs may reproduce the behaviors of their nurse colleagues in the dominant culture in order to increase their "fit" with U.S. hospital nursing (Berry, 2005, p. 709); they obtain BSN degrees, do not see the relevance of participation in governance activities, and are uninterested in seeking promotions. Despite the knowledge IENs may have gained through their additional years of experience and work in countries besides their own and the United States, IENs may choose not to challenge the status quo in order to adapt. Other structures, especially the family, also influence nurses' adaptation but this study focused on nurses and their perceptions and behavior regarding their work.

This study suggests IENs tend to stay in nursing once practicing in the United States. This may be due to a combination of factors involving experience, age, culture and family. The process of migration and becoming a nurse in the United States is

complicated and involves time and money. IENs might be reluctant to leave a profession in which they have invested so much. Nurses who are older and/or have many years of experience may also be uninterested in leaving a field in which they have expertise. Their cultures may expect individuals to stay in their profession for their working lives. Family may also influence IENs' decisions to remain in nursing. However, this study also suggests IENs may be just as likely as U.S. RNs to change employers because they have been employed in several places and understand they have other opportunities if they are dissatisfied.

The issue of empowerment underlies analysis of agency and structure, especially when applied to women. The findings of this study may indicate empowerment is an important aspect of U.S. nursing. The perceptions and actions of hospital nurses in this study could reflect the feminist interpretation of individual empowerment, or "power within," as power achieved by the attainment of knowledge and expertise (Smith & Troutner, 2004). In this sense, bedside nurses are empowered in their work by their knowledge and expertise providing direct patient care. The total patient care model of care delivery emphasizes this empowerment by making individual nurses responsible for the wellbeing of a certain number of patients. This individual responsibility is reinforced by the risk of litigation and the ensuing requirement that nurses meticulously record all of their actions on behalf of their patients. Thus, in their role as bedside nurses they exercise a high degree of influence, therefore they may value this role over any other.

The nurses in this study do not seem to reflect collective empowerment, or "power with," to mobilize to make changes (Smith & Troutner, 2004) which is valued by the U.S. nursing profession. The U.S. nursing profession advocates empowerment of

nurses via increased education and participation in decision-making through its emphasis on the benefits these will bring to the quality of patient care. Researchers, professional nursing organizations, and government organizations produce studies, programs (like Magnet recognition) and reports (like those of the Institute of Medicine) that support nurses' key role beyond the bedside in advancing health care and nursing. Promotion of BSN degrees and governance committees are top-down strategies designed to engage bedside nurses in collective empowerment to help advance health care and the profession.

In this study, most nurses value education and consider it to be part of their identities, demonstrating they have internalized education as a route to empowerment. Nurses are willing to make the effort to obtain BSN degrees because the BSN provides official recognition of the knowledge and skills attained for bedside nursing practice. The degree becomes a part of the individual's identity as a nurse, obtained through individual abilities and effort. The nurse practitioner degree is similarly valued, which may be why it was the degree nurses were most interested in pursuing after the BSN. Other graduate degrees, including doctoral degrees, do not seem to be similarly valued by bedside nurses perhaps because they are not seen as empowering nurses' work at the bedside. Instead, these degrees are oriented towards collective empowerment because they provide skills and knowledge in, for example, education, policy and research that influence the profession as a whole.

The reason nurses do not participate in governance, especially in its form of committee work in these hospitals, may be because they do not perceive it will empower them at the bedside thus nurses perceive it is not worth their time. Their individual power in the committees is diffused; shared with all other committee members. The time nurses

spend in meetings away from their patients is a temporary abdication of power, which is the equivalent of disempowerment. According to the feminist perspective, providing the opportunity to engage in decision-making does not ensure that people will be collectively empowered (Rowlands, 1995). In this study, nurses' lack of participation, despite opportunities and expectations, may reflect their disengagement from collective empowerment.

The findings from this study suggest bedside nurses, who experience empowerment through providing direct patient care, may be hesitant to risk losing this power by seeking promotions. Although promotions might seem to increase individual empowerment, nurses may perceive they will be less empowered because they no longer provide direct patient care. At the same time, nurses may perceive they lack the education and training to prepare them to assume the responsibilities associated with a supervisory role. This insecurity may be compounded by the increased scrutiny nurses would experience by those in positions above and below if the nurses rose to supervisory positions. Promotions also involve a different kind of power; some nurses may be comfortable exercising power temporarily over someone who is ill but may be less comfortable doing so on a permanent basis over a peer.

Discrimination has the potential to disempower nurses because their abilities are questioned based on external racial and/or national characteristics that are beyond nurses' control. In general, nurses employed individualized coping strategies to protect themselves from the sense of disempowerment. When propagated by certain patients, nurses excused or ignored discriminatory behavior because nurses have control over those in their care and may not perceive that these patients pose serious threats to their

power. When other professionals exhibited discriminatory behavior, some nurses mentally disengaged from or physically left the environment. In all situations, nurses often also relied on their individual inner confidence as expert nurses to protect themselves psychologically from disempowerment. Some nurses coped collectively by supporting each other or confronting discrimination directly. Both of these strategies attempt to mitigate discrimination on a broad level to prevent it from continuing or happening to others.

Assessment of Theoretical Framework

Structuration theory provided a useful framework for planning this research because of its breadth, generality, and lack of predictive capacity and because of its conceptualization of agents as responsible actors who have some control over their environment. The broad scope of this theory fostered the study's exploratory nature because it provided flexibility, allowing research to be data-driven without limiting its direction. Its conceptualization of agents meant that interview questions were designed to elicit nurses' thoughts about their roles as agents with the power to change the hospital structures around them. This is appropriate because registered nurses are educated professionals, implying they have some power to affect their environments.

Structuration theory's emphasis on agents' understandings of structural rules and resources helped frame interview questions to elicit information about nurses' understandings of the rules framing their actions and resources that facilitated or inhibited action. This also kept the researcher from making assumptions that nurses understood certain rules or had access to certain resources. For example, the researcher did not

assume any nurses knew the process involved in obtaining a promotion or the potential value of obtaining an advanced degree.

A significant weakness of structuration theory for empirical research is its lack of guidance for operationalization of the theory's concepts (Gregson, 1987) and its lack of ability to account for the overlapping influence of multiple structures on agency. This is challenging because rules and resources overlap structures. That is, rules and access to resources in one interactive context might influence another. In this study, the most common overlap was between the work and the family contexts. For example, for some nurses, seeking further education may have had less to do with rules and resources in the hospital and more to do with rules and resources in the family context. It would then follow that the rules and resources in the family may depend on other contexts, like the spouse's work, a religious group or a school, and so on. The structuration framework has no provision that accounts for the effect of all these contexts have on a specific interaction.

Structuration theory might best be used in future nursing research in case studies that employ multiple data sources. An ideal case study would involve in-depth interviews with the participants and reviews of documents that record the participants' actions, such as minutes of hospital governance committee meetings, portfolios presented when applying for a promotion, patient care notes in charts, and personnel records involving commendations as well as disciplinary actions. Hospital and unit policies should also be reviewed. Interactions between the participants and co-workers, patients, supervisors and administrators should be observed and these individuals should also be interviewed. This

would seem the best way to capture a micro-level understanding of agent and structure based on structuration theory.

Limitations

The most important limitation to this study involved the different cultures of the participant population. Interviews involve trust, and culture can affect levels of trust (Birman & Trickett, 2001; Creswell, 2003; Weiss, 1994). IENs' information could be unreliable if IENs were suspicious of the purpose of the research and intended use of the results. IENs may have been reluctant to discuss aspects of their experiences with a cultural outsider. As migrants, they may have felt obligated to participate and to describe only positive experiences, fearing their jobs might be threatened. The researcher attempted to establish trust by treating informed consent as an ongoing process instead of a one-time event, involving repeated explanations of the research process and intended use of results, assurances of confidentiality, and emphasis on the importance of providing true data (Holloway & Wheeler, 1995; Richards & Schwartz, 2002). To minimize the potential for coercion, the researcher emphasized that participation was voluntary, reiterating that participants could withdraw from the study at any time.

How the researcher was perceived by the participants may have affected the quality of the data collected (Hoddinott & Pill, 1997; Richards & Emslie, 2000). Some participants may have perceived certain characteristics positively, strengthening their relationship with the researcher, while other participants may have perceived certain characteristics negatively, impeding the relationship. To attempt to mitigate this, the researcher considered carefully which characteristics she should emphasize and which should be downplayed and in general how to present herself to the participants based on

her understanding of each participant's cultural background, age and nursing position (Richards & Emslie, 2000). The researcher attempted to emphasize participants' expertise and what she had in common with the participant. The researcher de-emphasized her connection to Emory University by identifying herself as a nurse researcher first and a doctoral student in nursing second, only specifying her relationship with Emory if asked.

The researcher's personal beliefs and background may have impacted data collection, especially since she was the only interviewer (Charmaz, 2006; Creswell, 2003; Mays & Pope, 1995). They might have affected questions she asked, how she asked them, and which ones she chose to follow up. To mitigate this, during data analysis the researcher attempted to understand participants' situations from their perspectives and to focus on what participants said without trying to interpret meaning behind the words (Charmaz, 2006).

Interview time and location also potentially affected the data. Participants were asked to choose when and where they wanted interviews to be held and most participants chose to be interviewed on the units during their shifts, which may have affected the data. First, despite efforts to find quiet, private places for the initial interviews, in some cases this was not possible and the interviews suffered from interruptions and a lack of privacy, which may have inhibited the free responses from the participants (Richards & Emslie, 2000). This was mitigated during the second phase of interviews, almost all of which (38 of 40) were conducted in private at the hospitals (27) or neutral places (11). Second, for the interviews that occurred during working hours, participants may have limited their responses because they felt pressure to return to work. The researcher attempted to mitigate this by making it clear that their work came first and she was willing to wait

until they had a break or finished their shift. Third, participants may have felt loyalty to their employers and may have refrained from saying anything negative about their units or the hospitals. The researcher tried to mitigate this by reassuring participants of their anonymity and that she was working independently of the hospitals.

Implications and Recommendations

Hospitals could help IENs in a few specific ways. Spoken language is particularly difficult, so initial language assistance would be beneficial for most IENs. It would help strengthen not only their communicative abilities, but also their confidence and perhaps their adjustment. IENs with strong accents would benefit from extra support to help them be understood better by those with whom they interact. IENs also need some cultural orientation to help them manage U.S. patients and their families. IENs' perceptions that some U.S. patients are disrespectful may stem from cultural differences in the nurse-patient power relationship. U.S. culture permits questioning of authority and imbues patients with more power (especially in terms of litigation), which IENs may perceive as a threat to their power if they come from cultures where patients do not question nurses' authority. Initial orientation programs for IENs could include discussion about what is considered respectful behavior in the United States and that some degree of questioning is to be expected. IENs might benefit from examples of how American patients and their families may behave and what responses are culturally appropriate on the part of the nurse. Most hospitals have a patient bill of rights that could be explained to the IENs along with the hospital's philosophy and policies regarding the consumer. This is a complicated issue, but recognizing that IENs come from cultures where patients and their

families behave differently and providing support to IENs as they manage difficult patient/family relationships could help smooth interactions.

The similarities between IENs and U.S. RNs suggest that some hospital policies could address these groups together. IENs who are adjusting to total patient care, or just a heavier workload than they were accustomed to, have similar time management issues as newly-licensed U.S. RNs. These IENs could receive the same kind of precepting as new U.S. RNs. Litigation was a particular concern for some IENs but is also an issue for U.S. RNs who are new to a state. It would benefit both IENs and US RNs from out-of-state to be made aware of the state nursing practice guidelines as well as key nursing protocols in the hospital to protect the institution, the nurses, and the patients. Nurses also need to be informed of their rights and responsibilities and how the hospital will or will not support them if litigation is brought against them. Both IENs and U.S. RNs would benefit from resources to continue their education. Hospitals need to demonstrate to all nurses that Magnet recognition means the organization values nurses, especially their participation in decision-making and their professional advancement. Hospitals also need to demonstrate they support their nurses by not tolerating discriminatory behavior. Policies for preventing discrimination in hiring and promoting and for reporting discrimination should be developed, supported, and/or widely disseminated depending on the facility.

The findings from this study that these IENs do not plan to return to their home countries to practice nursing has implications for international efforts to control nurse migration and the loss of skilled health professionals from lower-income countries. Nurses in this study were much less likely to plan to return to their home countries, even if they would prefer to, if they had children in the United States. Any strategy to prevent

IENs from migrating or to convince them to return to their home countries should take the nurses' families into account, especially their children.

These findings also have implications for the advancement of the profession of nursing. In order for bedside hospital nurses to become collectively empowered, changes may need to be made in both how they are educated and how they do their work. Nursing schools could train nurses to work together, including coursework about teamwork and conflict resolution in their curricula. Total patient care may isolate nurses; other ways to provide patient care that involve shared responsibility could establish greater camaraderie among nurses, decrease their psychological stress, and have a positive effect on patient outcomes. In addition it might foster collective empowerment as nurses learn to share and trust each other's ideas and perspectives. It might be beneficial to design leadership positions in such a way that nurses can continue to provide direct patient care to some degree. Not only might this make them happier, but it might also help them remain connected to what is happening at the bedside. It would give nurses more confidence if they acquired skills and knowledge for leadership roles early in their education and/or careers. This could include coursework about management and conflict resolution in nursing schools that is reinforced in hospital education programs. More research is needed to explore these concepts of empowerment in nursing and to discover how they can be bridged in practice.

Discrimination against nurses needs to be recognized because of its negative impact on nurses. More research is needed to assess the pervasiveness of the behavior and its impact on nurses' job satisfaction, burnout, and retention. Just as nursing programs discuss culturally competent ways of providing care to diverse populations, so

they should discuss working with a culturally diverse nursing workforce. Schools and hospitals should emphasize teamwork among nurses, and management training should include strategies to deal with discriminatory behavior. Patients and healthcare employees need to be educated about other cultures and the benefits of having nurses with different backgrounds.

Conclusion

This study aimed to explore how IENs exercise agency given that they were born, raised, educated and practiced as nurses outside the United States in order to determine how this might impact patient care. The study found that IENs do not plan to leave the profession and they exhibit similar perspectives and behaviors as U.S. RNs in terms of their education and participation in governance. It also revealed issues of discrimination against nurses. Viewed broadly, these findings can be interpreted as reflective of underlying issues of empowerment in U. S. nursing; specifically the tension between nurses' valuation of their individual empowerment and the nursing profession's desire for collective empowerment. The nursing profession wants society to recognize not only the key role nurses have in health care, but also the high level of knowledge and skill needed to manage the complexity of patient care. They advocate collective empowerment strategies like promotion of higher education and participation in governance structures to increase nurses' status and advance patient care. Yet hospital bedside nurses' work is so highly individualized that they lack either the vision and/or the energy to work towards collective empowerment. Instead they focus their agency on maintaining their empowered role at the bedside. The actions of IENs, as foreigners who have come into this culture, are focused on adapting to U.S. hospital nursing. Since they are conforming

to the behavior they observe around them, they may not act to change the environment unless they see U.S. RNs act. Thus this study suggests there may be more issues with agency in U.S. nursing as a whole than with the IENs who come in as outsiders.

References

- Alexis, O., Vydelingum, V., & Robbins, I. (2007). Engaging with a new reality: experiences of overseas minority ethnic nurses in the NHS. *Journal of Clinical Nursing, 16*(12), 2221-2228.
- Berry, J. W. (1997). Immigration, Acculturation, and Adaptation. *Applied Psychology: An International Review, 46*(1), 5-68.
- Berry, J. W. (2005). Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations, 29*(6), 697-712.
- Birman, D., & Trickett, E. J. (2001). Cultural Transitions in First-Generation Immigrants. *Journal of Cross-Cultural Psychology, 32*(4), 456-477. doi: 10.1177/0022022101032004006
- Charmaz, K. (2006). *Constructing Grounded Theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage.
- Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (2 ed.). Thousand Oaks: Sage Publications, Inc.
- Daniel, P., Chamberlain, A., & Gordon, F. (2001). Expectations and experiences of newly recruited Filipino nurses. *British Journal of Nursing, 10*(4), 254-265.
- Dicicco-Bloom, B. (2004). The Racial and Gendered Experiences of Immigrant Nurses from Kerala, India. *Journal of Transcultural Nursing, 15*(1), 26-33. doi: 10.1177/1043659603260029
- Giddens, A. (1984). *The Constitution of Society: Outline of the Theory of Structuration*. Berkeley: University of California Press.

- Gregson, N. (1987). Structuration theory: some thoughts on the possibilities for empirical research. *Environment and Planning D: Society and Space*, 5, 73-91.
- Hoddinott, P., & Pill, R. (1997). A review of recently published qualitative research in general practice. More methodological questions than answers? *Family Practice*, 14(4), 313-319.
- Holloway, I., & Wheeler, S. (1995). Ethical issues in qualitative nursing research. [Journal Article]. *Nurs Ethics*, 2(3), 223-232.
- Jose, M. M. (2010). Lived experiences of internationally educated nurses in hospitals in the United States of *International Nursing Review*, 58, 123-129.
- Magnusdottir, H. (2005). Overcoming strangeness and communication barriers: a phenomenological study of becoming a foreign nurse. *International Nursing Review*, 52(4), 263-269.
- Matiti, M. R., & Taylor, D. (2005). The cultural lived experience of interationally recruited nurses: a phenomenological study. *Diversity in Health and Social Care*, 2, 7-15.
- Mays, N., & Pope, C. (1995). Rigour and qualitative research. *British Medical Journal*, 311(6997), 109-112.
- Omeri, A., & Atkins, K. (2002). Lived experiences of immigrant nurses in New South Wales, Australia: searching for meaning. *International Journal of Nursing Studies*, 39(5), 495-505.
- Richards, H., & Emslie, C. (2000). The 'doctor' or the 'girl from the University'? Considering the influence of professional roles on qualitative interviewing. *Family Practice*, 17(1), 71-75.

- Richards, H., & Schwartz, L. (2002). Ethics of qualitative research: are there special issues for health services research? *Family Practice, 19*(2), 135-139.
- Rowlands, J. (1995). Empowerment examined. *Development in Practice, 5*(2), 101-107.
- Smith, P. H., & Troutner, J. L. (2004). Empowering Women: Agency, Structure, and Comparative Perspective. In P. H. Smith, J. L. Troutner & C. Hünefeld (Eds.), *Promises of empowerment: women in Asia and Latin America* (pp. 1-34). Plymouth, United Kingdom: Rowman & Littlefield.
- Turriffin, J., Hagey, R., Guruge, S., Collins, E., & Mitchell, M. (2002). The experiences of professional nurses who have migrated to Canada: cosmopolitan citizenship or democratic racism? *International Journal of Nursing Studies, 39*(6), 655-667.
- Weiss, R. S. (1994). *Learning from Strangers: The art and method of qualitative interview studies*. New York: The Free Press.
- Yi, M., & Jezewski, M. A. (2000). Korean nurses' adjustment to hospitals in the United States of America. *Journal of Advanced Nursing, 32*(3), 721-729.