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Shifting Paradigms: The Development of Nursing Identity in  
Foreign-Educated Physicians Retrained as Nurses Practicing in the United States

by

Liqliwa Reyes Villagomez

A dissertation submitted in partial fulfillment  
of the requirements for the degree of  
Doctor of Philosophy  
College of Nursing  
University of South Florida

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Physician-Nurses, Transprofessional

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## Dedication

*To my husband, Christian — the love of my life. My best friend forever.*

*To my children, Aga, Kris, and Ian — the amazing trio who brings rhythm to my life.*

*To my father, the late Rt. Rev. Clemente G. Reyes and mother, Mrs. Pompeya S. Reyes  
who raised me to become what I am today.*

*To all my brothers and sisters who share the joys of education with me.*

*To all foreign-educated physicians who found meaning and renewed purpose in nursing.*

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Shifting Paradigms: The Development of Nursing Identity in  
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Liwliwa R. Villagomez

ABSTRACT

A unique breed of nurses for the US market is emerging—the Physician-Nurses. They are foreign-educated physicians who have retrained as nurses. The purpose of this study was to generate a theory that can explain the development of their nursing identity. Specific aims were to discover barriers that participants perceived as problematic in their transition to nursing and catalysts that influenced how they addressed the central problematic issue they articulated. Grounded theory methodology guided by the philosophical foundations of symbolic interactionism was used. Twelve Physician-Nurses were interviewed. Transcribed interviews were imported to ATLAS.ti. Text data were analyzed by constant comparative method. Concept formation, development, modification and integration were accomplished through different levels of coding. Methods were employed to ensure trustworthiness of findings. Core categories were discovered and a central social psychological problem *experiencing the burdens of a new beginning* and a basic social psychological process *combining the best of two worlds* emerged. Further theorizing generated the substantive theory *combining the best of two worlds* and the beginnings of a formal theory. The substantive theory explained the three-dimensional central problem and the five-stage basic social psychological process. Dimensions of the central problem were (a) crossing cultures, (b) starting from zero, and (c) crossing

professions. Stages of the basic process were (a) letting go of professional identity as physician, (b) experiencing growing pains, (c) seeing nursing as a saving grace, (d) gaining authority to practice as a nurse, and (e) engaging self to nursing and asserting “I am a nurse.” The substantive theory is a springboard toward the development of a formal theory which may be able to further explicate the development of nursing identity in Physician-Nurses. This theory named, Theory of Transprofessionalism, was initially conceptualized as having five phases namely: (a) disengagement, (b) discouragement, (c) enlightenment, (d) encouragement, and (d) engagement. These stages correspond to the five stages of the substantive theory. The key concept *nursing identity* was operationalized by utilizing three statements published by the American Nurses Association that describe the professional registered nurse, the knowledge base for nursing practice, and the code of ethics for nurses.

## Chapter One

### Introduction

*Besides that I couldn't go into my profession here, I had an experience when I first came here to the United States. I went to Kansas, and I was alone there. And, I became sick and I had to go to the hospital. And, I was very, very, very lonely. Very sick. There was a person[who] helped me feel better. That person [who] made me feel better was a nurse; [who] held my hand and encouraged me to feel better. And that really, really made an impact on me.~Maira*

A unique breed of nurses for the US market is emerging—the Physician-Nurses. Physician-Nurses are foreign-educated physicians (FEPs) who have retrained as nurses and who are now practicing in the United States (US). This qualitative research study using grounded theory methodology and guided by the philosophical foundations of symbolic interactionism was designed to explore the basic social psychological process that influenced the development of their nursing identity. Shifting from a discipline traditionally viewed by society as more prestigious and powerful than nursing, development of their nursing identity is fundamental in their transition to nursing practice. Being a relatively new phenomenon in nursing, evidence of scientific exploration specifically examining nursing identity development in former physicians who have become nurses does not exist. This research study intends to fill this gap.

#### *Organization of Dissertation*

This dissertation consists of six chapters. Each chapter begins with a brief introduction that sets the tone of the chapter and concludes with a summary intended to



capture the salient points. This opening chapter provides an overview of the entire research study and puts the study in the appropriate context and perspective. Background information regarding the sensitizing concepts of identity and socialization in general, and nursing identity, anticipatory socialization, and professional socialization to nursing, in particular, and background information regarding the population and phenomenon of interest, the Physician-Nurses and interprofessional migration, are presented. A discussion of the differences between nursing and medicine is provided as well. Also included in this chapter are the statement of the problem, statement of purpose and specific aims, rationale and significance, the researcher's position in the context of the study, researcher's biases and assumptions, and definition of terms and meanings of acronyms.

The literature review presented in Chapter Two brings into context a three-dimensional body of knowledge that directly and indirectly pertains to Physician-Nurses and interprofessional migration namely: (a) the emergence of the phenomenon of interprofessional migration, (b) the current limited research about Physician-Nurses, and (c) literature about the needs and problems of non-US native nurses and nursing students during their transition to US ways and US nursing practice. Due to the limited literature regarding Physician-Nurses, the population *non-US native nurses* is used as proxy population for them. Chapter Three provides a comprehensive discussion of grounded theory as a research methodology and symbolic interactionism as a philosophical perspective. Chapter Four presents how grounded theory is applied in this study. Participant demographics and characteristics, research instruments, procedures for data generation, data analysis, and theorizing are discussed. It also includes a discussion of the four criteria for establishing trustworthiness in qualitative studies namely: credibility, dependability,

confirmability, and transferability and how these concepts are applied in this current study. Chapter Five presents the findings and discussion of the study. Theoretical explanations of the central social psychological problem and the basic social psychological process and the interrelationships of the concepts which form the substantive theory are discussed. Chapter Six provides a discussion of the interpretation of findings and study conclusions. The key sensitizing concept *nursing identity* defined as the *persona* of a professional individual that portrays the expected knowledge, skills, roles, behaviors, attitudes, values, and norms that are appropriate and acceptable in the culture of the nursing profession is operationalized utilizing three statements published by the American Nurses Association namely: (a) description of the professional registered nurse, (b) knowledge base for nursing practice, and (c) code of ethics for nurses. The essence of the substantive theory *combining the best of two worlds to cope with experiencing the burdens of a new beginning* and the beginnings of a formal theory “Theory of Transprofessionalism” are presented. The conclusion, limitations and strengths of the study, and implications for the future provide closure for this research report.

### *The Sensitizing Concepts*

To put this study in the proper context and perspective, it is important to provide background information regarding the concepts of nursing identity and the related concepts of identity, socialization, anticipatory socialization, and professional socialization to nursing. It is important to review these because they are the sensitizing concepts which serve as background ideas and starting points for this study (Charmaz, 2006). According to Blumer (1969), sensitizing concepts provide the general sense of reference and guidance in approaching empirical studies. He asserts that they are not prescriptive concepts which

provide prescriptions of what to see, but rather they “merely suggest directions along which to look” (Blumer, 1969, p. 148). Working within the perspectives offered by Blumer and Charmaz, the researcher of this study selected nursing identity and its related concepts as sensitizing concepts to use as starting points in this research of Physician-Nurses.

### *Identity and Nursing Identity*

*Identity.* Identity is defined as the set of physical, mental, behavioral or personal characteristics by which an individual is distinctively known or recognizable as a member of a group (Webster II New College Dictionary, 1995). Identity is a basic human psychological need, and a core sense of identity is integral to normal function. It predicts people’s responses to their own behaviors and to those of others (Tredwell, 2007). Identity is a concept that generally answers the question “Who am I?” (Biddle, 1979, p.89). As a broad concept, identity encompasses all the characteristics that a person may legitimately assert about himself as a social being which may include but is not limited to his name, status, ethnicity, religion, family affiliation, profession, personality, past life, etc. A person may have multiple identities depending upon the number of structured role relationships in which he is involved; thus, a man may have identities such as physician, husband, father, uncle, son, tennis player, etc. which when taken together comprise the person’s self (Biddle, 1979; Stryker, 1980; Thoits, 1983; Tredwell, 2007). Identity has been used informally by social scientists for a number of years, but E.H. Erikson is credited for the modern enthusiasm about the concept using it as a formal “vehicle for discussing the problems of self-awareness and personal identification” (Biddle, 1979, p. 89).

A more focused use of identity as a concept can be related to the act of labeling. To illustrate this, Biddle (1979) uses an example of a stranger who has mannerisms and accent

that may not be apparent at first. With closer observation, the stranger becomes identified as a Frenchman. It is in this focused context that the concept of identity is used in this study. Identity in its broad framework as a social concept takes the form of a more focused framework labeled as professional identity and further narrowed down to its subconcept, nursing identity.

*Nursing identity.* Nursing identity is defined vaguely in extant nursing literature. Gleaning from what is found in nursing literature, it is apparent that the operationalization of this concept has eluded the early works of nursing theorists and researchers. The professional identity of the nurse, although a frequent theme of discussion and concern is linked to diverse meanings and concepts such as professionalism, perceptions of the nurse role, and professional self or self-concept of nurses (Fagermoen, 1997). Öhlén and Segesten (1998) describe it as having a feeling of being a person who can practice nursing skillfully and responsibly. They further assert that “the nurse’s professional identity refers to the commonality of the nursing profession and to the special way the nurse utilizes this commonality with the nursing profession” (p. 721). The authors use the term commonality to refer to the goals which all nurses have in common. Wengstrom & Ekedahl (2006) define it in the context of what it encompasses from both subjective and objective viewpoints. From the subjective viewpoint, nursing identity is defined as the person’s feelings and perception of oneself as a nurse. From the objective viewpoint, it is defined as other people’s views of the person as a nurse. Gregg and Magilvy (2001) define nursing identity within the context of the term professional identity and they describe it as the individual’s self-identification with the nursing profession contingent upon the individual’s possession of a license obtained by passing the national licensing examination.

For the purposes of this study, nursing identity is defined as the *persona* of a healthcare professional that portrays the expected knowledge, skills, roles, behaviors, attitudes, values, and norms that are appropriate and acceptable in the culture of the nursing profession (Cohen, 1981; du Toit, 1995; Fetzer, 2003; MacIntosh, 2003; Mooney, 2007; Shinyashiki, Mendes, Trevizan, & Day, 2006). This definition is adapted from the definitions of professional socialization found in the literature. Such *persona* or the role that an individual assumes or displays in society is the substantive outcome of the process of professional socialization to nursing.

#### *Socialization and Anticipatory Socialization*

*Socialization.* “Socialization is the process of becoming, of acquiring knowledge and skills and internalizing attitudes and values specific to a given social group” (Creasia & Parker, 2001, p. 55). It is a broad concept basic to sociological thinking which is concerned with the learning of socially relevant and acceptable behavior at various stages of the life cycle (Biddle & Thomas, 1966). Socialization experiences can either be accidental or planned. The process, facilitated by socialization agents, brings about changes in the behavior or conceptual state of a person. The change in behavior or conceptual state subsequently leads to a greater ability of the person to participate in the social system where he belongs (Biddle, 1979; Kramer, 1974).

The concept of socialization has been problematically conflated with the concepts of learning and education. To distinguish these concepts, the following viewpoints are provided: learning refers to any non-facilitated change in the behavior or conceptual state of a person that can either be positive such as good habits or negative such as bad habits, and

education refers to the deliberate process where one person intends to instruct the other so as to change behavior and conceptual state (Biddle, 1979).

*Anticipatory socialization.* In contemporary society, movement of people from one status to another, particularly from a lower to a higher status is common (Merton, 1966). It is in this context that Merton gives his discourse about anticipatory socialization. He defines anticipatory socialization as the process by which a person acquires the values and behaviors distinctive of a group of which he is not currently a member but of which he is aspiring to belong (Merton, 1966). The purpose of anticipatory socialization into a new group is two-fold: to promote acceptance by the members of the prospective group and to facilitate transition into the dynamics of the prospective group (Merton, 1968).

This concept which emerged from the study of soldiers during World War II by Stouffer, Suchman, Devinney, Star, and Robins (1949) showed evidence that soldiers who successfully assumed new statuses had proactive stance in acquiring the essential behavioral characteristics, attitudes, and role orientations before they formally made the change (Merton, 1966/1968; Kramer, 1974). Although this process has positive implications, it also has complexities. Merton observed that the person in transition often becomes marginal to both his current group and his prospective group. While anticipating the change in position and group membership, he may find himself no longer accepted in his current group and not yet fully accepted by his prospective group (Merton, 1966).

The concept of anticipatory socialization is relevant to the population-of-interest in this study. In the shift from being physicians in their home countries to being nurses in the US, it is an assumption that early in their nursing education program, the former physicians feel marginalized by both their previous physician group and their prospective nursing

group. During this transition period, they are in a very intricate situation. They are no longer members of their old group but not yet members of their new group. Early in their retraining to nursing, the Physician-Nurses make the effort and commitment to acquire the values and behaviors distinctive of nursing, a process indicative of anticipatory socialization.

In the natural course of the socialization process; in the cycle (Kramer, 1974) or in the continuum (du Toit, 2003), anticipatory socialization as experienced by Physician-Nurses will eventually progress to professional socialization to nursing contingent upon their successful resolution of the sociological and psychological tasks of each defined stage (Cohen, 1981).

### *Professional Socialization*

*Professional socialization.* Professional socialization is a process of adult socialization. Adult socialization is the process by which individuals develop new behaviors and values associated with roles they assume as adults to fulfill particular life goals. Professional socialization is also referred to as occupational socialization (Hardy & Conway, 1988). Cohen (1981, p. 14) defines professional socialization as “the complex process by which a person acquires knowledge, skills, and sense of occupational identity that are characteristic of a member of that profession.” Cohen further articulates that there are four goals of professional socialization namely: (a) learning the technology of the profession—the facts, skills, and theory; (b) learning to internalize the professional culture; (c) finding a personally and professionally acceptable version of the role; and (d) integrating this professional role into all the other life roles. To fulfill these goals, the process of professional socialization must encourage and permit novices to interact successfully with experts within the profession. The outcome of the process is a person who possesses not

only the technical competencies of the profession but also, and more importantly, the internalized values and attitudes required by the profession and expected by the public (Cohen, 1981).

*Professional socialization to nursing.* Professional socialization to nursing is a function of both adult and professional socialization. Applying the concepts of adult and professional socialization to nursing, and using the components of the definition of nursing identity, professional socialization to nursing can be defined as the complex process by which a person acquires the knowledge, skills, roles, behaviors, attitudes, values, and norms that are appropriate and acceptable in the culture of the nursing profession. Professional socialization to nursing plays an important role in the development of nursing identity (Mooney, 2007). MacIntosh (2003) asserted that professional socialization begins in nursing school where students learn the preparatory knowledge and skills, and acquire the qualities and the ideals of the nursing profession. Du Toit (1995) studied the influence of professional socialization on the development of nursing identity among nursing students in two universities in Brisbane, Australia. She stated that professional socialization is a process that takes place over time and has three stages: (a) the pre-socialization stage, (b) the formal socialization stage, and (c) the post-socialization stage. In a different perspective, Kramer (1974) identified that the process of professional socialization is circular. The different phases are not distinct but are overlapping. The four phases according to Kramer are: (a) skill and routine mastery, (b) social integration, (c) moral outrage, and (d) conflict resolution. Changes in the behaviors of individuals occur gradually through a process of personality drift. These gradual behavior changes become cumulative making individuals become different from what they were in the beginning.



The preceding discussion offered enlightenment regarding the central concept of study which is nursing identity and the related concepts of identity, socialization, anticipatory socialization, and professional socialization specifically to nursing. These concepts are important in the overall formulation of the report of this current research study. The researcher in operationalizing these concepts made it transparent that she views professional socialization to nursing as a process and the development of nursing identity as the outcome of that socialization process. It is in this regard that a caveat must be articulated. This caveat is that there is debate in the nursing community whether socialization is a process or an outcome. As a process, it is viewed as the route by which new members acquire the unique values, norms, and ways of seeing unique to nursing. As an outcome, it is the development of a person's professional identity as a nurse which represents that person's self-view as a member of the nursing profession (Blais, Hayes, Kozier, & Erb, 2006).

### *The Phenomenon-of-Interest — The Migration of Physicians*

#### *International Physician Migration*

The migration of physicians from one society to another to practice medicine, particularly from developing to developed countries is an established phenomenon (Aluwihare, 2005; Guzder, 2007; Galvez Tan, 2009; Salsberg & Grover, 2006; Shual & Bernstein, 1997; Terhune & Abumrad, 2009). This movement of physicians across geographical boundaries can be explained by the push and pull theory of migration. The push factors of migration include the poor economic benefits, limited career opportunities, and substandard working conditions in their home countries. The pull factors include the prospect of greater financial rewards and greater job satisfaction as well as better security

and future education of their children in developed countries (Aluwihare, 2005; Guzder, 2007; Hashwani, 2006). In a study about physician migration from developing to developed countries, a list of factors that motivated physicians to migrate were identified as their desire (a) for higher income, (b) for increased access to enhanced technology and equipment and health facilities for medical practice, (c) to travel to a country with higher number of medical jobs available, (d) to work in an academic environment with more colleagues in one's field of interest, (e) for increased prestige associated with being a physician abroad, (f) to live in a country with a higher level of general safety, (g) to live in a country with economic stability, and (h) for better prospect for one's children (Astor et al., 2005).

In the US, a huge wave of physician immigration began in the 1950s and continued through the 1970s resulting in a 30% saturation of US residency programs by foreign educated physicians (FEPs). But in the late 1970s to the late 1980s, immigration of FEPs hit a nadir due to the expansion in the enrollment capacities of US medical schools. In the early 1990s, a steady rise in the immigration of FEPs was noted again due to changes in the dynamics of the US healthcare industry brought about by two policy changes in medical education and immigration. The first change in policy occurred in 1984 when Medicare reimbursement for hospitals was correlated to the number of medical residents they trained. With a fixed pool of US medical graduates, hospitals sought FEPs to train. The second change in policy which occurred in 1990 was related to immigration. The H-1B visa for temporary workers which was previously limited to researchers was made available to all physicians. Both policy changes brought renewed interest in physician migration to the US; hence, increasing the number of FEPs. This rise hit a peak in 1999 and has since remained at this level. The majority of physician immigrants came from South Asia (Cooper, 2005).

With this type of migration, physicians expect to practice medicine in their new society with the cognizance that they have personal and professional adjustments to make. Such adjustments include processes that are inherent to professional socialization and occupational integration to medical practice as well as integration to the lifestyle and culture of their new society. The theory of occupational status persistence comes into play. This theory hypothesizes that “success in resuming one’s former occupation after migrating to a new society is a key determinant of overall adjustment and well-being” (Bernstein, 2000, p. 183). Occupational continuity is crucial for immigrant physicians because it provides them uninterrupted income as well as a stable anchor to preserve their self-identity during a time when they are dealing with a plethora of physical, social, and psychological stressors.

#### *Interprofessional Physician Migration*

In the last ten years, it has been observed that a different type of migration is occurring in FEPs. Some FEPs are no longer just migrating across geographical boundaries. Some of them are actually migrating across professional borders: from the profession of medicine to the profession of nursing. Depending upon their unique personal and past professional circumstances, interprofessional migration may have happened as a result of their geographical migration, or it perhaps happened to facilitate their migration to the US or to other developed countries of the world.

During the conceptualization of this research study, this migration of physicians across professional boundaries was originally labeled by the researcher as the MD-to-Nurse phenomenon. With the progress of this research study and the steady knowledge acquisition and conceptualizations by the researcher, the MD-to-Nurse phenomenon or nurse medic phenomenon as it is known in the Philippines (Galvez Tan, Sanchez, & Balanon, 2004;

Pascual, Marcaida, & Salvador, 2003) has been renamed interprofessional migration. This phenomenon can be explained by a new twist in the push and pull theory of migration. Instead of the push and pull forces impacting geographical migration, these forces are impacting interprofessional migration. The push factors exerted by the medical profession in the US include the arduous process and the dense licensure requirements for immigrant physicians (American Medical Association [AMA], 2009a; Educational Commission for Foreign Medical Graduates [ECFMG], 2009), the uncertainty of getting a residency assignment despite success in the US licensure examinations (Terhune & Abumrad, 2009), and the stark disparities in the incomes of physicians and nurses between developing and developed countries. As an illustration of the latter push factor, many physicians in the Philippines report receiving an annual salary equivalent to less than the monthly salary of a nurse in a US hospital (Chan, 2003; Guzder, 2007). The pull factors exerted by the nursing profession include the high demand for nurses in the US and other developed countries secondary to the prevailing global nursing shortage (Ross, Polsky, & Sochalski, 2005), the less arduous licensure process required for nurses in the US (Jerdee, 2004; Pendergast, 2006), the autonomous, respected, and trusted status of nurses in the US (Koerner, 2001; ANA, 2004), and the prospect of better income opportunities (Connolly, 2008; Jones, 2001; Sison, 2003). The prospect of enormously better income opportunities working as nurses in the US and other developed countries than working as physicians in developing countries exerts a very strong interprofessional migratory pull (Guzder, 2007). In the Philippines, a country whose governmental policies encourage the production of nurses for export (Aiken, Buchan, Sochalski, Nichols, & Powell, 2004; Joyce & Hunt, 1982), many physicians have

retrained as nurses (Galvez Tan et al., 2004; Lorenzo, Galvez Tan, Icamina, & Javier, 2007).

With geographical and interprofessional migration, occupational discontinuity occurs. Occupational discontinuity interrupts income capacities as well as rids physicians of the anchor that preserves their self-identity during a time when they are dealing with a plethora of physical, social, and psychological stressors. With this type of migration, immigrant physicians undergo a more complex socialization process. In addition to the task of integrating to the culture of their new society, they have to undergo occupational integration and professional socialization to nursing and must work toward developing their professional nursing identity.

#### *The Population-of-Interest — The Physician-Nurses*

##### *Physician-Nurses in the US: The Current State*

Two distinct groups of Physician-Nurses currently exist. One group comprises immigrants already residing in the US who were former physicians in their home countries but who have been unable to obtain licensure to practice medicine in the US. The other group comprises former physicians from the Philippines who intentionally retrained as nurses while still in their home country to facilitate their migration to the US. Although distinct in the context of immigration and resettlement, members of both groups are similar because they are now members of the mainstream US healthcare industry through the nursing profession. Exact statistics are not known as to how many Physician-Nurses currently work in the US. What is known is that approximately 500 Physician-Nurses have graduated from the New Americans in Nursing Accelerated Program also known as the FEP- to-Bachelors of Science in Nursing (BSN) Program at Florida International University

(FIU) in Miami (D. Grossman, personal communication, August 17, 2009). There is possibly a large population of Physician-Nurses in the US west coast. An observation shared by one of the participants in this study indicates that there are at least a thousand Filipino Physician-Nurses in Nevada. This is reflective of the high number of Filipino physicians becoming nurses (Galvez Tan, 2006, February; Galvez Tan, 2006, November; Galvez Tan et al, 2004; Lorenzo, 2005; Pascual et al., 2003). In addition, the retraining programs administered by the Welcome Back Center in San Diego, California for internationally educated healthcare professionals to become US healthcare workers has assisted more than 1,200 professionals since its inception in the early 2000s (Penner, 2006), with approximately 100 of whom have become Physician-Nurses (Wirkus, 2008).

#### *Physician-Nurses in the US: The Foreseen Future*

It is foreseen that the growth of the Physician-Nurses population in the US will be significant and steady. Through flexible and accelerated nursing educational programs designed to retrain physicians to become US nurses, immigrant professionals who belong to cultural minority groups and who already possess high-level medical knowledge and healthcare skills are drawn to the nursing profession (Grossman & Jorda, 2008). According to Grossman and Jorda, there are more than 700 FEPs in the applicant pool for the FIU program awaiting completion of admission requirements. A program in California at the InterAmerican College (IAC) will graduate its first cohort of 15 students in December 2009 (V. Glaser, personal communication, August 3, 2009). In the Philippines, Galvez Tan approximates that Physician-Nurses are graduating at a rate of 1,200 a year from nursing schools across the country. His latest estimate indicates that there are now a total of 9,000 Filipino doctors who have become nurses (J. Galvez Tan, personal communication, July 26,

2009). Due to the absence of a gatekeeper to monitor Physician-Nurse exodus from the Philippines, it is not exactly known how many of the Physician-Nurses have already immigrated to the US and to other developed countries; however, Galvez Tan (2009) indicates that 6,000 doctors are now in the US practicing as nurses. The phenomenon of interprofessional migration as it is occurring in the Philippines has major socio-political implications (Galvez Tan et al., 2004); however, the discussion of such implications is beyond the scope of this study.

*The Paradigms of Nursing and Medicine — How do they Compare?*

Together, nurses and physicians represent the major providers of healthcare in the US, but with 2.9 million nurses, nursing is the largest of the healthcare professions (Buerhaus, Staiger, & Auerback, 2000; Health Resources and Services Administration [HRSA], 2006; Jones, 2001). Although nursing is separate and distinct from medicine, nursing practice is closely allied to medical practice (Deloughery, 1977). This is perhaps the reason why it is not unusual to hear prospective nursing students say that they have always been interested in the medical field that is why they decided to go to nursing (Ellis & Hartley, 2001). The alliance between nursing and medicine is manifested in their collaboration. Through collaboration, the professions empower each other (Wolf, 1989). Nurse-physician collaboration is described as the cooperative working relationship between nurses and physicians where they share problem-solving and decision-making responsibilities for the formulation and implementation of patient care plans (Gillen, 2007). This collaboration implies that they *labor together* linked by a common bond they share which is to provide healthcare to the population – to individuals, families, and communities

(Grossman & Jorda, 2008). Although nursing and medicine share this common bond, nursing and medical paradigms are different.

The concept of collaboration between nursing and medicine did not come easy because it was preceded by professional conflict and jurisdictional competition (Abbott, 1988). Evidence of conflict between the two professions is generally acknowledged in the literature (Wolf, 1989). Discussion of the various conflicts between nursing and medicine is not included in this paper. What is included is a discourse about the perspectives that differentiate the two professions. The study conducted by Wolf (1989) provides a basis for a concise differentiation of nursing and medicine. Twenty years ago today, these differences remain to prevail. See Table 1.1. Wolf's differentiation is supplemented by narratives that describe the educational preparation required to fulfill each role and the nurse-physician relationship. It is important to acknowledge that in the US and in about 50 other countries globally, there are two types of physicians: the Doctor of Medicine or allopathic medicine (MD) and the Doctor of Osteopathy or osteopathic medicine (DO) (AOA, 2008-2009). This fact was factored-in in the differentiation of nursing and medicine as seen in Table 1.1.

#### *Educational Preparation for Nursing and Medicine*

The professions of nursing and medicine have each a different set of expected knowledge, skills, roles, behaviors, attitudes, values, and norms. These are acquired through formal academic education, as well as through continuous life-long learning and experiences in the practice setting. In the context of educational pathways, a notable difference is evident between nursing and medical education: nursing has three routes for entry-level practice while medical education has a single standard route. Nursing education in the US offers three types of programs that prepare students to take the national certification



licensing examination (NCLEX) for registered nurses. They vary in length and course requirements. The three educational pathways to registered nursing are the diploma, baccalaureate, and associate degrees. The diploma school program, the first type of nursing education to develop in the US, is traditionally held in a hospital setting. The length of training is usually between 27 to 33 months after which the students earn a diploma of nursing upon graduation, but do not earn college credits or an academic degree. The trend has been to move away from diploma education; hence, many diploma school programs have affiliated with colleges or universities and have transferred into their existing associate or baccalaureate degree programs. Even in this scenario, there are still a few, approximately less than a hundred diploma schools that exist throughout the US. They are mostly located in the Midwest and East (AllNursingSchools, 2009).

The baccalaureate degree nursing education, the second type of educational program to develop in the US, requires four to five years of study in the college or university setting. Upon graduation, students earn their bachelor of science degree. This educational pathway is the foundation for graduate nursing education. The associate degree program, the third type of nursing program to develop, is offered in community and junior colleges. The program is two academic years in length. Graduates earn college credits which can be credited toward a bachelor's degree. Efforts have been made to make the baccalaureate degree the minimum requirement for professional nursing practice but these efforts which have been influenced by the American Nurses' Association (ANA) Position on Nursing Education, have been opposed by many nursing educators, particularly those in diploma and associate degree programs ( ANA, 2004; Doheny, Cook, & Stopper, 1997; Ellis & Hartley, 2001; Kozier, Erb, & Blais, 1997).

Table 1.1

*Comparison of Nursing and Medicine*

Focus of Comparison	Nursing: Nurses	Medicine: Physicians (MDs and DOs)		
Definition and Purpose	The protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations. (ANA, 2003, p. 6).	The science and practice of the prevention, diagnosis, and curing of human diseases, and other ailments of the human body or mind.  <i>Two Types</i> Allopathic Medicine (MD) Osteopathic Medicine (DO)		
Focus	The art of nursing is based on caring and respect for human dignity...embraces dynamic processes that affect the human person including...spirituality, healing, empathy, mutual respect, and compassion....Nursing provides... holistic and up-to-date comprehensive care . (ANA, 2004, p. 12).	Diagnosis and treatment of illness (curing) <i>Allopathic Medicine</i> Diagnose illnesses; prescribe and administer treatment for people suffering from injury or disease.	<i>Osteopathic Medicine</i> Use all diagnostic/therapeutic methods as MDs but place special emphasis on body's musculoskeletal system, preventive medicine, and holistic pt.care.	
Approach to Patient Care	Whole person	Disease-specific	Whole person	
Methods of Action for Patient Problems	Lead to actions/interventions to be done <i>for</i> or <i>with</i> the patient	Lead to actions/interventions to be done <i>to</i> or <i>by</i> the patient		
Gender	Predominantly female	Predominantly male		
Political-economic Power	Lower	Higher		
Nurse-Physician relationship	Viewed as occupying a position of subservience under medicine. Nurses carry out treatment orders.	Viewed as occupying a position of dominance over nursing. Physicians give treatment orders.		
Educational Preparation	<u>Three Routes for Entry-level</u> Diploma in Nursing AS Degree BSN  There is also a category of licensed, vocational nurses: LPN or LVN	<u>Advanced Degrees</u> Masters Level DNP PhD	<u>Standard for MD</u> 4 years undergraduate 4 years of med. school 3 – 8 years internship and residency in specialty of choice	<u>Standard for DO</u> 4 year academic study 1 year internship 2 – 6 residency training in specialty of choice
Examination and Licensure	NCLEX-RN APRN Certification	USLME I USMLE II USMLE III	COMLEX I COMLEX II COMLEX III COMLEX-PE	

*Note.* Acronyms are defined in the Definition of Terms section on pp 32-34. Information obtained from the websites of the American Association of Colleges of Osteopathic Medicine [AACOM], 2008-2009; American Osteopathic Association [AOA], 2008-2009; American Nurses Association [ANA], 2003, 2004; Bureau of Labor Statistics [BLS], (2008-09b, 2008-09c; Doheny, Cook, & Stopper, 1997; Ellis & Hartley, 2001; Wolf, 1989

In comparing the educational preparation of nurses and physicians, it is important to recognize that the American ideology holds a bias that the longer the educational preparation is for a profession, the higher that profession's standing. Thorne (1973) describes the training for the medical profession as longer and probably more demanding, intense, and cloistered than any other profession. Through a lengthy training program combined with licensing regulations, graduates of medical education are viewed as practitioners of highest prestige and "with it the highest median income" (Hughes, 1973, p.2). The Flexner Revolution established consistency in medical education. The length and sequence of medical training is standardized across institutions: from three to four years of general liberal arts education, four years of medical school divided into basic science and clinical phases, and additional years of internship and residency (Hughes et al., 1973). Residency training prepares physicians for autonomous practice and the length of residency varies depending upon the resident's choice of specialty practice (Ellis & Hartley, 2001).

Nursing and medical education do not stop at graduation. Nurses and physicians become life-long learners. Nurses attend continuing nursing education classes to enhance their knowledge and skills and to meet requirements for license renewal. Many nursing graduates continue to pursue graduate level education to give them the competitive edge for autonomous specialty practice, and for leadership positions in the domain of nursing research, education, and practice (ANA, 2004). Physicians whose entry to their profession is at the graduate level also employ systematic methods to continue their learning, hone their skills, and benefit maximally from their experiences and some pursue further graduate studies (Manning & DeBakey, 1987).

### *The Nurse-Physician Relationship*

In the hierarchy of professions, when nursing and medicine are compared, medicine, although not the largest of the healthcare professions, is placed in the position of dominance (Bullough & Bullough, 1984; Remennick & Shakhar, 2003; Thupayagale & Dithole, 2005). This overall dominance occupied by medicine is apparent in the use of the word *medicine* to connote healthcare whether provided by physicians, nurses, or other healthcare providers (Thompson, 2008). Although nursing has made significant progress in establishing itself as a profession, its position as a subordinate profession to medicine prevails in a hierarchical society such as the US.

In line with the dominant position of medicine in the hierarchy of professions, the nurse-physician relationship is one where nurses are considered subservient to physicians (Ellis & Hartley, 2001). This perception perhaps might have its roots in the Nightingale era. Nightingale believed that nurses were well-suited for supportive roles and fought to establish nursing as a woman's profession (Bullough & Bullough, 1984). She believed that "to be a good nurse is to be a good woman and that the role of nurses was to be obedient to doctors in order not to hinder and diminish doctors' work" (Hein, 1998, p. 3). She assigned indirect roles to nurses. By contrast, she assigned the active intervention roles to physicians specifying that their duty was to remove anomalous organs or to intervene in various disease processes (Bullough & Bullough, 1984).

Although more men are venturing into nursing, it seems that the impact of Nightingale's viewpoint has prevailed through today. Nursing remains to be predominantly female, and medicine remains to be predominantly male. The gender make-up of a particular profession is an important factor in its perceived position of dominance, significance, and

value in society. Nursing, viewed mostly as a feminine profession as much now as it ever was (Blais, Hayes, Kozier, & Erb, 2006), has historically been afforded lesser significance in terms of social value when compared to medicine (Wolf, 1989). In role theory, the imbalanced gender distribution in these two professions can be described as occupational sex structuring or sex segregation which is rooted in cultures with paternal patterns and characteristics. This phenomenon occurs “when 70% of the workforce in a given job category is one sex” (Hardy & Conway, 1988, p. 311). See Table 1.2 for gender distribution of nurses and physicians in the US. The distribution as shown here is better than in the 1970s when nursing was 99% female (Hardy & Conway, 1988).

The preceding discussion differentiated the paradigms of nursing and medicine. It is the existence of these paradigmatic differences between the two professions and the ability of the Physician-Nurses to transcend these differences that make the phenomenon of inter professional migration unique. But do former physicians really transcend these differences?

Table 1.2

*Gender Distribution of Nurses and Physicians in the US*

Profession	Total	Males	Females
RNs in the US	2,909,357 <sup>a</sup>	168,181 (5.8%)	2,741,176 (94.2%)
Physicians in the US	921,904 <sup>b</sup>	665,647 (72%)	256,257 (28%)

*Note.* <sup>a</sup> Data obtained from the “The registered nurse population: findings from the March 2004 national sample survey of registered nurses,” Health Resources and Services Administration, 2006, Bureau of Health Professions, US Department of Health and Human Services; and from the <sup>b</sup> “Minority Affairs Consortium, Physician Statistics,” published in the American Medical Association website (last updated July 29, 2009).

Can they truly shift from their previous professional identity as physicians and embrace their new professional identity as nurses? Can they successfully develop their self concept as nurses? Can they become nurses?

### *Statement of the Problem*

The idea of retraining physicians to become nurses is not without controversy. According to Alpert, director for the St. Jude Family Nurse Practitioner (FNP) Program at University of Nevada Las Vegas (UNLV) , she encountered opposition when the FNP program for Filipino Physician-Nurses was being conceptualized (P. Alpert, personal communication, April 16, 2008). Similarly, the FEP-to-BSN Program at FIU met some opposition at the outset. A number of influential nursing leaders doubted its usefulness and benefits. Such opposition was attributed to their skepticism about the ability of physicians to be socialized into the nursing profession. Questions and concerns were expressed whether physicians can successfully transition to nursing. Some of the questions and concerns were:

1. How are you going to make doctors into nurses? Because their roles are so different.  
A comment by an unnamed commentator to D. Grossman (Rexrode, 2007).
2. Physicians are used to having greater control over patient care. A physician's primary focus is to diagnose and treat. Nurses provide holistic care (D. Horner, as quoted in Jorda, 2005).
3. The change is difficult if not impossible for physicians to achieve. Physicians view their role in healthcare as scientific and intellectual, while they perceive the role of nurses as nurturing, visceral, and mundane (C. Fagin as quoted in Kennedy, Ferri, & Sofer, 2002).

4. Not all former doctors will necessarily make good nurses. Even though they come with some knowledge, nursing and medicine are two distinct disciplines, so they have to make some adjustments (G. Bednash as quoted in Mangan, 2004).

The outspoken opponents have included:

1. Claire Fagin, Professor Emeritus at the University of Pennsylvania School of Nursing.
2. Diane Horner, former dean of the University of Miami School of Nursing. Miami, Florida.
3. Geraldine Bednash, executive director of the American Association of Colleges of Nursing.

While these concerns were surfacing regarding the establishment of university-based nursing retraining programs for FEPs in the US, reports were circulating about Filipino Physician-Nurses who were functioning beyond their scope. For instance, two Physician-Nurses from the Philippines working at a hospital in the South Central US were reported to have been terminated by their employers because they functioned beyond their scope of practice as nurses. In addition, seven other Physician-Nurses were repatriated to the Philippines for failing to fulfill their roles as nurses (Filipino Reporter, 2004). Other similar incidents were also reported at a British Hospital. Honorable Ruth Padilla, RN, past president of the Philippine Nurses' Association and currently the commissioner of the Philippine Professional Regulation Commission cited an incident in the aforementioned British Hospital where a Physician-Nurse performed suturing in an emergency situation (Esguerra, 2005). Although some stories are speculative, they can worsen the perceived potential hazards of retraining physicians to become nurses or they can serve as precautions for program administrators so that they can be keener in preventing issues of this nature through

appropriate curriculum development. As with any role change, physicians who have completed retraining or who are still in the process of retraining as nurses are expected to experience adjustment woes. A journalist in the Philippines poignantly stated, “doctors have to be nursed into fine nursing form” (INQ7.net). The development of their nursing identity requires a major paradigm shift. Because very little is known about the process by which this paradigm shift occurs, and about how former physicians become nurses, it needs to be explored and examined.

The problem can be summarized in the words of Grossman and Jorda (2008):

Physicians may be able to easily master the cognitive and psychomotor skills of nursing, but refocusing perceptions of their role and position in the healthcare setting may be more difficult. Redefining their attitudes, values, and beliefs to navigate the healthcare system from a vantage point of diminished power and prestige and from a philosophy based on care instead of cure will need to occur to ensure their success. (p. 549).

#### *Statement of Purpose and Specific Aims*

The purpose of this qualitative study using grounded theory methodology and guided by the philosophical foundations of symbolic interactionism was to generate a theory that can explain the basic social psychological process that influenced the development of nursing identity in FEPs who have retrained as nurses and who are now practicing in the US. This study was designed to find the answer to the research question, “What is the basic social psychological process that influences the development of nursing identity in FEPs who have retrained as nurses and who are now practicing in the US?” The specific aims were to discover barriers that participants perceived as problematic in their transition to nursing and catalysts that influenced how they addressed the central problematic issue they articulated.



### *Rationale and Significance*

In the face of the current nursing shortage and the national mandate to increase healthcare workforce diversity (Sullivan Commission, 2004), Physician-Nurses are evolving vital components of the US nursing workforce. Exploring their identity development was timely and significant because it provided the opportunity to determine and empirically study this emerging unique breed of nurses for the US and global markets. It provided discoveries that offered theoretical explanations of the basic social psychological process that influenced the development of nursing identity in a sample of professionals who previously belonged to the discipline of medicine, a discipline traditionally viewed as more prestigious and powerful than the discipline of nursing (Ellis & Hartley, 2001) especially in paternalistic societies. The rationale and significance of this research study was framed in the perspective of the domains of nursing research, education, and practice.

#### *Domain of Research: Filling the Scientific Gap*

Empirical literature about Physician-Nurses is sparse. No previous study has been conducted that addressed the specific topic of nursing identity development in Physician-Nurses. This research study which was both exploratory and explanatory was designed to fill this scientific knowledge gap. It was designed to find answers to the research question that probes about the development of nursing identity in FEPs who are now practicing as nurses in the US. This study was both timely and significant because it provided the opportunity to explore and empirically study this emerging unique breed of nurses for both the US and the global markets. It provided theoretical discoveries that defined the central social psychological problem and the basic social psychological process that addressed the central problem as experienced by Physician-Nurses in the process of shifting their professional

identity from being physicians to being nurses. Furthermore, it provided baseline data for future longitudinal studies regarding the performance and retention of Physician-Nurses within the nursing profession.

*Domain of Education: Aiming to Dispel Doubts About Retraining Programs*

This research study is significant to the domain of education because it presents to the nursing community a small sample of immigrants who were former physicians in their home countries who have found new meaning and purpose in nursing and who are now gainfully employed as nurses. It provides initial empirical support that academic programs that retrain FEPs to become nurses are viable and worthwhile ventures as evidenced by the exemplars given by the participants. The results of this study may help dispel doubts about the likelihood of physicians becoming nurses.

*Domain of Practice: Assessing Needs of Physician-Nurses in a Diverse Practice Setting*

Physician-Nurses, who by demographics are described as belonging to a minority group, are helping to change the landscape of the US nursing workforce. Although small yet in numbers in the context of the 2.9 million RNs in the US, they contribute in increasing the diversity of the US nursing workforce not only because they belong to ethnic minority groups but because a larger percentage of them are men (Grossman & Jorda, 2008). As members of minority groups, Physician-Nurses have unique needs. These needs must be assessed and attention must be given to these unique needs. Fostering a culturally-sensitive work environment where staff members function with cultural competence in dealing with every customer they encounter, whether patients and their families, or fellow healthcare workers and supervisors, is desirable and will help them integrate successfully into an ethnic and professional culture different from their own. It will greatly impact the practice of their new

profession. Their success is nursing's success. The conduct of this study placed value in the contributions of Physician-Nurses to a culturally diverse practice setting. It is anticipated that the findings of this study will assist hospital administrators, nurse leaders, and educators who employ Physician-Nurses in planning and implementing evidenced-based culturally-sensitive strategies for their socialization, adaptation, and support.

#### *The Researcher's Position in the Context of the Study*

As a constructivist researcher, the researcher in this study recognized and acknowledged that her own, social, cultural, and historical background and experiences might have helped shape the analysis and interpretation of the data (Bloomberg & Volpe, 2008). Articulation of her position in the context of this research was essential in establishing the trustworthiness of the study.

The researcher's interest in the topic of nursing identity development stemmed from her personal and professional relationships with generic nursing students and non-nursing professionals desiring to pursue nursing as a second career. Her experiences as a faculty member in the academic setting and as a mentor for professional nurses in the hospital setting, and her interactions with fellow graduate students have served as sources of personal reflection and scholarly inquiry. She has always wondered about the process by which new nursing professionals develop and embrace their new professional identity, whether it is their first career or their second career. On one hand, she has always been amused by what it entailed for nurses to be able to affirm with extreme pride and conviction the statement, "I am a nurse." On the other hand, she has also been perplexed why some nurses sometimes respond, "I am *just* a nurse" when asked about what it is they do. In her view, no nurse is *just* a nurse. In her view, "I am *just* a nurse" represents lack of pride and commitment to the

nursing profession. It paints a picture of someone who has not fully recognized the true essence of the profession. “I am *just* a nurse” is a manifestation that the individual has not fully connected with the nursing profession, and has not fully developed his or her nursing identity.

As a migrant healthcare worker in the US who has experienced life-changing events related to her employment as a professional nurse, the unique breed of Physician-Nurse is of special interest to the researcher. The proliferation of the phenomenon in her home country stimulated initial questioning. Her initial questions emanated from the general societal view that nursing is subservient to medicine. Initially, she had similar doubts as expressed by the opponents of the FEP-to-BSN retraining program at FIU; however, those doubts were short-lived. Through reading Physician-Nurses blogs, discussions with colleagues, and direct observations, she observed that most Physician-Nurses have successfully transitioned to nursing. On the other hand, she also encountered a few who have not successfully transitioned to nursing. Her encounters with a few medical professionals in her personal network who have become Physician-Nurses but who have not successfully transitioned to nursing in spite of passing the NCLEX spurred more questioning. This questioning provided the impetus for this study. The researcher initially became interested with Physician-Nurses who struggled with their professional transitions and had originally conceptualized a phenomenological study to explore their lived experiences. Through further self-reflection and deeper scholarly questioning, a proposed grounded theory study focused on those who have successfully transitioned to nursing in contrast to a phenomenological study focused on those who have not transitioned to nursing was conceptualized. This was how this exploratory and explanatory research was conceptualized.

The researcher is currently an adjunct clinical professor for FIU's FEP-to-BSN Program, Tampa Bay Cohort. As a faculty member for this group of students, she viewed herself as a key agent in their socialization to nursing and a key influence in the development of their nursing identity. She taught the group during their first semester of nursing school. Teaching this unique group of ethnically diverse students in their first semester of nursing school enriched her knowledge about the phenomenon of interprofessional migration. Witnessing the behaviors of the students in the clinical setting on the first day of clinical rotation and on subsequent clinical rotations enabled her to witness directly some of the stories her participants have told her. Her relationship with FEPs currently retraining to become nurses provided her with the opportunity to experience prolonged engagement with the phenomenon under study and helped her to control her biases. None of the students whom she taught were participants in this study.

#### *Researcher's Biases and Assumptions*

In qualitative research, it is important that biases and assumptions are articulated so that they can remain in check (Miles & Huberman, 1994). Throughout the course of the study, the following biases and assumptions surfaced through the researcher's self-reflection.

#### *Pertaining to International Migration*

1. International migration of professionals particularly from developing to developed countries results to loss of professional status in immigrants.
2. International migration of healthcare professionals is largely driven by economic factors.

*Pertaining to Interprofessional Migration*

1. Shifting from a discipline traditionally viewed as more prestigious and powerful than nursing has negative psychological effects; hence, may be difficult and painful.
2. Immigrant physicians from paternalistic societies view nurses in their native countries as handmaidens. Initial exposure to the US healthcare system as ancillary personnel provides unlicensed immigrant physicians an *inside look* at nursing practice in the US and negates the handmaiden view.
3. Immigrant physicians who are working as support personnel in healthcare facilities are more likely to choose to become nurses.
4. Transition to nursing is dependent upon the type of jobs immigrant physicians held while they were beginning a new life in their new society.
5. Immigrant physicians who enroll in nursing programs view nursing as a profession of equal value and status to medicine.
6. Transition to nursing is dependent upon the length of prior medical practice. Younger physicians: easier transition; older physicians with well-established practices: difficult transition.
7. Physician-Nurses in training feel marginalized by both their previous physician group and their prospective nursing group.
8. The economic rewards of being a nurse in the US buffers the negative psychological effect and facilitates transition to nursing. The researcher believes that for nursing identity to develop, these individuals must recognize the value and meaning of nursing beyond the economics and they must possess

self-motivation and commitment strong enough to move forward in their new profession.

9. Although there maybe truth to the saying, “once a doctor, always a doctor”, physicians can successfully transition to nursing.
10. Transition to nursing may be an easy and effortless to some; but to others it may be something that requires extra effort not only psychologically but physically, as well.

#### *Definition of Terms and Meaning of Acronyms*

Throughout this paper, there are terms and acronyms that will be used. To operationalize them, the following definitions and meanings are given:

#### *Terms*

Autonomy	degree of discretion and independence a practitioner has (Craven & Hirnle, 2007, p. 1416).
Categories	the major units of analysis for grounded theory, and they are defined as abstractions of phenomena that are observed in the data (Chenitz & Swanson, 1986).
Culture	refers to learned, shared and transmitted values, beliefs, norms and lifeway practices of a particular group that guides thinking, decisions, actions and patterned ways (Leininger, 1989, p. 152).
Curriculum	a planned sequence of course offerings and learning experiences which comprise the nursing education program (Florida Board of Nursing, 2007, p. 18).
Lead People	individuals with Physician-Nurses in their professional and personal networks who helped with participant recruitment.

Nurse Medic	term used in the Philippines for a physician who has retrained as a nurse (Galvez Tan et al., 2004). Also called MD-Nurse.
Nursing Identity	the <i>persona</i> of a professional individual that portrays the expected knowledge, skills, roles, behaviors, attitudes, values, and norms that are appropriate and acceptable in the culture of the nursing profession.
Nursing Medics	term used in the Philippines to refer to the phenomenon of interprofessional migration from medicine to nursing (Galvez Tan et al., 2004).
On-duty	the term used in the Philippines to refer to nursing student's clinical rotation.
Paradigm	the prevailing thought in a specific discipline.
Persona	the role that an individual assumes and displays in society.
Physician-Nurse	a former physician who has retrained as a nurse.
<i>Acronyms</i>	
APRN	Advanced Practice Registered Nurse
AS	Associate in Science
ATLAS.ti	German: Archiv fuer Technik, Lebenswelt und Alltagssprache English translation: Archive for technology, the life world and everyday language. The extension <i>ti</i> means <i>text interpretation</i> (Bishop & Corti, 2004)
BSN	Bachelor of Science in Nursing
CGFNS	Commission on Graduates of Foreign Nursing Schools
CINAHL	Cumulative Index of Nursing and Allied Health Literature



COMLEX	Comprehensive Osteopathic Medical Licensing Examination
DNP	Doctor of Nursing in Science Practice
ECFMG	Educational Commission for Foreign Medical Graduates
ELMSN	Entry Level Master of Science in Nursing
FEP/FEPs	Foreign-Educated Physician/s
FIU	Florida International University
FNP	Family Nurse Practitioner
IELTS	International English Language Testing System
LPN	Licensed Practical Nurse
LVN	Licensed Vocational Nurse
MD-NP	Physician-turned-Nurse Practitioner
NCLEX-RN	National Council Licensure Examination for Registered Nurses
TOEFL	Test on English as a Foreign Language
UNLV	University of Nevada Las Vegas
USMLE	United States Medical Licensing Examination

### *Chapter Summary*

This chapter offered an overview of the entire research project. Background information regarding the sensitizing concepts of identity, nursing identity, socialization, anticipatory socialization, professional socialization, and professional socialization to nursing was provided. It was discussed that nursing identity is defined vaguely in extant nursing literature. An adaptation of the definition of professional socialization was used to define nursing identity as the *persona* of a healthcare professional that portrays the expected knowledge, skills, roles, behaviors, attitudes, values, and norms that are appropriate and

acceptable in the culture of the nursing profession. It was asserted that nursing identity is the substantive outcome of professional socialization to nursing, and that socialization to nursing begins in nursing school where students learn the preparatory knowledge and skills, and acquire the qualities and the ideals of the nursing profession. A description of the population-of-interest, the Physician-Nurses was provided. It was discussed that there are two distinct groups of Physician-Nurses that currently exist in the US: one group comprises immigrants already residing in the US who have been unable to obtain licensure to practice medicine in the US, and the other group comprises immigrants from the Philippines who intentionally retrained as nurses to facilitate their migration to the US. In the face of the current nursing shortage and the national mandate to increase diversity of the US healthcare workforce, it was discussed that MD nurses are evolving vital components of the US and global nursing workforce. A steady growth of this unique breed of nurses is foreseen in the future. A brief discussion about international physician migration as well as interprofessional physician migration to nursing was presented. Interprofessional migration was the term used to replace the term MD-to-Nurse Phenomenon. It was stated that with geographical and interprofessional migration, occupational discontinuity occurs. A comparison of the medical and nursing paradigms was also presented. A table summarizing their differences was presented in Table 1.1 and an expanded narrative discussion of the differences of nursing and medical education and nurse-physician relationship was also provided. In comparing the two professions, curing was associated with the medical paradigm and caring was associated with the nursing paradigm. It was asserted that the ability of the Physician-Nurses to transcend these differences that makes the phenomenon of interprofessional migration unique. It was mentioned that there are two types of physicians in the US: the doctor of medicine (MD) and

the doctor of osteopathy (DO). The statement of the problem listed some questions and concerns from leaders in the nursing community that revealed their doubts about the successful transition of physicians to become nurses. The statement of purpose and specific aims as well as the rationale and significance were also discussed. The purpose was to generate a theory that can explain the basic social psychological process that influenced the development of nursing identity in foreign-educated physicians who have retrained as nurses and who are now practicing in the US. This study was designed to find the answer to the research question, “What is the basic social psychological process that influences the development of nursing identity in foreign-educated physicians who have retrained as nurses and who are now practicing in the US?” The specific aims were to discover barriers that participants perceived as problematic in their transition to nursing and catalysts that influenced how they addressed the central problematic issue they articulated. The significance and rationale were framed in the perspective of the domains of nursing research, education, and practice. In the domain of research, it was conceptualized to fill the scientific gap that currently exists regarding the phenomenon of nursing identity development in Physician-Nurses. In the domain of education, it was conceptualized to help dispel doubts about the likelihood of physicians becoming nurses. In the domain of practice, it was conceptualized to place value on the contributions of the Physician-Nurses to a culturally diverse practice setting. This chapter also presented the position of the researcher in the context of this research study and the list of her biases and assumptions. Definition of terms and meanings of acronyms used throughout this dissertation was also provided.

The next chapter, Chapter Two will present the literature review regarding interprofessional migration which includes an account of its origins, its current state in terms

of theory and knowledge building, and answers to the questions: (a) What were the driving forces that motivated foreign-educated physicians to pursue nursing as their careers in the US? (b) What are the needs and problems encountered by non-US native nurses and nursing students during their transition to US ways and US nursing practice?

## Chapter Two

### Literature Review

*When someone stands in the library stacks, he is, metaphorically, surrounded by voices begging to be heard. Every book, every magazine article, represents at least one person who is equivalent...to an interviewee. In those publications, people converse, announce positions, argue with a range of eloquence, and describe events or scenes in ways entirely comparable to what is seen and heard during fieldwork. The researcher needs only to discover the voices in the library to release them for his analytic use. ~ Glaser and Strauss, 1967, p. 163.*

During the conceptualization phase of this qualitative research study, an extensive literature review was not conducted to avoid pre-conceived researcher-bias regarding the topic of study. What was conducted was a limited exploratory literature review regarding the sensitizing concepts and population-of-interest adequate enough to formulate study methodology. The researcher used three articles pertaining to professional socialization and nursing identity development to conceptualize the study (Du Toit, 1995; Kramer, 1974; MacIntosh, 2003).

During data analysis and concept development, an extensive literature review was conducted to provide the researcher with a *comprehensive body of knowledge* to help define concepts and clarify relationships in the theory that was emerging from the empirical data (Bloomberg & Volpe, 2008). The paradox faced by the researcher was that there was no *comprehensive body of knowledge* found directly pertaining to the phenomenon and population under study. Interprofessional migration and Physician-Nurses are novel concepts devoid of established theoretical and empirical foundations that can be utilized to advance

knowledge. Metaphorically, the researcher was not “surrounded by [clear] voices begging to be heard” (Glaser and Strauss, 1967, p. 163) but was surrounded by indiscernible noise needing to be filtered. Using the metaphor *filtering the indiscernible noise*, the researcher constructed an outline of related topics to review that would constitute the *comprehensive body of knowledge* that would help propel her study toward scholarly completion.

Chapter Two aims to bring into perspective a three-dimensional body of knowledge that directly and indirectly pertains to interprofessional migration and to Physician-Nurses. The three dimensions of this body of knowledge can be conceptualized as components of a time capsule characterizing the progression of the phenomenon under study: its past, its present, and its future. For its past, literature about its emergence is reviewed; for its present, current research is reviewed; and for its future, literature about the needs and problems that non-US native nurses and nursing students encounter in their transition to US ways and US nursing practice is reviewed. Because of the absence of literature directly pertaining to the needs and problems of Physician-Nurses in their transition to nursing, literature about non-US native nurses is relevant because Physician-Nurses, although they are unique, fit the characterization of being non-US native. Concepts can be borrowed from this existing literature to inform future research, education and practice.

Review of literature was accomplished by both computer and manual searches. Computer search was conducted through on-line data bases namely CINAHL, PubMed, PsycINFO, and ProQuest Dissertations and Theses Digital Data Base and through internet search engines Google and Yahoo. Electronic communication with topic experts in the Philippines, and with researchers in the US was also utilized. Manual searches of books, journals, and newspapers were also conducted.

This phase of this study was not without logistical challenges. While conducting the literature search, it became evident early in the undertaking that several factors would complicate the process. First, empirical literature about the emergence of interprofessional migration was discovered to be nil; therefore, the researcher trekked the unscientific body of popular print and internet media literature to accomplish the aim of this first dimension of the review of literature. Internet search of popular media literature using the search engines Yahoo and Google was undertaken. When the search phrase physician retraining as nurse was used, it gave a yield of 226,000 items. The search term was modified to “physicians retraining as nurses” which resulted to a yield of 231 items. The titles of the 231 items were scanned briefly and most of the articles were discarded. Twelve media articles were initially selected that were assessed to be able to shed light to the emergence of interprofessional migration by their ability to provide a chronological account of its origins and to answer the question “What were the driving forces that motivated foreign-educated physicians to pursue nursing as their second careers?” Two additional articles recently published in 2008 and 2009 were added later on. Second, at first glance, the limited current research about interprofessional migration and Physician-Nurses offered no unifying theme; hence, the researcher was concerned that in presenting them, it may appear as if they were a meaningless bricolage of unconnected studies conducted in different parts of the world. The unifying theme that cuts across them is what they are not—they are not studies that directly pertain to the development of nursing identity in Physician-Nurses. Third was the multi-dimensionality of the phenomenon and population-of-interest which warranted an extensive review of a wide range of topics that included migration of healthcare professionals, cultural diversity, cultural assimilation or acculturation, accelerated second-degree nursing programs for non-traditional

students, and the integration of non-US native nursing professionals into the US mainstream healthcare industry. The researcher felt that conducting and reporting a comprehensive review of literature regarding these topics would provide full understanding of the many dimensions of the central topic of study which subsequently would offer a compelling assessment of the knowledge gap that currently exists. However, by refocusing on the main purpose of the study, the researcher narrowed the additional review to only include the dimension pertaining to the transition process of non-US native nurses currently training or already practicing as nurses in the US. The researcher felt that the descriptive phrase non-US native nurses can serve as a proxy to represent the population-of-interest in this study. This part of the literature review sought to answer the question, “What were the needs and problems encountered by non-US native nurses and nursing students during their transition to US ways and US nursing practice?” Fourth was the dearth of literature yield when the key word “nursing identity” was used and the paradoxical massive yield when the key words “nursing professional socialization and nursing identity development” were combined. For example, using “nursing identity” without delimiters only yielded 48 items in CINAHL and 22 in PsycINFO. Using *peer-reviewed* as a delimiter, the yield decreased to 17 and 35 items, respectively. Visual scanning of the titles further decreased the number of items to two and eight, respectively. In contrast, when the keywords “nursing identity construction” or “nursing identity development” was used in CINAHL, the yield of the search was in the thousands. This was also true when the key words “nursing professional socialization combined with nursing identity development” were used. To taper down the results of the search, search terms were combined in multiple ways. Additional search terms included nursing identity construction, accelerated nursing programs, second bachelors degree, and retraining foreign-educated



physicians. In CINAHL, using a combination of the search terms nursing identity development, nursing identity construction, professional socialization, accelerated nursing programs, second bachelors degree, and foreign-educated nurses with no delimiters yielded 218 articles for the period between 1981 to 2009. Source types included all [periodicals, dissertations, CEUs, proceedings]. When delimiters *peer-reviewed* and *research article* were added, the yield became 85. The titles of the articles were scanned and through this process, 30 articles were rejected decreasing the number to 55. Abstracts were read and a final pool of 20 articles were placed in a *literature bank* to be used during iterations to help define concepts and clarify relationships in the theory that was emerging from the empirical data in this current study. Additional six dissertations were included. The main criterion was that the article had to describe the process of socialization to nursing. With the recursive and iterative nature of data collection, literature review, and data analysis in grounded theory, selection of articles about professional socialization to nursing and nursing identity development was greatly influenced by the theory that was emerging from the empirical data in this current study.

With the collection of literature comprising the three-dimensional body of literature that directly and indirectly pertains to the phenomenon and population-of-interest, this chapter is organized into the following major headings and subheadings: (a) the emergence of interprofessional migration with two subheadings, the origins of interprofessional migration and driving forces that motivated FEPs to pursue nursing, (b) current research about Physician-Nurses, and (c) the needs and problems that non-US native nurses and nursing students encounter in their transition to US ways and nursing practice.

*Examining the Past: The Emergence of Interprofessional Migration*

The first dimension of this literature review aims to provide an account of the significant past and origins of interprofessional migration and to answer the fundamental question, “What were the driving forces that motivated FEPs to pursue nursing as their careers in the US?” The current state of this phenomenon is such that there is very limited empirical literature available to build knowledge upon. Taking this into consideration, the researcher as stated earlier, trekked the unscientific body of media literature to accomplish the aims of this dimension of the literature review. Fourteen stories featuring narratives about Physician-Nurses posted in the internet between 1999 and 2009 were selected to serve as primary data. The main criterion for inclusion of a story was that it provided dated information about retraining programs as well as description of factors that motivated FEPs to pursue nursing (Associated Press, 2003; Burnett III, 2006; Contreras, 2004; Gatbonton, 2004; Gunn-Lewis & Smith, 1999; Hatcher, 2007; Jimenez, 2003; Kelly, 2007; Mangan, 2007; Mosqueda, 2006; Ojito, 2009; Rexrode 2007; Ruiz 2004; Thrall, 2008). Additional news articles were retrieved that provided information necessary for the construction of a comprehensive chronological account of the origins of nurse retraining programs for physicians (Adler, 1999; ETA News Release, 2004; Kennedy, Ferri, & Sofer, 2002; Wirkus, 2008). Stories were retrieved using internet search engines Google and Yahoo. Key words used were “doctors retraining as nurses”, “physicians retraining as nurses”, “MD-to-RN phenomenon”, “MD-to-Nurse phenomenon”, nurse medic phenomenon, and nurse medics. When these key words were used in CINAHL, PubMed, and OVID, the search yielded zero results.

### *The Origins of Interprofessional Migration*

The first aim of this dimension of the literature review was to identify the origins of interprofessional migration. To accomplish this aim, information about nurse retraining programs for immigrant physicians in the US and in other parts of the world was extracted from the media stories. The researcher was cognizant of the limitations of the information she was able to obtain from media literature, but she was able to construct a logical and chronological timeline to illustrate the early beginnings of the phenomenon. See Figure 2.1. It can be hypothesized that the origins of nursing education programs that retrain FEPs to become nurses were modeled after the accelerated second bachelors degree programs which began in the US in 1971 (Miklancie & Davis 2005; Seldomridge & DiBartolo 2005, 2007). The country-by-country discussion that follows intends to shed light on its early beginnings and to demonstrate that the phenomenon is of global nature. In exploring its origins, it is also important to examine how nursing academicians shaped this phenomenon by scrutinizing sample curricula that were collected during this literature review. Scrutiny of curricula is important because socialization to nursing begins in nursing school; however, critical curriculum analysis is beyond the scope of this current study. Therefore, in this context, all sample curricula that the researcher uncovered were superficially examined and then included in the appendices for the readers' perusal and analysis.

*Training of Physician-Nurses in New Zealand.* The article that accounted for the retraining of Chinese immigrant physicians to become nurses in New Zealand (NZ) was a case study and a program evaluation report, but it was included in this category of popular media and internet literature because it provided crucial information for the chronological account of the origins of the phenomenon of interprofessional migration. The article by Gunn-

Lewis and Smith (1999) gave the earliest account of physicians retraining as nurses. What can be inferred from this story is that interprofessional migration from medicine to nursing started in NZ. In 1998 and 1999, immigrant physicians resettling in NZ, mostly coming from China, attended the UNITEC Institute of Technology in Auckland to obtain a Bachelors Degree in Nursing. The curriculum was a three-year full time program with

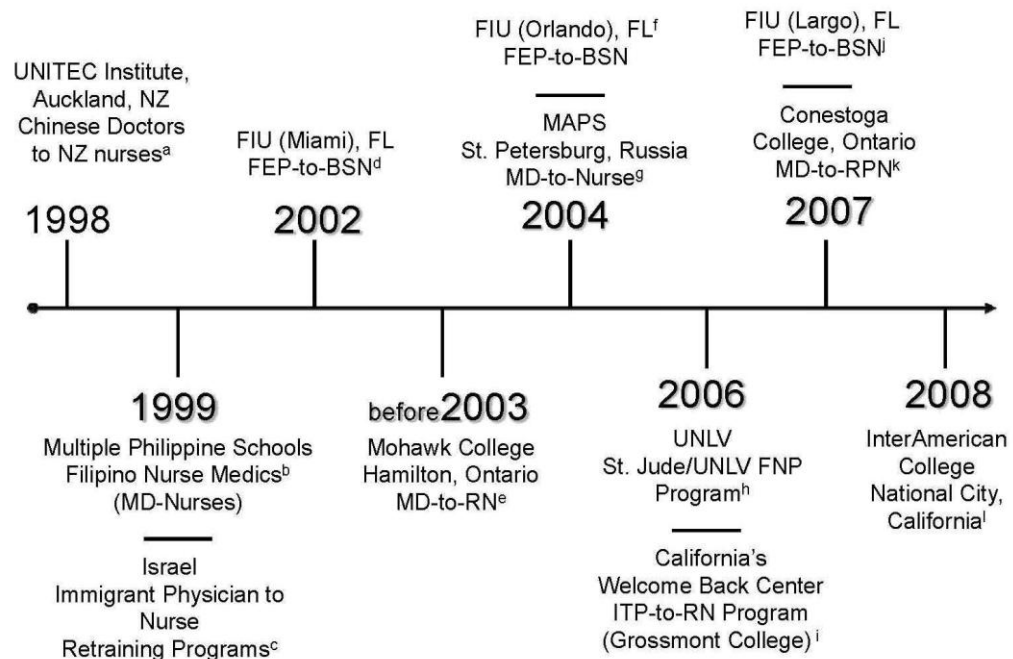


Figure 2.1. Chronology of the origins and evolution of nurse retraining programs for immigrant physicians. <sup>b, c, d,</sup>

<sup>g, h, j, l</sup> With certainty that programs still exist to today. <sup>a, e, k</sup> Uncertain if programs still exist today. <sup>f, i</sup> With certainty that programs no longer exist today. <sup>i</sup> Program through the Welcome Back Center in San Diego, CA that awarded AS degree discontinued at Grossmont College. <sup>l</sup> ELMSN program at InterAmerican College currently exists. <sup>b</sup> Physicians in the Philippines retrain as nurses before they immigrate. MAPS = Medical Academy of Post Graduate Studies. ITP = Internationally Trained Physician. NZ = New Zealand. RPN = Registered Practical Nurse.

English-proficiency requirements. Accelerated curriculum for the Physician-to-Nurse program did not exist. The physician in the case study debated that it was unfair to require Chinese physicians to undergo a three-year retraining program to become nurses while Chinese nurses were only required to attend training as short as six weeks (Gunn-Lewis & Smith, 1999).

*Training of Physician-Nurses in the Philippines.* It is important to note that the Philippines is the leading exporter of nurses to developed countries (Aiken, 2007; Aiken et al., 2004; Brush, Sochalski, & Berger, 2004; Joyce & Hunt, 1982; Lorenzo et al., 2007; Perrin, Hagopian, Sales, & Huang, 2007). With the prevailing global demand for nurses and the Philippine government's policies that encourage the production of nurses for export, the nursing education sector in the Philippines experienced a rapid and unprecedented growth in early 2000. Currently, there are approximately 460-470 nursing colleges (Galvez Tan, 2009) across the nation that offer the Bachelor of Science in Nursing (BSN) program and produce about 20,000 nurses per year. In addition to offering the traditional four-year undergraduate BSN curriculum, schools in the Philippines have revolutionized the two-year accelerated second-degree nurse education programs by opening these programs specifically to physicians (Lorenzo et al., 2007). Findings in a 2004 survey showed that at least 40 nursing schools across the country were offering accelerated nursing programs specifically tailored for medical graduates (Galvez Tan et al., 2004; Lorenzo et al., 2007). It is noted in media literature that Filipino physicians started making professional transitions to nursing beginning in 1999 (Galvez Tan et al., 2004; Pascual et al., 2003); however, one of the participants in this current study indicated that he had colleagues who were in nursing school as early as 1994. In succeeding years, this trend of physicians becoming nurses became very popular in the

Philippines where it has become known as the nursing medic phenomenon. A nurse medic is an individual who holds both MD and RN degrees and who chooses to work as a nurse (Lorenzo et al., 2007; Pascual et al., 2003). The Philippines is the first country that intentionally trains its own physician population to become nurses so that they can be employed as nurses in the US and in other developed countries. A prototype of a curriculum to retrain physicians to nursing in the Philippines is presented in Appendix A. The Related Learning Experience (RLE) is the equivalent term used to refer to Clinical Experiences. Appendix B summarizes the content and the number of hours required for the RLEs (Villagomez, 2008).

Filipino physicians of all specialties have retrained as nurses. Because of the absence of systematic tracking and trending mechanisms, exact statistics as to how many physicians have retrained as nurses in the Philippines are not available. A study conducted in 2001 revealed that there were approximately 2,000 physicians who became Physician-Nurses that year. In 2003, that number increased to approximately 3,000 (Pascual et al., 2003). In 2005, approximately 4,000 physicians were actively pursuing nursing education in schools across the country (Galvez Tan, 2006 November). According to an estimate by the Philippine Hospital Association (PHA), 80% of all public sector physicians were currently or had already retrained as nurses in 2004 (Lorenzo et al., 2007). The current estimates indicate that there are approximately 9,000 to 11,000 Filipino Physician-Nurses today (J. Galvez Tan, personal communication, July 26, 2009).

*Training of Physician-Nurses in Israel.* The retraining of physicians to nursing in Israel came as a response to the need of immigrant physicians from the former Soviet Union who either were unable to pass the Israeli physician certification exams or who decided to

avoid the process of physician re-licensure from the beginning. From 1989 to 2001, there were approximately one million immigrants to Israel and a large percentage consisted of physicians. Remennick & Shakhar (2003) indicated that the retraining of former physicians to nursing was opposed by Nurses Union; therefore, no physicians were retrained to nursing. It was found that this was inconsistent with the paper by Adler (1999) which reported that nursing retraining programs for physicians became part of the government retraining programs for immigrant healthcare professionals. The inconsistency was clarified with Remennick through electronic communication. She responded stating, “there was never a major retraining stream of that kind, as far as I know. Some individuals or small groups may have got this permit here and there. Yet, I am not a nursing specialist and this wasn’t a focus of my study” (L. Remmenick, personal communication, August 5, 2009).

The report by Adler (1999) regarding the existence of nurse retraining programs for physicians in Israel was supported by an article by Kennedy, Ferri, and Sofer (2002) stating that Israel had the experience of retraining FEPs to become nurses. The authors quoted Shoshana Riba, Israel’s national chief nursing officer and director of Division of Nursing at the Ministry of Health in Jerusalem asserting that success of the FEPs in their new profession depends on socializing them to the nursing profession. She said, “The socialization must begin at the very start of the conversion course and be supported and reinforced after the doctor-students’ graduations from the course into the early stages of their new employment as nurses” (¶ 4). In searching for additional evidence, it was also identified that the Barzilai Medical Center School of Nursing located in Ashkelon, Israel offers a career retraining program for physicians and graduates of other academic professions to nursing (Barzilai Medical Center School of Nursing, 2009).

Due to the inconsistency that was found in the literature and in the result of the researcher's personal communication with Remmennick, it is not totally clear when the retraining programs started in Israel. It can be deduced that they probably started in 1999 or earlier because Adler's report was dated December that year.

*Training of Physician-Nurses in the US.* In the US, the Florida International University in Miami offers an innovative nursing education program that retrains FEPs to become nurses with a BSN degree. The FEP-to-BSN Track is an accelerated program requiring the completion of 123 credits of didactic coursework, clinicals, and community projects over five semesters (FIU, 2007). Appendix C outlines the curriculum of the FIU program. Its development was in response to an initial request for nurse training by a group of Cuban-trained physicians who were residents of Miami but who were not licensed to practice medicine in the US (Mangan, 2007). Global interest in the program became evident very early in its conceptualization with inquiries from physicians in the Philippines, Haiti, and Nicaragua, as well as from American-born physicians who trained outside the US (Peters, 2002). For its first cohort of 40 students who started the program in May 2002, FIU screened more than 500 applicants and graduated 32 in December 2003 (Clinical Rounds, 2004). For the second cohort, 632 students vied for 60 slots. Forty percent of the applicants were from Cuba, and 40% came from other Latin American and Caribbean countries. The other 20% came from India, Nigeria, Pakistan, and Romania (Mangan, 2007). The program was initially approved by the Florida Board of Nursing in 1998 but lack of funding delayed its implementation. In 2002, four hospitals in Miami and Fort Lauderdale provided funding; then in 2004, a federal grant of \$1.4 million administered by the US Department of Labor's Employment Training Administration which was a part of President George Bush's High



Growth Job Training Initiative was awarded to FIU to fund the expansion of the program (Clinical Rounds, 2004; ETA News Release, 2004; Grossman & Jorda, 2008). In August 2004, the FIU program branched out to Orlando, Florida through distance education method with 10 students (D. Grossman, personal communication, November 21, 2008). In January 2007, in partnership with Hospital Corporation of America (HCA), FIU's distance education program added the Largo, Florida cohort with 13 students. These students were from Bulgaria, Colombia, Cuba, Nicaragua, Philippines, and Russia and were chosen from a pool of almost 200 applicants (Rexrode, 2007). According to the faculty coordinator of the program, FIU has graduated approximately 300 Physician-Nurses as of December 2007 (S. Simon, personal communication, 2008). This number has increased to approximately 500 as of August 2009 (D. Grossman, personal communication, August 17, 2009).

In the US west coast, a program administered by the San Diego Welcome Back Center in partnership with Grossmont College in El Cajon, California retrained internationally educated physicians to become nurses. The program was able to place more than 100 immigrant physicians in the mainstream of the US healthcare industry by retraining them as nurses since 2004 (Wirkus, 2008). The curriculum at Grossmont College was a 14-month program and awarded graduates with an associate degree. Grossmont College no longer offers the nurse retraining program for physicians. Another program is now offered at the InterAmerican College (IAC) in National City, California (C. Girsch, personal communication, August 3, 2009). The first group of 15 students at IAC who started in May 2008 will be graduating in December 2009 (V. Glaser, personal communication, August 3, 2009). The program at IAC is a pre-licensure, post-baccalaureate entry level Master of Science in Nursing (ELMSN) program. Stipulations for eligibility for admission into the

program state that applicants must possess a bachelors-level degree from an accredited US college or university, or its equivalent from a foreign country as documented by an authorized Foreign Credentialing Service. It further stipulates that applicants who do not possess the equivalent of a US bachelors-level degree but are graduates of a medical school in a foreign country may enroll in the IAC Bachelor of Science Degree Program so that they can progress to the ELMSN. The purpose of the ELMSN program is to prepare students for RN positions as generalists. Upon successful completion the ELMSN program, graduates are eligible to take the California NCLEX-RN Examination (InterAmerican College, 2009). See Appendix D for the ELMSN curriculum.

In Nevada, a master's level nursing education program is offered by the University of Nevada Las Vegas (UNLV) to train physicians to become family nurse practitioners (FNPs). This program, exclusively designed for Filipino physicians who have BSN degrees, is a joint venture between the UNLV and St. Jude College in Manila, Philippines (UNLV, 2007). Didactic classes are taught online and clinical training is held in the students' locality (P. Alpert, personal communication, April 16, 2008). The Physician-to-FNP students spend 18 hours a week in clinical training. See Appendix E for UNLV's curriculum. The vision of Carolyn Yucha, PhD, RN, dean of the School of Nursing at UNLV is that the physicians who train in the St. Jude MSN Program will develop a relationship with UNLV and will practice or teach in Nevada when they immigrate to the US (Howard, 2006).

Other accelerated programs known to have retrained FEPs to entry-level nursing, but not on an exclusive basis such as FIU, include the Miami Dade College in Florida (Hatcher, 2007) and the Cuyahoga Community College in Ohio (Mangan, 2007).

*Training of Physician-Nurses in Canada.* The limited literature found in the internet about nursing retraining program in Canada does not provide adequate information to allow for the logical sequencing of events that led to the development of interprofessional migration there. It can be inferred that a Physician-to-Nurse education program at Mohawk College in Hamilton, Ontario existed before 2003. The program taught Chinese anesthesiologists, Iranian general practitioners, and Pakistani gynecologists medication dispensing and clinical nursing techniques (Jimenez, 2003). The program which had approximately 160 international medical graduates as students was discontinued as a result of the Canadian government's requirement that took effect in 2005 mandating that all new RNs must have Bachelor of Science degrees (Jimenez, 2003; Registered Nurses' Association of Ontario [RNAO], n.d.). As of April 2008, a pilot program at Conestoga College which started in August 2007 was training 13 internationally trained health professionals, including nine physicians to earn degrees as registered practical nurses (RPNs), a degree similar to the Licensed Practical Nurse in the US. Students comprising this group were chosen from an applicant pool of 36. The program is a joint effort between the Waterloo Wellington Training and Adjustment Board and Conestoga College and is funded by a grant from the Ontario Ministry of Citizenship and Immigration and from the Citizenship and Immigration Canada (Kelly, 2007).

*Training of Physician-Nurses in Russia.* In St. Petersburg, Russia, an MD-Nurse Diploma Program is being offered to medical graduates at the St. Petersburg State Medical Academy of Post Graduate Studies (MAPS). This program is being advertised as 'Green Cards for Doctors'. The purpose of this MD-to-Nurse program is to award nursing diplomas to physicians trained in Russia so that they can qualify to sit for the Commission on Graduates of Foreign Nursing Schools International (CGFNS) and NCLEX-RN examinations and

immigrate to the US with a green card. Information provided to potential applicants is that they will use the two-year contract period working as nurses to prepare to pursue their respective professional medical careers. The intent of this program is to make nursing the route by which medical graduates from Russia facilitate their entry to the US and make nursing their temporary careers while they pursue the certification requirements of the Educational Commission for Foreign Medical Graduates (ECFMG) (Mosqueda, 2006).

Description of the curriculum for the MAPS MD-Nurse Diploma states:

The purpose of education is the reorientation of medical graduates to acquire theoretical knowledge and the practical skills, corresponding to the educational standards required to work as a first level registered nurse and to improve the general level of nursing care; and the educational task is to acquire theoretical knowledge and practical skills, necessary to work as first level registered nurse that corresponds to the educational standard in the field of Medical-Surgical nursing, psychology, and psychiatric nursing, Maternal and Infant nursing, nursing care of the new born, Pediatric nursing and also to understand the features of nursing process in the care of elderly persons, to know basics of Community health nursing and to understand necessary diagnostic and medical procedures. The submitted program is prepared on the basis of the three-year program of training in nursing and meets the requirements of the [United] State educational standards.

The sample curriculum used in Russia is presented in Appendix F.

#### *Driving Forces that Motivated FEPs to Pursue Nursing*

This second segment of the first dimension of the literature review intends to answer the fundamental question, “What were the driving forces that motivated FEPs to pursue nursing as their careers in the US?” To answer this fundamental question, a qualitative analysis of the 14 print and media stories as primary data sources was conducted. A collective case study design was used with each story representing one case. Text data were analyzed using content and context analysis, specifically cross-case analysis. Cross-case analysis facilitated the exploration, description, and in-depth analysis of text data extracted from the

source documents, and it allowed for the identification and discovery of key words, patterns, themes, concepts, and the relationships among concepts from across the cases. Immersion in the data facilitated the formation of categorical groupings of the key words, themes, and concepts. The variable-oriented approach or clustering technique—one that deals basically with the relationships among the concepts, was utilized. Clustering is an intuitive, first-level process that is analogous to ordinary coding. This approach allowed for the themes and the patterns that cut across all cases to appear (Miles & Huberman 1994).

To facilitate cross-case analysis, a case-level display of partially ordered meta-matrix was created (Appendix G). This display presents each story as a case and key words and phrases that have been extracted from every case are listed. Visual scanning of the case-level display was done followed by a more in-depth content analysis. Through content and cross-case analysis, identifying similarities and clustering keywords in patterns were accomplished. This made it possible to create a content analytic structure consisting of 10 component parts (Appendix H). This was more manageable than the raw data of hundreds of text from the 14 documents. The 10 clusters were identified as the *factors* that influenced the decision of FEPs to pursue nursing. The factor cluster labels were: (a) economic; (b) socio-cultural; (c) political; (d) factors related to immigration; (e) factors related to the availability of education programs for FEPs; (f) factors related to regulatory requirements for physician licensure in host country; (g) factors related to the worldview that medicine and nursing are professions of equal value; (h) factors related to better job opportunities as nurses in the US than as physicians in home country; (i) factors related to family dynamics; and (j) factors related to underemployment and underutilized medical talent.

While the 10 clusters of factors were forming, the data was concurrently analyzed to see what conceptual framework was emerging. From the 10 clusters, four major categories became apparent. These four categories emerged through the process of subsuming the particulars into the general (Miles & Huberman, 1994). The four categories were labeled as *forces* and they were displayed using a conceptually-ordered content-analytic summary table (Table 2.1) and a conceptual diagram (Figure 2.2). These *forces* were named in the context of the relationship of the FEPs to themselves, to their families, to their professions, and to the wider society; hence, they were labeled as (1) individual-driven forces, (2) family-driven forces, (3) profession-driven forces, and (4) society-driven forces. *Force* is synonymous to the terms strength, energy, vigor, and power (Agnes & Laird, 2002). The term *force* in the context of this analysis is conceptualized as a multidimensional construct that motivates and drives individuals to pursue actions toward the hierarchical fulfillment of basic human needs—from physical needs through the better economic gains attained by becoming a nurses for the US and global markets to self-actualization through the psychological lift resulting from the removal of *the self* from underemployment.

*Individual-driven forces.* These are the *factors* that are internal to the individual. This major category is made up of the cluster of factors that are within *the self* and include the impact of underemployment and underutilized medical talent while working in careers and low-paying jobs outside of medicine or nursing. In their new country, FEPs had series of minimum-wage jobs to support their families: bellman, delivery driver, dishwasher, hotel cleaner, grocery stocker, housekeeper, janitor, landscaper, mover, personal support worker,

Table 2.1

*Driving Forces that Motivate Foreign-educated Physicians to Pursue Nursing*

<b>1</b> Individual-driven Forces	<b>2</b> Family-driven Forces	<b>3</b> Profession-driven Forces	<b>4</b> Society Drive Forces
Factors related to underemployment and underutilized medical talent	Factors related to family dynamics	Factors related to regulatory requirements for US physician licensure	Economic factors
		Factors related to the availability of nursing retraining programs	Socio-cultural factors
		Medicine and nursing viewed as professions of equal value	Political Factors
		Better job opportunities in the US as nurses	Factors related to immigration

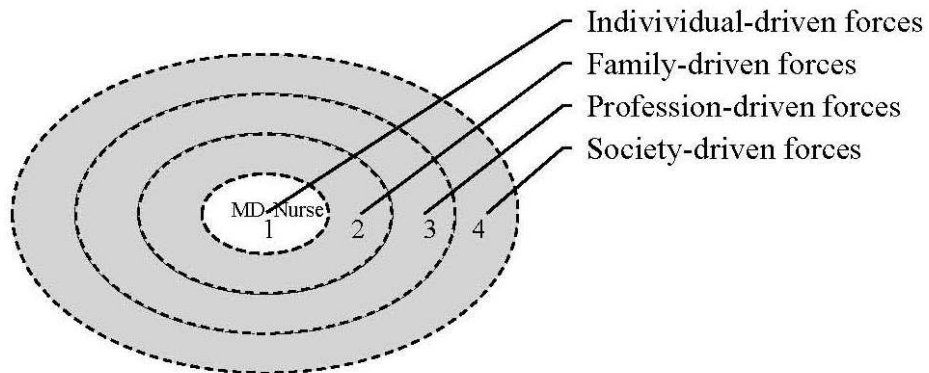


Figure 2.2 Driving Forces that Motivate Foreign-educated Physicians to Pursue Nursing

pizza delivery, produce sorter, security guard, taxi driver, or waitress. FEPs also worked in healthcare facilities as medical recorder, medical records clerk, or phlebotomist.

*Family-driven forces.* These are the *factors* that stem out from the influence of the FEPs' family dynamics. A common theme that emerged in this major category was the priority of supporting their families as only secondary to pursuing licensure to become physicians. Family-driven forces also include factors related to the FEPs' strong desire to build a more promising future for them in the US—a country with higher standard of living.

*Profession-driven forces.* These are *factors* inherent to the professions of medicine and nursing, whether in the US or in other developed countries. This major category includes the cluster of factors related to regulatory requirements for physician licensure in the US such as the three-part licensing examination required by the Educational Commission for Foreign Medical Graduates (ECFMG) followed by mandatory training under US standards. This is also true in Canada and NZ. Physician-Nurses identified this factor cluster as a major hindrance in their ability to practice as physicians in their new countries. In this major category, it is important to note that FEPs who become Physician-Nurses view medicine and nursing as professions of equal value. This is contrary to the assumption of the general public that pursuing nursing is a downward professional mobility for them. They perceive being a doctor or being a nurse as both important because both are noble professions. In their perspective, nursing is as much about caring as doctoring. This category also includes *factors* related to better job opportunities as nurses in US than as physicians in their home countries. In the Philippines, poor working conditions exist and the job market for medical graduates is not good. This is in contrast to the better working conditions as nurses in the US or in other developed countries. There are more employment, training, and career growth opportunities



as nurses in developed countries than as physicians in their home countries. This category also includes the availability of nursing retraining programs especially designed for FEPs that allow them to continue working while going to school and that give credit for courses they have taken as part of their medical training. In Canada, they also have retraining programs funded by the government.

*Society-driven forces.* These are the *forces* that are present in the wider society. In this analysis, the clusters of factors that comprise this major category include economic, socio-cultural, political, and immigration factors. Salaries are very low in home countries for physicians. In Cuba as a doctor, one is fortunate if earnings have an equivalence of \$30 per month. In the Philippines, most doctors earn between US\$300.00 to \$1,000.00 per month. In 2002, median gross annual income for self-employed physicians was reported as P230,347.75 [Philippine Pesos], equivalent to US\$4,189.00 calculated at the prevailing dollar exchange rate during that time of P54.98[Philippine Pesos] per dollar. Medical retraining in the US and Canada is very expensive, lengthy, and impossible for some. Even after spending significant amounts of money to prepare and pass licensing examinations, FEPs are not assured of acceptance to residency programs. Socio-cultural factors include the enormous challenges preventing transition to a medical career because of language barrier, cultural differences, and lack of social knowledge of their new country. Political factors include the FEPs' lack of faith in home country and feeling of hopelessness related to political uncertainty; poor peace and order; and corruption. Factors exist related to immigration because it is less arduous to obtain a US visa as a registered nurse than as a physician.

### *Relevance of this Dimension of Literature Review*

This first dimension of the literature review provided an account of the phenomenon's past and early beginnings by describing its origins from a global perspective and by answering the question about the driving forces that motivated FEPs to pursue nursing. This dimension of the literature review contributed to the evolving body of knowledge about this research domain by transforming data found in popular media literature into a systematic body of knowledge. This initial systematic body of knowledge is anticipated to incite further scholarly inquiry regarding this phenomenon.

From the themes that emerged in the analysis of the 14 media stories, it can be concluded that the motivating factors for FEPs to pursue nursing is an interplay of the push and pull forces of migration and of Maslow's hierarchy of human needs. This means that FEPs are motivated and are driven to pursue actions toward the hierarchical fulfillment of basic human needs—beginning with the primal and most basic physical needs to higher level psychological needs such as self-actualization.

### *Examining the Present: Current Research About Physician-Nurses*

The second dimension of the review of literature focuses on research studies that currently exist regarding the phenomenon and population under study. Nine empirical articles were identified. Two of the studies were available only in their abstract forms. Due to the current scarcity of existing research in this domain, all available articles whether published or unpublished were analyzed to appraise what they might be able to contribute to the emerging concepts in this current study. Critical and systematic analysis of each study was conducted using Moody's Research Analysis Tool (Moody et al., 1986), Version 2004, a 46-item comprehensive research analysis tool. Table 2.2 provides a summary of the purpose and

Table 2.2

*Summary Across Current Studies: Purpose/Outcomes*

Studies	Setting	Purpose	Instruments	Outcomes/Conclusions
Gunn-Lewis and Smith (1999)	New Zealand	Describe and assess effectiveness of 'support sessions', an intervention to address language and communication barriers that physicians retraining as nurses from non-English speaking backgrounds (NESB) encountered during their clinical training.	Interview	Chinese physicians experience diminished self-esteem retraining as nurses in NZ. Support sessions effective in addressing language and communication barriers in NESB.
Pascual, Marcaida, & Salvador (2005)	Philippines	Explore history of nurse migration in the Philippines; determine reasons why Filipino doctors are taking up nursing.	Semi-structured interviews	Reasons for shift to nursing related to push and pull factors of human migration; economic factor main reason. See Table 2.1.
Galvez Tan, Sanchez, & Balanon (2004)	Philippines	Explore multifaceted causes of nursing medics phenomenon; examine major consequences of phenomenon to healthcare delivery system in the Phil.	Key informants	Reasons for shift to nursing similar to Pascual et al. See Table 2.1.
Lorenzo, Galvez Tan, Icamina, & Javier (2007)	Philippines	Describe nurse migration patterns in the Philippines and their benefits and costs.	Focus Groups	Shortage of skilled nurses and massive retraining of physicians to become nurses have created severe problems for health system .
Poblete (2007) <sup>a</sup>	Philippines	Examine nursing medics phenomenon in the Philippines, particularly the participation of men.	Interviews Participant observation	Phenomenon consequence of state policy that fosters export of workers. Meaning of migration to participants = means of working on self, reconstituting self as new kind of man, a different category of professional, and a novel type of citizen.

Table 2.2 (Continued)

*Summary Across Current Studies: Purpose/Outcomes*

Studies	Setting	Purpose	Instruments	Outcomes/Conclusions
Jorda (2005)	US	Explore whether former physicians can be socialized into nursing by comparing three groups of students (1) generic/basic BSN students; (2) RNs pursuing BSN; and (3) FEPs pursuing nursing.	Stones' Healthcare Professional Attitude Inventory (SHCPAI)	Differences in demographic data noted; no significant differences in socialization scores. Study concluded that socializations of physicians into nursing was possible
Grossman & Jorda (2008)	US	Determine effectiveness of the New Americans in Nursing Accelerated Program by collecting data on 3 program outcomes .	SHCPAI for the measurement of socialization.  CCTDI <sup>b</sup> for the measurement of Critical Thinking Skills.	Accelerated program demonstrated success in educating unlicensed FEPs to become US nurses.
Jauregui and Xu (2008)	US	Examine the transition-into-practice of Filipino nurse medics in the nurse practitioner role.	Interviews	Four themes: Unfamiliarity with US health insurance policies ; Limited scope of practice and legal requirement to have physician collaborator; Working in a litigious environment ; Having education and experience as physician facilitated transition to NP role.
Vapor and Xu (2008)	US	Describe and interpret the lived experiences of Filipino physician-turned nurses in the US	Interviews	Experiences of participants involved multi-dimensional issues, both in the context of emigration and shift from physician to nurse.

*Note.* <sup>a</sup>Poblete also interviewed five nurses practicing in California Nursing Homes before and after his fieldwork in the Philippines. <sup>b</sup>CCTDI = California Critical Thinking Dispositions Inventory.

outcomes of the studies and Table 2.3 provides a summary of the theoretical background and design of the studies. The organizing framework in presenting the synopsis of each study is according to the country where each was conducted.

### *Profile of Studies*

Four studies (44.5%) were conducted in the Philippines, four (44.5%) in the US and one (11%) in New Zealand. Three studies (33%) had been published in refereed journals (Grossman & Jorda, 2008; Lorenzo et al., 2007; Pascual et al., 2005). A copy of the published version of Pascual et al. (2005) was not able to be obtained so the unpublished version (2003) which was obtained by the researcher from the primary author was used in this analysis. The research of Jauregui & Xu (2008) US has been accepted for publication in a refereed journal (Y. Xu, personal communication, June 29, 2009).

The number of authors ranged from one to four. Cumulative total was 19. Three studies (33%) had 1 author, three (33%) had two authors, two (22%) had three authors, and one (11%) had four authors. Of the 19 authors, one (5.3%) was a Physician-Nurse, three (15.8%) were registered nurses with doctoral degrees, one (5.3%) was a physician, one (5.3%) was an Anthropology undergraduate student, one (5.3%) was a nursing graduate student and 12 (63.2%) were either bachelors or masters prepared in the field of healthcare or sociology.

### *Profile of Subjects in Studies*

Except for the three variant cases in the study by Pascual et al. (2003), all participants were physicians training to become nurses or they were physicians already licensed as nurses. See Table 2.3 for sample sizes. All participants belonged to the Asian and Hispanic minority groups.

Table 2.3

*Summary Across Current Studies: Theoretical Background/Design*

Studies	Theoretical Background/ Conceptual Model	Major Analytic Design	Specific Study design	Sample Size
Gunn-Lewis and Smith (1999)		Qualitative	Case Study Intervention	1 Chinese MD-Nursing Student (case study)  10 Chinese MD-Nursing students (intervention study)
Pascual, Marcaida, & Salvador (2003)	Critical Social Science Perspective	Qualitative	Descriptive	21 doctors (18 taking up nursing; 3 not taking up nursing)
Galvez Tan, Sanchez, and Balanon (2004)	The Pull and Push Theory of Human Migration (implied)	Qualitative Case study	Descriptive	19 (Study #1) 37 (Study #2)
Lorenzo, Galvez Tan, Icamina, & Javier (2007)	The Pull and Push Theory of Human Migration (implied)	Case Study	Descriptive	48 focus groups
Poblete (2007)	Human migration (implied)	Qualitative Ethnography	Descriptive	6 licensed nurse medics 3 nurse medic students
Jorda (2005)	Sociological theories of Professional Socialization: Niklas Luhmann & Pierre Bourdieu	Quantitative	Comparative Descriptive	76 total (32 generic; 19 RN-to-BSN; 25 FEP-to-BSN)
Grossman & Jorda (2008)		Quantitative	Descriptive Measurement of program outcomes	Variable : 76 (socialization) 40 (critical thinking) 120 (NCLEX-RN Pass Rates)
Jauregui and Xu (2008)	Collaizi's Method	Qualitative Phenomenology	Descriptive Interpretive	8 MD-NPs <sup>a</sup>
Vapor and Xu (2008)	Collaizi's Method	Qualitative Phenomenology	Descriptive Interpretive	8 MD-NPs <sup>b</sup>

*Note.* <sup>a,b</sup> There is some overlap in the participants between the two studies (Y. Xu personal communication. October 14, 2009).

### *Research Purpose, Study Design, Instruments, and Data Collection*

As seen in Tables 2.2 and 2.3, analysis of the purposes of the studies showed that the majority (78%) were exploratory and descriptive with the other 22% as effectiveness studies that evaluated program outcomes. Seven studies (78%) were qualitative and two studies (22%) were quantitative. Data collection for the qualitative studies were mostly done by interviews but isolated studies also used focused groups and participant observation. One of the quantitative studies conducted in the US employed a survey method for data collection and the other one used data from the university program outcomes.

### *Summaries of Studies*

*Research in New Zealand.* The primary purpose of this study by Gunn-Lewis and Smith (1999) was to describe and reflect upon the successes and limitations of the ‘support sessions’ that were organized at the UNITEC Institute of Technology in New Zealand (NZ) to address the language and communication barriers that nursing students from non-English speaking backgrounds (NESB) encountered during their clinical training. The *support sessions* were an intervention in response to identified needs of NESB nursing students in their struggles with the profound language and communication barriers they were experiencing. The classes were one-hour sessions held weekly which consisted of four components: (a) role playing in communication techniques wherein dyads were created—*student nurse-to-nurse* and *student nurse-to-client*, (b) discussion and analysis of language used for specific functions, (c) vocabulary, and (d) pronunciation of particularly troublesome phonemes and new vocabulary items. The role playing were video-taped and were played back for peer and tutor feedback. The *support sessions* were effective in addressing the

language and communication barriers that nursing students from NESB were encountering while starting out in NZ.

A case study of a Chinese physician named Jiang [pseudonym] who immigrated to NZ in 1996 and who started retraining as a nurse in February 1998 was used to put this study in the appropriate context. Jiang's case is related to the current research because it provided narratives about the process of transition from being a physician from one country to a nurse in another country. It also explained the barriers that immigrant physicians in NZ faced when attempting to obtain licensure to practice medicine. The reasons in NZ were found to be identical to the reasons in the US which included the difficult medical licensure requirements, different language, and different culture. Medical licensure consisted of three steps which needed to be completed over three years. The first two examinations were written examinations and the third one was a practical examination in the clinical setting. Diagnosing and prescribing treatment were identified as not being issues because the Chinese immigrant physicians were confident with their clinical skills. It was the language and the manner of speaking of the examining doctors that posed the problems.

This case study focused on the development of Jiang's English communication skills for clinical practice. Jiang was identified to have significant English language deficits. His clinical tutor expressed concerns about his ability to understand and to be understood especially during telephone conversations. He was considered unsafe because of his perceived English language deficits. He failed his first year of nursing school but through an appropriate appeal process, he was allowed to move on to his second year of nursing school. Prior to commencing his second year, he worked diligently on improving his English skills by working voluntarily in the *rest home* where he had his first year clinical experience. This



activity which he completed during his three-month holiday break helped him with his communication skills. With improved English, he began his second year of nursing school. This time, Jiang received positive feedback about his clinical and communication skills. Staff members were impressed with his clinical skills and asked him if he had been a doctor in China. Jiang said he was just a nursing student in China. This statement from Jiang indicated his desire not to be open about his status as a physician in his home country while now a nursing student in NZ. When asked if his parents knew what he was doing in NZ, he said, “No I cannot tell them. Last weekend I phoned my parents and my father asked me, ‘What are you doing? Are you wasting everything you studied in China?’ I cannot tell them I study to be a nurse” (Gunn-Lewis & Smith, 1999, p. 4). On a broader perspective, beyond his own, Jiang articulated the dilemma of Chinese immigrant physicians about shifting to nursing as follows:

Many doctors from my country come here. Only some study to be nurses. For many, it is a waste, they don't want to move from being doctors. Don't want to shift their positions. It is a waste. It is very hard to make the decision. I know some Chinese doctors who have post-graduate training in America, Japan, Britain — still they can't get registered here. So some of them have shops and dairies. It is a waste; it is hard. They can't tell their parents. The family member asks, “What are you doing in NZ?” but they cannot tell them. They just say, “I am studying.” “Study what?” It is really hard. It is very hard.

With Jiang as a representative case, this study identified problematic issues that Chinese immigrant physicians experienced when they were starting out as immigrants in NZ. These difficulties were mostly rooted in language difficulties and culture shock rather than in scholastic inadequacies. Culture shock was identified as having two dimensions — the shock of the NZ culture and the shock of assuming the status of nursing students from being physicians or surgeons. Additionally, they faced difficulties because of different expectations of teaching-learning styles and because of their prior background knowledge of academic

areas. The latter was a significant issue because they felt insulted that they had to be assessed on materials that seemed so basic.

*Research in the Philippines.* Pascual, Marcaida, and Salvador (2003) conducted a study using the critical social perspective to explore the history of nursing migration in the Philippines, determine the reasons why Filipino doctors were taking up nursing, discuss the different factors that interplay that urge them to study nursing and propose recommendations to address the matter. This was a qualitative research study with 21 participants. Eighteen participants were enrolled in nursing and three were not. The three physicians served as variant cases to provide a broader picture by getting the perspective of physicians who decided not to pursue nursing. Nurse medic was the term they used to refer to a physician who has retrained as a nurse or an individual with both MD and RN titles who chose to work as a nurse. Nursing medics phenomenon was the term they used to refer to the phenomenon of physicians shifting their careers to nursing. Pascual et al. discovered that all types of physicians, regardless of age, sex, or specialty were joining the nursing medics bandwagon: anesthesiologists, general practitioners, obstetricians, pediatricians, surgeons, etc. In the classroom, nursing faculty addressed them as doctors. In the clinical areas, when they were on duty as students, they had to assume the identity of nursing students and not as physicians; however, it appeared that faculty still addressed them as doctor. The authors stated that during training, nurse medic students had difficulty in nursing topics such as community interventions and nursing care. Nurse medic students completed clinical hours which they refer to as being *on duty* but many generic nurses voiced concerns that nurse medic students did not get sufficient training in nursing skills. The duties on the ward such as changing bed sheets became a tough reality check for them. There were anecdotal accounts that indicated

that some nurse medic students especially established consultants did not attend nursing classes but they still obtained a nursing diploma. This was identified as a major socio-political issue within the Philippine nursing education system which impacted and continually impacts the quality of nurses produced. Nurse medic students kept their nursing studies a secret to the extent possible, even among their families and colleagues. Their secrets usually were first revealed when their names appeared in the list released by the media of successful Philippine Nursing Board Examinees. Once physicians obtained their diplomas, they immigrated to the US or to other developed countries. The reasons why Filipino doctors shifted their careers to nursing were identified as directly related to the push and pull factors of human migration. A summary of these reasons is provided in Table 2.4. It is important to note that the reasons listed in this research study mimics the reasons identified in the media stories. The main factor identified was the economic factor. To put this factor in context, a comparison of the basic monthly salaries of nurses worldwide is presented in Table 2.5.

Galvez Tan, Sanchez, and Balanon (2004) authored a paper that explored the multifaceted causes of the nursing medics phenomenon, a phenomenon which they described as an “out-of-the box phenomenon in health human resource development, never before seen in any country” (p. 2). They also examined the major consequences of the phenomenon to the healthcare delivery system in the Philippines and provided strategic solutions to be acted upon globally and nationally to prevent an impending health crises and health human resources disaster in the Philippines. Because the socio-political impact of the phenomenon in the Philippines is beyond the scope of this study, such impact will not be included in the discussion of this study. In the narrative version of the paper, the authors did not discuss their study methodology, but they did so in an accompanying power point presentation (Galvez

Tan, Balanon, & Sanchez, n.d.). Using a case study methodology, the authors explored the phenomenon as it existed in Southern Philippines. Case Study #1 was about 19 nurse medics in Davao del Sur and Case Study #2 was about 37 nurse medics in Cotabato. Davao del Sur and Cotabato are both provinces in Mindanao, the big island in Southern Philippines. The reasons identified in this study why physicians pursue nursing are identical as the findings in the study by Pascual et al. (2003). See Table 2.4.

Lorenzo, Galvez Tan, Icamina, and Javier (2007) conducted a Philippine case study to describe the nurse migration patterns in the Philippines and their benefits and costs. Although the main focus of this study was not the nursing medic phenomenon, it is included in this review because it further illuminated the nursing medic phenomenon in the context of the wider Philippine healthcare system. It also provided a comparison of the profiles of generic nurses and nurse medics by drawing on data from the study conducted by Lorenzo (2005), Pascual et al. (2003), and from 48 focus groups held in five urban and rural localities. The profile of the migrant generic nurses revealed that they were predominantly female, young—in their early twenties, single and come from middle-income backgrounds (Lorenzo et al., 2005). The paper did not specify exact statistics but it was stated that few of the migrant generic nurses had masters level education and the majority had the basic university education [BSN]. Many had specialization in intensive care, emergency room, and operating room nursing and had one to 10 years of service in the Philippines before migration. On the other hand, the profile of the migrant nurse medics showed a slightly different set of characteristics. They were also predominantly female, but were older (37 years old and older), more likely to be married, and had higher incomes. Twenty-four percent were single and 76%

Table 2.4

*The Push and Pull Factors of International and Interprofessional Migration of Filipino Physicians*

	Push Factors	Pull Factors
Economic	<ul style="list-style-type: none"> <li>▪ Low salary as a physician</li> <li>▪ No overtime or hazard pay, poor health insurance coverage</li> </ul>	<ul style="list-style-type: none"> <li>▪ Higher income as a nurse [in the US] than as a physician [in home country]</li> <li>▪ Better benefits and compensation package</li> </ul>
Job Related	<ul style="list-style-type: none"> <li>▪ Poor working conditions</li> <li>▪ Inadequate resources to perform function [as a doctor in the Philippines] which include lack of facilities</li> <li>▪ Decreased stature of doctors</li> <li>▪ Exclusivity of some physician practices leading to the exclusion of doctors not coming from family of physicians</li> <li>▪ Hospital politics, greed, and professional jealousy</li> </ul>	<ul style="list-style-type: none"> <li>▪ Better working conditions</li> <li>▪ Nursing deemed as a challenge</li> <li>▪ Nursing perceived as a more caring profession</li> <li>▪ More opportunities for career growth</li> <li>▪ Better and constant trainings provided</li> <li>▪ More options in working hours</li> <li>▪ Can work even over the age of sixty</li> </ul>
Personal and Family Related	<ul style="list-style-type: none"> <li>▪ Peer pressure [everybody else is doing it]</li> </ul>	<ul style="list-style-type: none"> <li>▪ Opportunity for family to migrate</li> <li>▪ Opportunity to travel and learn other cultures</li> <li>▪ Higher standard of living</li> </ul>
Socio-political and Economic Environment	<ul style="list-style-type: none"> <li>▪ Limited opportunities for employment</li> <li>▪ Decreased health budget</li> <li>▪ Socio-political and economic instability in the Philippines</li> <li>▪ Threat of malpractice law and compulsory malpractice insurance</li> <li>▪ Peace and order problem</li> </ul>	<ul style="list-style-type: none"> <li>▪ Advanced technology</li> <li>▪ Better socio-political and economic stability</li> </ul>
Immigration Related	<ul style="list-style-type: none"> <li>▪ Difficult to obtain US visa as a doctor</li> </ul>	<ul style="list-style-type: none"> <li>▪ Easier to obtain a US visa as a nurse than as a doctor</li> </ul>

*Note.* From “The Philippine phenomenon of nursing medics: Why Filipino doctors are becoming nurses” by J. Z. Galvez Tan, et al., 2004; “Reasons why Filipino doctors take up nursing: A critical social science perspective” by H. Pascual, et al., 2003; “Nurse migration from a source country perspective: Philippine country case study” by F. M. Lorenzo et al., 2007. These illustrate that the reasons that were identified from media stories are similar with those identified in empirical studies.

Table 2.5

*Basic Monthly Salary of Nurses Worldwide*

Basic Monthly Salary	Philippines	Singapore	Saudi Arabia	UK	US
Philippine Pesos	P8,500 <sup>a</sup>	P42,000	P54,000	P119,000	P216,000
Host Country's Currency Equivalent		S\$1,400	R 3,724	£1,408	\$4,521 RN <sup>b</sup> \$2,873 LPN <sup>c</sup>
US Dollar Equivalent	\$177	\$875	\$1,125	\$2,479	\$4,376
% Increase		390%	530%	1300%	2900%
Taxes	10%	15%	None	23%	30%
Net Salary	P7,650	P35,700	P54,000	P91,630	P151,200

*Note.* From “Reasons why Filipino doctors take up nursing: A critical social science perspective” by H. Pascual, et al., 2003. Data also obtained from “Philippine suffers from hemorrhage” by P. L. Adversario, 2003. <sup>a</sup>Average basic salary of a nurse in the Philippines varies widely depending upon employer. In 2004, a nurse at the Philippine Heart Center was earning a basic salary of P12,000, approximately equivalent to US\$250 (G. Calub, personal communication, October 21, 2009). <sup>b,c</sup>RN and LPN salaries are calculated averages per month of data obtained from the Bureau of Labor Statistics Occupational Outlook Handbook, 2008-09 edition.

were married with an average of one to three children (Pascual et al., 2003). Income of nurse medics as physicians in the Philippines had a wide range depending upon where they worked: from below US\$2,400 to US\$9,600 annually. The majority (63%) had 10 years or more of physician experience. Their previous medical specialties are presented in Table 2.6. The US was identified as the top destination country for migration. The researchers gave the following discourse to summarize their principal findings:

The Philippines is a job-scarce environment and, even for those with jobs in the healthcare sector, poor working conditions often motivate nurses to seek employment overseas. The country has also become dependent on labor migration to ease the tight domestic labor market. National opinion has generally focused on the improved quality of life for individual migrants and their families, and on the benefits of remittances to the nation. However, a shortage of highly skilled nurses and the massive retraining of physicians to become nurses elsewhere have created severe problems for the Filipino health system, including the closure of many hospitals... (p. 1406).

Table 2.6

*Previous Medical Specialties of Filipino Nurse Medics in Studies*

Previous Medical Specialty	Percentage
Internal/General Medicine/ Family Medicine	43%
Pediatrics	14%
Surgery	8%
Pathology	6%
Orthopedics, Obstetrics, Anesthesiology, and Public Health	29%

Poblete (2007) conducted an ethnographic research study to examine the nursing medics phenomenon in the Philippines, particularly the participation of men, while he was an undergraduate summer research fellow at the University of California, Berkeley. He was very interested with the participation of men in this phenomenon because of his worldview of nursing as a profession for women and as a profession of lower status than medicine. He asserted that “becoming a nurse entails that these men cross both professional and gendered boundaries” (p.4). His field work was conducted mainly in the Philippines. The setting of his study was a large tertiary hospital located in the city of Manila. He conducted his observations over a period of 10 weeks encompassing the period of June to August 2006. Study participants were nine male physicians, six of whom were nurse medics and three were nurse

medic students. He also conducted some field work at two nursing homes in California before and after his Philippine field work. Although his main focus was the participation of men in this phenomenon, he interviewed a combination of five male and female nurses during the California phase of his study.

Poblete did not specifically examine the process of professional transition of nurse medics to nursing; however, he offered an exemplar of how a second-course nursing education program designed for physicians taught doctors how not to be doctors. He discussed the importance of clinical rotations but observed that nurse medic students were not given much to do during clinical rotations. He discovered the rationale for this through the words of Ms. Gomez [pseudonym], the lead clinical instructor. He was told that the nurse medic students already possess the clinical knowledge they need as nurses. The main challenge was changing their attitudes and their roles at the bedside. In his report, Poblete described his observations of the teaching-learning continuum in nurse medics as follows:

There are other things to learn as well. Whereas doctors are expected to approach each patient clinically and with detachment, nurses are supposed to be softer and more caring. This, too, must be practiced during clinical rotations. At patient's bedsides, nursing medics in training practice softer kinds of care, making small talk with patients, changing soiled sheets, and engaging in non-clinical observations of patient's moods and feelings. They fill out charts and make recommendations, and afterwards, Ms. Gomez checks their work, removing things that go out of bounds and excising language that sounds too clinical, too doctor-like. (p. 11)

In summary, research in the Philippines regarding the nursing medics phenomenon is mostly focused on the socio-political and economic aspects. Isolated narratives about the difficulty of nurse medics to shift their mind-set from being a physician to being a nurse is mentioned peripherally but topics about how they socialize to nursing or how they develop their nursing identity is absent.



*Research in the US.* Jorda (2005) conducted a quantitative study aptly titled “Can Physicians Become Nurses?” The purpose of her study was to explore whether former physicians can be socialized into nursing, a profession that is viewed by many physicians and by the public as ancillary to medicine. Using Stones’ Healthcare Professional Attitude Inventory, she conducted a comparative study between three groups of students in their last semester of nursing school using one-way analysis of variance (ANOVA). The three groups were (a) generic or basic students (n = 32), (b) RNs pursuing BSN (n = 19), and (c) physicians trained in other countries who were taking nursing (n = 25). Jorda identified that the three groups of nursing students were different in their demographic characteristics: the class comprised of FEPs were older, there were more males, and they considered English as a second language. FEP participants considered the English language as a significant cause of their difficulties to become licensed physicians in the US. The conclusion of the study indicated that socialization of physicians into nursing was possible and might have occurred in the population studied.

Grossman and Jorda (2008) analyzed the outcomes of the New Americans in Nursing Accelerated Program, the name given by the Department of Labor for the FEP-to-BSN program at FIU. Outcomes that were examined were (a) socialization to nursing, (b) critical thinking skills, and (c) NCLEX pass rates. The program was shown to demonstrate success in transitioning unlicensed physicians residing in the US to become nurses. In this study, the results of the prior study by Jorda (2005) comparing the socialization of three groups of nursing students was used to illustrate the socialization of FEPs to nursing. Critical thinking abilities were measured by using the California Critical Thinking Dispositions inventory. The instrument has various components that include truth seeking, open-mindedness,

inquisitiveness, systematicity, maturity, critical thinking, self-confidence, and analyticity. The critical thinking data were collected from the program's cohort I, and they were compared with generic BSN students. The results demonstrated that the FEPs scored significantly higher. The third outcome indicator that was examined was the first attempt NCLEX-pass rate. The pass rate of the program's cohorts I, II, and IIIA were higher than FIU's generic BSN students and also higher than the state and national averages. Grossman and Jorda concluded that the accelerated program at FIU to retrain FEPs to become nurses demonstrated success in the three outcome measures that were examined in their study. They asserted that it was an attractive and cost-effective option to help in addressing the critical nursing shortage and in diversifying the nursing workforce.

In Las Vegas, two separate qualitative phenomenological studies were conducted by Jauregui and Xu (2008) and by Vapor and Xu (2008) exploring the transitions into practice of Filipino nurse medics into the nurse practitioner role. These studies have not fully been reported; however, preliminary reports obtained from the faculty advisor indicate that in the first study (Jauregui & Xu, 2008), four themes emerged from the data, namely: (a) unfamiliarity with the U.S. health insurance policies and guidelines was identified as the most frequent and challenging barrier to transition and successful work performance; (b) limited scope of practice and the legal requirement to have a physician collaborator posed problems to some Filipino MD-NPs who were once independent, full-fledged physicians; (c) working in a litigious US healthcare environment changed their attitudes and practices; (d) having the education and experience as a physician facilitated their transition and role to nurse practitioners and led to a higher job satisfaction than working as staff nurses. The authors recommended further research on transitional issues in this population including development

and testing of an evidence-based transitional program. The results of the second study by Vapor and Xu (2008) revealed that the experiences of Filipino physicians-turned nurses involved multidimensional issues, both in the contexts of emigration and a professional shift from physician to nurse. When the full study is reported, the authors indicated that it will enlighten society of the lived experiences of Filipino physicians now working as nurses in the US. Furthermore, this research study will contribute to the existing literature on cross-cultural adaptation, particularly involving role compromise in an unfamiliar social and cultural context.

In summary, research conducted in the US regarding Physician-Nurses provided results of early scientific work focused on the socialization of former physicians to nursing. The study by Jorda (2005) is a landmark study that provided the nursing profession with a basis for the development of an empirical body of knowledge regarding this emerging unique group of nurses. Grossman and Jorda (2008) affirmed in their analysis of three program outcome measures that the FEP-to-BSN Program is a viable strategy to help assuage the nursing shortage as well as to increase the diversity of the nursing workforce in the US. The studies conducted in Las Vegas by Jauregui and Xu (2008) and by Vapor and Xu (2008) provided perceptions of interprofessional migration from the vantage point of being prepared at the masters level. Jauregui & Xu (2008) articulated a very important finding in their study which was unarticulated before — that having the education and experience as physicians in their home country facilitated the participants' transition to the role of nurse practitioners in the US.

The studies reviewed offered diversity in research design and focus through the use of both qualitative and quantitative research designs in examining the socialization of FEPs to

nursing and the role transitions in participants who are prepared at the baccalaureate as well as at the masters level. Although more evidence needs to be constructed, the unifying concept in these initial studies regarding Physician-Nurses is the indication that FEPs can become US nurses.

### *Findings Across Studies*

*Theoretical frameworks of studies.* Three of the studies (33%), although not explicitly discussed in the articles, utilized the Push and Pull Theory of Migration, two (22%) used Collaizi's method of phenomenological interpretation, one (11%) used Critical Social Science Perspective, one (11%) used the Sociological Theories of Professional Socialization of Luhmann and Bourdieu, and two (22%) had no theoretical framework. It is evident from the identified theoretical frameworks used in the current studies that the research domain of interprofessional migration and Physician-Nurses lacks a universal framework that can be used as theoretical basis for ongoing research studies. It is important to note that the study by Jorda (2005), the one that is most closely related to this current study utilized a theory from Sociology.

*Progress and gaps in theory building: Concepts or models generated.* No unifying model was generated from the limited number of studies; however, valuable concepts that can be taken into consideration when studying this phenomenon emerged. For instance, the study in NZ generated concepts about the barriers of language and culture when resettling in a new society. It also generated the concept about the impact of professional discontinuity when shifting from a once valued, highly regarded profession to an alternative one necessitated by profession-driven limitations. "Chinese doctors adapt quickly to the scholastic demands of the program but may suffer loss of face and drop in self esteem due to the change in status from

Chinese doctor to NZ student nurse” (Gunn-Lewis & Smith, 1999, p. 9). This study pointed out the importance of interactive communication skills in providing good nursing care. Without interactive communication skills, one cannot succeed as a nurse. In the study by Jorda (2005), she also generated concepts about the barriers of language and culture and the concept of professional discontinuity in immigrant physicians. She said, “Due to language barriers, these physicians were unable to obtain licensure to practice medicine in the United States. The inability to practice medicine was conceived as a great deprivation” (p. 43). These physicians turned to nursing and their socialization to nursing was viewed as driven by both desire and motivation. She identified economic concerns as a motivator toward socialization to nursing. Poblete (2007) in the context of his conceptualization of migration among the nurse medics he worked with argued that that “migration is a means of working on the self, of reconstituting one’s self as a new kind of man, a different category of professional, and a novel type of citizen” (p. 45). In this argument he generated the concept about *flexible citizens*, the label he gave the men in his study. Their professional flexibility, he said “make them globally mobile and desirable workers” (p. 46).

*Progress and gaps in knowledge building.* The body of scientific knowledge that currently exists regarding interprofessional migration and Physician-Nurses is weak. What these current studies contribute to the conduct of this current study on the development of nursing identity in FEPs retrained as nurses is *what they are not*. They are not studies focused on the central concept of nursing identity development in the population-of-interest. Acknowledging this significant knowledge gap provides nurse scholars whose work pertains to this research domain the reality that there is significant amount of work to accomplish; a significant knowledge-building to do if the nursing profession intends to take hold of the

science of this particular phenomenon. Perhaps this is an opportune time for nursing to come to the forefront and start building the empirical foundation of this phenomenon.

*Relevance of this Dimension of Literature Review*

This second dimension of literature review enabled the researcher to examine the present state of the body of knowledge in this research domain. Use of the MRAT-2004 allowed for the systematic identification of the current gaps in theory and knowledge in this domain. This dimension of the literature review contributed to the evolving body of empirical knowledge about this research domain by synthesizing what appears to be a bricolage of unconnected studies to a scientific body of knowledge unified *not by what they are* but by *what they are not*. To restate, these studies are studies not focused on the central concept of nursing identity development in Physician-Nurses; nevertheless, they are worthwhile studies that can be used as the foundation for further knowledge-building.

*Examining the Future: The Needs and Problems of Non-US Native Nurses*

*A Diverse Workforce for a Diverse Society*

According to the report of the Sullivan Commission on diversity in the healthcare workforce (2004), by 2050, “the Hispanic population in the US will nearly triple from today’s level of about 36 million to 103 million. Asian populations will triple from 11 million to more than 33 million. The African-American population is expected to almost double from 36 million to 61 million” (p. 14). What these statistics show is that the current minority population is emerging to become the majority population in the near future. This is of significance to the healthcare industry because meeting the healthcare needs of an increasingly diverse society will be a challenge given the slow growth rate of minority healthcare professionals. To meet the wide array of future healthcare challenges of a future

highly diverse society, a national mandate exists to increase the diversity of the healthcare workforce (Sullivan Commission, 2004). The future means implementing strategies to tap minorities and underrepresented groups to enter the mainstream US healthcare industry, particularly nursing. One such strategy is the retraining of unemployed or underemployed immigrant physicians to become nurses. They represent a rich yet untapped healthcare human resource group (Grossman & Jorda, 2008). The task has begun. The future has been charted.

The above discourse segues into the aim of the third dimension of this review of literature which is to answer the question, “What are the needs and problems encountered by non-US native nurses and nursing students during their transition to US ways and US nursing practice?” Although Physician-Nurses are a unique group of minority healthcare workers, the researcher felt that the descriptive phrase *non-US native nurses* can appropriately serve as a proxy for them because by the nature of the phenomenon, most Physician-Nurses currently practicing in the US and most of those potentially becoming Physician-Nurses in the future perhaps will be *non-US natives*. Reviewing the body of literature that provides answers to the question at hand is essentially equivalent to examining the needs of immigrant physicians who are currently training or who recently have become Physician-Nurses. It is essentially assessing the future needs of the future Physician-Nurses. It is providing a foretaste of what strategies and professional development programs may be needed to assist them to facilitate their transition to their new society and to their new profession.

To accomplish the aim of this dimension of the literature review, integrative and synthesis work of experts in the field were selected as a starting point. An integrative review conducted by Kawi and Xu (2009) using Cooper’s procedure for integrative review and three metasynthesis using the meta-ethnographic approach of Noblit and Hare conducted by Alicea-

Planas (2008), Starr (2009), and Xu (2007) provided a body of knowledge rich with insight that described the barriers and facilitators that impact the adjustment of non-US native nurses and nursing students to the US. From the work of Kawi and Xu (2009), only those studies conducted in the US were extracted (n = 9). The work of Alicea-Planas (n = 12) and Starr (n = 10) were all conducted in the US. Xu (2007) reviewed 14 studies but only six of these studies were conducted in the US. These six articles were duplicates of the literature reviewed by Kawi and Xu (2009). Further selection for relevancy decreased the number of articles to 11. With one integrative review, three metatheses, 11 articles extracted from these and an additional five articles, a yield of 20 articles was available for this dimension of the literature review. The five additional primary sources included in this body of literature were Bond, Gray, Baxley, Cason, Denke, and Moon, (2008); DeLuca (2005); Sherman and Eggenberger, (2008); Xu (2008); and Yi and Jezewski (2000). The main criterion for including these studies was that their focus was on problems and challenges encountered by non-US native nurses or nursing students in their transition to US ways and to US nursing practice. Summaries of the integrative review and metatheses are presented in Table 2.7 and the summaries of the other studies are presented in Appendix I.

#### *Language and Communication Problems*

What cut across these studies was the problem of cultural differences specifically language and communication. With different levels of English proficiency and various ethnic accents, non-US native nurses were sometimes perceived by others as lacking knowledge and skills due to their manner of speaking. During cross-cultural communication, non-US native nurses had been placed in embarrassing situations because of language difficulties. The perceived incompetence during cross-cultural communication was not often due to lack of



Table 2.7

*Needs and Problems Encountered by Non-US Native Nurses & Nursing Students During their Transition to US Ways and US Nursing Practice*

Studies/Purpose	Sample	Needs and Problems	Solutions or Strategies
Alicea-Planas (2009) Metasynthesis: identify facilitators and barriers for Hispanic nursing students along their journey to success	12 studies	Lack of financial support; unprepared for the difficulty of nursing school; family obligations & responsibilities language barriers; unsupportive faculty, perceived discrimination by faculty and peers, lack of advisement, scarcity of role models; lack of Hispanic faculty; feeling different & isolated	Availability of financial aid; membership in ethnic student organization; develop sense of belonging
Kawi & Xu (2009) Integrative Review: synthesize what is known about specific facilitators and barriers when INs adjust to foreign-healthcare environments	29 studies	Language and communication inadequacy; differences in culture; lack of support; inadequate pre- and post-arrival orientations; differences in nursing practice; inequality of opportunity	Positive work ethic; persistence; psychosocial and logistical support; learning to assume an assertive role; continuous learning
Starr (2009) Metasynthesis: synthesize current qualitative literature on challenges faced in nursing education for students with English as an additional language (EAL)	10 studies	Language: unprepared for the kind of English spoken in nursing Lack of resources: financial, family Academic challenges: heavy academic load; need for study groups, tutoring; lack of orientation to academic setting; minimal role models culture	Financial aid; greatest resource is students' personal strengths and coping mechanisms: self-motivated, determined, with aspirations, resolve, persistence, capable or being able to overcome; instructors who were culturally aware; peer support; memberships to clubs and associations; felt proud when acting as advocates and translators in the clinical setting
Xu (2007) Metasynthesis: provide cumulative insight into the collectively lived experiences of Asian nurses to advance knowledge	14 studies	Communication barriers: unfamiliar accents; use of informal language/slang/jargon; telephone communication problematic; problems with indiscernible physician hand writing; differences in nursing practice between US and home country; marginalization, discrimination, and exploitation	

cognitive abilities on the part of non-native US nurses but due to problematic phonemes and the differences in enunciation and accents.

The ability to conduct one's self in an effective cross-cultural communication encounter is important because effective communication is critical in the healthcare setting. What has been found in research is that cross-cultural communication in non-US native nurses was problematic. This is an issue which the nursing profession must face because ineffective communication can compromise patient safety (Xu, Gutierrez, & Kim, 2008). With the national mandate from the Sullivan Commission about increasing minority representation in the healthcare professions, it is anticipated that the human resource landscape of the US healthcare industry will change and will gain more members from ethnic minority groups. Extrapolating from the overarching theme that emerged in this review of literature, the problem that must be dealt with in the future is language and communication barriers in non-US native nurses. The paradox seen in the literature presented here is the paucity of structured programs to assist non-US native nurses overcome their language and communication difficulties. This is not to imply that nothing is being done by the profession of nursing in relation to this but there is need for more. For example, an intervention research program, *Speak Up for Success* which aims to help internationally-educated nurses communicate more effectively and efficiently is being conducted in Las Vegas, Nevada. The participants in the program learn about the US customary behaviors and the terminology in the American healthcare system. Speech pathologists work with them to improve English pronunciation. The project is funded by a two-year grant from the National Council of State Boards of Nursing with Dr. Yu Xu as the primary investigator (Weddingfield, 2009). The results of the program has not been reported but it seems that it is something that may be worth replicating

and putting in place as a mandatory component of programs designed to transition non-US native nurses and nursing students to US ways and US nursing practice.

#### *Relevance of this Dimension of Literature Review*

This third dimension of literature review enabled the researcher to examine literature pertaining to the needs and problems encountered by non-US native nurses and nursing students during their transition to US ways and US nursing practice. Although Physician-Nurses are a unique group of minority healthcare workers, the researcher felt that the descriptive phrase *non-US native nurses* can appropriately serve as a proxy for them because by the nature of the phenomenon, all Physician-Nurses currently practicing in the US and most of those potentially becoming Physician-Nurses in the future will perhaps be non-US natives. The information gained in this dimension of the review of literature will help inform practice, education, and research about Physician-Nurses and about their needs and problems in their transition to US ways and US nursing practice. Concepts identified in this dimension of the literature review also helped clarify concepts in the emerging central problematic issue perceived by the participants in their transition to US nursing practice.

#### *Chapter Summary*

Chapter Two brought into perspective a three-dimensional body of knowledge that directly and indirectly pertains to Physician-Nurses and interprofessional migration. The three dimensions of this body of knowledge were likened to the components of a time capsule characterizing the phenomenon of interprofessional migration: its past, its present, and its future. For its past, literature about its emergence was reviewed. Given that there was very limited empirical literature pertaining to this subject matter, popular print and internet sources were used to accomplish the aim of this dimension of the literature review. Fourteen articles

were reviewed and from these articles, a diagram illustrating the chronology of its origins was created. It became clear that this phenomenon was of a global nature. It was discovered that the first documented physician-to-nursing retraining program happened in New Zealand where Chinese physicians who were unable to obtain licensure as physicians retrained as nurses. Other countries with physician-to-nurse retaining programs were the Philippines, Israel, Russia, Canada, and the United States. The Philippine case which is referred to as the nursing medic phenomenon is unique because physicians intentionally retrain to become nurses to facilitate their migration from their home country to wealthier countries of the world. Sample curricula of retraining programs were provided in the Appendix. In this dimension of the literature review, the driving forces that motivated FEPs to pursue nursing were identified. Using the 14 media articles, a collective case study using each media story as a single case was conducted. Using content and context analysis, specifically cross-case analysis, four major categories to describe the driving forces that motivated physicians to pursue nursing emerged. These driving forces were identified as individual-driven, family-driven, profession-driven, and society-driven forces.

For its present, current research literature about Physician-Nurses and about interprofessional migration was conducted. Only nine empirical articles were identified, two of which were in abstract form. Critical and systematic analysis of each study was conducted using Moody's Research Analysis Tool, Version 2004. These studies were unified *not by what they are* but *by what they are not*. The studies were studies not focused on the central concept of nursing identity development in Physician-Nurses. Nevertheless, valuable concepts that can be taken into consideration when studying Physician-Nurses emerged. For instance, the study in New Zealand generated concepts about the barriers of language and culture when

resettling in a new society. The concept of professional discontinuity was also evident in the Chinese physicians in the process of their shift from their once valued, highly regarded profession of medicine to nursing.

For its future, literature about the problems and challenges that non-US native nurses and nursing students encountered in their transition to US ways and US nursing practice was reviewed. Because of the absence of literature directly pertaining to the problems and challenges that Physician-Nurses encountered in their transition, literature about non-US native nurses was conceptualized as relevant because Physician-Nurses, although they are unique, fit the characterization of being non-US native. Concepts can be borrowed from this existing body of literature to inform future research, education and practice pertaining to the phenomenon of interprofessional migration and about Physician-Nurses. Language and communication problems was the common theme that cut across cases. A paradox existed in that there seems to be lack of programs designed to help non-US native overcome language and communication problems. An intervention project *Speak Up for Success* was mentioned briefly. The aim of the project was to help international nurses become more proficient with the English language.

Literature about professional socialization and nursing identity was also retrieved but not critically and systematically analyzed. This literature was placed in a literature bank to be used during iterations to help define concepts and clarify relationships in the theory that was emerging from the empirical data in this current study. The next chapter, Chapter Three will provide a discussion of the grounded theory research tradition and symbolic interactionism.

## Chapter Three

### The Grounded Theory Research Tradition

*Proficiency with grounded theory comes with continued study and practice. One must study thoroughly the methods set forth in Discovery and Theoretical Sensitivity and be prepared to follow them. Taking a class on grounded theory is a good requisite beginning, but does not make a grounded theorist. It is only by applying the methods in research that one gains the sufficient delayed understanding of how they work and what they produce, and the openness and flexibility to apply them to diverse fields of substantive study. ~Glaser, 1992, p.17-18.*

This research study which was designed to develop an explanatory model depicting the basic social psychological process that influences the development of nursing identity in FEPs who have retrained as nurses and who are now practicing as nurses in the US used grounded theory methodology. The researcher opted to isolate this chapter from the research methodology chapter because she believes that a comprehensive description of the grounded theory research tradition and an in-depth discussion of the theoretical underpinnings and philosophical traditions of the approach is crucial in framing this current study. She believes that knowledge-building and dissemination is influenced by how a researcher understands and interprets the particular research tradition she is employing (Murphy, 2008), and knowledge-assimilation by the practitioners within the scientific, academic, and practice settings is greatly impacted by how they understand the research tradition for a particular study. Coyne & Cowley (2006) asserts that grounded theory as a method is not easy to understand and researchers have had disagreements about its central premise and how its different key components are interpreted and applied; hence, “it is important that researchers publish their

techniques of using grounded theory to provide guidance and structure for new researchers” (p. 514).

This chapter includes the definition of grounded theory, its assumptions, its origins and development, and its use in the discipline of nursing. The steps in the grounded theory research process are presented. Topics discussed are (a) data generation techniques which include the concept of data saturation; (b) data analytic methods which include the principles of constant comparative method and memoing; (c) concept formation which is paralleled with Level 1 or open or substantive coding; (d) concept development which is paralleled with Level 2 or axial coding or clustering and includes topics about reduction sampling, selective sampling of data and theoretical sampling, selective sampling of literature, and the emergence of core categories, (e) concept modification and integration which is paralleled with Level 3 or selective coding and includes discussion about theoretical coding and the discovery of the basic social psychological process, and (f) theorizing which is the substantiation of a grounded researcher’s theoretical sensitivity which includes the definition of theory. The role of symbolic interactionism, the philosophical framework that guided this study is also discussed.

### *Grounded Theory Defined*

Grounded theory explores a process and is a method based on the philosophical foundations of symbolic interactionism (Hutchison & Wilson, 2001; Richards & Morse, 2007). Grounded theory is best defined in the context of its goal which is to “generate a theory that accounts for a pattern of behavior which is relevant and problematic for those involved” (Glaser, 1978, p. 93). It is a qualitative research approach to the study social life that uses inductive analysis to generate a substantive or formal theory from the constant

comparing of unfolding observations (Babbie, 2004). Inductive analysis means that “patterns, themes, and categories of analysis come from the data; they emerge out of the data rather than being imposed on them prior to data collection and analysis” (Patton, 1980, p. 306).

### *Assumptions of Grounded Theory*

The main assumption of grounded theory research is that the variation in people’s patterns of behaviors when experiencing a specific phenomenon can be explained by an unarticulated central concern that they perceive as problematic and by the resultant basic social psychological process that they utilize to address such problem (Chenitz & Swanson, 1986; Glaser & Strauss, 1967; MacIntosh, 2003; Morse & Field, 1995; Speziale & Carpenter, 2003; Stern, 1980). Hutchinson & Wilson (2001) states that grounded theorists are guided by the assumption that people, although their world may seem to be disordered and nonsensical to observers, have order in their lives and that they make sense of their environment.

### *The Origins of Grounded Theory*

#### *The Discovery by Glaser and Strauss*

Based on the symbolic interactionist view of human behavior, the roots of grounded theory as a qualitative research method can be traced back to the discipline of sociology (Babbie, 2004; Richards & Morse, 2007; Speziale & Carpenter, 2003). Sociologists Barney Glaser and Anselm Strauss are credited with the development and explication of grounded theory methodology (Glaser, 1978, 1992; Glaser & Strauss, 1967; Strauss, 1987 as cited in Strauss & Corbin, 1998). Glaser, a sociologist with quantitative background trained at Columbia University, and Strauss, a sociologist with qualitative field research background trained at the University of Chicago, shared a common bond in their interest in studying basic social or social psychological processes within a particular social experience such as in the



setting of a chronic illness. In the early 1960s, while they were both at the University of California in San Francisco, in their research of the dying process in hospitals, Glaser and Strauss analyzed data and constructed theory about the social organization and temporal order of dying. In the process, they developed systematic methodological strategies that can also be adopted by social scientists to study many other topics (Charmaz, 2006).

Glaser and Strauss co-authored the book *The Discovery of Grounded Theory* (1967) which contains their classic statements about grounded theory. Through their joint research endeavors, grounded theory originally emerged as one coherent and complete method. As they worked independently from each other, and as grounded theory evolved, the method diverged into two different paradigms—the Glaserian and Straussian grounded theory (Richards & Morse, 2007). The existence of these two divergent paradigms has been cause for academic debate regarding grounded theory. Other versions of grounded theory include dimensional analysis, constructivist grounded theory, and situational analysis (Richards & Morse, 2007); however, they are not discussed in this paper.

### *The Divergent Paradigms*

#### *The Glaserian Grounded Theory*

Glaser continued with the original canons of the classic grounded theory that he and Strauss discovered in the early 1960s. He defined grounded theory as a method of discovery that treated categories as emergent from the data and relied on direct and narrow empiricism, and analyzed basic social processes. He refuted the Straussian paradigm of grounded theory because he viewed the procedures as forcing data into pre-conceived categories. He argued that the Straussian procedures contradict the very fundamental canons of grounded theory (Charmaz, 2006; Glaser, 1992).

The canons of the Glaserian grounded theory are more objectivist in perspective, with the data treated as separate and distant from the participants, as well as from the analyst and allowing the data to tell their own story (Charmaz, 2006). Glaserian grounded theorists may examine the data and ask, “What do we have here?” (Stern, 1994, p. 220 as cited in Richards & Morse, 2007, p. 63). As originally designed, analysis focuses on the various components of the theory: on the processes, categories, dimensions, and properties. It is through the interaction of these components that the theory to emerges. In Glaserian approaches, a diagram is utilized to illustrate the relationships between concepts and categories in the theory (Richards & Morse, 2007).

#### *The Straussian Grounded Theory*

Strauss diverged from the original canons of the classic grounded theory toward deduction and verification or validation. His collaboration with nurse researcher Juliet Corbin furthered his direction toward verification. Straussian grounded theorists examine the data and stop at each word or phrase to ask “What if?” and maybe concerned about transcending the face value of the data to develop more abstract concepts and their descriptions. What Straussian grounded theorists are striving for is to bring every possible contingency that could relate to the data, whether it appears in the data or not. As in the Glaserian paradigm, theories are created in the interaction with the data. There is that focus on processes, emerging categories, dimensions, and properties. The Straussian paradigm strongly encourages open coding. Corbin and Strauss (1990) describes the tenets of grounded theory as procedures that intend to lead to the design of a framework consisting of a well-integrated set of concepts that provide a clear theoretical explanation of a particular phenomenon. In Straussian approaches, diagrams are not often used (Richards & Morse, 2007).

### *Grounded Theory in Nursing*

Although grounded theory was not specifically designed for nursing science, nursing has enthusiastically embraced it as one of the most prevalent qualitative approaches to the study of various nursing phenomena (Reed & Runquist, 2007; Speziale & Carpenter, 2003). The philosophical basis of grounded theory is applicable to nursing phenomena because of the very nature of nursing as articulated in Speziale and Carpenter (2003), “nursing occurs in a natural rather than controlled setting, and the nursing process requires constant comparison of collected and coded data, hypothesis generation, use of literature as data, and collection of additional data to verify or reject hypothesis” (p. 201). It is a research method that can be utilized to explore the robust and diverse human experience that is inherent in the various facets of nursing practice that can lead to the development of middle-range theories (Speziale & Carpenter, 2003). It is in this context that the importance of grounded theory in knowledge building for the discipline of nursing cannot be under-estimated. Chenitz & Swanson (1986) provides their viewpoints and affirm that grounded theory offers the nursing profession a systematic method to collect, organize, and analyze data from empirical world of nursing practice. “Grounded theory holds promise for a fuller and deeper understanding of nursing knowledge and a method to generate theory in a practice profession” (Chenitz & Swanson, 1986, p. 24).

### *Steps in Grounded Theory Research*

This current research study is using a hybrid model of the divergent paradigms of Glaser and Strauss. It is not pure Glaserian nor is it pure Straussian. The researcher draws broadly on the methodological writings and dicta of both grounded theory co-founders as well as other contemporary grounded theory methodologists. What follows is a comprehensive

discussion of the steps of grounded theory methodology from data generation to the development of a substantive or formal grounded theory using an adaptation of the conceptual map in Speziale and Carpenter (2003, p. 117) as organizing framework. See Figure 3.1. The diagram is designed to be read from the bottom to the top; hence, the label “The Grounded Theory Process: From the Ground Up.”

#### *Data Collection: Data Generation in Grounded Theory*

In grounded theory, data is generated from formal or informal interviews, participant observations, and field notes. Additional data sources include journals and the literature. There is no required a priori number of participants because data collection continues until data saturation is achieved. Data saturation is “ the point at which the ongoing analysis of new data is not producing any new insights relevant to the emergent theory” ( Kennedy & Lingard, 2006, p. 104). Data saturation is said to be achieved when new data and new conceptual information are no longer emerging, and one core category is discovered to be able to explain the relationship between all the others (Chenitz & Swanson, 1986).

#### *Data Analysis: Theory Generation in Grounded Theory*

The process of theory generation in grounded theory is accomplished by the analysis of the patterns, themes, and common categories discovered in data observed in naturalistic settings. The rule in generating theory is not to have any pre-conceived hypothesis but to have theoretical sensitivity toward the evidence. In the process of discovering theory, conceptual categories or their properties are generated from evidence. The evidence from which the category has emerged is used to illustrate the concept. The illustration of the concept then becomes the relevant theoretical abstraction that explains what is going on in the area studied (Glaser & Strauss, 1967).

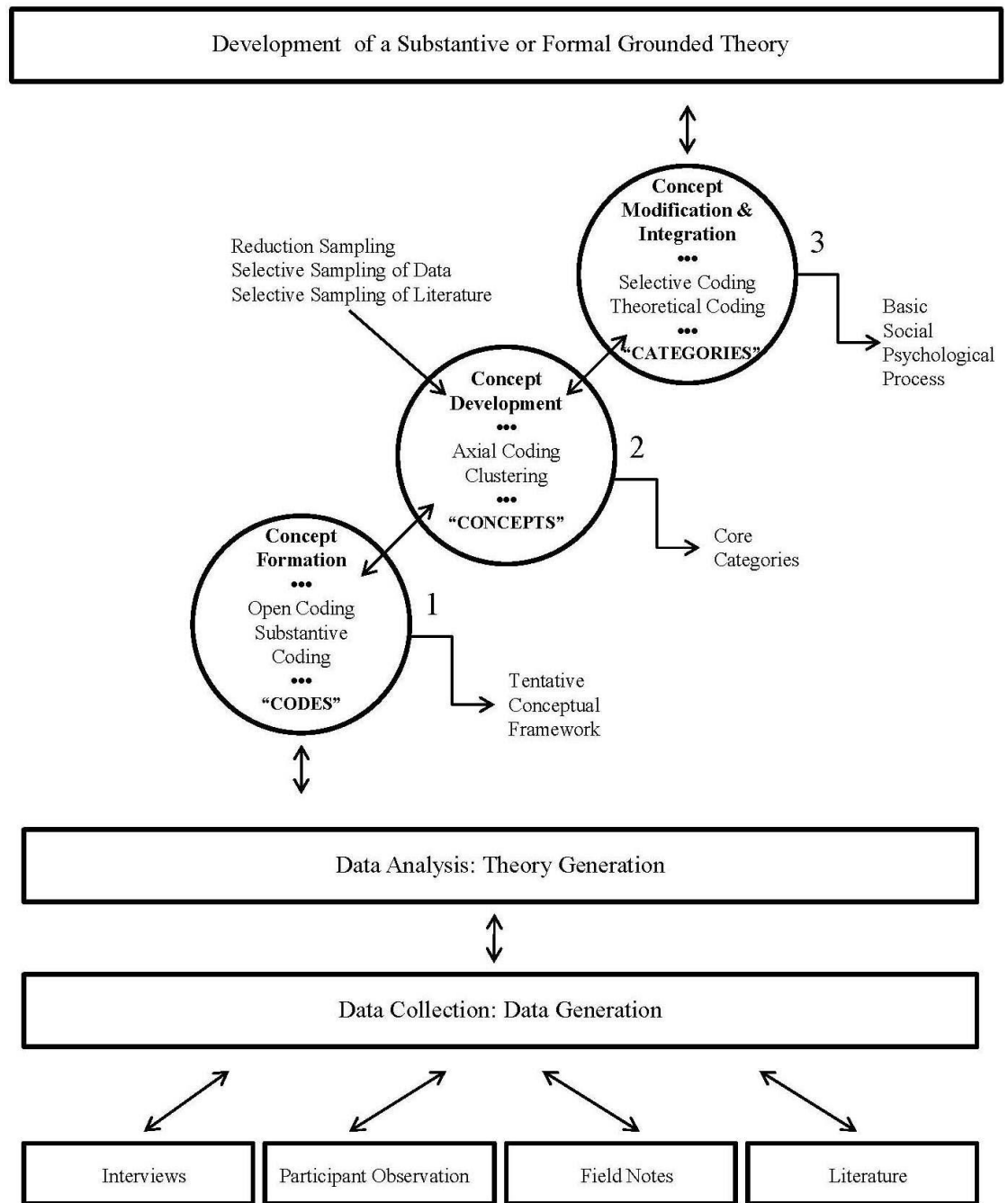


Figure 3.1. The Grounded Theory Process: From the Ground Up. Adapted from Figure 7-1 "Grounded theory and connections among data generation, treatment, and analysis," by H. J. S. Speziale and D. R. Carpenter, 2003, *Qualitative Research in Nursing*, page 117; and from "Grounded Theory Methodology: Its uses and processes," by P. N. Stern, 1980, *Image*, pp. 21-23.

Through inductive and deductive analytical thinking that occur during the memoing phase (Hutchinson & Wilson, 2001; Speziale & Carpenter, 2003), grounded theory uncovers a core category, also referred to as core variable—one that represents a central problem that exists within the interactions of the participants in their natural world (MacIntosh, 2003). Inductive analysis is a characteristic of grounded theory research that moves the analytical process toward a higher level of abstraction and toward the identification of thematic relationships as well as to the articulation of the reasons and meanings why such thematic relationships exist. Inductive analysis means that the grounded theorist is actively conceptualizing. Deductive analysis, on the other hand, means that the grounded theorist is actively assessing how the concepts fit together. Repetitive examination of the data as well as theoretical sensitivity facilitates the process (Kennedy & Lingard, 2006).

*Constant comparative method.* Constant comparative method is a “method of analysis that generates successively more abstract concepts and theories through inductive processes of comparing data with data, data with category, category with category, and category with concept” (Charmaz, 2006, p. 187). Constant comparative method is the central data analytic principle in grounded theory. Through an iterative process, issues and incidents of interest, concepts, themes, and categories are compared against other examples from ongoing data collection and from the literature for similarities and differences. This allows for the continual refinement of emerging theoretical constructs (Kennedy & Lingard, 2006).

Constant comparison of many groups makes their differences and similarities perceptible making it possible to generate abstract categories and their properties which can explain the kind of behavior being observed (Glaser & Strauss, 1967). The use of constant comparative method permits the construction of a complex theory that corresponds closely to

the data because the method forces the analyst to consider the diversity in the data. The method produces the richness that is typical of grounded theory analysis (Glaser & Strauss, 1967).

*Memoing or memo-writing.* Memoing is a concept that was originally described by Strauss. Memoing or writing memos enables grounded theorists to reflect upon the data, themes, emerging hypotheses, analytical schemes, hunches, and abstractions. Memos are written contextual narratives by grounded theorists regarding the data and data analysis that provide clarity to the concepts discovered (Mullen, 2007). Memos trigger the thinking processes of grounded theorists as they engage in personal internal dialogue (Bloomberg & Volpe, 2008). Memos allow the grounded theorists to fully link and integrate the concepts and categories into either a substantive or formal theory that is grounded in the data. These written reflections serve many purposes as grounded theorists bring closure to their current research projects or even as they plan for the genesis of the next research project.

#### *Coding in Grounded Theory*

In grounded theory methodology, data collection and analysis occur simultaneously. Data analysis is iterative. The basic analytical process that is used is coding (Stern, 1980). Coding is not simply a part of grounded theory data analysis. It is the key strategy used by the researcher to craft and transform hundreds of text data from mere transcribed words to concepts and constructs and ultimately to theory (Walker & Myrick, 2006). Coding is “the process of data analysis in grounded theory whereby statements are grouped and given a code for ease of identification later in the study” (Speziale & Carpenter, 2003, p. 361). Coding is essentially a process that enables the researcher to create a taxonomy about the properties of a specific phenomenon being studied. It is a process of scrutinizing particular segments of the

data that are of significant interest or relevance to the study being undertaken and labeling them with meaningful names so that they can be organized coherently (Bloomberg & Volpe, 2008). Grounded theory coding allows the researcher to generate and shape the analytic framework of the study by defining what the data are all about. To facilitate the coding process, a computer software program for qualitative data analysis such as ATLAS.ti can be used.

With the divergences in grounded theory methodology as discussed earlier, the different types or levels of coding are named differently as well. The researcher in this study compared and contrasted the names assigned to the various types or levels of coding and the expected outcomes from each type or level and she discovered that each name is parallel to another name. The comparison of the various names of the various types or levels of coding are found in Table 3.1. The contents of the table also serve to explain the data analytic steps as illustrated within the circles in Figure 3.1. Table 3.1 is borrowed from Heath and Cowley (2004). It provides a summary of the coding types or levels in grounded theory that compare Glaser's and Strauss' techniques, as well as the data analytic phases as outlined in Speziale and Carpenter (2003) and in Stern (1980). These phases begin from concept formation to concept modification and integration and they are paralleled with the different types and levels of coding.

### *Concept Formation*

Concept formation is the initial phase in the interpretive coding process. This phase produces *codes* and it is accomplished through open coding or substantive coding which is akin to Level 1 coding. The goal of this phase is to break down the raw data into analytical segments and to give these analytical data segments referential names or labels. In this phase,



Table 3.1

*Data Analysis in Grounded Theory*

Coding Level Product of Analysis	Speziale and Carpenter; Stern	Strauss and Corbin	Glaser
Level 1 Coding Codes	Concept Formation <i>Data-dependent tentative conceptual framework</i>	Open Coding <i>Use of analytic technique</i>	Substantive Coding <i>Data dependent</i>
Level 2 Coding Concepts	Concept Development <i>Reduction Selective sampling/literature Selective sampling/data Emergence of core variable</i>	Axial Coding <i>Reduction &amp; clustering of categories (paradigm model)</i>	Continued from previous phase; <i>comparisons with focus on data; become more abstract; categories refitted; emerging frameworks</i>
Level 3 Coding Categories	Concept modification and Integration <i>Theoretical coding Memo-writing Basic Psychological Process</i>	Selective Coding <i>Detailed development of categories, selection of core, integration of categories</i>	Theoretical Coding <i>Refitting and refinement of categories which integrate around emerging core</i>
Theorizing Theory	Generation of Substantive or Formal Theory	Detailed and dense process fully described	Parsimony, scope and modifiability

*Note.* From “Data Analysis: Glaser and Strauss compared [Table 1] in Developing a grounded theory approach: a comparison of Glaser and Strauss” by H. Heath & S. Cowley, 2004, *International Journal of Nursing Studies*, 41. Other sources are Charmaz, 2006; Chenitz and Swanson, 1986, and Speziale & Carpenter, 2003.

grounded theorists read and examine the text data line- by-line, multiple times to identify processes, and form groups of codes into concepts through the initial conceptualization of underlying patterns and themes (Corbin & Strauss, 1990; Kennedy & Lingard, 2006; Speziale & Carpenter, 2003; Stern, 1980). A tentative conceptual framework is generated using the data from the point of view of the participants as reference (Stern, 1980).

At this level, Hutchinson and Wilson (2001) remind grounded theorists to treat codes as provisional and to avoid censoring ideas. They emphasize that further analysis and

delineation of codes through the iterative process of constant comparative method will yield codes that fit the data and that “remaining open to theoretical ideas is essential to generating theory that is abstract enough to be interpretive rather than merely descriptive” (p. 227). At this level, constant comparison is accomplished by reading through the entire set of raw data, chunking the data into small segments, labeling each segment with a descriptive code, comparing each new segment of data with previous codes so that similar segments are labeled with the same code, grouping each code by similarity, and identifying and documenting patterns and themes based on each grouping (Onwuegbuzie, Dickinson, Leech, & Zoran, 2009). The decision to use specific code names is facilitated by questioning what each Level 1 code might mean and comparing each Level 1 code with all other Level 1 codes. When major patterns and themes are identified, Level 2 coding occurs (Speziale & Carpenter, 2003).

### *Concept Development*

Concept development brings the grounded theory research process to the next level. This phase enables grounded theorists to further develop the group of codes that formed in the initial phase of open or substantive coding into related concepts by exploring and defining the connections between them to form categories (Kennedy & Lingard, 2006). This is accomplished through Level 2 coding or clustering or categorizing which is akin to axial coding. Axial coding is accomplished by using a coding paradigm of “conditions, context, strategies (action/interaction), and consequences” (Corbin & Strauss, 1990).

The iterative process of constant comparative method is continually employed by grounded theorists and the coded text data are assigned to clusters or categories. To accomplish this phase, three major processes occur namely: (a) reduction sampling, (b) selective sampling of data, and (c) selective sampling of the literature. These processes are

precursors to the emergence of the core categories. They are discussed here using the viewpoints of Speziale and Carpenter (2003) and Stern (1980).

*Reduction sampling.* The process of reduction is a fundamental step in generating the core categories during grounded theory research. This process is called clustering. The goal of this step is to reduce the number of categories that initially emerged during the early phase of concept formation and coding. This is accomplished by comparing categories with each other, examining their relationships, and linking them into already existing clusters to form broader ones.

*Selective sampling of data.* When the main categories become observable, grounded theorists compare these categories with the data to determine the circumstances in which they occur, as well as to ascertain if these categories are truly central to the emerging theory. In this step, the collection of additional data in a selective manner through theoretical sampling may become imperative to enable grounded theorists to develop the hypothesis and discover the properties and characteristics of the main concepts and categories of the emerging theory.

Theoretical sampling in grounded theory research “means that the study sample is not set prior to data collection, but rather the participants or other data sources are selected purposefully as the analysis progresses” to enable the researcher to collect data that would advance the development of the emerging theory (Kennedy & Lingard, 2006, p. 104).

Therefore, further sampling is based not on the representation of a population but based on the ability of the sample to confirm, challenge, or expand the emerging theory. Glaser and Strauss (1967) mandates that grounded theory data be collected by theoretical sampling. This type of sampling facilitates the development of theoretical categories because the researcher intentionally examines the phenomena where it is known to exist. What this means is that the

researcher moves on to the next population or participant to gather data as informed by the emerging theory (Chenitz & Swanson, 1986). This is crucial because the wisdom of Glaser & Strauss (1967) states that if the data collected by theoretical sampling is analyzed at the same time as it is collected, the integration of the theory is more likely to emerge by itself. In theoretical sampling, participant selection is made purposively from sources known to have relevant data for the phenomenon under study. This is to make the advancement of theory construction possible. When engaging in theoretical sampling, “the researcher seeks people, events, or information to illuminate and define the boundaries and relevance of the categories” (Charmaz, 2006, p. 189). Simply put, theoretical sampling is a type of sampling scheme where individuals or groups are selected on the basis of their theoretical relevance to the research study being conducted (Babbie, 2004). This strategy strengthens and makes the theoretical categories denser with meaning (Chenitz & Swanson, 1986).

*Selective sampling of literature.* By convention, literature review in grounded theory is not conducted prior to the study because of the potential for researcher bias. Selective sampling of literature generally occurs with data analysis. As the theory begins to develop, grounded theorists conduct a literature review to identify what has been published regarding the emerging main concepts and categories. A sampling of the literature is conducted selectively and a careful scrutiny of such literature is undertaken. The findings in the existing literature are “woven into the matrix consisting of data, category, and conceptualization” (Stern, 1980, p. 22) and these findings are then included in the constant comparison of emerging concepts and categories.

### *Emergence of Core Categories*

The process of reduction and constant comparison during this second phase in grounded theory analysis leads to the emergence of core categories. Core categories always exist in a grounded theory study. They are the fundamental elements which serve to clarify the main theme and explain what is going on with the data. As the analytical process proceeds in grounded theory, it is probable that multiple core categories emerge from one study. It is also probable that only one core category emerges. When the core categories are discovered, further explorations lead to the identification of the emerging basic social psychological process (Babbie, 2004; Charmaz, 2006; Glaser & Strauss, 1967; Richards & Morse, 2007; Speziale & Carpenter, 2003).

### *Concept Modification and Integration*

The completion of the processes in the concept development phase of a grounded theory study opens the route to concept modification and integration. Grounded theorists become very immersed in the data. While this is desirable, it is this time that grounded theorists must step back from the data and begin to delve deeper into the relationships between the *categories* by employing Strauss and Corbin's selective coding or Glaser's theoretical coding as well as memoing. This phase is akin to Level 3 coding. During this phase, data analysis proceeds from descriptive conceptualizations to higher levels of theoretical abstractions. The main aim of this level is the discovery of the basic social psychological process and its related properties. This is accomplished by the further examination of the categories. The conditions, phases, consequences, and other properties of the basic social psychological process are identified (Hutchinson & Wilson, 2001). Suggested questions to ask during the search for the basic social psychological process are: “(a) What is

going on in the data? (b) What is the focus of the study and the relationship of the data to the study? (c) What is the problem that is being dealt with by the participants? (d) What processes are helping the participants cope with the problem?” (Speziale & Carpenter, 2003, p. 118).

*Selective coding.* At this level of coding, all the categories are pulled toward a core category which leads to the identification and description of the basic social-psychological process . A basic social psychological process is a process that addresses or resolves the central problem within specific human social interactions (Babbie, 2004; Charmaz, 2006; Glaser & Strauss, 1967; Richards & Morse, 2007;Speziale & Carpenter, 2003).

*Theoretical coding.* Theoretical coding is the method by which descriptions that are theoretical rather than descriptive are given to the emergent categories. Theoretical codes allow for the organization and the clarification of the categories that have emerged, and this process makes possible the creation of theoretical links between the categories. These links will lead to the development of a process or processes and subsequently the generation of theory (Chenitz & Swanson, 1986). There are 18 families of theoretical codes that are listed by Glaser (1978) that can enable novice researchers to ask questions about their data. To explain the use of the families of theoretical codes, Glaser uses what he refers to as 6Cs family (Table 3.2). He recommends the use of this family to beginning researchers who may need to present a beginning theoretical scheme of pilot interviews conducted (Chenitz & Swanson, 1986). The components of Glaser’s 6Cs family of theoretical codes are similar to the components of Corbin and Strauss’ axial coding paradigm.

The family of 6 Cs offers a systematic approach to conceptualizing the relationships among the categories and integrating them into a theory. For instance, when categories are

Table 3.2

*A family of Theoretical Codes: The Six Cs*

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1. Causes	4. Consequences
2. Context	5. Covariances
3. Contingencies	6. Conditions

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initially developed from substantive codes, each category is compared and matched to each of the six theoretical codes. The researcher is prompted to ask questions such as: (a) Is this category a cause of another category? (b) Is it in context with another category? (c) Is it a contingency, bearing on another category? (d) [Is this category a consequence of another category?] (e) Does this category co-vary with other categories? (f) Is this category a condition of some other category? (Swanson, 1986). Another useful question at this level of data analysis is “Is this category a strategy?” (Swanson, 1986, p. 126). Using coding families improves the theoretical sensitivity of grounded theorists. Every grounded theory study is ‘of one of these codes (Glaser, 1978).

*Emergence of the Basic Social Psychological Process*

Basic social psychological process is the basic concept in grounded theory that illustrates a social process that serves to address or resolve issues that participants experience as problematic in their world (MacIntosh, 2003). For novice grounded theorists, it is imperative that the concept of basic social psychological process is well understood. The level of understanding regarding basic social psychological process can be enhanced by first viewing it as a type of core category; hence, a basic social psychological process is always a core category but not all core categories are basic social psychological processes. In addition, in a grounded theory study, a core category always exists; but a basic social psychological

process may not. It is also of importance to understand that a core category can be any theoretical code such as a cause, condition, or consequence from a family of theoretical codes such as process or strategies (Chenitz & Swanson, 1986). Basic social psychological processes account for the process of change which occurs over time. One characteristic of a basic psychological process is that it is a gerund, a noun formed from a verb describing an action or movement and it is formed from the “-ing” form of the verb. Examples are “becoming”, “constructing”, or “experiencing”.

### *Theorizing*

According to Charmaz (2006), theorizing involves stopping, pondering, and rethinking in new ways in order to explore studied life from multiple vantage points and to make comparisons, follow leads, and build on ideas. Charmaz further states that theorizing is getting down to fundamentals, probing into experience, cutting through the core of studied life, posing new questions about it, and reaching up to abstractions. Theorizing fosters seeing possibilities, establishing connections, and asking questions. Theorizing is the means by which grounded theorists develop theoretical sensitivity.

### *Theoretical Sensitivity*

Charmaz (2006) refers to theoretical sensitivity as acts of theorizing. Theoretical sensitivity is essential in grounded theory (Richards & Morse, 2007). It is the ability and skill of grounded theorists to think inductively and to perceive categories and their relationships so as to move from the particular (data) to the general (abstract) toward the development of a theory (Schneiber & Stern, 2001). With theoretical sensitivity, grounded theorists seek to discover theory by constantly working with the data, codes, concepts, and categories to establish their relationships and linkages. This might provide the structure for the integration



and synthesis of categories (Richards & Morse, 2007) and the framework for rich theoretical explanations. Grounded theory analysis is deemed completed when the theoretical explanations convey an understanding of the social phenomenon under study (Kennedy & Lingard, 2006) and a substantive or formal theory grounded in the data has been generated through the constant comparative method.

### *Theory Defined*

“Theory is a set of well defined concepts related through statements of relationship, which together constitute an integrated framework that can be used to explain or predict phenomena” (Strauss & Corbin, 1990, p. 15). A theory is the product of grounded theorists’ deep reflection, discussion, and detailed examination of text data, constructed from codes and memos dense with meaning (Richards & Morse, 2007). A theory can either be substantive or formal. Glaser and Strauss (1967) asserts that substantive theory is that which is developed for substantive or empirical area of inquiry. According to Speziale & Carpenter (2003), substantive are considered middle-range theories because they are within the range of working hypothesis and the all-inclusive grand theories. Formal theory, on the other hand is developed for a formal, or conceptual area of inquiry which may include the concepts of socialization to professional nursing, development of nursing identity, or authority and power in nursing practice.

### *The Role of Symbolic Interactionism*

In Chapter One, it was asserted that nursing identity is the tangible outcome of professional socialization to nursing, and that socialization to nursing begins in nursing school where students learn the preparatory knowledge and skills, and acquire the qualities and the ideals of the nursing profession (MacIntosh, 2003). The professional socialization process as

facilitated by socialization agents brings about changes in the behavior or conceptual state of a professional individual (Kramer, 1974). Two major theoretical approaches have been used to explain professional socialization to nursing in the context of the primary mechanism by which individuals are socialized to the profession: through the forces of society or through the individual themselves (Jorda, 2005). These two approaches are the functionalist approach and the interactionist approach. Functionalist approach puts the forces of society (i.e., nursing faculty as socializing agents) as the primary mechanism by which individuals are socialized into the profession. In this perspective, students are considered relatively passive recipients of education (Ware, 2008) such as what occurs in the classroom setting (Reutter, Field, Campbell, & Day, 1997). The functionalist perspective is what predominates in the early phase of nursing education and socialization. It is the primary approach to acquiring the ideal norms and values of the profession; thus, it focuses on the ideal world (Ware, 2008).

The interactionist approach puts the self as the primary mechanism by which individuals are socialized into the profession; hence, socialization is accomplished by the ability of the individual to define societal expectations (Jorda, 2005) through a reflective process (Ware, 2008) and through their active interaction with others and the environment. Such interaction with others brings about the change in behavior or conceptual state as influenced by the new role they are taking (Biddle, 1979; Kramer, 1974). The interactionist approach focuses on the real world rather than on the ideal world.

Grounded theory is based on the symbolic interactionist perspective of human behavior (Richards & Morse, 2007; Speziale & Carpenter, 2003). Symbolic interactionism is a theory about human behavior and it is a practical approach to the study of human conduct and human group life (Blumer, 1969; Chenitz & Swanson, 1986). The empirical world of

symbolic interactionism is the natural world. It lodges its problems about group life and conduct in the natural world, conducts its studies in it, and derives its interpretations from naturalistic studies (Blumer, 1969).

The major concepts in symbolic interactionism are the mind, the self, and society (Stryker, 1980) and it was conceived by social psychologist George Herbert Mead and has been expounded and interpreted by several sociologists throughout the years (Meltzer, Petras, & Reynolds, 1975). Mead's best known student, Herbert Blumer coined the term symbolic interactionism which he first used in the book *Man and Society* published in 1937. According to Blumer (1969), there are three basic premises that support the nature of symbolic interactionism. The first premise and the most profound is that "human beings act toward things on the basis of the meanings that the things have for them" (Blumer, 1969, p. 2). These things may include anything that individuals encounter in the realities of their daily lives—objects, other people, institutions, guiding ideals, or any combination of these. The second premise is that "the meaning of such things is derived from, or arises out of the social interaction that one has with one's fellows" (Blumer, 1969, p. 2). This refers to the source of meaning and such source could be the psychological elements of an individual's perceptions. The third premise is that "these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters" (Blumer, 1969, p.2).

The worldview of symbolic interactionists is that human behavior is a result of a social process. It is a result of human social interactions. This process entails the study of human behavior on two levels: (a) the behavioral or interactional level, and (b) the symbolic level. On the first level, referred to as the behavioral or interactional level, the meaning of events,

experiences, and human conduct are understood from the perspective of the participants in their natural, everyday lives. Meanings of events are derived from the participants' view of self. The concept of self is central to symbolic interactionism (Blumer, 1969). On the second level, referred to as the symbolic level, meanings of events, experiences, and human conduct are derived from social interaction. Social interaction allows individuals to share events and experiences and align their behaviors with others. This process is facilitated by communication through the use of a common language (Chenitz & Swanson, 1986).

As a grounded theory study, using the philosophical underpinnings of symbolic interactionism as theoretical framework is fitting. Within this theoretical structure, the Physician-Nurses in developing their nursing identity are expected to journey through a two-level continuous process in the real world not in the ideal world. The first level of this process involves assigning meanings to events, experiences, and conduct through views of their new and different selves as nurses. The second level involves sharing the meanings of events and experiences with others, as well as aligning their conduct with others in the profession of nursing through social interaction and through the use of a common language distinctive of nursing.

### *Chapter Summary*

Chapter Three presented a comprehensive review of the grounded theory research tradition. The researcher opted to isolate this chapter from the research methodology chapter because she believes that a comprehensive description of the grounded theory research tradition is crucial in framing this current study and she believes that knowledge-building and dissemination is influenced by how a researcher understands and interprets the particular research tradition she is employing and knowledge-assimilation by the practitioners within the

scientific, academic, and practice settings is greatly impacted by how they understand the research tradition for a particular study. Using Glaser's definition, grounded theory was defined in the perspective of its purpose to which is "generate a theory that accounts for a pattern of behavior which is relevant and problematic for those involved" (Glaser, 1978, p. 93). The main assumption of grounded theory research is that the variation in people's patterns of behaviors when experiencing a specific phenomenon can be explained by an unarticulated central problem and by the resultant basic social psychological process that they utilize to address such problem.

The divergent paradigms of Glaser and Strauss that evolved since their original discovery of grounded theory in 1967 were discussed. The use of grounded theory in nursing was also discussed. Grounded theory is fitting to use in studying nursing phenomena because nursing occurs in a naturalistic rather than a controlled setting. Using a diagram (Figure 3.1) as organizing framework, the steps of grounded theory research from data collection to theorizing as understood by the researcher were discussed. The plethora of important concepts in grounded theory that include data saturation, theoretical sampling, constant comparative method, memoing or memo-writing, coding, reduction sampling, selecting sampling of data, selective sampling of literature, emergence of core categories, selective coding, theoretical coding, emergence of the basic social psychological process, theoretical sensitivity and theorizing were discussed. The different levels of coding in grounded theory were paralleled to concept formation, concept development, and concept modification and integration as seen in Table 3.1.

Grounded theory is based on the symbolic interactionist perspective of human behavior, so the role of symbolic interactionism was also discussed. Symbolic interactionism

is a theory about human behavior and it is a practical approach to the study of human conduct and human group life. The empirical world of symbolic interactionism is the natural world. The major concepts in symbolic interactionism are the mind, the self, and society. The worldview of symbolic interactionists is that human behavior is a result of human social interactions . This process entails the study of human behavior on the behavioral or interactional level as well as the symbolic level. On the first level, human conduct is understood from the perspective of the participants in their natural, everyday lives. On the second level, human conduct is derived from their social interaction.

The next chapter, Chapter Four will present how grounded theory methodology was applied in this study. It will discuss the participants and their demographic characteristics, research instruments and procedures for data generation, and data analysis and theorizing. It will also include a discussion about the general concepts of establishing trustworthiness in qualitative studies and how these concepts were applied in this current study.

## Chapter Four

### Research Methodology: Applying Grounded Theory

*The requisite conceptual skills for doing grounded theory are to absorb data as data, to be able to step back or distance oneself from it, and then to abstractly conceptualize the data.... grounded theory is a methodology that is designed to bring out skills of conceptual analysis that many researchers did not either realize they had or were forbidden to use by the theoretical capitalists in their midst... ~ Glaser, 1992, pp. 11-12.*

This chapter presents the study methodology. It includes discussions regarding (a) the rationale for using qualitative research design, (b) rationale for using grounded theory methodology, (c) ethical considerations, (d) research participants, (e) research instruments, (f) procedures for data generation, (g) data analysis and synthesis, (h) preliminary discussion toward a grounded theory, (i) verification procedures, and (j) limitations of the study.

#### *Rationale for Qualitative Research Design*

The purpose of a research study and the ensuing choice of research approach are greatly influenced by the paucity of empirical data regarding the phenomenon and population-of-interest being explored. Qualitative research design, an approach that generates theory rather than quantitative research design, one that tests theory, is intended to increase knowledge about a phenomenon by examining it and its properties in the natural world of the participants. Currently, very little is known about the Physician-Nurses practicing in the United States and about the development of their nursing identity.

Qualitative research design was chosen as the approach for this study because of its obvious fit to the research problem, purpose, and specific aims. The purpose of this study was

to generate a theory about the development of nursing identity in FEPs retrained as nurses; therefore, a qualitative research design was deemed appropriate. Through qualitative interviewing and data collection, the researcher was able to enter the world of the Physician-Nurses and was afforded the opportunity to experience a holistic and constructionist rather than a deterministic and reductionist understanding of the phenomenon being examined (Bloomberg & Volpe, 2008). Qualitative research offered insight into this unique phenomenon by ensuring that a diversity of contextual information, demographic information, perceptual information, and theoretical information were discovered and acknowledged (Bloomberg & Volpe, 2008; Miles and Huberman, 1994).

#### *Rationale for Grounded Theory Methodology*

When the purpose of a research study is the development of theory about a dominant social process, researchers must utilize qualitative research traditions that can lead them to do just that. Grounded theory methodology was chosen for this study because it is a qualitative research tradition that is methodologically congruent with the purpose of the study. Grounded theory enabled the researcher to develop a new theory that is grounded in the data gained from participants' voices and experiences as well as from their interactions with the phenomenon-of-interest (Charmaz, 2006). The rationale for using grounded theory was further supported by the perspective offered by Stern (1980) that grounded theory is especially useful when there is little research or when no research exists on a topic. Research pertaining specifically on nursing identity development in Physician-Nurses practicing in the US does not exist; hence, the empirical base about the phenomenon is nil. A grounded theory study was therefore deemed essential and appropriate to establish an empirical base about the phenomenon upon which further knowledge-building can occur. Through the iterative process



of constant comparative analysis, a complete exploration and discovery of theoretical explanations pertaining to the development of nursing identity in Physician-Nurses practicing in the US was accomplished.

### *Ethical Considerations*

USF Institutional Review Board (IRB) approval was obtained before data collection began. See Appendix J. This study qualified for expedited review under USF IRB Expedited Category Number 7. This type of study is described as “research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies” (USF IRB Expedited Review Addendum, 2006).

The process for informed consent was followed. See consent form in Appendix K. The alternatives, benefits, risk, compensation, and safeguarding confidentiality were discussed with each participant. The research study was identified as not having the potential to pose any major risk for the participants; however, cognizant that participants may potentially become emotional during the interview, the researcher made it explicit to participants that the interview would be halted should anyone become emotionally distressed in the process.

Due to the nature of qualitative data collection, participant anonymity to the researcher was not possible; but participant anonymity to others was maintained. The participants were made aware of this before obtaining informed consent. Safeguarding confidentiality of all participant information was done with utmost vigilance. All participant information was maintained in secure password protected computer files and locked file cabinets located in the

researcher's home. No participant identifier was included in the transcriptions of the interviews. Code numbers and pseudonyms were assigned to participants. It was explained to the participants that certain individuals may be allowed to see their records including the researcher's faculty mentors and certain government and university personnel such as members of the USF IRB and support staff of the IRB. In one instance, the real name of a Physician-Nurse was used in this report because she has been featured in a news article .

### *The Research Participants*

#### *Sampling Method*

Purposive, snowball, and theoretical sampling were utilized in this study to allow the researcher to recruit a representative sample of diverse participants, who could offer rich text data about the phenomenon being studied. Although the dictum of grounded theory mandates that the study sample is not set prior to data collection, the researcher defined specific inclusion criteria so as not to lose sight of the focus of the study. Purposive sampling method was used to identify Physician-Nurses of various ethnicities who met inclusion criteria as follows: registered nurses who (a) were physicians in their native country, (b) had worked in the US for at least six months, (c) were not actively pursuing continuing medical training in the US, and (d) were able to speak, read, and write English. In the early stages of the research study, the research protocol specified that to be included in the study a Physician-Nurse must be an RN; however, guided by the concept of theoretical sampling which dictates that participants are selected purposefully as the analysis progresses for their ability to provide data that would confirm, challenge, or expand an emerging theory (Kennedy & Lingard, 2006), the inclusion criteria was modified to include RN board-eligible LPNs. A request for modification was submitted to the IRB in July 2009. See Appendix L for the approval letter of

the modification. Snowball sampling was also used whereby earlier participants referred additional participants to researcher. Combining these sampling methods facilitated the collection of data that provided a more valid explanatory model depicting the basic social psychological process that influenced the development of nursing identity in Physician-Nurses practicing in the US.

There was no a priori determination of the number of participants. Participants were recruited and interviews were continued until data saturation was achieved. Data saturation was determined to have been reached by the 10<sup>th</sup> interview but the researcher continued to conduct the 11<sup>th</sup> and 12<sup>th</sup> interviews to add rigor to the theoretical sample as well as ethnic variation to the participant pool.

#### *Recruitment*

Introductory letters (Appendix M), and recruitment flyers (Appendix N) bearing the researcher's contact information were sent to various individuals and entities that included the researcher's personal and professional networks, the Program Director of the Foreign-Educated Physician-to-BSN program at FIU, a faculty member of the FIU program, the Human Resource Office of hospitals known to have Physician-Nurses as employees, the president of the Philippine Nurses Association of Tampa Bay, and the St. Luke's Nursing Alumni Foundation, USA.

A total of 12 interviews were conducted for this study. The first two interviews were intended to be pilot interviews; however, because no changes were made in the interview guiding questions after their interviews and because their perspectives were rich with substance, data collected from them were included in the final data analysis. Through the researcher's professional and personal networks, a total of 47 potential participants were

identified. They were practicing as nurses in various states such as California, Connecticut, Florida, Nevada, New Jersey, and New York. The researcher provided flyers to colleagues and lead people and requested that the flyers be given to Physician-Nurses within their personal and professional circles. Electronic and telephone follow-up with colleagues and lead people were made to stimulate participant recruitment. Through the assistance of lead people, a few of the 47 potential participants called the researcher to indicate their willingness to participate. Most of the potential participants asked that information about the research be e-mailed or mailed to them. The researcher sent the study consent form as well as the consent for audio taping, the demographic data collection form, and the interview guiding questions to potential participants via e-mail and regular mail. Most of those who initially showed interest did not respond. This created a major setback in participant recruitment because three of the potential participants who did not respond after they received the packet were also lead people who indicated that each had five to six Physician-Nurses in their personal and professional circles. The reasons for their hesitancy to participate were unclear; however, three potential participants responded that they could not participate because of lack of time secondary to their 5-day or 6-night work week schedule. Through lead people, the researcher was informed that perhaps the reason why three potential participants declined to participate was due to prior issues with their clinical professor. One barrier in participant recruitment was the hesitancy of some Physician-Nurses for self-disclosure. Multiple lead people indicated that the Physician-Nurses within their personal and professional circles did not want to reveal their former professional identities. To illustrate, two participants were married to Physician-Nurses but their spouses declined to be participants of this study. Two Physician-Nurses did not participate because they were reviewing for USMLE.

In the beginning of the participant recruitment efforts, the researcher presented her research plan at one of the local hospitals in the Tampa Bay area; however, the researcher did not pursue conducting direct recruitment through this institution. This decision was made so as not to compromise participant privacy. The potential for compromising participant privacy existed because of the small population of Physician-Nurses in that institution.

### *Participant Demographics*

Pseudonyms were assigned to the 12 participants. They are listed here alphabetically and not according to when they were interviewed. Adela, Alina, Annabelle, Arnel, Dante, Maira, Nina, Ollie, Orlando, Paolo, Rachel, and Zaida ranged in age from 30 to 54 with a mean age of 39.25 years. There were five males and seven females. One participant was divorced, two were single, and nine were married. Five of the participants had no children, and seven had one to three children, with one as average. Six participants were from the Philippines, two from Russia, two from Colombia, and one each from Nicaragua and China. Five participants completed their nursing education in the Philippines and seven completed their nursing education in the US. Nine of the participants had BSN degrees, two had AS degrees, and one was a licensed practical nurse (LPN) who has completed his coursework for AS degree. Participants worked as nurses in various settings including cardiology, critical care, emergency care, endoscopy, extended care, labor and delivery, medical-surgical nursing and nursery. The full demographic profiles of the participants are found in Tables 4.1, 4.2, and 4.3. The demographic data are presented in three categories, namely: (a) personal and immigrant characteristics, (b) characteristics as nurses, and (c) characteristics as physicians.

Table 4.1.

*Participant Demographic Data – Personal and Immigrant Characteristics*

Component	Characteristic	n	%
Age (Age Range = 30 – 54) (Mean Age = 39.25)	30-35	4	33%
	36-40	3	25%
	40-45	3	25%
	46-50	1	8%
	51-55	1	8%
Gender	Male	5	42%
	Female	7	58%
Marital Status	Single	2	17%
	Married	9	75%
	Divorced	1	8%
Number of Children	0 child	5	42%
	1 child	4	33%
	2 children	2	17%
	3 children	1	8%
Native Country	China	1	8%
	Colombia	2	17%
	Nicaragua	1	8%
	Philippines	6	50%
	Russia	2	17%
Year Immigrated to the US	1991-1995	1	8%
	1996-2000	3	25%
	2001-2005	7	58%
	2006-2009	1	8%
Number of Years Since Immigration to the US	15 years	1	8%
	13 years	1	8%
	10 years	2	17%
	7 – 8 years	2	17%
	6 years	3	25%
	4 – 5 years	2	17%
	< 1 year	1	8%
Type of Visa on Entry	Asylum/Refugee	2	17%
	Fiancé	2	17%
	Immigrant	4	33%
	Visitor	4	33%

Table 4.2

*Participant Demographic Data – Characteristics as Nurses*

Component	Characteristic	n	%
Number of Years in US Before Became Nurse	0-5 years	6	50%
	6-10 years	5	42%
	11-15 years	1	8%
Location of Nursing School	Philippines	5	42%
	United States	7	58%
Nursing Degree Obtained	AS	2	17%
	BSN	9	75%
	LPN-to-AS	1	8%
Examinations Taken as Pre-requisite for NCLEX	None	10	83%
	CGFNS, TOEFL, IELETS	2	17%
Location Where NCLEX Taken	Outside the US	1	8%
	United States	11	92%
Location of First US Employer	Florida	7	58%
	Nevada	5	42%
Length of Nursing Experience in US	6 months to 2 years	5	42%
	3 – 4 years	7	58%
Length of Nursing Experience Outside the US	0 year	8	67%
	1 year	2	17%
	2 years	2	17%
Nursing Specialty	Cardiology	1	8%
	Critical Care	4	33%
	Emergency Department	1	8%
	Endoscopy	1	8%
	Extended Care	1	8%
	Labor and Delivery	1	8%
	Medical-Surgical	2	17%
	Nursery	1	8%

Table 4.3

*Participant Demographic Data – Characteristics as Physicians*

Component	Characteristic	n	%
Year Graduated from Medical School	1981-1985	2	17%
	1986-1990	0	0%
	1991-1995	4	33%
	1996-2000	4	33%
	2001-2005	2	17%
	2006-2009	0	0%
Former Medical Specialty	Anesthesiology	1	8%
	Family Physician	1	8%
	General Medicine	1	8%
	General Practitioner	4	33%
	General Surgery	2	17%
	Internal Medicine	1	8%
	Pediatric-Neonatology	1	8%
Sports Medicine	1	8%	
Number of Years MD Experience Before Nursing School	1-5 years	8	67%
	6-10 years	2	17%
	10-15 years	1	8%
	16-20 years	0	0%
	20-25 years	1	8%

*Note.* The medical specialty “general practitioner” was used by participants from the Philippines. Included in this category was a former physician from Russia who indicated “general practice” to describe previous medical specialty. The equivalent, “general medicine” was used by the participant from Nicaragua.

*Instruments**The Researcher as Instrument*

In qualitative research, the individual researcher is the primary data collection instrument (Miles & Huberman, 1994). As such, it is imperative to identify and control the biases of the researcher. Through self-reflection, the researcher was able to put her pre-existing biases and assumptions in the proper context so as not to dilute the meanings of the



data collected. As a graduate student in nursing trained in qualitative research methodology, the researcher was a credible research instrument for this study. She was trained in qualitative methodology by experts at the USF College of Nursing and College of Education. Moreover, she possesses the markers of a good qualitative researcher-as-instrument as enumerated by Miles and Huberman (1994, p. 38). These markers include (a) some familiarity with the phenomenon and the setting under study, (b) a strong conceptual interest, (c) a multi disciplinary approach, as opposed to a narrow grounding or focus in a single discipline, (d) good investigative skills, including doggedness, the ability to draw people out, and the ability to ward off premature closure.

#### *Demographic Data Collection Form*

A demographic data collection form was included as a data collection instrument. (Appendix O). The instrument consisted of questions regarding the participant's personal and immigrant characteristics, demographic information as a physician, and demographic information as a nurse. The demographic data that were collected provided the researcher with a glimpse of the participant's personal, social, cultural, and professional background before the actual interview which facilitated the establishment of a relaxed interviewer-interviewee rapport (Speziale & Carpenter, 2003).

#### *Semi-structured Interview Schedule*

Data collection was conducted via a semi-structured interview that was guided by ten open-ended interview guiding questions. The interview questions were constructed by the researcher. The initial set of interview guiding questions consisted of 12 open-ended questions. Through open discussion and expert advice provided by the members of the researcher's dissertation committee, the questions were modified and enhanced resulting in

the final version of ten items. Some of the interview guiding questions were: (a) What experiences influenced your decision to pursue nursing? (b) Tell me about how nursing school was for you? (c) Describe how you were able to shift from your identity as a medical doctor to being a registered nurse? The complete set of interview guiding questions is presented in Appendix P.

The interview guiding questions were formulated to elicit in-depth responses from the participants to answer the overall research question “What is the basic social psychological process that influences the development of nursing identity in Physician-Nurses?” The questions were written clearly leaving minimum room for misinterpretation. In instances where the participant provided ambiguous responses, simple clarifying questions were used (Janesick, 1998). Examples of simple clarification in this study were, “You mentioned something that caught my attention. You said something to the effect that you don’t put effort into thinking that you are a nurse now. What do you mean by that?” (Question to Rachel); and “You mentioned about the phrase ‘nursing and medicine are the same, just different philosophy.’ Does that mean you think the functions of a nurse and a physician are the same?” (Question to Arnel). Probing questions were also utilized to elicit richer responses to open-ended questions (Babbie, 2004). An example of a probing question was “Tell me more about that.” (Question to Zaida).

#### *Participant Observation*

Data was also collected by observing the participants’ nonverbal communication techniques of kinesic, proxemic, chronemic, and paralinguistic communication. Kinesic communication is body movements or posture; proxemic communication involves the use of interpersonal space to communicate attitudes; chronemic communication is the pacing of

speech and length of silence in conversation; and paralinguistic communication includes the variations in voice quality, volume, and pitch (Lichtman, 2001; Onwuegbuzie, Dickinson, Leech, & Zoran, 2009). Chronemic and paralinguistic communication were especially useful in the three phone interviews that were conducted. Vignettes of the researcher's reflections of her phone interviews with two of the participants illustrate the importance of nonverbal cues.

When I interviewed Annabelle via the phone, I asked what her husband does for a living. She paused for a few seconds and then she said softly, "He is also a nurse. But he was also a doctor in the past." When I asked if I could invite him to participate in my study, Annabelle quickly responded with a firmer tone of voice repeatedly saying *no*. She said with a sigh, "he doesn't like things like this [being interviewed]."

When Ollie discussed with me about considering going back to medical practice, he mentioned his doubts about his physical ability to do those long hours of residency anymore. His tone of voice indicated his doubts.

Nonverbal communication patterns are an important source of data that is neglected by many, if not by most researchers (Onwuegbuzie, et al., 2009).

### *Field Notes*

Field notes are the "notations ethnographers generally make to document observations" (Speziale & Carpenter, 2003, p. 33). Use of field notes is not limited to ethnographers. Qualitative researchers employing other qualitative methodologies such as grounded theory, can use field notes to document observations and assumptions about what they heard and observed during the interview. Field notes can also serve as the researchers' narrative accounts of their thoughts and feelings during specific encounters with study participants. The following field notes were written by the researcher as she attempted to interview Alina after her shift.

Although I had indicated in my data collection strategy that I would avoid interviewing Physician-Nurses in their work setting, I had to amend that because most of the Physician-Nurses verbalized time constraints due to work schedules and family responsibilities; so I am meeting with Alina this evening. I obtained her verbal agreement to participate sometime in February. It is now March and I have yet to conduct my interview with her. She is working until 7:15 tonight and she told me it would be perfect if I meet her as soon as her shift ends so we could do it quickly. Then she'll go home to take care of her two children. She said she should be done right at 7:15pm because she is on orientation and so she does not have her own set of patients yet. This is Alina's orientation to Critical Care. After only a few months in a Med-Surg Unit, she is now transitioning to Critical Care. This is impressive! The other day, while I was doing clinical teaching at the hospital, I met Alina's preceptor and she told me about how impressed she is with Alina's nursing skills. I am now at the hospital and Alina is not in ICU. I found out Alina worked at a different unit today. Her preceptor was assigned to staff the post-cardiac intervention unit, so she had to follow her there. Alina and her preceptor are trying to close the post-cardiac intervention unit before the day ends. It is now past 7:15pm. There is one more patient to transfer. I don't want to be in the way but this is a good time for me to observe. I observe Alina briefly as she goes about her meanderings to transfer the patient. I was thinking to myself, "I used to run around like this when I was a younger nurse." While observing her, if I did not know she was a physician before, I would not have known. She was conducting herself as if she has been doing this for a while. She was caring for the patient. And caring meant not only assessments, giving meds and treatments, but taking care of all the affairs of the patient—from ensuring patient belongings are going with the patient to letting patient family know what's going on. Alina was doing all those [packing patient belongings, removing the IV, pulling and pushing the bed to transfer]. In consideration of her time and knowing that she had children waiting at home that evening, I told her I would re-schedule and thanked her. (Field notes written March 6, 2009).

### *Procedures*

#### *Data Collection: Data Generation in this Study*

In qualitative research, the open-ended interview is one of the most frequently used data collection methods. Open-ended interviews with a set of guiding questions rather than a set of rigid closed-ended questions allow participants to explain the focus of interest extensively (Speziale & Carpenter, 2003). In qualitative research interviewing, the researcher must possess good interviewing skills to be able to elicit meaningful responses from participants. The researcher in this study had acquired interviewing skills through lessons in

qualitative research methods in graduate school and was deemed adequately prepared to perform this task. Performing some of the exercises described by Janesick (1998) and studying the ethnographic interview techniques by Spradley (1979) provided her with a strong foundation and with tools for the incremental acquisition of interviewing and observation skills.

In this research study, the unstructured open-ended interview was the primary mode of data collection. Interviews were conducted between July 2008 and July 2009. A set of ten interview guiding questions was used. Probing questions were used to elicit richer responses from participants. Face-to-face interviews were conducted with nine of the 12 study participants. Phone interviews were conducted with three of the participants due to time and travel limitations. Prior to each interview, the researcher obtained informed consent, consent for audio taping (Appendix Q), and demographic data from each participant. For the three participants who were interviewed by telephone, consent forms and demographic data tool were sent ahead of time by mail and the participants returned the signed forms to the researcher in a self-addressed stamped envelope. The face-to-face interviews were audio taped using a digital tape recorder and the telephone interviews were audio taped using a telephone in-line recording device. In addition to audio taping, participant observation and field notes were also written. The field notes were used to enrich data collection (Speziale & Carpenter, 2003). They served to document the researcher's observations, assumptions, thoughts, and feelings about what was heard and observed. Field notes facilitated the researcher's recall of each participant's demeanor when listening to the taped interviews and reviewing transcribed interview data.

The interviews were 45 to 90 minutes long with an average of 60 minutes. In the conceptualization of this research study, interviews were to be conducted in a private office at the USF College of Nursing especially for participants who resided locally. This did not occur because most of the participants preferred to be interviewed in an office at their workplace during their meal breaks or immediately after work hours. One participant requested that the interview be conducted at the home of the researcher and another one opted for the outdoors. The setting did not interfere with the interview process. Heeding the participants' preferences for the location of the interviews actually resulted in a more relaxed and informal yet professional interviewer-interviewee encounter. Each participant was given a \$50.00 cash stipend upon completion of the interview. Data collection and data analysis occurred concurrently, enabling the researcher to determine occurrence of data saturation and to apply principles of theoretical sampling.

*Data Analysis: Theory Generation in this Study*

*Data transformation: interview transcriptions.* When data collection from each participant was completed, the audio taped interviews were transcribed verbatim by a paid transcriptionist. After transcription, the interview transcripts were read and reviewed by the researcher for accuracy of content. After accuracy of transcriptions was established, text units were further read and re-read multiple times. The tape recorded interviews were also reviewed further to validate the initial perceptions of the researcher regarding the participants' chronemic and paralinguistic communication patterns. Although this was extremely tedious, this activity allowed the researcher to be fully immersed in the data. Clarifications were sought from specific participants through e-mails, telephone text messages, or telephone calls when the researcher was not clear about the viewpoint of a participant. In addition, eight of

the 12 interview transcriptions chosen at random were sent back to their specific owners by e-mail for member checking.

*Data transformation: computer software.* To facilitate data analysis and to provide an audit trail for the qualitative data collected, all the transcribed interviews were imported into ATLAS.ti. ATLAS.ti is one of the many computer assisted qualitative data analysis softwares (CAQDAS) that has proliferated in the market since the early 1990s. CAQDAS such as ATLAS.ti assist researchers in coding, searching, indexing, and analyzing data (Bhowmick, 2006). ATLAS.ti does not actually analyze data. It is not a data analysis program that can be equated to a quantitative software program such as the Statistical Package for Social Sciences (SPSS). It does not have an *analyze* button that would automatically produce an analytical output of the qualitative data entered. There is no command to click for a short story or non-fiction or essay output that would accomplish a qualitative results report. ATLAS.ti is much more like a word-processing program like Microsoft Word than SPSS. It is basically a concept database. Its utility is driven by the ability of the researcher to create codes, concepts, and thematic categories that give meaning to segments of text data; the aptitude to conceptualize relationships among concepts and categories; and the skill to build networks among these concepts and categories. ATLAS.ti assists the researcher in organizing, relating, and writing about the concepts (Woolf, 2008).

ATLAS.ti student version 6.0.23 was the CAQDAS chosen by the researcher to use because it has been shown to be the ideal program for making linkages and hierarchical connections between different data elements. It has also been shown to be ideal for theory building (Bhowmick, 2006) which is the goal of this current study. Another factor that was

considered in choosing ATLAS.ti is the presence of faculty members at the USF College of Nursing who are trained in its application.

The 12 interview transcripts were imported into ATLAS.ti as one hermeneutic unit (HU). Initial coding of text fragments based on content or in-vivo coding was done by the researcher. This process yielded hundreds of in-vivo codes which were meaningless in the context of the purpose and aims of this study. With the help of the researcher's ATLAS.ti consultant, a coding framework was established to facilitate coding and to create order in the thousands of text data. The coding framework was created and its components were labeled using the key words found in the specific aims of the study, namely: (a) barriers, (b) catalysts, and (c) process.

Although grounded theorists are cautioned against using predetermined coding categories and seeking to fit the data into such categories and running the risk of analyzing data by coding text units according to what one expects to find (Bloomberg & Volpe, 2008), the researcher in this study, identified the need to establish an initial coding framework. Establishing this coding framework allowed the researcher to perform Level 1 or open coding in a systematic and organized fashion. The initial coding framework as suggested by the researcher's consultant was discussed with two of the researcher's dissertation committee members. As the iterative data collection, coding, and analysis progressed and as categories and theoretical explanations were discovered, the researcher used the network builder in ATLAS.ti and conceptualized relationships and linkages among the concepts. She also wrote memos within the HU file.



### *Constant Comparative Method*

Constant comparison was the main analytical method employed. A systematic analytical process that included coding, defining, developing, and integrating text data into categories was followed. Emergence of categories was not sequential. It was overlapping and iterative. Memoing or memo-writing was also conducted by the researcher throughout data analysis. The analytic steps and coding procedures in grounded theory as described in Chapter Three was followed.

With constant comparison, codes, concepts and categories were initially discovered through questioning. A sample question the researcher asked during the early phase of discovering categories using constant comparison was “Have I observed the stages of the process of professional socialization as described by Cohen (1981), du Toit (1995), Kramer (1974), or MacIntosh (2003)?” As concepts emerged, they were compared against other examples from the data and the literature for similarities and differences. Ongoing data collection provided new and fresh information for constant comparison and served to refine the theoretical constructs that were emerging. This process produced the richness of conceptualization in this study and as typical in grounded theory analysis (Kennedy & Lingard, 2006).

To illustrate the systematic process that the researcher followed during the data analytic coding process, random examples are used in this section. The examples in this section do not give a logical and coherent story regarding this research. Full results and comprehensive discussion of findings are presented in Chapters Five and Six. The sections in the discussion that follows align the analytic activities of the researcher with concept formation, concept development, concept modification and integration, and theorizing.

### *Concept Formation*

During concept formation, Level 1 or open coding or substantive coding was accomplished. Using the initial coding framework that was created with the components labeled barriers, catalysts, and process helped the researcher in the process. Interview transcripts were read line-by-line and the audio tape recordings were reviewed multiple times. Each interview transcription was examined in its entirety. Phrases were selected, highlighted, and coded using referential labels. The body of text data was dissected through questioning. Examples of the questions asked were: What motivated immigrant physicians to pursue nursing as second careers? What problems did the participants encounter during their transition to nursing? How did they cope with problems? What were the factors that facilitated the transition of participants to nursing? In Level 1 or open coding, the formation of concepts was actualized through the labeling of data segments into meaningful codes. See Appendix R for an example of the open coding ATLAS.ti output.

During the life span of this research study, names of codes, themes and categories that emerged during the open coding phase were revised and refined. For instance, the code *skeleton in the closet* which was used to denote the reluctance of some participants to openly reveal their former professional identities to others was changed to *avoiding self-disclosure*. Another example is the use of the code name *lack of control in life's events*. During the early phase of the open coding, this code seemed to capture what the participants were saying about their seemingly serendipitous fate in nursing; however, on further analysis, the researcher felt that it would be more meaningful to re-name this code *destined to become a nurse*. Another example is the code *acquiring nursing knowledge and skills* which was initially used to refer

to the first step of becoming a nurse. Through further conceptualization, the code was re-named *receiving the knowledge and wisdom of nurses*.

During Level 1 or open coding, the researcher reflected deeply upon the segments of data and the codes associated with them and wrote memos about them and also reviewed literature. Reflecting upon the code *recognizing that nursing and medicine are different but have same purpose and are equal* which captured segments of text data that were conceptualized to define catalysts, the following memo was written:

A common theme that resonated from the participants is their recognition that medicine and nursing are different but they have the same purpose (which is caring), and are equal. In my literature review, I found a dissertation written in 1989 by Beryla Branson Wolf (University of Colorado Health Sciences Center) entitled “Nursing Identity: The Nursing-Medicine Relationship.” Wolf articulated that, “both professions make a difference in the lives of people and both demonstrate caring. Medicine demonstrates caring by making a difference, adding possibilities for life that would not exist without the medical perspective. Medicine adds life possibilities from without. Using caring as epistemology and methodology, nursing enables persons to make existing and provided possibilities come into being and work within their lives. Nursing enables living possibilities from within. In collaboration, life to living, the professions empower each other (from the abstract, no page number).”

I think what Wolf meant when she said that “medicine adds life possibilities from without” is that physicians’ methods of dealing with patient problems are through therapies that are external and man-made such as life-prolonging devices to include ventilators, pacemakers, defibrillators among others; whereas what she meant by “nursing enables living possibilities from within” is that nurses tap on the strength of the patient’s inner self; on the patient’s psyche to help them deal with their health problems.

### *Concept Development*

In concept development, the researcher brought the current study into the next level of analysis. Questioning continued. Some of the questions that the researcher asked during this phase were: “What is going on in the data? What is the focus of the study and the relationship of the data to the study? What is the central social psychological problem that is being dealt

with by the participants?” This was the phase where the core categories emerged. The researcher developed the codes into related concepts. The method of constant comparison was continuously utilized and the iterative process facilitated the exploration and definition of the connections between the major thematic categories. The thousands of text data that were reduced and dissected into meaningful segments during Level 1 coding were put together in new ways. They were grouped into major thematic clusters and categories. During this Level 2 coding phase, concepts evolved and developed. As discussed in Chapter Three, this phase is akin to Strauss and Corbin’s axial coding also known as clustering or categorizing.

Similar codes were grouped together. To illustrate, using the initial coding framework labeled as barriers, catalysts, and process and guided by the specific aims of this study, the following examples of major categories and linkages were formed: (a) barriers with the sub-themes intrinsic and extrinsic barriers; (b) catalysts with the sub-themes intrinsic and extrinsic catalysts; and (c) process with the sub-themes shift from physician identity, finding the right niche, and shift to nursing identity. The following examples illustrate how the researcher formed the initial categories and linkages: (a) the codes *tug-of-war in desire to become a nurse and remain a physician*, and *nursing minimizes use of knowledge and skills* were categorized as dimensions within intrinsic barriers; (b) the codes *cultural differences* and *physician has ultimate power over clinical decision-making* were categorized as dimensions within extrinsic barriers; (c) the codes *conscious decision to become a nurse* and *appeal of nurse autonomy* were categorized as dimensions within intrinsic catalysts; (d) the codes *nursing as an easier route to healthcare*, *nursing as a saving grace*, and *nursing as way to economic gain* were categorized as dimensions of extrinsic catalysts; (e) the codes *door of opportunity to the profession of medicine closes*, and *disengaging self from the profession of*

*medicine* were categorized under *shift from physician identity*; (f) the codes *experiencing burdens of a new beginning and sticking it out with determination* were categorized under *finding the right niche*; and (g) the codes *door of opportunity to nursing opens* and *acquiring nursing knowledge and skills* were categorized under *shift to nursing identity*. See Appendix S for a sample screen shot of an ATLAS.ti network illustrating the major category process named *shifting paradigms: the process of identity shift* with the sub-themes *shift from physician identity*, *finding the right niche*, and *shift to nursing identity*. These categories and concepts were generated during the early phase of conceptualization.

The researcher continued to reflect and examine the data and she captured these reflections with consistent memo-writing. An example of a memo written regarding an extrinsic barrier during concept development illustrates the reflective thinking of the researcher and is as follows:

I have much to say about the code *physician has ultimate power over clinical decision-making*. The perception that the profession of medicine has dominance over the other health professions, particularly over nursing in the context of this study is evident in my conversations with the participants. This may partly be true. In our modern times, the physician remains to be in control of clinical decision-making but it is in a milieu of interdisciplinary collaboration. In this collaboration, the doctor is still considered the figure-head that represents the person with the ultimate power and responsibility for the treatment plan of the patient. I quote from my original concept paper: Medicine is traditionally viewed as more superior than nursing. By tradition, nurses hold subservient roles in the doctor-nurse relationship. This tradition perhaps might have its roots in the Nightingale era. Nightingale assigned active intervention roles to physicians and surgeons specifying that their duty was to remove anomalous organs or to intervene in various disease processes. She assigned the more indirect role to nurses, and she believed that nurses were well-suited for supportive roles and fought to establish nursing as a woman's profession. Gillen (2007) suggests that the balance of power maybe tied to the different educational requirements between nurses and physicians, which may result in economic disparity, ultimately with physicians making more money than nurses. This economic difference can alter the balance of power with physicians seemingly holding more power, whether true or imagined, and nurses then are placed in a more subordinate role.

In the analytic phase of concept development, the aim of the grounded theorist is to reduce the number of categories without changing meaning. To accomplish this aim, the researcher employed reduction sampling, selective sampling of data, and selective sampling of literature as discussed in Chapter Three. To illustrate reduction sampling, there was a code labeled *powerless to win over conflicting ideology*. Through clustering which is the characteristic of this analytic phase, this code was merged with the code *physician has ultimate power over clinical decision-making* (2009-07-17T15:17:20\*\*ATLAS.ti). The memo written pertaining to the original code is as follows:

Sometimes, conflicts among healthcare providers regarding care of patients occur. Nurses feel that they are powerless to challenge the decision of the physician. For a professional who has been programmed to be the one with the final say, such as the foreign-educated physician (who is now learning to become a nurse), it is perhaps a difficult and awkward situation. The reality though is that physicians and nurses should work collaboratively with each other to define a patient care plan that is patient-centered and family-centered so that differences in ideologies can be brought out in the open to be discussed and if necessary negotiated with.

It is during reduction sampling that the core categories began to emerge. Diverting away from the descriptive work of identifying and clustering intrinsic and extrinsic barriers and catalysts impacting the development of nursing identity in Physician-Nurses, the researcher moved on to exploring the actual process of nursing identity development in Physician-Nurses. During this phase, the researcher further examined the initial coding framework which had *barriers*, *catalysts*, and *process* as labels for the major categories. Through iteration and constant comparison and higher level conceptualization, the researcher identified that some codes which clustered under *barriers* were emerging to be aspects of the central social psychological problem and some codes which clustered under *catalysts* and *process* were emerging to be stages of the emerging basic social psychological process. It was

during this higher level of concept development that the core categories steadily emerged. The researcher initially identified nine core categories as shown in Appendix T. The initial nine core categories were discussed with the researcher's dissertation committee members during a committee (peer) debriefing session. With this discussion, and with closer analysis of the categories using constant comparison, further reduction in the number of core categories occurred. The categories *new role strengthened by past medical knowledge, skills, and experiences* and *valuing differences and experiencing professional integration* were combined with the core category *combining the best of two worlds*. This process reduced the number of core categories to seven. See Table 4.4. The first core category, *experiencing burdens of a new beginning* was identified tentatively as the central social psychological problem in the natural world of the participants; the last one, *combining the best of two worlds* was identified tentatively as the basic social psychological process; and the categories in the middle were identified tentatively as the stages of the emerging substantive theory. With further concept development and focusing on the *self* as guided by the philosophical underpinnings of symbolic interaction, the name of the core category *successful transition to US nursing practice* was changed to *engaging self to nursing and asserting "I am a nurse."* Appendix U provides an illustration on how the researcher initially envisioned the relationships of these core categories through clustering.

As the core categories were emerging and developing, selective sampling of data was accomplished by theoretical sampling. As discussed in Chapter Three, theoretical sampling purposively brings the researcher to sources known to have relevant data for the phenomenon under study to enable her to confirm, challenge or expand the emerging theory (Glaser &

Table 4.4

*The Seven Core Categories*

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Core Categories

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Experiencing burdens of a new beginning  
Letting go of professional identity as physician  
Experiencing growing pains  
Nursing as saving grace  
Gaining authority to practice as nurse  
Engaging self to nursing and asserting “I am a nurse”  
Combining the best of two worlds

---

Strauss, 1967). To illustrate how the researcher accomplished theoretical sampling, the following example is given:

In the interview with Dante, he gave a discourse that it was good being a physician in the past, but he said that “this is how it is now and that you can’t keep dwelling on that.” The researcher was building on the concept of *letting go from being a physician* and so she sought participants that were within the inclusion criteria but of different ethnic origin to continue to expand, or challenge, or confirm the emerging concept. The researcher was led to Zaida, who was from a country different from Dante, who said that since she moved to this country she no longer regarded herself as a physician. “I’m not a doctor since I moved to this country. So I’m not a doctor” (Zaida). Another participant was sought to explore *letting go from being a physician*, and Rachel provided her view, “I’m a nurse. I studied and graduated as a medical doctor, took up nursing course afterwards and now, I am working here in the United States as a nurse. I am a nurse right now!”



Another example that illustrated theoretical sampling was when the researcher discovered that the mentor-mentee or preceptor-preceptee relationship which was conceptualized as *willingness to accept the wisdom of others* came up as a catalyst in the development of nursing identity in Physician-Nurses, the researcher moved on to a participant who possessed the characteristics as defined in the inclusion criteria and who was employed in a healthcare facility that was known by the researcher as having a strong transition program for new nurses. This allowed her to gather richer data as informed by the emerging concept *willingness to accept the wisdom of others*.

During concept development, the researcher also conducted selective sampling of literature. As core categories were emerging, the researcher concurrently conducted literature review to determine what has been published regarding the emerging core categories. During concept development, the iterative process of constant comparison continued as well as memoing or memo-writing and it became evident during the process that the themes were coming together in new ways toward the emergence of core categories and a basic social psychological process. An example of selective sampling of literature was related to the core categories *experiencing burdens of new beginning*. To illustrate, the researcher wrote a memo as follows:

I think there are three dimensions of the central problem. These dimensions have something to do with the *self*—the new self in the context of a new culture and a new profession and the resultant new self-concept that comes with the diminished position in the socio-cultural strata. The literature is rich with information about people adjusting to new places; adjusting to new ways of life. *[This was when I turned to the literature about non US-native nurses and nursing students and the problems that they encounter in their transition to US ways and to US nursing practice.]*

### *Concept Modification and Integration*

Concept modification and integration was conceptualized by the researcher as akin to Strauss and Corbin's selective coding and Glaser's theoretical coding. As such, this phase moved the grounded theory analysis toward higher levels of theoretical abstractions. While the researcher became very immersed with the data in the previous phase, she had to step back during this phase to enable her to obtain a fresher perspective on the data and on the concepts that were emerging before delving deeper into discovering the relationship between concepts and categories. In this phase, keeping in mind the tentative central social psychological problem that had been identified in the previous phase, the researcher continued to explore and examine the core categories and pulled the categories toward a main phenomenon, one that represented a central theme which was the basic social psychological process. The basic social psychological process was the strategy that was employed by the participants to address the central social psychological problem that they experienced in the process of their transition to nursing.

In order to accomplish the main aims of this phase of data analysis, the researcher defined the properties of the core categories, formulated hypotheses, identified the links between the categories, identified theoretical codes, explored for range and variation, change over time and diagrams of the relationships between the categories (Chenitz & Swanson, 1986). The codes and concepts that were formed in Level 1 or open or substantive coding, and the concepts that evolved and developed during Level 2 coding or clustering were modified as deemed necessary and integrated during this phase of the data analytic process. In this phase of the analytical process, the loosely formulated categories were ordered and linked into a logical whole through the process of questioning and constant comparative analysis method.

As discussed in Chapter Three, questioning occurred during this phase of the analysis. The main question that the researcher asked in this phase was: What is the central social psychological problem that is being dealt with by the participants? What processes are helping the participants cope with this central problem? (Speziale & Carpenter, 2003). Theoretical coding utilizing the coding family of 6Cs (refer to Table 3.2), and other coding families which included process, dimensions, strategy, identity-self and cutting point or critical juncture (Glaser, 1978) was conducted. Completion of this phase was facilitated by using the network builder in ATLAS.ti. Theoretical coding enabled the researcher to firm up the central social psychological problem and the emerging core categories and facilitated the discovery of the corresponding basic social psychological process that addressed the central problem.

Theoretical coding was the phase of the coding process whereby the researcher integrated all the coded data with the corresponding concepts and constructs that have emerged toward the development of a grounded theory. During this phase of high-level abstraction, the researcher made deliberate and discriminate choices about what sample and data to use to provide theoretical explanations.

The central social psychological problem that was identified was labeled *experiencing the burdens of a new beginning* and the corresponding basic social psychological process was labeled *combining the best of two worlds*. In-depth discussions of the central social psychological problem, the basic social psychological process, and the substantive theory are found in Chapters Five and Six. A principle to remember when discussing core categories and basic social psychological process is that a basic social psychological process is always a core category but not all core categories are basic social psychological processes.

During theoretical coding, the researcher delved deeper into the data. Memo-writing continued to capture the researcher's thoughts about what was going on with the data and with the concepts and thematic categories that have emerged. An example of a merged unedited memo written in ATLAS.ti about *experiencing the burdens of a new beginning and combining the best of two worlds* is presented here.

This can also be called "labor pains".

\*\*\* Merged with: reality shock (2009-07-03T05:39:47) \*\*\*

The *experiencing burdens of a new beginning* pertains to the struggles and challenges a person undergoes not only related to being a new immigrant but also related to being in a new profession.

>>-Comment/body for "reality shock":

Thinking about the life-changing events that the participants have experienced: moving to a new country; learning a new culture; and venturing into a new professional world, I cannot help but think of the "shock" (cultural and reality) they have been through. Reality shock is when a person becomes paralyzed by the overwhelming nature of the events in his/her life.

"Shock, as used in the construct of reality shock, means the total social, physical, and emotional response of a person to the unexpected, unwanted, or undesired, and in the most severe degree to the intolerable. It is the startling discovery that the school-bred values conflict with work-world values" (Kramer, 1974, p.4) Culture shock is a state of anxiety precipitated by the loss of familiar signs and symbols of social intercourse when one is suddenly immersed in a cultural system markedly different from his home or familiar culture.

<<-End of comment/body for "reality shock"

\*\*\* Merged with: boredom with the basics (2009-07-03T08:58:32) \*\*\*

>>-Comment/body for "boredom with the basics":

First semester of Nursing clinical education deals with learning the basics of nursing care: tasks that are considered menial such as (but not limited to) moving, cleaning, and feeding patients, and other activities that assist patients with their Activities of Daily Living (ADLs). Physicians retraining as nurses may find these activities mundane. It is during this phase that Physician-Nurses feel challenged or frustrated with the limits of skills they could perform in the clinical setting.

Physical Assessment is also taught during first semester of nursing school. Medical education has given Physician-Nurses with a strong foundation of physical assessment

skills. Re-learning Physical Assessment from a Nursing Professor does not seem logical.

<<-End of comment/body for “boredom with the basics”

Included in this code is the concept of reality shock. One problem confronted by the new graduate nurse is the seemingly impossibility of delivering quality care within the constraints of the system as it exists....may feel powerless to effect any changes and maybe depressed over lack of effectiveness in the situation. Marlene Kramer (1974) was the first to call those feelings reality shock. She noticed that the new nurse experienced considerable psychological stress and that it may exacerbate the problem (p.471).

Reality shock occurs when the ideal becomes only a dream. It is when the ideal is out on the back burner. The focus is usually accomplishing the required tasks in the time frame allotted. Reality shock is part of the passage from novice to expert. When nurses experience reality shock, they may become disillusioned. They may either job hop or leave nursing altogether. Or they may return to school searching for the perfect place to practice perfect nursing as it was learned (Ellis & Hartley, 2001, p.472)

In the process of transitioning to nursing, *combining the best of two worlds* reflect a hybrid form of a career or vocation. It is the act of picking the best characteristics of the medical profession that is within the Nurse Practice Role and picking the best of the newly acquired profession of nursing and combining them to provide healthcare to patients. What has emerged from the data is that when the FEPs experienced the role of a nurse, they became more appreciative of the hard work nurses do to care for patients. Their experience as a full pledged nurse validates their observed differences between nursing practice in their own countries and nursing practice in the US.

### *Theorizing*

The ultimate goal of a grounded theory study is the development of a theory that explains the phenomenon of interest. Guided by the philosophical underpinnings of symbolic interactionism that human behavior occurs on two levels, namely the behavioral or interactional level and the symbolic level, the researcher moved toward the development of a theory about human behavior, about human conduct, and about human group life as it pertained to the Physician-Nurses who were participants in this grounded theory study. In the conduct of this study, the participants and researcher interacted on the behavioral and symbolic levels. On the behavioral level, the participants interacted with the researcher in

their natural world allowing the researcher to gain an understanding of the meanings they place on the events and experiences of their everyday lives as FEPs retrained as US nurses. At this level, central to their meaning-making experiences was their view of their *self* or their self-concept, particularly their view of their different and *current professional self* as a US nurse combined with their view of their original and *former professional self* as FEP. To illustrate, Adela said:

I am a doctor, but I am a nurse, too. It's like you are a mother and you are a grandmother too; and you are a sister. When I go back to [my native country], I work as a doctor because we do a mission trips and...and now I am so happy because I can work as a nurse or as a doctor...

On the symbolic level, the participants shared the meanings of events and experiences in their lives with the researcher as FEPs retrained as US nurses personifying themselves as nurses to the researcher and to others. The symbolic component of the second level of this process is the portrayal of nursing identity by the Physician-Nurses which is defined as the *persona* of a healthcare professional that portrays the expected knowledge, skills, roles, behaviors, attitudes, values, and norms that are appropriate and acceptable in the culture of the nursing profession. To illustrate, Rachel said:

At the earlier part of my nursing career, I have to remind myself everyday that I am a nurse now. But since I am already in the nursing field for 3 years, I got used to it. I know that I am living as a nurse and interacting with nurses plus the fact that I'm doing what the nurses are doing. Yes it comes naturally now since I've been in the profession for some time... I am a nurse. Working, learning and taking care of my patients as a nurse.

The researcher's theoretical sensitivity enabled her to theorize; to think inductively; to perceive categories and their relationships so as to move from the particular (data) to the general (abstract) toward the development of the theory. In this study, building from the core categories that were discovered, a substantive theory and the beginnings of a formal theory

were generated that can explain the process of nursing identity development in FEPs who have retrained as nurses.

*Verification Procedures: Establishing Trustworthiness in Qualitative Studies*

Verification is the process of checking, confirming, making sure, and being certain. In qualitative research, verification refers to the mechanism used during the process of research to incrementally contribute to ensuring reliability and validity and, thus, the rigor of the study. These mechanisms are woven into every step of the inquiry to construct a solid product by identifying and correcting errors before they are built [into] the developing model and before they subvert the analysis....good qualitative research moves back and forth between design and implementation to ensure congruence among question formulation, literature, recruitment, data collection, strategies, and analysis. Data are systematically checked, focus is maintained, and the fit of data and conceptual work of analysis and interpretation are monitored and confirmed constantly. Verification strategies help the researcher identify when to continue, stop or modify the research process in order to achieve reliability and validity and ensure rigor (Morse, Barret, Mayan, Olson, & Spiers, 2002, p. 9).

By tradition, the concepts of validity and reliability have been claimed with exclusivity by quantitative researchers (Bloomberg & Volpe, 2008; Polit & Beck, 2004); however, some qualitative researchers argue that they are appropriate terms to describe the concepts for attaining rigor in qualitative research studies (Morse, Barret, Mayan, Olson, & Spiers, 2002). In quantitative research, validity is defined as the “degree to which something measures what it purports to measure and reliability is the consistency with which it measures over time” (Bloomberg & Volpe, 2008, p. 85). The researcher in this current study does not oppose the use of the terms validity and reliability in establishing rigor in qualitative studies because she believes that these concepts have their right place in qualitative research; however, she believes that the term trustworthiness is more inclusive. Lincoln and Guba (1985) advocated the use of the term trustworthiness to denote rigor in qualitative research. Their proposition which has the four criteria of (a) credibility, (b) dependability, (c) confirmability, and (d) transferability is considered the gold standard for qualitative

research assessment. Using concepts in quantitative research as parallels, each criterion is discussed.

### *Credibility*

Credibility is the parallel of validity in quantitative research. This criterion determines the match between the participants' perceptions with that of the researcher's portrayal of them. It determines the level of accuracy by which the researcher represents the participants' thoughts, feelings, and actions (Bloomberg & Volpe, 2008). It "refers to confidence in the truth of the data and interpretations of them" (Polit & Beck, 2004, p. 430). Onwuegbuzie and Leech (2007) sub-categorized credibility into internal credibility and external credibility. Their definitions of the sub-categories overlap with the other criteria as defined by Lincoln and Guba. Internal credibility is defined as "the truth value, applicability, consistency, neutrality, dependability, and/or credibility of interpretation and conclusions within the underlying setting or group (Onwuegbuzie and Leech, 2007, p. 234). External credibility, on the other hand, pertains to the confirmability and transferability of findings and conclusions. It is defined as "the degree that the findings of a study can be generalized across different population of persons, settings, context, and times" (Onwuegbuzie and Leech, 2007, p. 235). Polit and Beck (2004) provides a list of techniques for improving and documenting the credibility of qualitative research which includes (a) prolonged engagement and persistent observation, (b) the four major types of triangulation (data, investigator, method, and theory) (c) peer debriefing, (d) member checking, (e) searching for disconfirming evidence, and (f) researcher credibility. Not all these techniques were utilized in this study. The techniques that were utilized will be discussed in the section of this report entitled Establishing Trustworthiness in this Current Study.



### *Dependability*

Dependability is the parallel of reliability in quantitative research. This criterion determines whether the processes and procedures used to collect and interpret the data in a specific qualitative research study can be tracked (Bloomberg & Volpe, 2008), and it determines the stability of qualitative data over time and over conditions (Chenitz & Swanson, 1986; Polit & Beck, 2004). As noted in the discussion of credibility, Onwuegbuzie and Leech (2007) uses dependability as part of their definition of internal credibility. Bloomberg and Volpe (2008) instructs qualitative researchers, "...you are expected to be able to describe in detail your analytic approach and to show that you are able to demonstrate how you got from your data to your conclusions. This step is necessary to enhance both the credibility (validity) and dependability (reliability) of your study" (p. 99). Polit and Beck (2004) recommends two approaches that can be employed to assess the dependability of data namely (a) stepwise replication , and (b) inquiry audit.

### *Confirmability*

Confirmability is the parallel of objectivity in quantitative research. Objectivity is the notion that the findings in the study are the results of research and not merely the manifestation of the subjective biases and prejudices of the researcher (Bloomberg & Volpe, 2008). It is the perceptual congruence that can likely occur between two or more people regarding the accuracy, relevance, or meaning of the data and research findings (Polit & Beck, 2004). According to Polit and Beck, confirmability can be established by developing an audit trail. An audit trail consists of records and documents that are systematically compiled that allow an independent auditor to make conclusions about the data. Examples of records for

audit trail may include the raw interview data and field notes, data reduction and analysis products, and drafts of the final report.

### *Transferability*

Transferability is the parallel of generalizability in quantitative research.

Transferability is the concept that findings of the research study can be transferred to other settings, persons, groups, context, and times (Bloomberg & Volpe, 2008; Polit & Beck, 2004). Onwuegbuzie and Leech (2007) liken transferability to external credibility. From the perspective of consumers of the final research product, transferability is how well they grasped or understood the entire research project as it occurred at the research site, and how well such understanding would help them decide if similar research can work in their own settings and communities. To achieve transferability, the researcher must therefore provide rich and thick descriptions in the research report (Bloomberg & Volpe, 2008) to enable others to evaluate if the data can be applied in other contexts (Polit & Beck, 2004).

### *Establishing Trustworthiness in this Current Study*

The inherent threats to trustworthiness in qualitative studies existed in the conduct of this research study; therefore, the application of the aforementioned verification procedures was critical. The researcher established trustworthiness by employing methods that ensure rigor which have been recommended by influential authorities in qualitative research (Polit & Beck, 2004). In employing methods to increase rigor in this study within the framework of the four criteria of qualitative study trustworthiness (credibility, dependability, confirmability, and transferability), it is noted that some of the methods overlap in their functions. The various methods are discussed with illustrations on how they were applied in this study and a summary is presented in Table 4.5.

Table 4.5

*Summary of Criteria and Methods for Establishing Trustworthiness in Current Study*

Trustworthiness Criteria	Meaning of Criteria	Application of Concepts in this Study
Credibility	Match between participant perception with researcher's portrayal	<ul style="list-style-type: none"> <li>▪ Prolonged engagement and persistent observation</li> <li>▪ Data triangulation</li> <li>▪ Investigator triangulation</li> <li>▪ Peer debriefing</li> <li>▪ Member checking</li> <li>▪ Researcher credibility</li> </ul>
Dependability	Processes to collect and interpret qualitative data can be tracked	<ul style="list-style-type: none"> <li>▪ Use of ATLAS.ti qualitative data analysis software</li> <li>▪ Audit trail</li> </ul>
Confirmability	Findings are results of research, not researcher bias	<ul style="list-style-type: none"> <li>▪ Controlling researcher-bias</li> <li>▪ Bias A and Bias B-reduction strategies</li> <li>▪ Audit trail</li> </ul>
Transferability	Findings can be transferred to other settings, people, context	<ul style="list-style-type: none"> <li>▪ Rich and thick descriptions by using direct quotes from participants</li> </ul>

*Credibility*

*Prolonged engagement and persistent observation.* The researcher was aware that the threat of unintentional observational bias existed in the conduct of this study. Cognizant that this type of threat may arise at the research design or data collection stage due to the insufficient sampling of behaviors or words from the study participants (Onwuegbuzie & Leech, 2007), the researcher used strategies to prevent this to occur. Inadequate sampling of behaviors usually occurs if either prolonged engagement or persistent observation does not prevail (Lincoln & Guba, 1985; Onwuegbuzie & Leech, 2007). Prolonged engagement and persistent observation imply that the researcher allocates sufficient time with the study

participants to allow for an in-depth understanding of the culture and views of the study population and the phenomenon under study. In this study, prolonged engagement with the participants was accomplished via follow-up e-mail and telephone communications, and persistent observation was accomplished by being immersed in the phenomenon under study by virtue of being a clinical professor for a group of FEPs retraining as nurses.

*Data triangulation.* To obtain sufficient sampling of behaviors and words from the participants, data triangulation was utilized. “Data triangulation involves the use of multiple data sources for the purpose of validating conclusions” (Polit & Beck, p. 431). A general statement can be stated that the multiple data sources utilized in this study to represent data triangulation were the words and behaviors of the participants obtained through face-to-face and telephone interviews, participant observation, and researcher field notes. The participants were the main data sources. The other data sources included extant literature that was directly and indirectly related to the phenomenon under study, and the observations and insights provided by a faculty member currently teaching a group of FEPs to become nurses.

A more specific discussion about data triangulation as applied in this study involves the three basic types of data triangulation: time, space, and person. In time triangulation, data collection is conducted at different times on the same phenomenon or on the same population. Different times may mean different time points of the day or of the year. Time triangulation is analogous to the test-retest reliability assessment whose purpose is not to study the phenomenon longitudinally but to determine the congruence of the phenomenon across times (Polit & Beck, 2004). Time triangulation was applied in this study with data collection occurring at different times of the day and at different times of the year as well as different days of the week. The researcher conducted interviews at night for Physician-Nurses working

the 7:00PM to 7:00AM shift. Interviews were also done on weekdays and weekends over a period of one year. The second basic type triangulation is space triangulation. This occurs when data collection on the same phenomenon is done at multiple sites. The purpose of space triangulation is to validate consistency across sites (Polit & Beck, 2004). Space triangulation was applied in this study by collecting data in two geographical sites—Florida and Nevada. The third basic type of triangulation is person triangulation. This type of data triangulation entails the collection of data from different levels of persons: individuals, groups, and collectives such as institutions. The purpose of person triangulation is to validate data by acquiring multiple perspectives on the phenomenon (Polit & Beck, 2004). In this study, the person triangulation was applied by acquiring data from the three different levels of persons. The individual level of persons was represented by each of the participants. Each one offered unique perceptual perspectives about the phenomenon because of their various ethnicities and different physician and nurse characteristics. The group level of persons was represented by the two distinct groups of Physician-Nurses that currently exist in the US, namely: (a) the group of former physicians already residing in the US who became Physician-Nurses by attending nursing school in the US, and (b) the group of former physicians from the Philippines who intentionally retrained as nurses while still in their home country. Members of each group consisted of the same individuals from the individual participant pool; however, as members of a specific Physician-Nurse group, each individual added a different level of unique perceptual perspective regarding the phenomenon. As an example, the primary motivation for interprofessional migration of the Physician-Nurses belonging to the group originally from the Philippines was their desire to facilitate their migration to the US. The last level of person triangulation is the collective level of persons. Conceptually, the faculty

member currently teaching a group of foreign-educated physicians retraining as nurses can represent the collective level of persons in this context of person triangulation because she symbolizes the institution of learning where the individual participants obtain their training as nurses. The faculty member provided her insights and observations regarding the phenomenon, the population being studied, and the evolving substantive theory.

My perspective is that the stages of your evolving theory are not linear. They have cyclical characteristics. For example, the quotes that you provided to support Stage Two, *experiencing growing pains*, and Stage Three, *seeing nursing as a saving grace*, seem to reflect participants' perceptions both before and after they have obtained their nursing license. (D. Allado).

*Investigator triangulation.* Investigator triangulation is a second major type of triangulation. This concept requires that “two or more researchers analyze and interpret a data set” (Polit & Beck, 2004, p. 431). The researcher's ATLAS.ti consultant, Nick Woolf, served as the second researcher to analyze and interpret the data. Collaboration between the two researchers occurred through online technology. An example of this collaboration is demonstrated in the following excerpts of e-mail communication exchange:

You have done a truly outstanding job in conceptualizing your data. Everything so far is in reasonable proportion – numbers of quotations and codes, and amount of memo writing in the code comments. The codes are of very high quality, and the comments insightful and clearly written. If we are thinking about the Strauss and Corbin Grounded Theory process, you have done all your open coding, with many exploratory forays into the axial coding process, i.e., the second phase of identifying some core categories and relating some of the other concepts to it. You have done it in hierarchical form (because I suggested it), starting out with barriers, catalysts and process. This has just been an organizing framework to get your concepts sorted out and in a little bit of order, particularly in clearly separating barriers from catalysts. But the hierarchy isn't really going anywhere further. It is not really a hierarchy, for example, you may have three codes underneath another code, but linked with relations that are not “class inclusion” relations. This shows you are clear what those relations are and they are great, but it is not hierarchical (e.g., “appeal of nurse autonomy” is a dimension of “conscious decision to become a nurse”, and “conscious decision to become a nurse” in turn supports “sticking it out with determination”, and also influences “recognizing that nursing and medicine are different...”. This is all great

and clear, but it does not mean “conscious decision to become a nurse” has three sub-codes or branches underneath it. And it doesn’t need to. Also, many codes have single codes underneath them for three or four levels. This is not a hierarchy either. But the tree structure has been a help in thinking out what the concepts are, but has not allowed you to fully represent your whole story accurately in a hierarchical way, because your theory is not going to be hierarchical. You have gone as far as you need with the hierarchy as an aid to open coding conceptualizing. You now have many components of a potential theory, and lots of insights written out on the components. Now you are ready for the next step...theorizing, and you so far have a number of concepts as components of a theory that you are now thinking out... pick the six to ten most significant codes you would like to talk about, the ones with the most meat on them, the ones that interest you the most, and once you have picked them, add all the codes already linked to them. Then think whether you would like to talk about them separately and independently, in any order, as yet unconnected or maybe when you look at them they unexpectedly form a sequence, making it feels like it [makes] most sense for you to talk about them in a certain order, or maybe you will accidentally discover they are related in a different way.

The four core categories below don’t ring true to me [successful reprofessionalization to nursing, reprofessionalization to nursing, physician-nurse integrative practice, professional integration to nursing]. They are rather empty. They may end up being titles or chapter headings possibly, but they are not high quality qualitative concepts to use as core categories.

My one concern is the code “cultural differences”, with 62 quotations, way more than any other code. A couple of codes have almost as many, i.e., “engaging self...” and “experiencing burdens...”, but they are “high quality” codes in gerund form that tell their own story. They just have lots of evidence. “Cultural differences” in contrast is not telling a story and has tons of data. It looks like this area has not been conceptualized as all the other areas have. This may need further open coding work.

The next step is to actually create the theory. This involves identifying the core categories, like the above process but more carefully and systematically, picking the best ones, and relating all the other concepts to them (N. Woolf, personal communication, July 18, 2009).

*Peer debriefing.* Peer debriefing is a technique used to establish credibility through external validation (Polit & Beck, 2004). Initial findings of this research study was presented to five faculty members of the FEP-to-BSN Program at FIU on July 20, 2009. Although not pre-planned as a peer debriefing session, the meeting with the faculty members provided the opportunity for the researcher to present emerging categories and obtain feedback from a

group of faculty members familiar with the study population. The faculty in attendance agreed that *letting go of professional identity as physician* must occur in FEPs retraining as nurses. Feedback regarding naming the emerging theory was also received.

The members of the researcher's dissertation committee represented another peer group that provided external validation. One-on-one sessions with individual members of her dissertation committee, and group meetings with them provided the researcher the opportunity to present and discuss written and oral summaries of the data that have been analyzed and to discuss the categories and themes that were emerging. During a debriefing session on September 9, 2009, committee members reviewed the emerging core categories and provided validation of concepts as well as feedback for further reduction in the number of core categories.

*Member checking.* Member checking, also known as informant feedback, was another technique employed by the researcher to ensure credibility. It is the most effective way of eliminating the possibility of misrepresentation and misinterpretation of the voices of the participants and it is considered the most critical technique in establishing credibility (Lincoln and Guba, 1985; Onwuegbuzie & Leech, 2007; Polit & Beck, 2004). This process involves the systematic process by which feedback about one's data is obtained (Onwuegbuzie & Leech, 2007). Member checking can be conducted during data collection and analysis, and during data interpretation. This technique gives the participants an active role in assessing the credibility of the researcher's account. Although the function of member checking is significant in establishing credibility, issues exist pertaining to its conduct. In the most ideal circumstance, a qualitative researcher anticipates the participation and cooperation of all participants in the process; however, the reality is that some participants may be unwilling to



participate. Another issue is that member checking may lead to misleading conclusions if participants' expression of agreement or lack of expression of disagreement with the data interpretation is influenced by their desire to be polite toward the researcher or in their belief that the researcher's analysis and interpretation of the data must be accurate because the researcher is someone more knowledgeable than they are (Polit & Beck, 2004).

Member checking can be conducted informally during study data collection phase and formally when data have been analyzed. It can be accomplished through the exchange of written correspondence or through face-to-face or telephone conversations between the researcher and the participants. In this study, it was undertaken as an attempt to maximize descriptive validity and it was conducted at two different times. The first one was conducted during data collection and it was accomplished by e-mail communication, voice telephone as well as texting, and face-to-face follow-up conversation. A random number of eight interview transcriptions were returned to their owners. Two participants responded to the researcher and validated accuracy of information and provided clarifications regarding some of their insights as originally captured in the verbatim transcriptions. Two additional participants provided corrections on their demographic data. The second time that member checking was conducted was after data analysis. Invitations were sent via e-mail and telephone text messaging to seven participants to request them to participate in member checking. In addition, a face-to-face encounter with one of the participants in the researcher's work setting provided the opportunity for the researcher to invite her to participate in member checking. Zaida agreed to provide her feedback to the researcher. Member checking was conducted face-to-face and she expressed agreement to the analysis and interpretation of the data. Zaida confirmed the reality and truth of the burdens of a new beginning and the logic of the stages of the substantive

theory and the phases of the formal theory. One other participant, Rachel, agreed to participate in member checking. Due to schedule conflicts, member checking with Rachel was conducted through electronic communication. Like Zaida, Rachel confirmed the reality and truth of the burdens of a new beginning, except for the burdens of starting from zero. Rachel, having strong family ties in the US, did not experience this dimension of the burden but she experienced the burdens of crossing cultures and crossing professions. Rachel also validated the stages of the substantive theory.

*Researcher credibility.* The researcher in this study is a clinical professor for a multi-ethnic group of foreign-educated physicians retraining to become baccalaureate-prepared nurses. She obtained formal training in qualitative research methods in the classroom setting and acquired qualitative research skills in the field through the mentorship of various expert researchers. Her dissertation committee is comprised of members who are doctorally-prepared registered nurses, and her ATLAS.ti consultant has a Ph.D. in instructional design who has taught qualitative data analysis in various fields since 1973.

#### *Dependability*

The ability to track the analytic approach established the dependability of this research project. Dependability was enhanced by utilizing ATLAS.ti computer assisted qualitative data analysis software. ATLAS.ti facilitated qualitative textual data management and analysis and created the audit trail for this research project.

#### *Confirmability*

Similar to the criterion of dependability, an audit trail was created consisting of raw interview data and field notes, data reduction and analysis products, and drafts of the final report to enhance confirmability or objectivity of this research study. Having an audit trail and

employing techniques to control biases enhanced confirmability. Researcher bias was possible because the researcher shared some similar sentiments with the participants: she experienced culture shock and reality shock when she first immigrated to the US; she has Physician-Nurses in her professional and personal social circles; and she has a significant number of pre-existing biases and assumptions as listed in Chapter One. In this study, the researcher ensured that procedures were in place to control for researcher bias. Being honest and open about her biases was critical. A reflexive journal kept the researcher's biases in check.

Researcher bias can be one of two categories. Bias A is the effect of the researcher on the case, and Bias B is the effects of the case on the researcher. Bias A may occur when the researcher disrupts the existing social or institutional relationships, and the participants may alter their responses to be congruent with what they perceive as what the researcher might want to see, hear, or observe. Bias A may also cause the participants to boycott the researcher because she may be viewed as an adversary; thus maybe considered a nuisance, spy, or voyeur. Bias B may occur when the researcher becomes native (Miles & Huberman, 1994).

Bias A-reduction strategies that were employed in this study included (a) the provision of a clear description of the purpose of the study to each participant, (b) prolonged engagement with the participants via e-mail and telephone communications, (c) persistent observations via follow-up communications with participants and by being a clinical professor for a group of foreign-educated physicians retraining as nurses, and (d) member checking. Bias B-reduction strategies included (a) examination of potential participant bias, and (b) firmly keeping research the question in mind.

### *Transferability*

To enhance transferability, the researcher provided rich and thick descriptions of perceptual text data in this research report by using appropriate and relevant quotes of participants.

### *Chapter Summary*

In this chapter, the rationale for using a qualitative research design and grounded theory methodology was discussed. A qualitative design was deemed appropriate for this study because very little is known about interprofessional migration and about Physician-Nurses and about the development of their nursing identity. When very little is known about a phenomenon, an appropriate study design would be one that generates theory rather than one that tests theory. Grounded theory was chosen as the research method because it is a research tradition that allows for the generation of a theory about a dominant social process such as in this current study.

This chapter reported how the researcher conducted the research. Data collection commenced after the approval to conduct the study was obtained from the USF IRB. The researcher was the primary research instrument. The process of informed consent was followed. Twelve Physician-Nurses of various ethnicities from a potential pool of 47 agreed to participate. They were recruited through purposive, snowball, and theoretical sampling. Prior to their interviews, they completed a 21-item demographic data instrument. The demographics collected were their personal and immigrant characteristics, their characteristics as nurses, and their characteristics as physicians. They were interviewed using a set of 10-interview guiding questions. Interviews were audio tape recorded and transcribed verbatim by a paid transcriptionist. The researcher ensured accuracy of transcription. After accuracy was

ensured, the interview transcriptions were imported to ATLAS.ti to facilitate data analysis. In addition to participant interviews, data was also generated from participant observation, field notes, faculty of FEP nurse retraining program, and literature. The iterative constant comparative method was used for data analysis. Concept formation, development, modification and integration were accomplished through open/substantive, clustering/axial coding, and selective/theoretical coding. Seven core categories were discovered and a central social psychological problem and a basic social psychological process emerged. Further theorizing allowed for the discovery of a substantive theory as well as the emergence of the beginnings of a formal theory.

Discussion about establishing rigor and ensuring trustworthiness of qualitative studies was also undertaken in this chapter. It was discussed that by tradition, the concepts of validity and reliability have always been claimed by quantitative researchers; however, some qualitative researchers argue that these terms can also be used appropriately in qualitative research studies. The researcher in this study does not oppose the use of the terms validity and reliability in establishing rigor in qualitative studies; however, she favors what Lincoln and Guba (1985) advocated as the gold standard for qualitative research assessment, i.e., the use of the term trustworthiness to denote rigor in qualitative research. The four criteria for establishing trustworthiness are (a) credibility, (b) dependability, (c) confirmability, and (d) transferability. Using concepts in quantitative research as parallels, each criterion was discussed. Credibility which is the congruence between participant's perceptions and researcher's portrayal of them is the parallel of validity in quantitative research. Dependability which requires that processes to collect and interpret qualitative data can be tracked is the parallel of reliability. Confirmability which means that findings are the results of research

and not researcher bias is the parallel of objectivity; and transferability which means that findings can be transferred to other settings, people, and context is the parallel of generalizability.

The concepts of establishing trustworthiness were applied in this study. Using as framework the four aforementioned criteria of establishing trustworthiness in qualitative studies, methods that were employed to increase rigor in this study were discussed. It was noted that some of the methods overlap in their functions. The various methods were discussed. To ensure credibility, the following methods were utilized: (a) prolonged engagement and persistent observation, (b) data triangulation, (c) investigator triangulation, (d) peer debriefing, (e) member checking, and (f) researcher credibility. To ensure dependability by creating an audit trail, ATLAS.ti was utilized. To ensure confirmability, Bias A and Bias B-reduction were employed. Bias A-reduction strategies included (a) the provision of a clear description of the purpose of the study to each participant, (b) prolonged engagement with the participants via e-mail and telephone communications, (c) persistent observations via follow-up communications with participants and by being a clinical professor for a group of foreign-educated physicians retraining as nurses, and (d) member checking. Bias B-reduction strategies included (a) examination of potential participant bias, and (b) firmly keeping research the question in mind. To ensure transferability, this research report contains rich and thick descriptions of appropriate and relevant quotes of participants.

The next chapter, Chapter Five, will present the findings and discussion of the study. Theoretical explanations of the central social psychological problem and the basic social psychological process and the interrelationships of the concepts which form the substantive theory will be discussed.

## Chapter Five

### Findings and Discussion

*I am a doctor, but I am a nurse, too. It's like you are a mother and you are a grandmother too; and you are a sister. ~Adela*

This chapter presents the findings of this research study. The purpose of this grounded theory study was to generate a theory that can explain the basic social psychological process that influenced the development of nursing identity in FEPs who have retrained as nurses and who are now practicing in the US. The specific aims were to discover barriers that participants perceived as problematic in their transition to nursing and catalysts that influenced how they addressed the central problematic issue they articulated. As a grounded theory study, core categories emerged and a central social psychological problem that was experienced by the participants in the process of their transition from being FEPs to being US nurses as well as a resultant basic social psychological process was discovered. Basic social psychological process is the basic concept in grounded theory that illustrates a social psychological process that addressed the issues participants experienced as problematic in their natural world (MacIntosh, 2003). In this chapter, the central social psychological problem is referred to as the *central problem* and the basic social psychological process is referred to as the *basic process*. In presenting the findings, the barriers are conceptualized as properties of the central problem and the catalysts are conceptualized as properties of the stages of the substantive theory; therefore, the terms barriers and catalysts are not used.

The discovery of a central problem and a basic process is congruent with what Glaser (1978) advocated in the conduct of a grounded theory study which was to search for social psychological problems and processes and to view them as essential to understanding people's patterns of behavior. The name assigned to the central problem that was discovered in this study is *experiencing the burdens of a new beginning* and the basic process that emerged which explains how the participants addressed the central problem is *combining the best of two worlds*. The central problem has three dimensions and the basic process has five stages. The three dimensions of the central problem occurred within the context of the participants' new society, new self-concept, and new profession. As immigrants in the US, the participants experienced three dimensions of burdens namely: (a) crossing cultures, (b) starting from zero, and (c) crossing professions.

In *combining the best of two worlds*, the *two worlds* that are implied are the professions of nursing and medicine; and the phrase *combining the best* implies the act of taking the good things about being a physician (the original self) and taking the good things about being a nurse (the new self) and blending them together to practice in the US healthcare system within the scope of the nursing profession. The five stages of the basic process *combining the best of two worlds* are: (a) letting go of professional identity as physician, (b) experiencing growing pains, (c) seeing nursing as a saving grace, (d) gaining authority to practice as a nurse, and (e) engaging self to nursing and asserting "I am a nurse." What forms the substantive theory of *combining the best of two worlds* to cope with *experiencing the burdens of a new beginning* is the logical combination of the dimensions of the central problem and the stages of the basic process and the various interconnected concepts. Figure 5.1 provides a skeleton framework of the central problem and the basic process, and serves as



a precursor to the explanatory model. Figure 5.2 provides the detailed framework of the substantive theory which shows the relationships among the concepts and serves as the explanatory model. The relationships as shown in Figure 5.2 resulted from selective coding and theoretical coding using the coding family of 6Cs (Table 3.2) and other relevant coding families namely process, dimension, strategy, identity-self, and cutting point or critical juncture (Glaser, 1978).

The first part of this chapter discusses the dimensions of the central problem and the second part discusses the stages of the basic process. To illustrate the findings, direct quotations from participants are used throughout the discussion.

*The Central Social Psychological Problem:*

*Experiencing the Burdens of a New Beginning*

*... Because you have to start everything over again. You start at zero. It really start[s] zero—your career, your financial, your everything, your social status. You start it over again.*  
~Zaida

The central problem *burdens of a new beginning* as experienced by the participants was identified as an all-encompassing problematic issue pertaining to the various aspects of their resettlement to the US. The various new aspects in their real world were identified as their new society, their new self-concept, and their new profession. From these three new aspects which were related to their resettlement in a new country, three dimensions of burdens emerged. These three dimensions of burdens were identified as (a) burdens of crossing cultures in the context of their new society and the accompanying issues of their new socio-cultural environment; (b) burdens of starting from zero which pertained to their new self-concept as new US immigrants and the inherent issues of assuming a lower social status in their new society; and (c) burdens of crossing professions which pertained to their seeking a

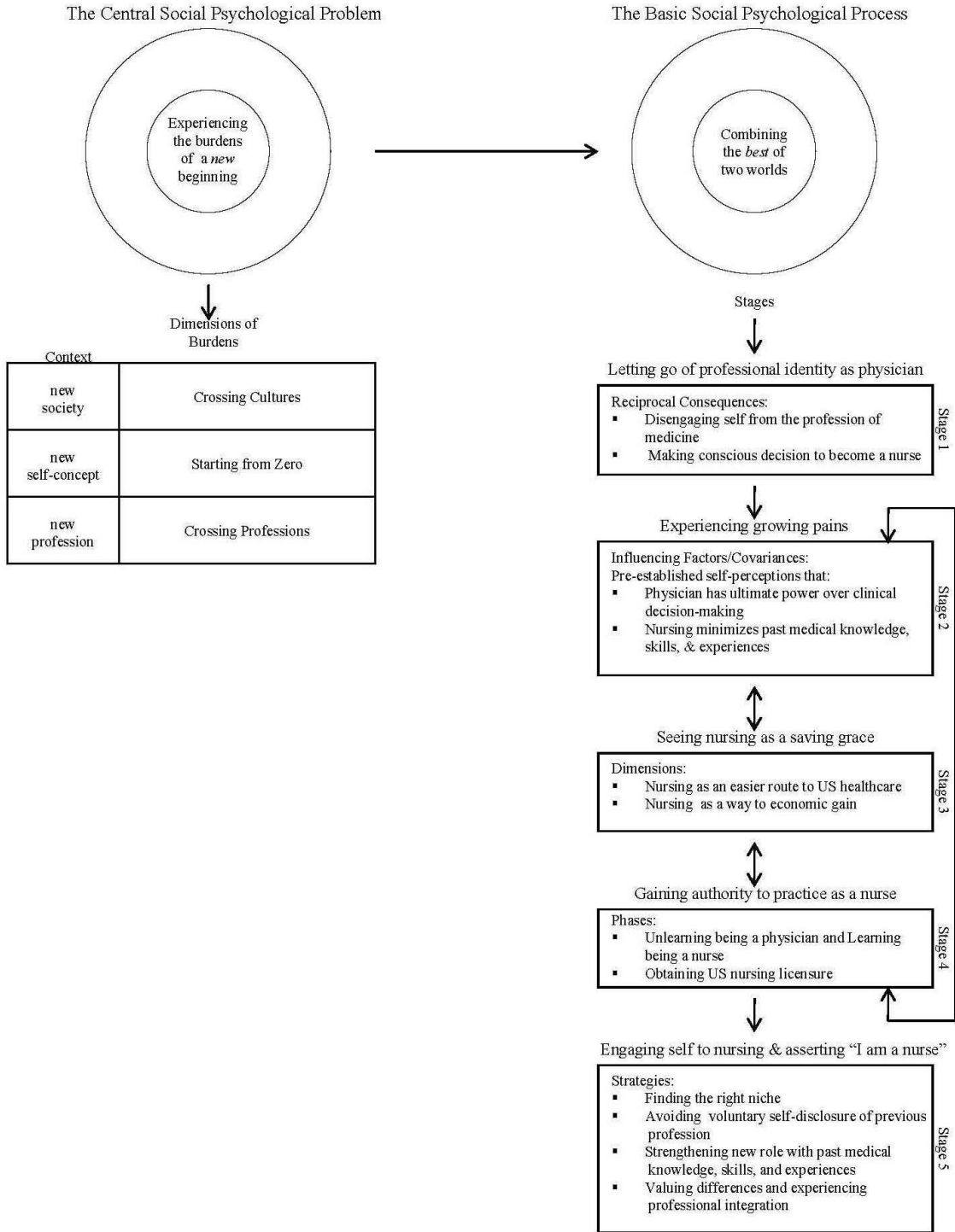


Figure 5.1. A Precursor to the Explanatory Model: The Central Social Psychological Problem of *Experiencing the Burdens of a New Beginning* and the Basic Social Psychological Process of *Combining the Best of Two Worlds*

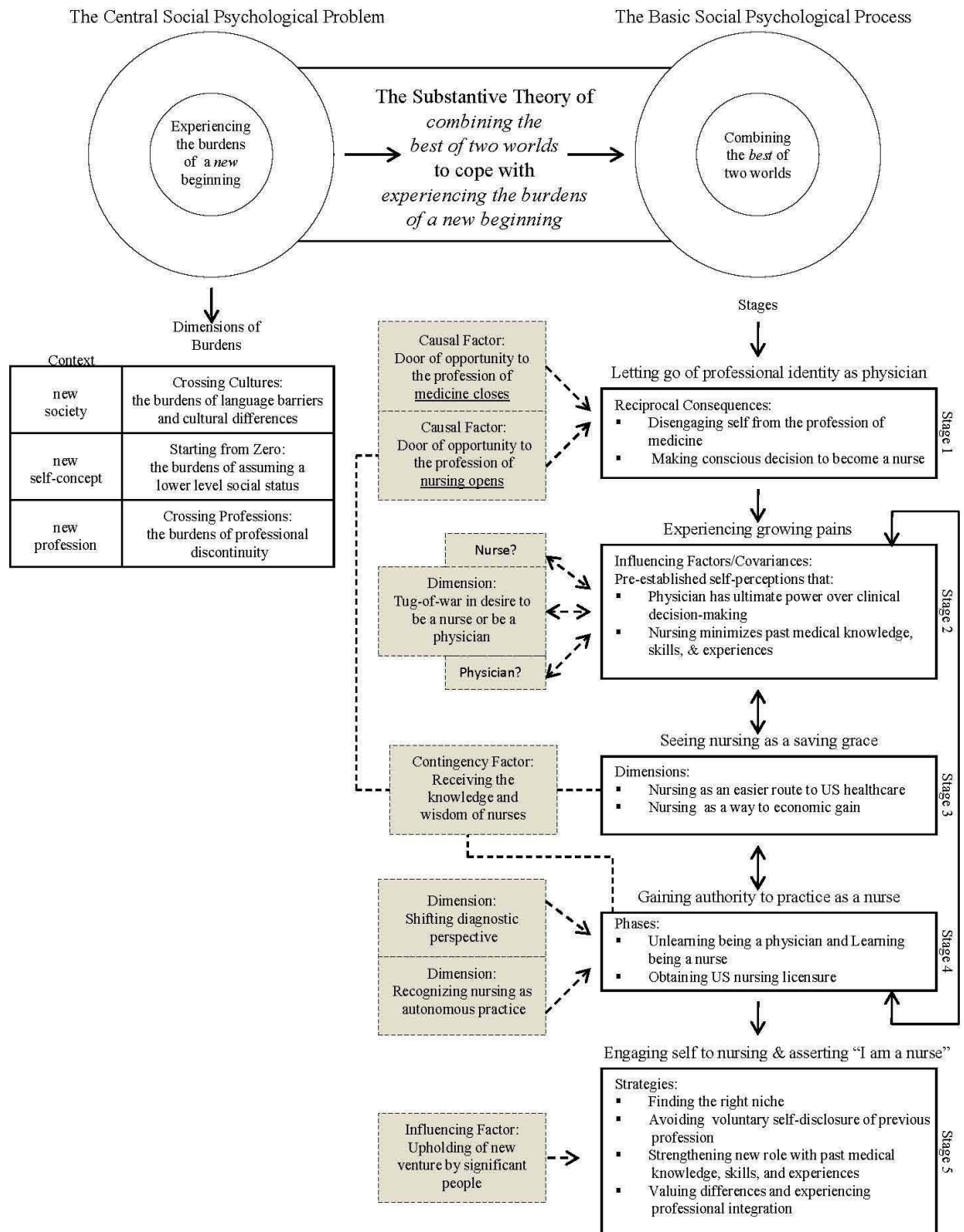


Figure 5.2

Explanatory Model: The Substantive Theory of *Combining the Best of Two Worlds*

new profession necessitated by the professional discontinuity that occurred with their immigration and resettlement in the US.

All the participants expressed their difficulties in starting a new life in a new place and their concerns about being different from the members of the mainstream of their new society. They expressed concerns about cultural differences, specifically language; about personal matters such as worrying and feeling depressed because of starting life over again and about feeling behind in every aspect of life; and about professional matters for being unable to start meaningful work because of immigration laws and professional regulations. Table 5.1 provides a summary of the participants, their home countries, their native language, and their original work in the US.

#### *The Burdens of Crossing Cultures*

The findings in this study showed that the first dimension of the central problem was *experiencing the burdens of crossing cultures*. Crossing cultures (DeLuca, 2004) particularly adjustments to new communication styles and new language, was expressed as burdensome by the participants. To illustrate the impact of language barriers, a sampling of the voices of the participants is presented in Table 5.2. Participants who were from the Philippines did not express that language was a main concern except for Arnel who verbalized that he had previously experienced problems communicating due to his thick Filipino accent. He said, “It’s really communication issues itself. Your first time in here, you still have those [thick Filipino] accent; so some challenges.” Professionals from the Philippines usually have a good command of English because English is the medium of instruction in high schools, colleges,

Table 5.1

*Cultural, Employment, and Training Background of Participants*

Pseudonym	Native Country	Native Language	Employment in the US Before Nursing	Location of Nursing School
Adela	Nicaragua	Spanish	Unemployed by choice while preparing for USMLE	United States
Alina	Russia	Russian	Office Clerk, Telemetry, Technician, C.N.A.	United States
Annabelle	Philippines	Pilipino	Unemployed while waiting for work permit as a nurse	Philippines
Arnel	Philippines	Pilipino	Unemployed while waiting for work permit as a nurse	Philippines
Dante	Philippines	Pilipino	Fastfood worker; care staff and community guide for a group of mentally retarded population	United States
Ollie	Philippines	Pilipino	Unemployed while waiting for work permit as a nurse	Philippines
Maira	Colombia	Spanish	Home Health Aide	United States
Nina	Russia	Russian	Cleaning houses	United States
Orlando	Colombia	Spanish	Bagger at Publix, Hospital Orderly, Endoscopy Technician	United States
Paolo	Philippines	Pilipino	Unemployed while waiting for work permit	Philippines
Rachel	Philippines	Pilipino	Unemployed while waiting for work permit	Philippines
Zaida	China	Mandarin	Researcher for one year while with appropriate visa; then became a nail technician	United States

and universities; however, their enunciation and syllabication of words sometimes create misunderstandings.

The participants expressed concerns with their overall cultural integration in the US

articulating issues such as perceived prejudice from others. Arnel's perception of prejudice is illustrated in this quote, "They [customers] look at you, like you do not know what you're doing. You're Asian, you're from a poor country. Prejudiced."

The findings in this study regarding language and communication is similar to what is found in related literature regarding non-US native nurses. In Chapter Two, studies were reviewed which provided evidence of the negative impact of language and communication barriers in non-US native nurses and nursing students. As a specific example, in the phenomenological study by DeLuca (2004) that explored the concept of *crossing cultures* in Jordanian graduate nursing students in the US, she identified that "students face 'chaos' in the process of cultural adaptation. Issues of language and culture had to be faced before students were able to progress academically in nursing" (p. 661). In her review of literature she indicated that research studies showed that the most challenging experience students faced was adjusting to new language. In a qualitative research conducted by Sherman and Eggenberger (2008) that investigated the educational and support needs of internationally recruited nurses, they identified that cultural differences was a recurring theme as a challenge in transitioning them into the US clinical setting. Hospitals which participated in their study conducted intensive screening for English proficiency and held accent reduction classes for those who needed them. In a related grounded theory study of Pakistani immigrants (Hashwani, 2007), it was identified that their transitions to resettlement in the US involved becoming aware of the personal and social adjustments associated with navigating their new society, such as "learning the language, tempering one's accent, coping with the new society's expectations, living independently, understanding the various US systems..., interacting socially, and exploring job opportunities" (p.80).

With crossing cultures, the use of certain terminologies and the experience of stereotyping also burdened participants. As an example, Adela gave a discourse about the terms *clients and patients*,

Oh and I have a big problem with the ‘clients and patients.’ That client that was...for me it was like, “Oh my God, how can they call patients clients?” But now I understand. I realize that’s true. They are clients. That’s the service that the hospital offered to them. For us, no. I see them like a patient all the time.

Maira from Colombia expressed how difficult it was to be stereotyped. She stated:

Well it’s difficult. I mean, it really toughens you up. You know, in my country I was really protected. I had it good. When I came here, I was just really...oh, my God! I learned a lot of things. It was really, really tough. It was tough. Especially coming from [name of country], a country that has that bad reputation about drugs and everything, people always judge you. Not always, but most of the people think that because we deal with drugs, everybody that comes from there either do drugs, sell drugs, or is a bad person.

Cultural differences are not only based on ethnicity. Cultural differences are at different levels and categories and may include sub-cultural groups that are defined by age, education, gender, occupation, organizational affiliation, profession, religion, sexual preference, etc. The highest level is at the national or regional society manifested in the ethnic differences in people. Cultural differences can also be at the level of professions. For instance, the culture of the medical profession and the culture of the nursing profession are unique of each other. This uniqueness is manifested in the differences on how individuals enact their professional roles and functions. It can also be at the corporate or organizational level manifested in the way in which people behave and express their attitudes as members of a specific work organization (Stewart et al., 1995; Trompenaars & Hampden-Turner, 1998).

Table 5.2

*The Impact of Language Barriers*

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Voices of Participants

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My problem was...was the English. I'm scared about that one. Maybe because I don't practice...I...I didn't have the opportunity to go and..and have..and work with other people...Now, I am practic[ing] English.. ...It was scary for me to go and talk with the patient and did...and do the teaching... maternal teaching...the infant...I am still afraid, but I try...but it's...I'm getting ...confident...(Adela, Nicaragua)

Your first time in here, you still have those ethnic [language] accents. It's really communication issues [with families]. I don't know because this family ...really cannot understand. It's very hard; too difficult. They look at you like...like you do not know what you're doing. You're from [a foreign country]; you're from a poor country... (Arnel, Philippines)

I was not fluent but I knew a lot of things. You know, I could read English well. And maybe write a little bit of English. Still I kinda [kind of] write it pretty bad. It's very difficult. I think that's one of the challenges for me. When I went to Nursing school... all those papers that I had to write. Because one thing is to speak it and understand it but another thing is to write it...to write it correctly. So that was really, really tough for me. (Maira, Colombia)

I even I took my English class in [my home country] but when I came, it wasn't so good. I don't think it's good now either so...I watched TV and listened to the radio and I spoke to people around... I took a college level English here for my prerequisite for nursing. (Nina, Russia)

So, for me it was hard to understand people. Talking in front of them or on the telephone...you have to talk back to them. But they won't be able to understand you. So it was...it was challenging the first months of working here in a hospital. (Orlando, Colombia)

The thing is from the beginning, I feel my language barrier is... because [in my home country]we didn't teach... we doing, we have English class, and you think you take a good test but when you come, when I go to [city in the US], the [public transportation]... well, what do they talk about? [In] the [public transportation], you don't understand at all but I pick up pretty fast. I pick up because boyfriend is American and I live with him so I start to pick it up fast. But I still feel I have a language barrier. Writing... still I think I have a problem writing articles. And I just feel... I don't know... I just feel the language barrier. (Zaida, China)

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*The Burdens of Starting from Zero*

The second dimension of the central problem was *experiencing the burdens of starting from zero*. As participant Zaida expressed, "You start at zero. It really start[s] zero. Your career, your financial, your everything, your social status." Zaida's words were exactly the words of Radostina Pavlova who was a Pediatrician in Bulgaria who has also retrained as a



nurse. “Starting from zero” was how she described her experiences when she moved to Florida with her daughter few years ago, leaving her status as a physician in her home country. When she immigrated to the US, she did not speak English and spent two years cleaning hotels (Rexrode, 2007).

As new immigrants, half of the participants in this study literally started from zero. The other half of the participants had strong family ties in the US; hence, their experience of *the burdens of starting from zero* was not as significant as for Alina, Dante, Maira, Nina, Orlando or Zaida. Alina’s first job was an office clerk. She said “...cause I had nothing. I had to grab something to make money. To pay for the roof. I also had a second job. I worked as a waiter.” Dante worked as a care staff and community guide for the mentally retarded population to integrate them into the community. Dante also said that he had a second job and with heartwarming humor he said, “My second job was at night. It was a ‘sleep’ position.” The job description, he said, specified such and he likened it to being a night shift baby sitter for the residents of a group home. Maira worked as a home-health aide taking care of a lady in her community during the night, helping her with her basic elimination and other physical needs. Maira said, “... when I was doing that, I went to take some classes as a C.N.A. [certified nursing assistant] and I got my license that I need but I never went to work in a hospital.” Nina was cleaning houses. Orlando worked at Publix bagging groceries and earning a wage of \$7.50 per hour. Zaida, who initially worked in the US as a researcher until her visa allowed her to, learned how to do nails after that and worked in a nail salon to make a living. The consequence of *starting from zero* affected their sense of self-identity resulting to the construction of their negative new self-concept. Their new self-concept made them believe that they can only function in unskilled occupations. One of the participants said that he went

to apply as a housekeeper at a hospital because he thought that was the only way he could get near a hospital.

Survival in a new society with their new self-concept was their most immediate goal. This aligns with Maslow's hierarchy of needs (Bootzin, Loftus, Zajonc, & Braun, 1983). To survive, the participants shifted their priorities and assumed low-paying unskilled jobs which placed them at the lower end of the socio-economic stratum. Fulfillment of their most basic physical needs and those of their families became their *raison d'être*. They had to put aside their need for self-actualization. With the shifting of priorities came the barriers of pursuing their medical professions in the US. To illustrate, Orlando wanted to jump-start his life and his medical career in his new society on the right track so he took English classes at a local university. Due to financial constraints, he had to discontinue his English classes because he said, "I [had] to work. And I wasn't going to be able to choose to be a full time student. So I had to put my life as a student on the side. And start to survive. That's the word, survive."

*Starting from zero* also meant unemployment for participants because of visa constraints. Foreign-educated physicians who came to the US as board-eligible NCLEX nurses with visitor's visas experienced unemployment.

I stayed for like eight months here without work. Waiting for my work permit. So I was like jobless for eight months doing nothing. (Ollie)

I experienced all the depression because I was so far away from my family; and then I didn't have a job yet. I just had to stay 24/7 in the house doing nothing only house-work... and the fact that I didn't have job then sometimes it caused misunderstandings between me and my husband... (Annabelle)

### *The Burdens of Crossing Professions*

"When I moved to America in 1999, it was actually my intent to be a doctor, pass exam, and become a citizen here.... [things happened].... took me away completely from the

medical field” (Alina). The third dimension of the central problem was *experiencing the burdens of crossing professions*. As new immigrants in the US, all participants in this study experienced professional discontinuity from medicine. Such discontinuity occurred because of licensure-related and immigration-related constraints. Literature indicates that many highly skilled immigrant professionals usually face temporary or long-term downward occupational mobility (Shuval & Bernstein, 2000). In the account of the participants’ taking transitory unskilled jobs, it illustrated how they survived and how they supported their families while attempting to reclaim their professional selves as physicians. The participants faced major barriers in their attempts to accomplish this goal which was the main reason why they eventually shifted to nursing.

In the context of the prevailing general societal perception of nursing as a diminished professional status, *crossing professions* from being physicians to being nurses was found by the participants to be problematic and burdensome. Table 5.3 provides illustrative quotes of how former physicians educated in foreign countries experienced the *burdens of crossing professions*.

This problematic issue was compounded by their perceptions of the scope of nursing practice in their own countries. Orlando said, “In my country, if you can’t go to medical, [you] go to nursing school.” He added, “Sometimes it’s hard because you are a physician and you are working as a nurse.” He explained:

With my classmates at the university... I talk to them but it’s really sad. Because my friends, they finish residency, they are doing like fellowships. I talk with a friend, he was in France doing liver transplant; I’m being a nurse in endoscopy [here in the US]. So ...with your co-classmate it’s a little tough. Because, you know, they are in [my home country as doctors]. We are making more money here as nurses. But, you know, the status of being a doctor is different than being a nurse.

To Adela, the *burdens of crossing professions* manifested itself in her emotional outburst during her first day of clinicals. She recalled, “First time going to the clinicals. Oh my God, that was terrible. I cried. I almost quit.” She added, “The first two weeks, three weeks, it was hard. It was hard to see the doctors from the hospital with their white gowns [because] I used to do that.” Other participants expressed how difficult it was in the beginning. Maira said,

It was really surprising how hard it was. Because I thought that since I was a physician, I knew it all, you know. I thought that it was going to be really, really easy for me to go to nursing school but it was totally different. It was very, very difficult because there are so many things that we don’t know....all these things that I really didn’t even think about. So it was really, really difficult. Especially in the beginning, you know...

Table 5.3

*Illustrative Quotes: How Society Perceives Nursing*

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Voices of Participants

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Sometimes doctors...they are like the superior here...Even in my country... if you are a doctor and you say you’re going to be a nurse; they don’t like the idea. (Adela)

From my colleagues. They think that you are like a failure. They’re like, “How come you were a doctor and you come here and you can only be a nurse.” So that’s the way; not everybody but many people see it that way. (Maira)

Well, you can hear from other people, “Why are you suddenly training for nursing from a doctor? It’s a downgrade...(Paolo)

Well at first when I told them that I’m going to nursing, they were like, “Huh? You just graduated from medicine and you’re just starting to practice medicine, and you’re going to nursing?” and they’re saying, “Isn’t that not right for you to...you’re already a doctor, and you want to go to nursing?” ...My brother and my sister, I know they didn’t like it. (Rachel)

In [my country], they don’t think of nursing as high status....every time you go back with my friends... doctors...in the department...people think I should get a more... “Why did you do this? Why nurse? This is not you to...” (Zaida)

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And Orlando said,

So clinical was probably the...the hardest part of that. Because in the books, you read the book, you answered your test, and that time we have to go to a hospital and you have to do things that you have never done before. And people think that you are just a student and you don't know anything. And you know, ah, technology is little bit different between our countries and over here. They are going to think that you are stupid because you don't know how to handle a form that is used 2009 model and finished your medical school in 2000. It's a little bit frustrating...

*The Basic Social Psychological Process:*

*Combining the Best of Two Worlds*

*I have two views. I take the good things about being a doctor and the good things about being a nurse and for me that's the biggest...the biggest...the best 'recompensar' [reward].*

*~Adela*

*Combining the best of two worlds* is the name given to the basic process that was discovered in this study that explained how the participants addressed the central problem of *experiencing the burdens of a new beginning*. The two worlds that are implied are the world of nursing and the world of medicine. The basic process has five stages which also form the stages of the substantive theory of *combining the best of two worlds* to cope with the *burdens of a new beginning*. As illustrated in Figures 5.1 and 5.2, and as evident in the descriptions that the participants provided, the five stages do not occur in a perfectly linear and sequential pattern but rather in a somewhat recursive and cyclical pattern. The five stages with the causal factors, consequences, contexts, dimensions, influencing factors, and contingencies form the substantive theory and are discussed in this section.

*Stage One: Letting Go of Professional Identity as Physician*

Having been unable to re-establish their professional identities as physicians in the US, the participants in this study had to let go. "Well I guess you just have to be realistic 'cause if you keep thinking of yourself as a doctor and you know...you're doing this job now

and keep coming back to that thing, being a doctor in the past, it just hurts. So, I just moved on.” (Dante)

*Medicine closes its doors—nursing opens its doors.* There is an aphorism that goes like this, “When one door closes, another one opens.” *The door of opportunity to medicine closed and the door of opportunity to nursing opened.* In the experience of the participants, it set the starting point of their transition to nursing. Although the two events did not occur simultaneously, when the *door of opportunity to medicine closed*, a reciprocal event occurred, *the door of opportunity to nursing opened.* The unsuccessful attempts of the participants to meet all the requirements for physician licensure in the US caused the participants to give up on re-establishing themselves as physicians. The following voices of the participants illustrate this:

When I came here in 2005, I try to take the test [USMLE], but I really didn’t study and my English is not good at all and I didn’t pass the test...for a few points. (Adela)

I was not able to get into a residency training so instead of working in a job that has no connection to medicine, I decided to go to nursing. (Dante)

And then I passed it [USMLE], but to get into a residency was really difficult because I haven’t been practicing medicine in all those years. And, you know my scores were in really just like right there. You know, the passing score...the lower passing score. It was really, really tough to get a place somewhere to do a residency. So, I couldn’t; but I applied. I spent lots of money doing that. And time and everything. And I couldn’t do it [anymore]. (Maira)

Reestablishment of their professional identities was a basic need for the participants.

As Shuval (2000) said, “The most urgent and profoundly felt need of an immigrant is to reestablish a meaningful sense of identity of which the professional component is a major element” (p. 192). The participants in this study were unable to reestablish a meaningful sense of identity through the medical profession. Nursing then became an opportunity. Nurse

retraining program for FEPs became available. As had been discussed earlier in this paper, FIU designed a program specifically for FEPs when nursing school administrators saw the need and the benefit of such a program. Upon learning of the accelerated bachelors degree-level program, the participants saw it as a goal that they can achieve amid their family and existing work responsibilities. FEPs first learned of the availability of a program through their friends and networks:

Actually, it was funny, I was working here in the hospital as an orderly. And it was a dialysis tech who works in Dialysis of course. And his wife, she's a nephrologist from Cuba. And he was the one who told me, 'you know, there is a program for physicians. Why don't you call my wife?' So I called his wife and we went to USF because they were doing some preliminary test for that. Maybe [in] 2004... We took one test and after that we had to take the NET [Nursing Examination Test]. Some kind of English. I think they were trying to see who were good in English or not. Because after that some people went to English classes. (Orlando)

Adela said that after her unsuccessful attempt for the USMLE in 2005, she heard about the FIU Program and decided to enroll in it. In a different context, in the Philippines, programs to retrain physicians to nursing became available throughout the country. The participants who were physicians in the Philippines offered the same observation:

Because of this nursing boom...there was a program for us...we have...schools... There's a lot you can choose. There's a program that are only mostly for doctors because most of the nursing schools, don't want us to be with regular students. You can choose the schedule you want. After clinics, you can go to school. Or it's usually weekend. But there are some others. If you want to go with the regular students; you can do that. It's all up to you. It's like flexible... (Arnel)

There were two reciprocal consequences that resulted from the reciprocal closing and opening of doors of medicine and nursing: (a) disengaging self from the profession of medicine, and (b) making the conscious decision to become a nurse.

*Disengaging self from the profession of medicine.* This aspect of Stage One was a consequence of the closing of doors of opportunity to medicine. It is a critical juncture. A

critical juncture is “a period of time between stages when the occurrence or non-occurrence of a critical event will determine whether a new stage is entered...or the previous stage is maintained” (Glaser, 1978, p. 99). In the stories that the participants recounted, it became evident that an act of disengagement had to occur before they could actually let go. As the analysis of data progressed, it emerged later that such disengagement from the profession of medicine did not constitute total and permanent disengagement as will be described in Stage Five. Disengaging from the profession of medicine had to occur first before they could move on to consider replacing their previous professional identity with nursing. This was evident in their discourses which described their own experiences and the experiences of their colleagues.

...and it took me years to let go of being a physician. You know I tried everything I could, did everything I could and I finally said, “I’m not [going to] do it anymore. I don’t want to be a physician; I want to be a nurse.” When I decided that... I still say it, “I’m not...I’m never [going to] go back to being a physician.” And I don’t, and I can tell you truth...truthfully, I don’t want to be a physician anymore. I know all the things I know and all I went through but I’m a nurse now, you know. So, when I started studying this, I went to a Community College then I changed...and I went through all those things again because I...I wanted to be a nurse. I can tell you honestly. I didn’t want to be a physician anymore. (Maira)

Arnel gave a statement supporting why a physician should disengage themselves from medicine in order to transition successfully to nursing. He said, “We heard news that there are doctors [who] become nurses and they have a hard time coping. I think they still have that ego. Me. I’m a nurse...” He said that if physicians cannot disengage themselves from medicine, “that’s [going to] put you in trouble. Overpractice. Beyond your scope as a nurse. So you really have to be... nursing...beyond that...no. It’s just [going to] give you trouble, so just be a nurse. Just be a nurse.” To echo Arnel’s tale, Maira recounted a story as to why she was not able to do clinicals in a particular hospital:



I think there was another physician previously that was working in there. They had a problem with him. He was like acting like a doctor instead of like a nurse. So, they have to fire him. And they were, you know, really had problems with that...I think that caused a lot of problems. That's the problem; that's probably why we did not do our practice there. We only used the classroom and the classes...He was acting like a doctor. It was before us. Before we started there. So I think that's why I think they were really careful. And not many people from my class—only two other people are working in that hospital.

*Making conscious decision to become a nurse.* The conscious decision to become a nurse was the reciprocal step to *disengaging self from the profession of medicine* that FEPs had to do to initiate the process toward becoming US nurses. *Conscious decision to become a nurse* was the deliberate decision of the individual to shift professions. Table 5.4 presents quotes from the participants that provide a colorful array of their thoughts when they initiated their transition to nursing.

Furthermore, Rachel added:

It is all about knowing what you want to become and what you want to happen in the future. In my case, this is what I want to happen. I want to be with my fiancé, start a family, work as a nurse for the meantime he is working on in his career, and save some money for us. This will not become a reality if I don't have determination to do what I have to do regardless of whether I will be in a different profession and what other people will negatively say to me. It's choosing and sacrificing for the future. Being able to stand up to your decision, and be good at whatever profession you are in.

### *Stage Two: Experiencing Growing Pains*

*Experiencing growing pains* is Stage Two of the substantive theory of *combining the best of two worlds*. This is the stage when the participants experienced identity crisis, akin to what adolescents experience when trying to establish their self identity. Maira likened it to the stage of puberty. She said, "It's like going from puberty through teenage years...seriously.

Table 5.4

*Illustrative Quotes: Conscious Decision to Pursue Nursing*

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Voices of Participants

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[Nursing] It was an easy way to start working...and it's my passion...people that's why. (Adela)

I heard this [nursing] program was coming. I can start like this.... It's a short program and I will be in the medical field, I will be in the hospital.... So at this point, I can work at the same time and I can go to school for this. And somebody will pay for this. So it was just it was...just perfect at the time. (Alina)

Actually I did not have to struggle that much because when I decided to go through nursing, I was already decided. I did not have any doubts. I didn't encounter any struggles. I was really decided to be a nurse here in America... (Annabelle)

Actually, my decision is my decision.....Most of my friends were nursing students [also]...they were in California, Maryland, Texas. (Arnel)

I was not able to get into a residency training so instead of working in a job that has no connection to medicine, I decided to go to nursing. (Dante)

I decided to be a nurse. And I went to a regular college. Community College to do nursing.... When I decided to become a nurse, I completely...I knew in my heart...(Maira)

I always like to help people and treat people. That is why I continued that and for me it was easier to start in nursing than to go back to medical school or to pursue a career as medical doctor. (Nina)

It [the decision to pursue nursing] was personal on my part. Not even the family knew. (Ollie)

It wasn't what a want in the beginning...being a nurse. But this opportunity to get a degree...a Bachelor's Degree in Nursing.... I thought it was a good idea.... and Nursing has...a lot of possibilities. (Orlando)

I really made up my mind that I'll become a nurse...Not a doctor here... (Paolo)

When I entered nursing school, I was already decided that I have to finish it... I had no second thoughts about taking nursing. (Rachel)

People just encouraged me to go to school for being nurse here and ...they have a program at that time and they pay you for schooling, so I said, "Okay." I signed the contract with them, so I went to the school. (Zaida)

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It's a process...You cannot say just one moment in time." It is also interpreted as the pain of frustration as experienced by the participants due to their inability to perform certain clinical skills because of limitations imposed not by the absence of skills but by established

professional rules and regulations that specify scope of practice. Participants expressed these in their sentiments such as in the following example:

It was also tough to have all this knowledge and just doing different things.... You were not allowed to do anything, only like cleaning the patient, moving the patient. But you were not allowed to do like maybe the foley catheter. You cannot start an IV. You cannot. They weren't allowing us to do any. We were not allowed to do all these things so I feel [felt] like, "I can do more than this." (Maira)

An integral dimension of this stage is the manifestation of the feelings of uncertainty that the participants experienced as they began to learn and integrate into nursing. This feeling of uncertainty was conceptualized as analogous to the game *tug-of-war*. This stage has a recursive property because the participants experienced it during the early stages of their nurse retraining program prior to obtaining their license and it occurred again after they obtained their nursing license.

*Tug-of-war in desire to be a nurse or be a physician.* The uncertainty that was verbalized by the FEPs as they tread the path toward transitioning from being physicians to being nurses was conceptualized as analogous to the game *tug-of-war*. The mental image created by this conceptualization was a constant pulling and tugging between two opposing forces. The pull on one side was sometimes stronger than the other side. At the time of the interviews, all the participants were practicing nurses which indicated that their desire to be nurses overpowered their desire to be physicians; however, there were three participants who strongly voiced their uncertainty. The *tug-of-war* was evident in the following selected excerpts from their discourses:

Nursing is not what we are made. We are not made to be nurses. You can try to. But it is going to be hard to be a nurse. What you learned in 11 years of medical school is not going to be replaced by one-year-and-a-half of nursing. You understand me? ... You can see different ways the nurses [do] on the floor. You come over here and the patient is having a[n]... intervention. I am looking at the medical part of the

patient. Is he stable or anything like that? Let me hang the IV. Let me make sure the patient is warm and all those things. The approach to the patient that we have is a little bit different. I think it is going to be difficult to find my true identity as a nurse.... Yeah, what you learned in 11 years is hard to replace.... But it's very useful [to nursing].... I honestly think that as a physician...once you're a physician you would never forget that you are a physician.... Honestly, I don't think I'm going to be a nurse for a long time. I'm going to try to become a nurse anesthetist. But yeah, it's a nurse of course. When I am finished, I'm going to go to school to finish my medical studies because...you know....I'm telling you it is hard. Maybe ask me in 20 years of being a nurse.... I had been a nurse for 6 months and I have been a doctor ...longer than that.... Sometimes it's hard because you are a physician and you are working as a nurse....

The parts of the above discourse about “looking at the medical part of the patient; determining if the patient is stable or not for the planned intervention; hanging the [prescribed] IV; ensuring patient is warm” are independent nursing actions within the critical thinking framework of the nursing process. Orlando's view can be attributed to the status of nurses in his country. In his words, “...for example in my country, they [nurses] are sitting most of the time. They are in [on] the desk. They have like more administrative things.”

One of the participants who had been a nurse longer than Orlando, said the following:

I don't have a career satisfaction here. I don't. Until now. I don't have a career satisfaction. I don't think I'm proud of myself to be a nurse. I don't know.... my education for so many years...and being a nurse [now]...I have a problem of what I do here... (Zaida)

The theme that resonated with the above quotes was the length of time that the participants invested training as physicians in their home countries and how difficult it would be to replace such lengthy education with the shorter retraining to become nurses. It is not the intent of this study to compare physician training in other countries to physician training in the US; however, to use the US model of medical education as a benchmark, the length of medical education is “longer and probably more demanding, intense, and cloistered than any other....” (Thorne, 1973, p. 17).

The quote that follows further illustrates the *tug-of-war* that occurred within the self of a foreign-educated physician now practicing as a nurse in the US. This quote speaks about loving nursing yet still desiring to return to the profession of medicine amid self-doubts of one's physical and mental abilities to go through the rigorous US residency training.

It does, it does bother me. In the back of my mind, I am saying, I shouldn't be doing this. I can be a doctor if I want to but I still have to go through the process and apply. And until now, they are still re-evaluating my application; re-evaluating the test that I took decades ago. In the back of my mind too, [I also question] if I can still be able to go through residency program, how hard it is. I'm having my certification verified right now. And I know that maybe, I like it in my mind, but physically, I'm not that young to go through that rigorous training that the residents go through. I don't know how to deal with that. I want to deal with it when it's here. So right now I want to go ahead with my work as a nurse. I love it already. (Ollie)

*Medicine has ultimate power and nursing minimizes past.* It was discovered that Stage Two had two influencing factors or covariances. These were the participants' pre-established perceptions that *the physician has the ultimate power over clinical decision-making* and that *nursing minimizes the use of past medical knowledge, skills, and experiences*. These two pre-established self-perceptions shaped the biases of the participants and made them feel that as nurses they were powerless to make a difference in the care of patients. These two conditions were considered covariances because they covaried with *the stage of experiencing growing pains*. When their perceptions changed positively, their experience of growing pains lessened and when their perceptions changed negatively, their experience of growing pains intensified as illustrated in the words of Maira, "And I started to go more into nursing. Then I realized that it wasn't like I thought it was. I could make a difference in the treatment of the patients." Orlando's perspective was:

So it wasn't that that... that hard. You come all the way here, you see the difference what you want to do as a nurse. Do you know what I like being... working as a nurse. Part of it being working as patient advocates. Actually, it's the part that I really enjoy;

being a nurse. You know the relation between physician-patient over here, it's a kind of rough. You will see the patient. The patient they are very anxious. They need something to or somebody to link them with the doctor. That part is really nice. That's why I really like that role of a nurse. And believe it or not, you can use a lot of what you know from your background as a medical...

They were also influencing factors because they influence the level of uncertainty or *the tug-of-war* experienced by the participants.

*Physician has the ultimate power over clinical decision-making.* Within the healthcare professions, the perception that physicians have the ultimate power over clinical-decision making and that the profession of medicine has dominance over the other health professions, particularly over nursing is acknowledged (Bullough & Bullough, 1984; Remennick & Shakhar, 2003; Thupayagale & Dithole, 2005). In this study, this became evident in the discourses given by the participants. In this contemporary age when collaboration among healthcare providers should prevail, the physician seems to remain to be the figure head that has dominance and ultimate control of clinical decision-making. Gillen (2007) suggests that the difference in power between nurses and physicians may be attributed to the educational preparation and economic differences between the two professions. Physicians who are earning more hold more power, whether true or imagined, than nurses.

When conflicts occur among healthcare providers regarding the care of patients, nurses may feel that they are powerless to challenge the decision of the physicians. For professionals who in the past were accustomed to having the final decision in the treatment plan of patients but who are now unable because of their current circumstances in their new roles, such as in the case of the FEPs who have been retrained as nurses, it is perhaps a difficult and awkward situation.

You see how the doctors give the last word. Like this is what we are gonna [going] to do. And, still you have this knowledge that it should be done different and they're not. Even when you disagree. So that was tough. (Maira)

You just have to carry out what the doctor ordered. You don't even question it; you just go ahead and do this. You just carry out the order. (Ollie)

Basically, when I was a doctor we have...we have more responsibility. Like if anything fails, it's gonna be on you. As a nurse, you're just part of a support...to back us up. It's not as stressful. As a nurse, no. It was easier. (Dante)

*Nursing minimizes past medical knowledge, skills, and experiences.* The pre-established self-perception of the participants that *nursing minimizes the use of their past medical knowledge, skills, and experiences* had strong influence on the level of their uncertainty. Nursing practice in their home countries and their overall cultural orientation had strong impact on this influencing condition:

At the beginning.... [When I was] a nursing student ... [I was] cleaning, making bed, and cleaning.... 'Oh, I am a doctor in my country. Big name, you know and I am here.' Make you feel bad. That's your ego...But [that was] at the beginning. (Adela)

When I started to practice nursing, you know what, I thought that because the way I see it is if you are a doctor in another country and you come to this country to become a nurse, which is considered by everybody to be a lower level of a profession...The way I see it is that you really have to be a good person. You really have to be humble enough to do it. You know, because nurses do so many humble things for your patients. And so many caring things. I thought people would be accepting and nice. But they are not. They consider that you are, kind of, not good enough sometimes. Not good enough. (Maira)

It is important to note that as the participants progressed through their nurse retraining, and as they witnessed role models in the clinical setting, their pre-established perceptions about nursing practice in the US began to reshape. Reshaping of their perceptions allowed them to see US nursing practice as different from nursing practice in their home countries.

With the reshaping of their perceptions, they moved into Stage 3 of the substantive theory: *seeing nursing as a saving grace*.

### *Stage Three: Seeing Nursing as a Saving Grace*

Stage Three of *combining the best of two worlds* is *seeing nursing as a saving grace*.

Prior to nursing, participants experienced professional discontinuity. All participants experienced either being unemployed, waiting to be employed, or significantly underemployed working in unskilled jobs earning minimum salary. In their experiences of professional discontinuity, they experienced restlessness, sadness, and self-diagnosed depression. All the participants expressed that they wanted to return to work as professionals in the healthcare field—a field where they could land in jobs that they would find meaningful. Being a C.N.A., although it was in the healthcare field, was not meaningful. Cleaning houses was not meaningful. Working at Publix was not meaningful. They wanted to touch patients. It was impossible for them to accomplish these through medicine because the profession of *medicine has closed its doors of opportunity* on them. Then nursing came along and as *a saving grace*, pulled them out of the abyss where they have been trapped for a number of years. With nursing, new life was instilled in them. New energy. New hopes. New dreams.

Stage Three confirmed that the decisions and actions they made in Stage One were appropriate. *Seeing nursing as a saving grace* also diminished the uncertainty or the *tug-of-war* experienced by the participants. Orlando told it well, “But you know what, everyday that you work you feel that you are recognized as a nurse. And like a person certainly that have education. Thanks to nursing. I have a more respectable position in society. I enjoy being a nurse.”



This stage was contingent upon the *opening of doors of opportunity to the profession of nursing* and the availability of nursing re-training programs as well as the *receiving of knowledge and wisdom of nurses*. It had two dimensions as viewed by the participants: (a) nursing as an easier route to a US healthcare career, and (b) nursing as a way to economic gain.

*Seeing nursing as an easier route to a US healthcare career.* Nursing as an *easier route to a US healthcare* career resonated as an overarching theme in all the participants' responses when asked about the reasons why they pursued nursing. As discussed earlier, the route to medical practice in the US for FEPs is difficult and lengthy. It requires a series of three examinations and residency retraining programs that may last five to six years. In contrast, foreign educated nurses who come to the US take one test to obtain licensure, the NCLEX for registered nurses, and they are not required to undergo additional lengthy retraining programs.

In the context of immigration, due to the prevailing global nursing shortage, entry to the US as a nurse is easier than entry as a physician. FEPs, particularly those from the Philippines intentionally pursue nursing to expedite their immigration to the US. The accounts given by the participants in this study regarding the popularity of interprofessional migration from medicine to nursing and their first-hand experience with the Philippine nursing migration phenomenon is overwhelming. They validated what the researcher has found in media and popular literature regarding the phenomenon. They told of stories about how nursing was seen as an asset in their country. Nursing has become the less arduous route for Filipino physicians to pursue their American Dream. They spoke of the *nursing boom* and its current popularity among Filipino physicians. Annabelle said:

Ah..actually, nursing school for me was a great experience! It's a different...it's a different college from the College of Medicine. I did not have any difficulty doing that study because all my classmates were all doctors. We had 200 doctors [taking nursing].

The experience of Annabelle was typical of the experiences of Filipino Physician-Nurses. Arnel said that there were about 300 physicians taking up nursing in his batch. The same situation was true for Ollie, Paolo, and Rachel. Their accounts supported the notion that nursing was viewed as an easier route for Filipino doctors to pursue a healthcare career in the US.

Adela emigrated from Central America to the US by virtue of being married to a US citizen and she was unemployed, by choice, for a few years while studying for the USMLE. After her unsuccessful attempt to obtain physician licensure in the US, she turned to nursing. She said that because her passion was people, she felt that nursing was an easy way for her to start working. She made the following statement that likens the process of physician licensure in the US to a big mountain.

They asked me why you don't go for your medical. You don't revalidate your license here. I explained. This is like...medical [licensure] ... it's like a big mountain for me; and nurse is one thing I think I can do. It's easier and I thought it's a good for me to start practicing English and be in the hospital and see how is the environment. And after that I see. I think it's going to be easier for me even if I want to be a practitioner in medical [medicine] or [be] a physician assistant. This [nursing] was like the start for me.

Nina's experience was somewhat similar to Adela because she immigrated to the US primarily because of family. She came to the US with a fiancée visa and did not work initially. When she divorced and became a single mother, she looked to the US healthcare industry for employment. She said:

I always wanted to work in the medicine since I entered even medical school. I always like to help people and treat people. That is why I continued that and for me it was

easier to start in nursing than to go back to medical school or to pursue a career as medical doctor. It was easier for me at that point.

Dante's route to the US healthcare industry was slightly tortuous. It appeared that he perhaps obtained misinformation regarding how an individual can become a registered nurse in the US. In his interview, he indicated that in the information he obtained from the internet, it indicated that individuals must possess an LPN license before they could pursue being an RN. Through an LPN program with transition classes to AS degree, nursing was seen by Dante as an easier route to a healthcare career in the US. He passed the USMLE but he said his scores were not competitive enough so he decided to defer applying for residency training.

*Seeing nursing as a way to economic gain.* All the participants expressed that they saw nursing as a way to improve their socio-economic status. Orlando expressed how good nursing is in terms of the "economical status that it is going to give you." Dante who has been in the US since 1994 and who graduated from nursing school 2003 said, "...my going to nursing school was an upgrade of a sort because I was working another job that was paying much lower than a nurse..." A general concern of the participants, especially those with children, was their basic need to increase their income capacities to adequately support their families. Participants from the Philippines were very straightforward in their comments:

We all know the life in the Philippines. It is so hard. We needed a bigger, bigger, bigger income. So that's one of the reasons too. (Annabelle)

I have to provide [for my family] and I need another source. To provide for your family so this one, nursing was the best way that we saw. Actually, this [was] not just my decision. My wife was with me. So it was a family decision because we needed to get another source of income. Just being a doctor [in the Philippines was] just not enough...(Arnel)

...during my training days, I only earned an equivalent of one hundred dollars a month. That's for five years....because I was in [residency] training in surgery....then after residency training, I was already in my own practice, private practice. While in

private practice...the average...[was an equivalent to] two thousand to three thousand [dollars] a month, during my first year of practice. But eventually...after maybe seven years, there's no more paying patients. So that's the problem. We have more patients but less paying patients. So mostly I worked for...gratis...[pro bono]. During my first year of practice, [my charity work] was around 20%. On the second year, 30%. Then 40%, until before I left the Philippines, maybe by that time about 50%. So, it's just increasing and increasing... (Paolo)

The reasons for other people, for other doctors to take up nursing is primarily because they want to earn more than what they are earning in the Philippines. Like my friend who went with me in nursing...the one who encouraged me to go to the nursing school...his primary reason is because he wants to earn more than what he is earning in the Philippines as a doctor. I talked to my classmates in the nursing school, their reason is the same. They want to earn more. As a general practitioner, you just earn an average of 25,000 to 30,000 pesos. Maybe around 35,000 the most per month. In dollars, it's about 600 or 700 dollars a month. I earned more as a teacher [for nurses] than as a general practitioner....For the specialists, I'm sure they earn more. They're satisfied with what they're earning; but for the new graduates, who are just doing moonlighting; for the general practitioner; and for those who have already graduated for several years but still cannot find residency...and residency pays very little.. very little... residency [government hospital], you will only earn less than 400 dollars per month. Yeah, it's like 18,000 pesos the most. For the highest paying hospital, they pay you 20,000 pesos; but others will pay less, especially private hospitals. (Rachel)

Reflecting upon these stories from the participants and examining the salary comparisons of nurses in some parts of the world as seen in Table 2.5, the observer will comprehend why the economic factor plays a significant role in motivating physicians from the Philippines to become nurses. In the US, an LPN can earn an average of \$2,873 a month and an RN can earn an average of \$4,521 a month. The salary of a physician from the Philippines or from Cuba or from Russia is far, far less than a nurse in the US.

#### *Stage Four: Gaining Authority to Practice as a Nurse*

Stage Four of the substantive theory *combining the best of two worlds* is *gaining authority to practice as a nurse*. This stage was the second critical juncture in the process of

transitioning to nursing as experienced by the participants in this study. This stage was a process with two phases. The first phase was *unlearning being a physician* with its reciprocal *learning being a nurse*; and the second phase was *obtaining US nursing licensure*. Stage Four was contingent upon *receiving knowledge and wisdom of nurses*, which in turn was contingent upon the *opening of the door of opportunity to nursing* which in turn is a causal factor for Stage One.

*Unlearning being a physician and learning being a nurse.* To understand the process of unlearning being physicians as experienced by the participants in this study, one must first understand the concept of learning. In Chapter One, in the context of the concept of socialization, learning was referred to as any non-facilitated change in the behavior or conceptual state of a person that can either be positive or negative (Biddle, 1979). Learning can also be defined as “a relatively enduring change in behavior caused by experience or practice” (Bootzin et al., 1983, p. 178). A definition of unlearning can be derived from these definitions of learning as the intentional or unintentional undoing of the effect of what has previously been learned. It can also be defined as the active or passive act of changing previously established behavior. Learning and unlearning are not directly observable; hence they are inferred from the behaviors and performance of individuals (Bootzin et al., 1983). In applying these concepts as experienced by the participants in this study, they experienced changes in their previously learned behaviors as well as changes in their *persona* as physicians by *unlearning being physicians*. A reciprocal act of *learning being nurses* occurred. The active and passive shift of *unlearning being physicians to learning being nurses* actualized their *conscious decision to become nurses*. Rachel said, “I have to learn the things that a nurse should do or nurses should do.” Paolo in describing how he experienced the

unlearning-learning continuum while transitioning from being physician to being a nurse recounted , “I practiced then I went to private practice for a year then I went to nursing school. It was not a problem because most of my classmates were doctors, too.” Paolo’s experience illustrated how group membership impacts a person’s desire to learn. Adela experienced learning being a nurse as seeing the patient at a different level. She said, “It was nice to started studying classes. It’s nice to remember that it’s in a different level; and I like because I learned a lot—how to see the patient in a different level.”

This phase of *unlearning being physicians* with its reciprocal of *learning being nurses* was contingent upon *receiving knowledge and wisdom of nurses*. It also has two dimensions which were (a) shifting diagnostic perspective, and (b) recognizing nursing as autonomous practice.

*Receiving the knowledge and wisdom of nurses*. Stage Four of the substantive theory was contingent upon this concept of *receiving knowledge and wisdom of nurses*. The reciprocal actions of *unlearning being a physician* and *learning being a nurse* occurred with the participants *receiving knowledge and wisdom of nurses*. This concept is operationalized as the teaching-learning continuum. Diverging from the definition by Biddle (1979) and by Bootzin (1983), learning, in the context of this discussion regarding Stage Four *gaining authority to practice as a nurse* of the substantive theory of *combining the best of two world*, is defined as a facilitated process of change in behavior or conceptual state of a person. Within a general framework of the teaching-learning continuum conceptualized by the researcher as a triad comprised of knowledge-building through classroom instruction, skill-building through laboratory exercises, and skill-application in the clinical setting, it is implied that the knowledge and skills acquisition of nursing concepts in FEPs was facilitated by a

combination of academic-based and practice-based faculty members. In the classroom, participants received cognitive knowledge from academic-based faculty members who instilled in them the ideals, the theoretical, and the scientific basis of the profession. In the skills laboratory and clinical setting, they acquired psychomotor skills from clinical professors and clinical preceptors. As Rachel said, “We do conferences. We go to the bedside...[but] our clinical instructors...don’t really train us like how they train the regular students.” Rachel clarified her statement stating that their clinical instructors felt that their clinical skills as physicians were sufficient for nursing.

*Receiving the knowledge and wisdom of nurses* was critical in the process of the Physician-Nurses’ transition to nursing. Starting nursing school marked the beginning of the process of their socialization to the profession of nursing and the eventual development of their nursing identity. *Receiving the knowledge and wisdom of nurses* manifested their readiness to unlearn being physicians and learn being nurses. Selected quotes from participants serve to illustrate the unlearning-learning and teaching-learning process:

I was taking Fundamentals in Nursing, you know. Physical Assessment, Socialization, the first clinicals ...because you’re going into something different so you let go of the other. [Learning] the nursing process, yeah. It’s like assessing the patient and all that... but you don’t really realize how important it is until they start asking you those questions [NCLEX-type questions] and you have to think every time you answer. You have to think it, thinking about the Nursing Process, you know. So that’s when I realized how important it was and I started to pay a lot of attention to that. And it’s everything. You can apply that to medicine to. Because that’s what you do with your patient, you assess your patients; you evaluate; everything that the Nursing Process says. You do it also when you’re a doctor ...(Maira)

In another aspect of *receiving knowledge and wisdom of nurses*, Alina wanted good role models. She was very passionate when she talked about the importance of having excellent preceptors. She had a list of names of staff nurses she considered excellent

preceptors. She said that “a good preceptor is not necessarily somebody who knows everything... a good preceptor is a true person and who is organized who can teach.” Alina’s perspective is supported by the literature. In the research conducted by du Toit (1995), in her literature review, she gave a discourse about role models in nursing. This discourse is relevant to the circumstances of the FEPs retraining as nurses. She asserted that students who have a certain level of maturation may be critical and selective about their role models. She stated that students who have reached a level of maturity and have accumulated considerable experience are able to judge practitioners. The FEPs in-training to become possess past experiences that help them filter what they see and what they receive from their role models. Du Toit further asserted that students with past life experiences also select their anti-models, the models they want to avoid. Choosing role models and avoiding anti-models are important strategies for FEPs training to become nurses. The influence of others is important in the process of professional socialization to nursing. This is supported by the literature. In a meta-study of early socialization and career choice in nursing, the findings showed evidence how other nurses influence the process of socialization to nursing. Students and new nursing graduates spoke of how their own practices were influenced by the practices of more senior nurses (Price, 2008).

Another type of nursing teacher that was mentioned in the researcher’s conversations with the participants was nursing textbook authors. In the following discourse, the participant expressed his perception about the difference between how knowledge is imparted in nursing textbooks compared to medical textbooks.

In the beginning, ah, I thought it was going to be kinda little easier. Because you know, nursing should not be hard. But I think you find a lot of not obstacles but differences. First of all, the volume of information that you have to handle is a lot.



And English is not your, like, maternal language. So, you have to read a lot in English. So you need to be very proficient on that. And the second one, and probably the most important thing is how the nursing book. How they write those nursing books. You know. It's nothing against nurses. I just see that they go to more surround the information to give you something. Medical books, they are very concrete. You have the name of this disease, you have the causes, you have the symptoms, you have the treatment. Nursing, everything is a little bit more. How can I say that? Like more things around to give you more information. (Orlando)

One of the participants when telling her story about her struggles and how she coped with them during the early phase of her transition to US nursing said, "If you don't know something about nursing, just ask your colleagues or your co-workers....Don't think that even if you are a doctor, you know everything. You have to ask and seek for other's [nurses] help if you don't know. Don't pretend that you know everything." (Annabelle)

*Shifting diagnostic perspective.* A dimension in *unlearning being physicians and learning being nurses* is the *shift in diagnostic perspective*. The shift requires the mind-set to change from the point of view of providing medical diagnoses to a mind-set of formulating nursing diagnoses. A medical diagnosis "describes a disease or a pathology of specific organs or body systems" (Craven & Hirnle, 2007, p. 180). Physicians provide medical diagnosis after patient has been thoroughly evaluated using as criteria signs and symptoms and other clinical manifestations obtained through laboratory tests or other sophisticated diagnostic procedures. Physicians' scope of practice is focused on providing accurate medical diagnosis so that treatment of the existing pathology can commence. Medical diagnosis provides a clear and convenient way to communicate treatment requirements among healthcare practitioners. Nursing diagnosis, on the other hand, "describes an actual, risk, or wellness human response to a health problem that nurses are responsible for treating independently" (Craven & Hirnle, 2007, p. 180). Nursing diagnosis provides a standard nomenclature to communicate

independent nursing care interventions among nursing staff. RNs formulate nursing diagnoses after patient's responses to the disease process, developmental stage, or life process has been thoroughly evaluated by the RN. Nursing diagnoses have legal implications. RNs must be cognizant that only healthcare problems that fall within the scope of nursing practice can be labeled as nursing diagnoses. Diagnosing a medical disease is outside the scope of nursing practice. RNs are not licensed to independently treat medical diagnoses, but are licensed to intervene independently to resolve identified nursing diagnoses which are formulated within their scope, practice abilities, and education (Craven & Hirnle, 2007).

All the participants voiced their difficulty in formulating nursing diagnoses in the early part of their *unlearning being physician* and *learning being a nurse* phase. This is perhaps why the behaviors they manifested pertaining to the *shift in diagnostic perspective* were deviant at first. Although this was the case, they were all cognizant that in their new role as nurses, providing medical diagnoses was beyond their scope of practice. They stated that they were taught about nursing diagnoses in nursing school but their mind-set was still to think medical diagnoses. This must not be misconstrued that they provided and documented the medical diagnoses in patients' medical records. They just *think it*. A significant barrier to the application of what they learned from school regarding nursing diagnoses was perhaps their observation of the incongruence between the ideal and the real; between what was taught in school and what was practiced in the clinical setting. They observed that staff nurses in the practice setting did not use nursing diagnoses consistently. The following quotes from the participants illustrate their observations.

Zaida said that nursing diagnosis is totally different. She said "the funny thing is that nursing diagnosis is not even used in clinics here...nursing diagnosis, you don't use too much

in the clinical here. I don't feel I've used it." Initially this was also how Orlando perceived it stating, "I think it was easier for me to put interventions where I can use my medical knowledge. And I'll put like fear, what am I going to do with fear? I have to go in the book and look what is fear. Copy the books." Orlando who works in a procedural area at his place of employment has learned to use nursing diagnosis because in contrast with Zaida's statement, Orlando said, "Believe it or not, I use nursing diagnosis everyday where I work now. So I learned how to do it." He further stated, "Oh, you have to focus on the response of the patient" which is indicative that he was able to shift his diagnostic perspective. Orlando wondered about how generic students who have no past knowledge and experiences to draw upon formulate nursing diagnoses.

I don't know how...the regular nursing student, how they do [nursing diagnosis] because if you don't have so much knowledge how can you put so much diagnosis with so many interventions? For example, in impaired gas exchange, you know how many things can cause that? And, you know, I understand, I think you have to put like the patient is hypoxic. Something is in the lungs. You need to put too much information to produce nursing diagnosis together. We can do it easy because we have a lot of background to do that....The problem with nursing [diagnosis] is it's too broad. You know like impaired gas exchange—you know, you can have pneumonia, thrombo-embolism... So many things that can cause. Yeah, it's not hard. The care plans in the beginning were horrible. You learn how the nurse instructors want you to write that. And after that, doing the diagnosis was pretty easy. The medical diagnosis. I put that once. Well, ah, those were once like related to coughing. Those ones, we don't use that. I never used that once. I always use the nursing diagnosis that were more center like in disease process. Like impaired gas exchange...We have the book with the diagnosis. So, most of the time, I mean, sad to say, but most of the time we use the same things. 'Cause if you go to the hospital and if you have a patient with pneumonia, appendectomy or something, you are always going to try to use the diagnosis that is more medical. The anxiety or pain or fear, you know. What are you going to do with fear? What intervention? So, it was more...you've seen the diagnosis that they have, they have like a more medical approach. That was my particular way to do the care plan. I always try to do the diagnosis in which I can use my medical knowledge to my career....I think it was easier for me to put interventions where I can use my medical knowledge. And I'll put like fear, what I am going to do with fear? I have to go in the book and look what is fear. Copy the books. (Orlando)

Paolo who have been practicing as a nurse in the US for four years admitted that initially, he had problems changing his mind-set from medical to nursing diagnosis. Time has helped changed that. He gave the following discourse:

It's different. I always make my medical diagnosis. Not my nursing diagnosis. Because I'm used to it already. Nursing diagnosis is very different. Every doctor that turned into nursing, we always make a diagnosis...medical diagnosis... medical diagnosis not nursing diagnosis. There's a big, big difference. That's the problem. That's why during and before taking the [NCLEX] exam, we have to be very careful with that because we always make the medical diagnosis first. That's my problem. Every time I go to my computer and take the exam. That's always the problem. I always make a mistake about that...Paolo

Rachel also was confused about medical and nursing diagnosis: "...always put in mind that it's not medical diagnosis because sometimes we get confused. We put the medical diagnosis. But we are always reminded that it's not the medical diagnosis, it's always the nursing diagnosis, so we have a book."

*Recognizing nursing as autonomous practice.* The other dimension of *unlearning being a physician and learning being a nurse* and an influencing condition in *shifting diagnostic perspective* is *recognizing US nursing practice as an autonomous practice*. Every participant verbalized their observations regarding the differences in nursing practice in the US and nursing practice in their home countries. In the US, they observed that nurses function with autonomy, whereas nurses do not do so in their home countries. They observed that nurses in the US, most especially those working in specialty areas such as critical care units, emergency departments, and labor & delivery, have a significant level of autonomy and they perform functions that may be labeled more medical than more nursing. They observed also that in the US, nurses do not automatically carry out orders given by physicians. Nurses are expected to use critical thinking, to perform highly-skilled procedures that are routinely done

by physician residents in their home countries, and to educate patients about their disease processes and their collaborative plan of care. Nurses in the US were also observed by the participants as the professionals responsible for evaluating the effects of treatments and procedures in patients. Participants also observed that nurses in the US are permitted and encouraged to question physician orders if they deem them to be needing clarification.

The statement from the American Nurses Association about autonomy supports the observations of the participants in this study. “All nursing practice, regardless of specialty, role or setting, is fundamentally independent practice. RNs are accountable for judgments made and actions taken in the course of their nursing practice... The science of nursing is based on a critical thinking framework known as the nursing process which is the basis for the autonomous decision-making of registered nurses” (ANA, 2004, pp.10-11). In published studies, autonomy has been identified frequently as a key factor and critical element in both attracting nurses to new positions and in positively impacting job satisfaction for nurses. At the specialty level, the nurses with medical elements in their role includes nurse practitioners, nurse-midwives, nurse anesthetists, and critical care nurses (Bullough & Bullough, 1984).

Working as a nurse in here is different. It’s really, really different. They put more pressure on you. They put more responsibilities on the nurses. It’s just like you’re the doctor. That’s what I mean. (Arnel)

And the fact that I saw the nurses here in the United States really have more autonomy than the nurses in my country. That really only follow orders from the doctors but don’t question a lot of things. And don’t have this autonomy that I saw the nurses have in this country. (Maira)

How they perceive nurses in [my country] and how nurses are perceived over here...and really here they perceive nurses as independent thinkers and critical thinkers and then you have a patient all the time...you face them all the time so it really helps you to be on your own, independent, and...it’s pretty much the same you see in doctors in [my country]. The doctors in [my country] are with the patient all the time. You observe the patient. (Nina)

Over here, I think that the role of the nurse is more hectic. Depend [upon] where you work. For example, I like critical care. I think they have a lot of possibilities to use a lot of knowledge and analysis, and you know. That thing is very close to... to the medical profession. Because, particularly, in some hospitals, you see that in the Intensive Care Unit there is no physician 24 hours. So if you are the nurse and you are taking care of a patient who is not stable, like hypotensive or something. You know you have to have critical thinking and try to be a little aggressive because you know your things to be able to be [of help to] those patients. I think that's an advantage that probably we're not supposed to use. You are going to use it because you have it in your mind to benefit patients. (Orlando)

The nurse here, you have more autonomy. You get to make your own decisions... (Zaida)

*Obtaining US nursing licensure.* Obtaining nursing licensure was the ultimate turning point in the experience of the participants in their transition to US nursing practice. This was the second phase of Stage Four of the substantive theory of *combining the best of two worlds*. Their successful crossing of the line between graduation from nursing school to passing the NCLEX represented their successful efforts of crossing professions. *Obtaining licensure* determined the participants' entry into Stage Five which is the culminating stage, *engaging self to nursing and asserting "I am a nurse"* of the substantive theory; therefore, it can be considered a critical point within the critical juncture of Stage Four. Participants who retrained in the US voiced satisfaction with the nursing program they attended. Maira said, "Actually, I think we were really well prepared for that. The university prepared us a lot. I think that since the beginning we were taking in class questions that they were going to ask...in the end, I felt really prepared. I went. I took it. They only gave me 75 questions" (Maira). Orlando who attended a similar program but in a different geographical location and at a different time period confirmed what Maira said and also stated that he felt he was well-prepared for NCLEX, stating "I think the university, they do a really good job of getting you

ready ...preparing you.” In assessing the type of questions in the NCLEX, he also said that he felt that he used more of his medical knowledge compared to his nursing knowledge when he answered questions about Pediatrics, a subject matter that he was not too fervent about. This was also voiced by Arnel saying that he felt that his medical knowledge helped him pass NCLEX and that he would have been able to answer at least 50% of the questions correctly just by drawing from his past knowledge as a physician. Zaida was also confident, “the medical helped me knowledge-wise.” Alina said that NCLEX was not hard for her. On a different tone, Adela admitted that the days immediately following her taking the NCLEX constituted “the most scary three days of my life.” She said that her intuition indicated she passed but she was very scared of what might the true results be.

Participants originally from the Philippines were very methodological in their transition process. Paolo, for instance, had his trip to the US and NCLEX dates well-planned. He said that before he traveled to the US, he ensured that all his requisites for testing were complete. Upon arrival to the US, he took the NCLEX within a week and passed. Rachel who was anticipating her immigration to the US in 2007 or 2008 took NCLEX in Hong Kong, China in 2006 before the Philippines became an international NCLEX testing center.

All the participants, talked about the importance of having a strategy in answering the questions. Zaida, for instance said, “I think the NCLEX, they teach me how to judge the questions, why they ask the questions, or what’s the best answer for this.....how to deal with test.” For Rachel, it helped that she took the CGFNS examination before she took the NCLEX.

*Stage Five: Engaging Self to Nursing and Asserting “I am a Nurse”*

The fulfillment of the requirements for US nursing practice licensure brought the participants to the culminating stage, Stage Five of the substantive theory. It was in this stage that the Physician-Nurses manifested their successful transition to US nursing practice. This stage which is named *engaging self to nursing and asserting “I am a Nurse”* has one influencing factor and four strategies. The influencing factor is the *upholding of new venture by significant people* and the four strategies are (a) finding the right niche, (b) avoiding voluntary self-disclosure of previous professional identity, (c) strengthening new role with past medical knowledge, skills, and experiences, and (d) valuing differences and experiencing professional integration. With the influencing factor and the four strategies, Stage Five pulls the substantive theory of *combining the best of two worlds* to cope with *experiencing the burdens of a new beginning* together in a cohesive whole.

*Upholding of new venture by significant people.* Through the words of the participants, it was clear that they were not alone in their undertaking to pursue nursing. Significant people in their lives such as spouse, mother, and other close family and friends upheld their decisions for a career change. They encouraged them when they felt discouraged and they provided them with staying power. The positive influence of significant people in the success of nursing students in their pursuit of nursing is well supported in the literature (Rivera-Goba, 2007; Taxis, 2006; Villaruel, Canales, & Torres, 2001).

Rachel who emigrated from the Philippines where a significant number of physicians are retraining as nurses shared her insight regarding the influence of others on her decision to pursue nursing:



Family and friends also have big part on assuming a different identity and profession. With their help it was easy for me to assume the role of a nurse. Being with the people who are open minded, and supportive helped me become good and happy with what I'm doing.

The decisions of Arnel and Paolo to shift their professions to nursing were also supported by their spouses. For Orlando, his wife was also a nurse and she upheld Orlando's decision to pursue nursing. Orlando also had a sister in Canada who did the same thing he did. He said that his sister who was a biologist and a physician worked as a Nurse Tech for three years in Canada before she enrolled in an accelerated BSN program. He said that changing professions from medicine to nursing was nothing new in his house. Alina who had both medical and nursing degrees from her home country but who decided to attend a nursing program in the US said that her mother who was a physician was extremely supportive of her decision to pursue nursing. Alina said, "My mom, she was supportive. She was just like so excited about it. She was even looking at my books and said it's great... She helped me a lot through that."

*Finding the right niche.* *Finding the right niche* was the first strategy for Stage Five. To the participants, finding the right niche was locating themselves in the work places that felt just right for them. Nine of the 12 Physician-Nurses who participated in this study worked in specialty areas where nurses functioned with high-level autonomy like critical care, emergency department, endoscopy, labor and delivery, and nursery. Adela had doubts about her abilities to be a floor nurse, "I don't know if I can be a nurse in the floor." What Adela meant by *floor* was a Medical-Surgical Unit. She felt blessed for finding her niche early in her nursing career, stating, "I was blessed to be in the nursery. That's the place I like... and the nurses—they're very nice." Adela felt fortunate because she spent her 200 clinical preceptorship hours in the nursery and had considered it to be her *home* since. She said,

“...Then when I finished my preceptorship, I already knew all the nurses and then I start working there, and it was like...it was my home already.” Adela loves children. She continued on to say, “That’s part of why I like it because I love children, babies, and it’s easier than to be a nurse in MedSurg. You have to give like 20 pills and take care of the patients; some of them are total care. I don’t want to give nasogastric; and cleaning...I don’t like that.”

Maira found her niche also although it came seven months after she obtained her license. She wanted to work in labor and delivery immediately after licensure but she had to accept a position in the mother-baby unit because “they didn’t allow me to go to labor and delivery because they think...or they thought that I was not qualified for that...although I delivered tons of babies in my country....They didn’t let me do labor and delivery. So I had to go to be with the moms and babies, post partum patients.” Maira found it difficult to adapt in the mother-baby environment. She said that the part that was very difficult was learning the charting and the computer system. She found it challenging. The challenges she faced related to computers and documentation was compounded by the number of patients she was assigned to take care during her shift. “And then the fact that they gave you like 6 to 7 patients...but it’s like the mom and the baby. So you have to deal with all that.” Maira knew where her niche was, so she worked on pursuing to transition there. Within seven months, she transferred to labor and delivery.

Orlando was in a special predicament. Like Adela and Maira, he knew his niche early in his training. He was more a procedural nurse than a floor nurse. For Orlando to land on his niche immediately after nursing school, negotiations occurred between his nursing school hospital sponsor and the hospital where his niche was located. At the time of the interviews,

all the participants found their niches (see Table 5.5) and all of them expressed satisfaction with their nursing careers including those who have only been practicing for less than a year.

Finding the right niche also meant finding the right geographical location in the US where they would practice as nurses. In the early 2000s, Las Vegas was a popular destination for Physician-Nurses from the Philippines. According to two of the participants in this study who reside in Las Vegas, a staffing recruitment agency which specialized in the placement of Physician-Nurses was based in Las Vegas at that time. Arnel was in three places before he

Table 5.5

*Participants' Right Niches*

The Right Niche	Participant Pseudonyms
Cardiology	Zaida
Critical Care	Alina, Arnel, Paolo, and Rachel
Emergency Department	Ollie
Endoscopy	Orlando
Extended Care	Dante
Labor & Delivery	Maira
Medical-Surgical	Annabelle and Nina
Nursery	Adela

settled in Las Vegas. He started in Illinois, then went to California, and finally in Nevada. He found that no matter where he went, he found a niche of people within his Filipino culture which he found helpful in his adjustment to life in the US.

*Avoiding voluntary self-disclosure of previous profession.* All the participants expressed that they preferred that their previous profession be not disclosed to others to the extent possible. The participants found this strategy useful to avoid questioning from others. Ollie said, “Sometimes they ask me, ‘Are you a doctor somewhere?’ or they ask me ‘how long have you been a nurse?’ That’s a trick question. I just give them an answer. ‘I’ve been working for 20 years.’ Even though it is not true; just to stop their questioning.” Ollie also stated that when he received the job offer from his manager, he specifically requested that his previous profession not be disclosed to anyone due to his concern that people might have negative biases against professionals like him. Other illustrative quotes that show how the participants valued non-disclosure are as follows:

A few people knew. And I do not like people to know. I don’t like people to know. Yeah, I’d rather have them not know that because I’m a nurse here. I’m a nurse... It doesn’t matter if I was a doctor in my country ... (Maira)

Well, actually I was working as an examining physician in one of the clinics. They didn’t know... I mean the patients. They did not know so they did not ask about it... [Here, in the US], I never told them that I’m a doctor. They probably would have expected more from me if they know so I didn’t like that. I haven’t told them that I’m a doctor. (Annabelle)

In another context where voluntary self-disclosure was of value, Arnel spoke of what might his parents know or not know, “Actually, when I came here [to the US], I don’t know if they really understand why I’m going here. I think they still think I’m a doctor...”

There was another facet of *avoiding voluntary self-disclosure*. This other facet occurred when the participants did not voluntarily reveal to others, especially to their colleagues that they were pursuing nursing. For instance, Orlando, whose immediate family in the US supported his decision to pursue nursing did not make the fact known to his parents and to his colleagues in his home country or when he did, he made it very vague. He said he

was not open to them about it, stating “I never say to them, ‘Okay, I’m quitting medicine. I’m becoming a nurse.’ I say to them, ‘Okay, I’m going to school. I’m going to get a nursing degree’.” In the literature, physicians have been found to keep their nursing studies a secret to the extent possible. For instance, in the case study conducted by Gunn-Lewis and Smith (1999), Jiang and the other Chinese physicians who were retraining as nurses in New Zealand did not reveal to their families in China that they were pursuing nursing. They just claimed that they were studying.

*Strengthening new role with past medical knowledge, skills, and experiences.* In Stage One, it was determined that the participants had to *let go of their professional identity as physicians* and they had to *disengage from the profession of medicine* before they made their *conscious decision to become nurses*. In Stage Four, they *unlearned being physicians* and they *learned being nurses* by *receiving the knowledge and wisdom* of academic-based and practice based nurse teachers. In this culminating stage of the substantive theory, the participants retrieved their *past medical knowledge, skills, and experiences* and used those to strengthen their new roles as practicing nurses. The essence of the substantive theory *combining the best of two worlds* to cope with *experiencing the burdens of a new beginning* lies here. Adela puts the essence of this strategy eloquently in her view, “I have two views. I take the good things about being a doctor and the good things about being a nurse and for me that’s the biggest...the biggest...the best ‘*recompensar*’ [reward].”

Arnel discussed how he thinks his past profession as a physician *strengthened his nursing practice*. He said he felt that he was at an advantage:

Actually, being a doctor—it’s a big advantage. Actually, just about medications alone. [As a doctor], you are aware of this medication; the action of this medication, you are

aware of that... It was taken in nursing school, but not just as much as you learn it in medicine, so it's big one; a big advantage. (Arnel)

Paolo, a former surgeon who practiced for ten years before he became a nurse said that he feels he is also at an advantage over others because being a surgeon, he had seen the internal organs and because of that he could conceptualize patient problems better.

Additionally, as a medical intern, he learned all the nursing skills such as IVs [intravenous], insertion of foley catheters [urinary drainage] and NGTs [nasogastric tubes], etc. So when faced to perform such skills as a nurse he said "it was like a review." Paolo further claimed,

My advantage to other nurses is I know the physiology. I know the anatomy and pathophysiology. So I can explain to myself and to my other co-nurses what's happening to the patient, and I can easily assess what's going on and...most of the time the nurses here, they always come to me to ask for anything, if they have questions, if they don't know it. So that's my only advantage.

Dante's perspective is that being a physician in the past gave him the knowledge that he now uses in his decision-making as a nurse.

... it's still good that I went to medical school because I know some stuff that some nurses don't know. So it helps me. It helps me with my decision making and all that stuff. It's truly like different and we think a little differently...(Dante)

Orlando also felt that his past medical knowledge, skills and experiences strengthened his new role as a nurse. He referred back to his NCLEX experience and related that the questions were more medical interventions, "It wasn't too many like nursing interventions or too many nursing things." He further said:

You know the [medical] background that we have is pretty useful when you are starting nursing...What the disease and symptoms and some interventions...For example, like in the NCLEX. The NCLEX probably is 70 percent of what I learned in medical school... it was very medical approach. ...

Regarding clinical skills, Orlando stated:

We have those skills in the back of your mind. You know what, you start to do it again, it's easy. But you know, I think special medication is something basic you do in medical school. So it wasn't a problem. The IV— you get used to that. But you can learn to do. You learn to do IVs.

Ollie, whose specialty was internal medicine when he was a physician and who is now a nurse in the emergency department is consoled that he could still read EKGs. He said, “I do mentally [read EKGs].... of course I cannot do the reporting but I know what to do with the patient. That's my advantage.” Rachel also felt that her past knowledge, skills, and experiences helped her *strengthen her new role as a nurse* in the US. She had this story to tell:

So it [nursing training and orientation] was pretty much the same as the training in medicine because I trained mostly in the government hospitals; and in the government tertiary hospitals in the Philippines and what we do there, we help the nurses do their jobs and at the same time help the doctors do their jobs, assist the doctors. So I'm already familiar with what the nurses are doing except the preparation of medicine and the charting because we don't do the charting. So other things, I'm already familiar. It made it a little easier for me to adapt to the situation.

Maira felt that her obstetrical experience as a physician in her home country strengthened her new role as a nurse in labor & delivery. She found that her knowledge, skills, and experience were useful when collaborating with physicians in her role as a labor & delivery room nurse. She stated that when physicians learn that she was a physician in her home country, they would show her more respect and would encourage her to do more. Some physicians would actually seek advice from her.

Because I had experience delivering babies in my own country, I knew how to do the vaginal exam. I know when they are going to deliver. I know when the mom is going to deliver, I know...I knew all those things so it was actually easier for me to be in labor and delivery than in mother-baby.

All of the participants had stories to share regarding their past knowledge, skills, and experiences as physicians. What is apparent in their stories is that they were very technical- and skills-oriented as physicians. The psycho-social aspect of patient care was missing in their

stories except for the story of Nina when she stated, “You know, it’s not about being a doctor. For me it was about being help[ful] in this field.” The process of becoming nurses changed their views about their roles as healthcare providers. The discussion that follows provides a description of how the participants manifested their shift from being technical and skills-oriented former physicians (original self) to being psycho-social oriented nurses (new self).

*Valuing differences and experiencing professional integration.* This last strategy for Stage Five describes how the participants valued the differences of nursing and medicine and how they were able to transcend these differences to experience professional integration. A common theme that resonated from the participants is their recognition that medicine and nursing are two professions that are different but that they carry the same purpose which is to care for individuals needing healthcare. The discussion in Chapter One which compares nursing and medicine serves as a reference for the explication of this strategy. Voices of the participants are used for illustration.

*Valuing differences.* When something is valued, it is held in high regard. To the participants in this study, valuing the differences between nursing and medicine meant holding those differences in high regard and using the very aspects of those differences to transcend them. A theme that emerged here is the hierarchical positioning of nursing and medicine. Paolo said, “Of course, it’s the same medical field; but different profession. Being a doctor is different; being a nurse is different. For me, it’s [i.e., becoming a nurse] not a downgrade of profession. It’s [they are] two entire different thing.” Alina trails along Paolo’s perspective. She said, “to become a nurse, I don’t feel like that [minimized]. It’s just different profession, different philosophy.” Nina observed the differences and she wondered, “I don’t know why people think that being a doctor is such a big thing. But we are the same. I mean,



we have the same purpose to take care of the patient. I don't feel doctors are superior because in [my country], doctors do most of the work that nurses do here." On the other hand, Annabelle had a different perspective about physicians. She said, "sometimes you play as a boss, but as a nurse, you're just under, always under the doctor." This may explain her perspective about how she perceives her retraining from being a physician to being a nurse. She likened it to, "... I have one step down from the stairs." Annabelle values these differences and she is keen in observing that US nursing practice is different from nursing practice in her home country, stating that, "actually, here in the U.S., if they know that you are a nurse, they have high respect for you."

The differences in clinical focus between nursing and medicine are well documented in the literature, and the participants are able to articulate some of those differences as they experienced them. For instance, they all recognized that the physicians are the givers of treatment orders and the nurses are the doers of those orders. Paolo continued on his discourse and focused on diagnosing disease. He stated:

As a nurse you can't make any diagnosis. As a doctor, you have to make a diagnosis. So that's the difference. And as a nurse, you spend more time with the patients than the doctor. The doctor usually spends a little time with the patients unlike the nurses. So the picture is very, very different.

Maira also articulated her observations of the differences in patient-nurse relationship and patient-physician relationship. She said:

You know, a nurse is there with the patient most of the time. You know, the nurse can inquire about the social life of the patient and really realize what the changes that is going on with the patient. Because the doctor only goes there, examines the patient and then he leaves. But the nurse is there all the time.

Arnel was very keen about the Nurse Practice Act. He said, “it’s easy for me to intubate; to put into tracheal tube; it’s just *peanut* [easy]. But in here as a nurse, I cannot do that. Even saving this patient. I will not do that. I learned... being a nurse for 5 years.”

*Experiencing professional integration.* Professional integration in the context of the results of this current study is the integration of the *original self* and the *new self* in the participants. The essence of this section of this dissertation chapter is the presentation of the participants’ professional views of themselves and their assertions of “I am a nurse” as the qualitative descriptor of the development of their nursing identity. Their reflections are presented in Table 5.6. This section also pulls specific qualitative descriptors that operationalize the shifting of paradigms in participants’ as they transcend the differing medical and nursing paradigms. Participant voices and reflections that are used to illustrate the shift in paradigms and the experience of professional integration are drawn from selected responses to the interview guiding question, “Describe how you were able to shift from your identity as a medical doctor to being a registered nurse.”

### *Shifting Paradigms: Selected Voices and Reflections*

#### *The Voice and Reflections of Maira*

I don’t know how it happened. I think it helped me a lot when I went to the program at the Community College where not everybody was a doctor. I think it helped me a lot to go to that program that I went where everybody was...or nobody was a doctor. Everybody was just pursuing being a nurse. When I went to the Community College, because I was just like any other student, you know. I don’t know in what moment I changed....When I went to take my interview actually to go into the foreign physician program, the person that interviewed

Table 5.6

*Participants Asserting “I am a Nurse” when asked “What professional view do you have of yourself now?”*

Participant Pseudonym	Professional View of Self	Reflections of the Participants: Beyond Asserting “I am a nurse”
Adela	I am a nurse. (188)	I passed the tests...so I am a nurse, and I’m a doctor! (188) I don’t say ‘I’m doctor’ [to patients]. (190)
Alina	I am a nurse. (148)	I think when I’m here in America I see myself as I am a nurse. Because how can I view myself as a doctor when I am not practicing? (148)
Annabelle	I am a nurse. (110)	I am a doctor and a nurse. It is good to have two professions: a doctor and a nurse. (127)
Arnel	I am an RN. (155)	I think as a nurse. (172) Because you are bound by your practice act. (175)
Dante	I’m a nurse. (110)	I can talk comfortably and say I’m a nurse now because I’m actually not confident being a doctor anymore. It’s been a while. (110)
Maira	I’m a nurse. (120)	I don’t want to be a physician anymore. I know all the things I know and all I went through but I’m a nurse now.(134)
Nina	Nurse.(93)	It’s not about being a doctor because I’m still a doctor. I just don’t practice medicine here.(36)
Ollie	I’m an RN. (153)	I always remind myself that I’m a nurse here.(153) Well, I still like being a doctor. (149)
Orlando	A nurse of course.(144)	Honestly, I don’t think I’m going to be a nurse for a long time. I’m going to try to become a nurse anesthetist. But yeah, it’s a nurse of course. (144). When I am finish, I’m going to go to school to finish my medical studies because...you know, what I’m telling you [it] is hard. Maybe ask me in 20 years of being a nurse. I had been a nurse for 6 months and I have been a doctor longer than that. (146)
Paolo	A nurse. (124)	I’m still a doctor. That can’t be taken away from me. Everywhere you go, you’re still a doctor. You always carry your title wherever you go. So right now, I have two titles after my name. I am MD. I am also RN. (188)
Rachel	I’m a nurse. (142)	I’m a nurse. I’m a nurse. I graduated as a medical doctor, but I’m a nurse now. (142)
Zaida	Nurse. (505)	In America, I’m very proud to tell people I’m a nurse.(548)

*Note.* Numbers in parentheses indicate lines in ATLAS.ti files where quotes are found.

me, she was really happy for what I said. “Well tell me what is the difference.” I said, “You know, a nurse is there with the patient most of the time. You know, the nurse can inquire about the social life of the patient and really realize what the changes that is going on with the patient. Because the doctor only goes there, examines the patient and then he leaves. But the nurse is there all the time.” I really cannot tell you exactly what moment I change. But I did change, you know...my method of thinking and the way that I see the patient. I see the patient a little bit different, to tell you the truth. When I was a doctor and now that I’m a nurse. Because when you’re a doctor, you tend to see the patient like a system...like this is not what is working with the patient, this part of the patient. When you’re a nurse, you see the patient as a whole, like a person...You have a different connection with them. I really cannot tell you when I changed. I guess going through all those classes that I took. Tons of classes because I have to take all the pre-requisites to go there. And I have to take Fundamentals of Nursing. I went to the whole first and second semester in the Community College. Then I transferred to [the university] .

*The Voice and Reflections of Rachel*

I was able to change my role and identity from being a doctor to being a nurse by mind setting—that, I am working now as a nurse and not as a doctor. Physicians have different role and responsibilities than a nurse in the medical field. And there are things that doctors can do and nurses can’t do. It is a constant reminder to myself that I have a different role now and also a constant reminder of the limitations I have in my new field. I think I owe it also to my friends who help me accept my new identity. I was in a group of doctors who wanted to work as nurses, and I’ve never seen regrets or inferiority in what they are doing. Everyone has their own reasons of changing their profession. I’ve mentioned about ego, of

course anyone from a higher field will develop certain ego, doctors, lawyers, nurses, accountant, etc. and stepping down to another profession lower than what they have will hurt their ego. But for me, I didn't let it affect me to assume a different role. [Being a nurse] comes natural now. I've internalized it already. With the three years I've worked as a nurse, I learned to love it. What I'm doing is very close to what I was doing as a doctor before. It reminds me constantly about patient care. Sometimes it comes into my mind that I am a doctor and I just tell myself, yes, that was before and maybe in the future I can work again as a doctor but not now, because now, I am a nurse. Accepting a new identity wholeheartedly will help everyone be good in what they are doing.

*The Voice and Reflections of Adela*

It's because at the beginning, you have to switch role. How can I explain? They force you because [of] the test. For all of us, it was difficult because for example when we were taking a test, we answer like doctors, not answer like a nurse. At the beginning it was bad... That was very difficult. The first action from the doctor is different; it's different [from] the nurse. I don't know [how the switch happened]. It just happened. It's like when you are studying English. At the beginning you translate everything. For example, like I was talking, and I was translating everything in my mind. Now, I don't translate. If I'm listening, I'm not translating to Spanish in my mind. But at the beginning yes, I was doing translation. It's almost like it now...I forgot I am a doctor. I am working as a nurse. I don't how it happened, but it happened. Maybe...my experience [as general practitioner] was just two years, and I was without work for 5 years. It's like [it] was easier I think for me because I have other classmates, they have been a doctor for 30 years, surgeon and with a big background, and I was new. Maybe that helped me. I don't know.

If your focus is on name, in status. I don't know if you can be a nurse. If you're thinking about names and doctors, you cannot be a nurse. Now, I appreciate so much the nurse's job. If I go back to my country, I have a dream to build a clinic. I'm gonna treat them like a queen or princess because they work. Nurses work.

*The Voice and Reflections of Alina*

I like to be at the bedside. I like to be with the patient. I like to talk to them. I like being in service to the patient, you know. And it doesn't mean probably a lot of doctors here, they can do that. From the other side, I'm thinking sometimes, I don't have that power. I don't feel that power....[but as a nurse] I'm enjoying my profession because I feel like I can do something valuable and wise. People have different philosophies. My philosophy is I'm enjoying what I'm doing and I feel like...every time I go home I feel good. Sometimes I feel bad that you didn't get something. You tried to do the best and you're getting better. And plus you know, your patient is managed by somebody else beside you right now.... Most times [it] benefits to be nurse. You're free. You're very free.... you don't belong to yourself when you are a physician.

*The Voice and Reflections of Orlando*

...yeah you're a nurse and you see that the family sees you that you're a nurse. And you create this and you know you are respected. And all the things and it's not like I have at the back of my mind "Oh yeah, I'm a doctor, I'm doing this as a nurse." And you know that you are a doctor but you are a nurse. You enjoy being a nurse. And [they] give you some respect. And you help people, patients feel better. So yeah, I'm happy with the role of being a nurse, believe it or not. Yeah. It gives you something to be proud of. Yeah, I know that my job from being a physician to a being nurse, it's not easy to get a degree in this country when

you are not from here. So, I think that is an achievement and I should be proud of that....  
Actually, it was an easy transition because I knew what we were doing. And I was pretty close to the nurses over here. So it was nothing new for me. But yeah, different responsibilities and different things. But it was nothing completely new for me.

### *The Voice and Reflections of Annabelle*

To me, one word “willingness”. Willingness to do it. Willingness to work as a nurse here, it’s a big key. I’m really contented and I’m happy being a nurse here. And that comes within my heart. But sometimes when a patient calls me “the nurse”, I cannot deny to myself that “Oh my God, they called me a nurse.” Well, because I’m not used to go...as a nurse..they always called me doctor..And now the patient calls me... “Nurse...nurse...” [Annabelle refers to her transition to nursing as ‘reconditioned’]... When I went to nursing school, I was already decided and reconditioned.

### *Chapter Summary*

This chapter reported the findings in this study. As a grounded theory study, core categories emerged and a central social psychological problem that was experienced by the participants in the process of their transition from being FEPs to being US nurses as well as a resultant basic social psychological process was discovered. The name assigned to the central problem that was discovered in this study is *experiencing the burdens of a new beginning* and the basic process that emerged which explains how the participants addressed the central problem is *combining the best of two worlds*. The central problem has three dimensions and the basic process has five stages.

It was discussed in this chapter that there are three dimensions of the central problem. These three dimensions occurred within the context of the participants’ new society, new self-

concept, and new profession. As immigrants in the US, the participants experienced these three dimensions of burdens namely: (a) crossing cultures which pertained to the burdens of language and communication barriers and cultural differences; (b) starting from zero which pertained to the burdens of assuming a lower level social status secondary to assuming unskilled low-paying jobs in order to survive; and (c) crossing professions which pertained to the burdens of professional discontinuity from medicine and crossing over to the nursing profession.

In this chapter, the five stages of the basic process *combining the best of two worlds* and the related concepts were discussed in-depth to explain the substantive theory of *combining the best of two worlds* to cope with *experiencing the burdens of a new beginning*. Using voices and reflections of the participants, thick descriptions were provided to explain the five stages of the substantive theory which are: (a) letting go of professional identity as physician, (b) experiencing growing pains, (c) seeing nursing as a saving grace, (d) gaining authority to practice as a nurse, and (e) engaging self to nursing and asserting “I am a nurse”. It was discussed that what forms the substantive theory of *combining the best of two worlds* to cope with *experiencing the burdens of a new beginning* is the logical combination of the dimensions of the central problem and the recursive stages of the basic process and the various interconnected concepts.

Utilizing relevant coding families (Glaser, 1978) during conceptualization, causal factors, consequences, dimensions, influencing factors, contexts, and contingencies were identified for the five stages comprising the substantive theory. Stage One, *letting go of professional identity as physician*, was conceptualized as a critical juncture having two reciprocal causal factors, namely (a) door of opportunity to the profession of medicine closes,



and (b) door of opportunity to the profession of nursing opens; and that it had two reciprocal consequences namely (a) disengaging self from the profession of medicine, and (b) making conscious decision to become a nurse. Stage Two, *experiencing growing pains*, was conceptualized as having a dimension with a property of uncertainty labeled, *tug-of-war in desire to be a nurse or be a physician*. Stage Two also had two influencing factors or covariances which were identified as the pre-established self-perceptions of the participants that: (a) physician has ultimate power over clinical decision making, and (b) nursing minimizes past medical knowledge, skills, and experiences. Stage Three, *seeing nursing as a saving grace*, was identified as having two dimensions, namely (a) nursing as an easier route to a US healthcare career, and (b) nursing as a way to economic gain. It was also discussed that Stage Three was contingent upon opening of doors of opportunity to the profession of nursing and the receiving of knowledge and wisdom of nurses. Stage Four, *gaining authority to practice as a nurse*, was conceptualized as the second critical juncture in the process of transitioning to nursing as experienced by the participants in this study. This stage was conceptualized as a process with two phases. The first phase was *unlearning being a physician* with its reciprocal *learning being a nurse*; and the second phase was *obtaining US nursing licensure*. Stage Four was found to be contingent upon *receiving knowledge and wisdom of nurses*, which in turn was contingent upon the *opening of the door of opportunity to nursing* which in turn was a causal factor for Stage One. The second phase of this stage, obtaining US nursing licensure was conceptualized as the ultimate turning point in the experience of the participants in their transition to US nursing practice. *Obtaining US nursing licensure* determined the participants' entry to the culminating stage of the substantive theory.

Stage Five, *engaging self to nursing and asserting “I am a nurse”*, was conceptualized as having one influencing factor and four strategies. The influencing factor was identified as the *upholding of new venture by significant people* and the four strategies were identified as (a) finding the right niche, (b) avoiding voluntary self-disclosure of previous professional identity, (c) strengthening new role with past medical knowledge, skills, and experiences, and (d) valuing differences and experiencing professional integration. With the influencing factor and the four strategies, Stage Five pulled the substantive theory of *combining the best of two worlds to cope with experiencing the burdens of a new beginning* together in a cohesive whole. It was discussed in this chapter that Stage Five of the substantive theory is where the essence of this dissertation lies because it is in this section where the participants’ new professional views of themselves and their assertions of “I am a nurse” as qualitative descriptors of the development of their nursing identity were presented. To link the concept of *shifting paradigms*, selected reflections from some of the participants were included.

A quote eloquently stated by Adela was the quintessence of this chapter: “I have two views. I take the good things about being a doctor and the good things about being a nurse and for me that’s the biggest...the biggest...the best ‘*recompensar*’ [reward].”

The next chapter which is the final chapter, Chapter Six will provide a discussion of the interpretation of findings. The key sensitizing concept *nursing identity* is operationalized utilizing three statements published by the American Nurses Association namely: (a) description of the professional registered nurse, (b) knowledge base for nursing practice, and (c) code of ethics for nurses. The essence of the substantive theory *combining the best of two worlds to cope with experiencing the burdens of a new beginning* and the beginnings of a formal theory “Theory of Transprofessionalism” will be presented. The conclusion,

limitations and strengths of the study, and implications for the future will provide closure for this research report.

## Chapter Six

### Interpretation and Conclusions

*Although it is quite possible for one researcher to generate magnificent substantive theory in a relatively short time (using field or library data), it is virtually impossible for him to generate equally excellent formal theory through only his own field work. Usually he also needs either the primary field data gathered by other researchers or their published analyses and their illustrative quotes drawn from field notes. ~Glaser and Strauss, 1967, p. 175.*

In the early conceptualization of this grounded theory study and in the early phases of the research process, the statement of purpose and specific aims that guided the researcher were presented as follows:

The purpose of this qualitative study is to develop an explanatory model depicting the basic social psychological process that influences the development of nursing identity in foreign-educated medical doctors who have been retrained as nurses and who are now practicing in the US. The findings of this exploratory and explanatory study will provide significant insight into the process by which this unique breed of nurses shifts from their previous professional identity as physicians to their new identity as nurses. This proposed study intends to discover the answer to the research question, "What is the basic social psychological process that influences the development of nursing identity in foreign-educated medical doctors who have retrained as nurses and who are now practicing in the US?" The specific aims of this study are to: (a) identify and explain the intrinsic and extrinsic catalysts in the development of nursing identity in MD-Nurses, (b) identify and explain the intrinsic and extrinsic barriers in the development of nursing identity in MD-Nurses, (c) discover and explain the process by which MD-Nurses shift from their previous professional identity and embrace their new identity; and (d) formulate the concepts discovered into a logical, systematic, and explanatory model.

As the research process progressed and developed, significant modifications occurred in how the study purpose and specific aims were framed and stated. The statement describing the purpose of the study and specific aims became:

The purpose of this qualitative study using grounded theory methodology and guided by the philosophical foundations of symbolic interactionism was to generate a theory that can explain the basic social psychological process that influenced the development of nursing identity in foreign-educated physicians who have retrained as nurses and who are now practicing in the US. The specific aims were to discover barriers that participants perceived as problematic in their transition to nursing and catalysts that influenced how they addressed the central problematic issue they articulated.

*The Key Sensitizing Concept: Nursing Identity*

The key concept in this study was nursing identity which was conceptualized by the researcher as the substantive outcome of the process of professional socialization to nursing. Nursing identity was defined as the *persona* of a healthcare professional that portrays the expected knowledge, skills, roles, behaviors, attitudes, values, and norms that are appropriate and acceptable in the culture of the nursing profession. *Persona*, in this context, was defined as the professional role that an individual assumes and displays in society. The definition of nursing identity was adapted from definitions of professional socialization found in the literature (Cohen, 1981; du Toit, 1995; Fetzer, 2003; MacIntosh, 2003; Mooney, 2007; Shinyashiki, Mendes, Trevizan, & Day, 2006).

The knowledge, skills, roles, behaviors, attitudes, values, and norms of nursing are operationalized utilizing three statements published by the American Nurses Association namely: (a) description of the professional registered nurse (ANA, 2004), (b) knowledge base for nursing practice (ANA, 2003), and (c) code of ethics for nurses (ANA, 2001). In this chapter where interpretation of findings and concluding remarks are made, the researcher deems it essential to provide the readers with reference points about the registered nurse and

about the requisite knowledge and values of the nursing profession. The statements by ANA serve to expand the description of nursing which was provided in Chapter One. In doing so, credence and substance are afforded to the definition of nursing identity as specified in this dissertation. To prevent dilution of the statements provided by the American Nurses Association, excerpts are taken directly from the publications. The readers are referred to the actual ANA publications (2001/2003/2004) to obtain a comprehensive picture of professional nursing practice in the US.

*The Development of Nursing Identity in Physician-Nurses: "I am a Nurse"*

When the Physician-Nurses asserted "I am nurse," (refer to Table 5.6), what they conveyed to society was a view of their *new self* or their self-concept that possess the characteristics of a nurse. In Wengstrom and Ekedahl's (2006) definition of nursing identity in the context of what it encompasses from the subjective and objective viewpoints, the assertion "I am a nurse" represented the participants' subjective viewpoints. It manifested the feelings and perceptions of the Physician-Nurses of themselves as nurses. Their assertion "I am a nurse" symbolized their commitment to the nursing profession and it implied the possession of qualities congruent to the statements of the ANA that describe the professional registered nurse, the knowledge base for nursing practice, and the code of ethics for nurses which are as follows:

*The Professional Registered Nurse*

A registered nurse is licensed and authorized by a state, commonwealth, or territory to practice nursing. Professional licensure of the healthcare professions was established to protect the public safety and authorize the practice of the profession. Requirements for authorization of nursing practice and the performance of certain professional nursing roles vary from jurisdiction to jurisdiction. The registered nurse's experience, education, knowledge, and abilities establish a level of competence. The registered nurse is educationally prepared for competent practice at the beginning level upon

graduation from an approved school of nursing (diploma, associate, baccalaureate, generic master's, or doctorate degree) and qualified by national examination for RN licensure (ANA, 2004, pp. 12-13).

### *Knowledge Base for Nursing Practice*

Nursing is a profession and scientific discipline. The knowledge base for professional nursing practice includes nursing science, philosophy, and ethics, as well as physical, economic, biomedical, behavioral, and social sciences. To refine and expand the knowledge base and science of the discipline, nurses generate and use theories and research findings that are selected on the basis of their fit with professional nursing's values of health and healthcare, as well as their relevance to professional nursing practice.

Nurses are concerned with human experiences and responses across the life span. Nurses partner with individuals, families, communities, and populations to address such issues as:

- promotion of health and safety;
- care and self-care processes
- physical, emotional, and spiritual comfort, discomfort, and pain;
- adaptation to physiologic processes;
- emotions related to experiences of birth, growth and development, health, illness, disease, and death;
- meanings ascribed to health and illness;
- decision-making and ability to make choices;
- relationships, role performance, and change processes within relationships;
- social policies and their effects on the health of individuals, families, and communities;
- healthcare systems and their relationships with access to and quality of healthcare; and
- the environment and the prevention of disease.

Nurses use their theoretical and evidence-based knowledge of these phenomena in collaborating with patients to assess, plan, implement, and evaluate care. Nursing interventions are intended to produce beneficial effects and contribute to quality outcomes. Nurses evaluate the effectiveness of their care in relation to identified outcomes and use evidence to improve care (ANA, 2003, p. 7).

### *The Code of Ethics for Nurses (ANA, 2001, p. 4)*

1. The nurse in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

2. The nurse's primary commitment is to the patient, whether an individual, family, group, or community.
3. The nurse, promotes, advocates for, and strives to protect the health, safety, and rights of the patient.
4. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care.
5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.
6. The nurse participates in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the provision of quality healthcare and consistent with the values of the profession through individual and collective action.
7. The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.
8. The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.
9. The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy. (ANA, 2001, p. 4)

Having graduated from a nursing education program, having obtained US nursing licensure by passing the NCLEX, and having found their right niche in their current employers, the participants in this study possessed the educational qualifications and legal right to claim membership in the nursing profession and assert "I am a nurse." This is congruent with Gregg and Magilvy's (2001) definition of nursing identity that it is an individual's self-identification with the nursing profession and contingent upon the individual's possession of a license obtained by passing the national licensing examination.



Asserting “I am a nurse” enabled them to impart the message to society that they possess the identity of a nurse. It conveyed in words their *persona* that portrays the expected knowledge, skills, roles, behaviors, attitudes, values, and norms that are appropriate and acceptable in the culture of the nursing profession.

“I am a nurse” defined their nursing identity; however, because of their previous professional identity as physicians, a caveat exists. Their profile is unique from that of a generic nurse because of the presence of a silhouette of their *original self* as physicians hovering around their *new self* as nurses. In the experiences of the 12 participants, the degree of the presence of the silhouette was not consistent across. Some had it more than others. Fortunately, what was consistent was the absence of evidence that would have indicated that the presence of such silhouette was detrimental. What emerged was evidence that it had beneficial effects. First, it enabled the participants to strengthen their new roles as nurses with their past medical knowledge, skills, and experiences. Second, the differences between nursing and medicine in general, and differences in nursing practice in their home countries and in the US came into clearer view allowing participants to value such differences and use the very aspects of those differences to transcend them. For instance, Physician-Nurses observed the autonomous practice of nurses in the US compared to the practice of nurses in their home countries. Recognizing this difference enabled them to overcome their perception that nursing minimized their past medical knowledge, skills, and experiences.

#### *The Substantive Theory: Combining the Best of Two Worlds*

Substantive theory is “a theoretical interpretation or explanation of a delimited problem in a particular area...” (Charmaz, 2006, p. 189). According to Glaser and Strauss (1967), a substantive theory “is a strategic link in the formulation and generation of grounded

formal theory” (p. 79). In this study, the substantive area of nursing inquiry that was explored was the nursing identity development in a specific nurse population, the Physician-Nurses. This grounded theory study generated a substantive theory that explained the process of nursing identity development in a sample of 12 FEPs who have retrained as nurses now practicing in the US. The name given to the substantive theory is *combining the best of two worlds* to cope with *experiencing the burdens of a new beginning* or the shortened name *combining the best of two worlds*. The substantive theory has five stages. The stages are interpreted as a response-set on how the participants coped with the three-dimensional central social psychological problem that emerged. This response-set is also the process that led to the development of nursing identity in Physician-Nurses. The three dimensions of burdens comprising the central problem are (a) crossing cultures, (b) starting from zero, and (c) crossing professions. The five stages of the substantive theory are (a) letting go of professional identity as physician, (b) experiencing growing pains, (c) seeing nursing as a saving grace, (d) gaining authority to practice as a nurse, and (e) engaging self to nursing and asserting “I am a nurse”. The substantive theory of *combining the best of two worlds* is the logical combination of the dimensions of the central problem and the stages of the basic process and the various interconnected concepts. The discussion in Chapter Five provided in-depth explanations of the dimensions of the central problem and the stages of the substantive theory and the interrelationships among the concepts.

Within the philosophical framework of symbolic interactionism, there is interweaving of the elements of the substantive theory with the central concepts of the mind, the self, and society. In symbolic interactionism human behavior is viewed as a result of human social interactions or social process. This process entails the study of human behavior on two levels:

(a) the behavioral or interactional level, and (b) the symbolic level. On the first level, the meaning of events, experiences, and human conduct are understood from the perspective of the participants' view of their *self* in their natural, everyday lives. In the findings of this study, the participants' view of their *self* was initially at zero but improved as they acquired the views of their new and different *self* as nurses. The second level involved sharing the meanings of events and experiences with others, as well as aligning their conduct with others in the profession of nursing through their social interactions within the nursing profession and within society and through their use of a common language distinctive of nursing. Their use of a common language of nursing is part of their nursing identity.

The stages of the substantive theory do not occur in a perfectly linear and sequential pattern but rather in a somewhat recursive and cyclical pattern as was discussed in Chapter Five. The duration of each stage is variable depending upon which context and environment they occur. The essence of the substantive theory of *combining the best of two worlds* is that the participants take the good things about being a physician (their original self) and they take the good things about being a nurse (their new self) and blend them together to practice in the US healthcare system within the scope of the nursing profession.

To summarize, the stages of the substantive theory occur in the following pattern: To start the process, a critical juncture must occur. The Physician-Nurses must first let go of their professional identity as physician. With the occurrence of Stage One, two reciprocal consequences happen and the Physician-Nurses must act upon them before they can experience Stage Two. The two consequences which are reciprocal to each other are *disengaging self from the profession of medicine and making the conscious decision to become a nurse*. In Stage Two, the Physician-Nurses enter a stage where they experience

growing pains manifested as uncertainty related to the decisions they made in Stage One. They experience inner struggles akin to the game *tug-of-war*. The degree of their uncertainty depends upon the level of two pre-established self-perceptions. If their *perception of physicians having ultimate power* over clinical decision-making is high, their uncertainty is also high; if it is low, their uncertainty level is also low; if their *perception that nursing minimizes their past medical knowledge, skills, and experience* is high, their uncertainty level is also high; if it is low, their uncertainty level is also low. Stage two has a recursive property. Participants experienced it pre-licensure as well as post-licensure. When Physician-Nurses successfully pass through this stage, they advance to Stage Three which is *seeing nursing as a saving grace*. Stage Three has a recursive property as well. *Seeing nursing as a saving grace* is conceptualized to help with overcoming their growing pains. *Seeing nursing as a saving grace* is made possible by two dimensions that are characteristics of this stage: *seeing nursing as an easier route to a US healthcare career* and *seeing nursing as a way to economic gain*. After Stage Three, Physician-Nurses enter Stage Four which is *gaining authority to practice as a nurse*. This stage is the *second critical juncture* in the substantive theory. Three strategies characterize this stage: the reciprocal strategies of *unlearning being a physician* and *learning being nurses*, and *obtaining US nursing licensure*. The Physician-Nurses must successfully complete all three strategies in this stage to progress to Stage Five. Stage Five is the stage of culmination, *engaging self to nursing and asserting "I am a nurse."* The assertion of "I am a nurse" symbolizes the development of nursing identity in Physician-Nurses.

#### *Toward a Formal Theory: The Theory of Transprofessionalism*

A formal theory is a "theoretical rendering of a generic issue or process that cuts across several substantive areas of study. The concepts in a formal theory are abstract and

general and the theory specifies the links between these concepts.” (Charmaz, 2006, p. 187). Topics of inquiry that might lead to the development of formal theory include identity formation and construction of culture (Charmaz, 2006). Glaser and Strauss remind researchers that it is virtually impossible to generate an excellent formal theory through one’s own field work only. They state that usually, generation of a formal theory also involves the use of primary field data gathered by other researchers or published analyses and their illustrative quotes obtained from field notes. They further advise researchers that although they believe that formal theory can be generated directly from data; they strongly recommend that researchers start the generation of a formal theory from a substantive theory. Heeding the counsel of the experts in grounded theory generation, the intent of the researcher in this current grounded theory study is not to develop the formal theory in this phase of her research project.

The substantive theory generated in this study serves as a springboard toward the development of a formal theory; therefore, the researcher proposes a formal theory derived from the substantive theory *of combining the best of two worlds* and name it the “Theory of Transprofessionalism.” This theory is anticipated to able to further explicate the process of nursing identity development in Physician-Nurses. It is initially conceptualized as having five phases which correspond to the five stages of the substantive theory. This proposed formal theory can perhaps also explain the process of nursing identity development in other non-nursing professionals who choose to change careers to nursing at midlife. In proposing this formal theory, illustrations from the current study are used and they are framed according to the Conceptual-Theoretical-Empirical (CTE) Structure (Fawcett, 1999). Figure 6.1 illustrates the CTE structure to guide the proposed development of the theory. The empirical

research methods as listed in Figure 6.1 were those used in this current study and are listed in the proposed CTE structure for illustration purposes only. In a true CTE structure, the philosophical foundation (symbolic interactionism) as listed at the top of the structure would be labeled conceptual model. Figure 6.2 shows a detailed CTE structure of the proposed Theory of Transprofessionalism with its phases and dimensions. Table 6.1 and Figure 6.2 show how the phases of the proposed formal theory correspond to the stages of the substantive theory.

*Why the Name Transprofessionalism?*

The name of the substantive theory *combining the best of two worlds* inspired the naming of this proposed theory as “Theory of Transprofessionalism”. The prefix *trans* means across, over, beyond (Harper, 2001). From this meaning of the prefix *trans*, a definition is derived for ‘transprofessionalism.’ Transprofessionalism is a state when there are two or

Table 6.1

*The Relationship of the Stages of the Substantive Theory of Combining the Best of Two Worlds with the Phases of the Formal Theory of Transprofessionalism*

The Substantive Theory		The Proposed Formal Theory	
Stage #	Name of Stage	Phase#	Name of Phase
Stage 1	Letting go of professional identity as physician	Phase I	Disengagement
Stage 2	Experiencing growing pains	Phase II	Discouragement
Stage 3	Seeing nursing as a saving grace	Phase III	Enlightenment
Stage 4	Gaining authority to practice as a nurse	Phase IV	Encouragement
Stage 5	Engaging self to nursing and asserting “I am a nurse”	Phase V	Engagement

more professional identities existing in a professional individual. One professional identity would be dominant at any one time and that dominant professional identity would serve as the descriptor. The dominant professional identity would represent the profession that the individual is currently practicing. For instance, in the context of this current study that generated a substantive theory on the development of nursing identity in Physician-Nurses, the Physician-Nurse would be referred to as a transprofessional nurse. Other career changers could potentially become transprofessional nurses. What is conveyed in the term transprofessional if used in this context of the nursing profession is that “I am a nurse with previous life experiences.” With innovative nursing education programs that retrain career-changers, the nursing profession would have different categories of transprofessionals. The name Theory of Reprofessionalization was considered initially but the researcher’s interaction with nursing author and scholar, Dr. Kathleen Blais firmed up the naming of the proposed theory (K. Blais, personal communication, July 20, 2009).

In the current literature, the term *transprofessional* has been used to describe a model of care delivery that involves working together as a team of healthcare professionals beyond the traditional multidisciplinary and interdepartmental teams. Transprofessional patient care means that professions integrate with each other and each profession gets out of their professional box and translocate to other professional models to create synergistic, horizontal team models for patient care (Kerfoot, 1996). This is not the context in which the term is used in the proposed formal “Theory of Transprofessionalism.” The researcher in this study proposes to use the terms transprofessionalism and transprofessional in a fresh perspective, different from how it has been used and conceptualized by Kerfoot (1996). As used in naming the theory that explains the process by which FEPs transition to nursing , transprofessionalism

describes the state of being; of having two or more professional identities co-existing within the self of a professional individual with the one being practiced as the dominant one. In this context, transprofessional then describes a professional individual rather than a model of patient care.

### *Conclusion*

This grounded theory study achieved the purpose that it was designed to accomplish. It generated a substantive theory that explained the development of nursing identity in foreign-educated physicians retrained as nurses who are now practicing in the US. The five-stage substantive theory, *combining the best of two worlds* was able to provide theoretical explanations of the process that the participants followed to be able to assert “I am a nurse.” The substantive theory that was generated contributed to the body of scientific knowledge regarding the phenomenon of interprofessional migration and Physician-Nurses. It also served as a springboard for a proposed formal theory named Theory of Transprofessionalism that can explain the development of nursing identity in a wider-base population of Physician-Nurses and potentially in other non-nursing professionals who change careers at midlife.

### *Limitations of the Study*

The most significant limitation of this study is the potential for researcher and participant bias inherent to qualitative studies. The researcher came into the study with a number of biases and assumptions which needed to be constantly bracketed. Another limitation is the small number of participants, half of whom were from the Philippines. Although rich data were obtained from the 12 participants, a greater number of participants representing more ethnicities would have provided more perceptual and textual perspectives. This limitation was secondary to the difficulty in participant recruitment. Another limitation



was that the participants came from only two geographic locations in the US. It would have been ideal if participants came from multiple geographical locations. The last limitation that was identified was the realization that a question, “Tell me what you expected of US nursing practice before you decided to become a nurse” would have added substance to the textual and perceptual data gathered.

### *Strengths of the Study*

The pioneering nature of this research study contributed to its strength. No studies had been conducted in the past pertaining to the development of nursing identity in Physician-Nurses. The availability of funding through a Dissertation Award given by the Southern Nursing Research Society was a strength. The funds helped with participant recruitment, interview transcriptions, purchase of computer-assisted qualitative data analysis software and consultation on its utility, and other related expenditures that facilitated the conduct and completion of the research. The availability of support from the Department of Research at the USF College of Nursing, the multi-ethnic composition of the researcher’s dissertation committee, and the knowledge obtained from consultants with expertise on the phenomenon provided strong structures that supported the completion of this research project.

### *Implications for the Future*

#### *Domain of Research*

The work in this domain of research has just begun. In the immediate future, work must begin to pursue the development of the proposed formal *Theory of Transprofessionalism*. A skeleton framework has been established. Scholars from regions of the country dealing with



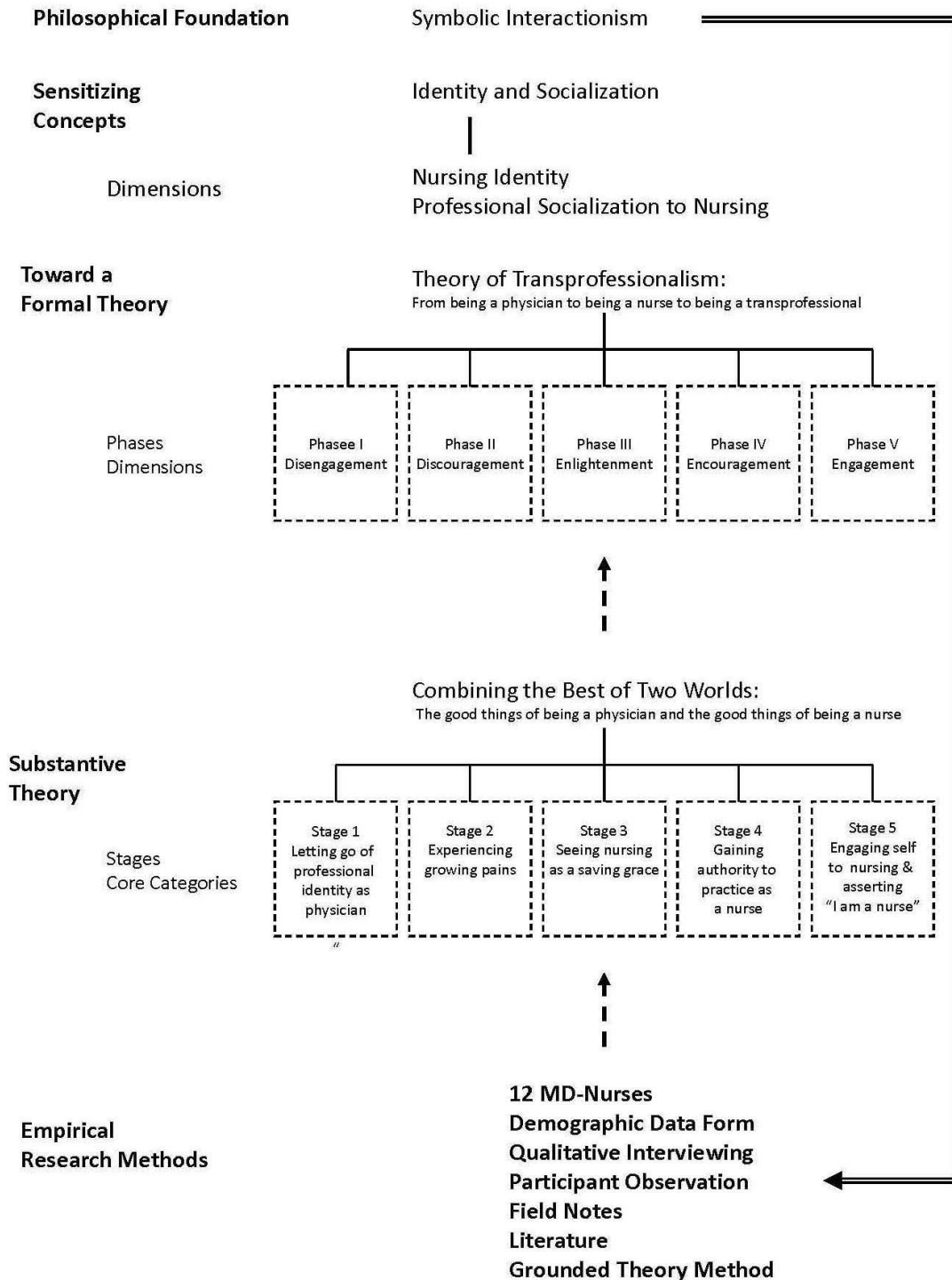


Figure 6.2. Toward a Theory of Transprofessionalism: A Diagram of the Proposed Theory of Transprofessionalism and its Phases and Dimensions (Fawcett, 1999).

similar populations are enjoined to replicate this study. Continued knowledge-building about the phenomenon of interprofessional migration and about Physician-Nurses is imperative in the immediate future. Qualitative research remains a necessary undertaking in this domain; however, measurable constructs pertaining to nursing identity development must be established so that instruments can be developed to begin measuring them quantitatively. It is hypothesized that the degree of nursing identity development correlates with commitment to the profession. Measuring it quantitatively might help in the design and implementation of nurse retention initiatives. Another immediate research project that can spin from this current research project is a longitudinal study to determine the retention of the participants in this study in the nursing profession.

#### *Domain of Education*

This study presented a small sample of immigrant physicians who have successfully transitioned to nursing and who are now gainfully employed. It is anticipated that the results of this study will dispel doubts about the effectiveness of retraining programs for FEPs and about the ability of physicians to become nurses. This study also presented a number of curricula designed to retrain foreign-educated physicians to become nurses. With its innovative nature, the model at FIU is proposed to become a national model. The need to expand the program exists as evidenced by the number of individuals in FIU's current applicant pool. Although not discussed in the findings, some of the Physician-Nurses expressed their frustration and dissatisfaction with clinical professors who were not sensitive to cultural differences. This might be a factor to consider by those planning to start similar programs when selecting faculty members. Another factor to consider is the inclusion of

ongoing classes throughout nursing school designed to increase English language proficiency and overall verbal communication skills.

### *Domain of Practice*

In the practice setting, the needs of this population of nurses must be assessed on a continual basis. Their cultural integration into their work-setting and into their new locality is essential. Because literature supported the notion that language and communication is a significant barrier in the transition of non-US native nurses, programs that help professionals with English as a second language should be promoted in the practice setting. Culturally-sensitive orientation and agency training programs should be implemented in hospitals who employ this unique group of nurses. Career counseling services and assistance in finding their right niche within the nursing profession should be offered to them as strategies for retention.

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## Appendices

## Appendix A

### Curriculum Prototype of MD-to-BSN Program, Philippines

Course Number	Theory	Lecture	RLE	# Units
NCM 100	Nursing Care Management (NCM) Foundations of Nursing I	2	1	3
NCM 101	Promotive and Preventive NCM Foundations of Nursing II	8	8	16
CHD	Community Health Development	3	0	3
NCM 102	Curative and Rehabilitative NCM	8	8	16
NR	Nursing Research	3	0	3
NCM 103	Related Learning Experience	0	4	4
NCM 104	Curative and Rehabilitative NCM	8	8	16
NCM 105	Nursing Management and Leadership	8	8	16

RLE = Related Learning Experiences



## Appendix B

### Related Learning Experiences for MD-to-BSN Program, Philippines

Year Level (Course #)	Related Learning Experience	#Hours
1 <sup>st</sup> year (NCM 100)	Foundations of Nursing Practice I	51
2 <sup>nd</sup> year (NCM 101)	Foundation of Nursing Practice II	408
3 <sup>rd</sup> Year (NCM 102)	Foundation of Nursing Practice III <ol style="list-style-type: none"> <li>1. Maternal and Child Nursing (135 hours) # of Deliveries : 5 handled; 5 assisted</li> <li>2. Child Nursing with 5 cord dressing (135 hours)</li> <li>3. Community Health Nursing (138 hours)</li> </ol>	408
3 <sup>rd</sup> Year (NCM 103)	Nursing Practice I <ol style="list-style-type: none"> <li>1. Concept of stress and illness               <ol style="list-style-type: none"> <li>a. Community Health—Illness Concept</li> <li>b. Sources of Stress in Illness</li> <li>c. Responses to Stress/Illness</li> </ol> </li> <li>2. Care of the Patients including Traditional Medicine</li> <li>3. Care of Patients with Problems Related to Illness               <ol style="list-style-type: none"> <li>a. Psycho-Social-Surgical Nursing</li> <li>b. Care of the Patients in Pain</li> <li>c. Care of the Patients Requiring Surgery OR: Major Scrubs: 5; Minor Scrubs 5</li> </ol> </li> <li>3. Care of Patients with Specific Problems               <ol style="list-style-type: none"> <li>a. Disturbances in Oxygenation</li> <li>b. Disturbances in Fluids and Electrolytes</li> <li>c. Disturbances in Metabolism</li> <li>d. Disturbances in Reproduction</li> </ol> </li> </ol>	204
4 <sup>th</sup> Year (NCM 104)	Nursing Practice II <ol style="list-style-type: none"> <li>1. Care of Patients with Specific Problems (continued)               <ol style="list-style-type: none"> <li>a. Disturbances in Sexuality</li> <li>b. Maladaptive Patterns of Behavior</li> <li>c. Disturbances in Immunologic and Inflammatory Responses</li> <li>d. Disturbances in Perception and Coordination</li> <li>e. Cellular Aberration</li> <li>f. Emergency and Disaster</li> <li>g. Acute Biologic Crisis</li> </ol> </li> </ol>	408
4 <sup>th</sup> Year (NCM 105)	Nursing Management and Leadership <ol style="list-style-type: none"> <li>1. Concern and Commitment</li> <li>2. Primary Nursing</li> <li>3. Leadership and Management</li> <li>4. Ethics Legal</li> <li>5. Research</li> </ol>	408

NCM = Nursing Care Management

## Appendix C

### The Foreign-Educated Physician-to-BSN Curriculum at FIU, Miami, Florida

Semester and Course Number	Course Name	Credits	Clinical Contact Hours
Semester I (18 credits)			
NUR 3026C	Foundations of Nursing I: Basic Skills	3	
NUR 3027	Foundations of Nursing	3	
NUR 3027L	Foundations of Nursing Clinical	6	90
NUR 3065	Client Assessment	3	
NUR 3825	Professional Nursing I: Socialization	3	
Semester II (12 credits)			
NUR 3535	Psychosocial Nursing	3	
NUR 3535L	Psychosocial Nursing Clinical	3	180
NUR 3145	Pharmacological Basis of Nursing Practice	3	
NUR 3165	Professional Nursing: Research Consumer	3	
Semester III (15 credits)			
NUR 3226	Nursing Care of Adults I	3	
NUR 3226L	Nursing Care of Adults I Clinical	3	90
NUR 3227	Nursing Care of Adults II	3	
NUR 3227L	Nursing Care of Adults II Clinical	3	90
NUR 3125	Pathophysiological Basis of Nursing Practice	3	

## Appendix C (Continued)

### The Foreign-Educated Physician-to-BSN Curriculum at FIU, Miami, Florida

Semester and Course Number	Course Name	Credits	Clinical Contact Hours
Semester I V (15 credits)			
NUR 4455	Care of Families: Childbearing Nursing	3	
NUR 4455L	Care of Families: Childbearing Nursing Clinical	3	90
NUR 4355	Care of Families: Childrearing Family	3	
NUR 4355L	Care of Families: Childrearing Family Clinical	3	90
NUR 4827	Professional Nursing: Leadership	3	
Semester V (15 credits)			
NUR 4636	Care of Communities: Community Health Nursing	3	90
NUR 4286	Nursing Care of Older Adults	3	
NUR 4940	Senior Clinical Synthesis	3	
NUR 4945L	Senior Clinical Practicum	6	120
Total Credits and Hours		75	840

*Note.* Information from “Transitioning Foreign-Educated Physicians to Nurses: The New Americans in Nursing Accelerated Program,” by D. Grossman and M. Jorda, 2008, *Journal of Nursing Education*, 47, p. 546; and from the website of the Florida International University College of Nursing and Health Sciences. Foreign-educated Physician to BSN track. [http://cnhs.fiu.edu/nursing/undergraduate\\_foreign\\_courses.html](http://cnhs.fiu.edu/nursing/undergraduate_foreign_courses.html)

## Appendix D

### Entry Level Master of Science in Nursing Curriculum at InterAmerican College

#### National City, CA

Course Prefix	Course Title	Academic Credits	Lecture Hours	Laboratory/ Clinical Hours
MSN 500	Foundations of Professional Nursing	3	45	
MSN 500L	Foundations of Professional Nursing Laboratory	3		90
MSN 501	Nursing Pharmacology	3	45	
MSN 502	Mental Health Nursing	2	30	
MSN 502L	Mental Health Nursing Laboratory	2		60
MSN 504	Nursing Care of Adults & Older Adults	4	60	
MSN 504L	Nursing Care of Adults & Older Adults Laboratory	4		120
MSN 505	Reproductive Health Nursing	2	30	
MSN 505L	Reproductive Health Nursing Laboratory	2		60
MSN 507	Nursing Care of Critically Ill Adults & Older Adults	2	30	
MSN 507L	Nursing Care of Critically Adults & Older Adults Laboratory	2		60
MSN 508	Child Health Nursing	2	30	
MSN 508L	Child Health Nursing Laboratory	2		60
MSN 509L	Clinical Nursing Internship 3 30 60	3	30	60
Total Credits and Hours		36	300	510

*Note.* Information obtained from the school website. <http://www.iacnc.edu/downloads/IAC%202008-2009%20catalog%2009-02-09a.pdf>

## Appendix E

### UNLV MD-to-Family Nurse Practitioner Curriculum, Las Vegas, Nevada

Semester & Course #	Course Name	Credits
1 <sup>st</sup> semester * Indicates has lab/clinical component		
NURS 705	Roles in Advanced Practice Nursing	1
NURS 703	Advanced Physical Assessment (*) (45 total lab hours)	3
NURS 704	Pathophysiology for Advanced Nursing Practice	3
NURS 706	Nursing Theory and the Research Process	3
NURS 714	Family Theory and Assessment	3
2 <sup>nd</sup> semester		
NURS 707	Nursing Research Methods and Utilization	3
NURS 730	Pharmacology for Advanced Practice	3
NURS 749	Primary Care of the Family I (*) ( 15 hours of clinical per week)	7
3 <sup>rd</sup> semester		
NURS 713	Health and Public Policy	3
NURS 766	Capstone I †	1
NURS 759	Primary Care of the Family II* (15 hours of clinical per week)	8
4 <sup>th</sup> semester		
NURS 752	Role of the Nurse Practitioner: Transition to Practice	2
NURS 796	NURS 796 Capstone II †	1
NURS 769	Primary Care of the Family III* (18 hours of clinical per week)	7
		†Students may select to do a thesis in place of the Capstone courses. However, thesis requirements include completion of 6 credits of thesis.
Total Credits		48

*Note.* Information from website <[http://nursing.unlv.edu/pdf/msn%20pdfs/msn\\_handbook.pdf](http://nursing.unlv.edu/pdf/msn%20pdfs/msn_handbook.pdf)>

## Appendix F

### The Curriculum of the MD-Nurse Diploma at MAPS, St. Petersburg, Russia

	Courses	# Hours
Course Name	<b>Fundamentals of nursing</b>	<b>135 Hours</b>
Components	1.1. Evolution of knowledge in nursing. 1.2. Nursing models. 1.3. Scientific researches in the practice of nursing. 1.4. Jurisprudence. The person and a society. Human rights. 1.5. Medical ethics. Basis of medical ethics; a historical context.	
Course Name	<b>2. Care of the Adult- Medical nursing including emergency nursing care</b>	<b>230 Hours</b>
Components	2.1. General nursing care of young adults, middle aged and elderly adults. 2.2. Pain – overview of physiology and pharmacological control. 2.3. Infectious diseases and general nursing care of patients with infections. Preventive and therapeutic aspects of infections. 2.4. General nursing care of patients with fluid electrolyte disturbances. 2.5. The basic diseases of Cardiovascular system. 2.6. Diseases of respiratory system. Nursing care during traumas of respiratory system. 2.7. Diseases of gastro-intestinal tract: 2.8. Diseases of endocrine system. 2.9. Diseases of skin :. Nursing care of patients with pathology of skin. 2.10. Nursing care of patients with pathology of neuromuscular system.	

MAPS – Medical Academy Post Graduate Studies

Appendix F (Continuation)

The Curriculum of the MD-Nurse Diploma at MAPS, St. Petersburg, Russia

	Courses	# Hours
	2.11 Nursing care of patients with pathology of urogenital system.	
	2.12. Emergency nursing care: <ul style="list-style-type: none"> <li>a) Role of Nurse in the Management of trauma . Cranio-cerebral trauma. Cardio thoracic trauma. Blunt abdominal injury. General management of fractures.</li> <li>b) Role of nurse in carrying out cardio-pulmonary resuscitation.</li> <li>c) Nursing care of patients with poisoning.</li> <li>d) Critical care nursing</li> </ul>	
Course Name	<b>3. Care of Adult-Surgical nursing</b>	<b>200 Hours</b>
Components	3.1. Pre operative, preoperative and post operative nursing care of patient . 3.2. The nursing care of patients with oncological diseases. 3.3. Disorders of heart. 3.4. Disorders of larynx, pharynx and thoracic cavity. 3.5. Disorders of gastro-intestinal tract. 3.6. Disorders of endocrine system. 3.7. Diseases of skin and appendages. 3.8. Burns --- Etiology and pathophysiology. 3.9. Neurological disorders and musculoskeletal system. 3.10. Disorders of vision. 3.11. ENT-diseases. 3.12. Disorders of urogenital system.	
Course Name	<b>4. Psychiatric nursing including psychology</b>	<b>180 Hours</b>
Components	4.1. Nursing in psychiatry 4.2. Medical psychology. 4.3. Methods of teaching and age psychology. 4.4. Psychology of professional dialogue.	

Appendix F (Continuation)

The Curriculum of the MD-Nurse Diploma at MAPS, St. Petersburg, Russia

Courses		# Hours
Course Name	<b>5. Nursing Care of children</b>	<b>180 hours</b>
Components	5.1. Growth and development of the child. 5.2. Health of the child at the first year of life. 5.3. Basics of care of children from 1 year till 4 years. 5.4. Care of preschool children. 5.5. Basics of care of children of school age. 5.6. Basics of care of teenagers.	
Course Name	<b>6. Maternal and Infant Nursing</b>	<b>230 Hours</b>
Components	6.1. Pregnancy and labor. Age features of female health. 6.2. Nursing care of newborns. An estimation of date of delivery of newborn and care of him. 6.3. Female health and planning of family. A role of the nurse in family planning. 6.4. Operation theatre techniques-general operation theatre, gynecological operation, and obstetric operation theatre techniques.	
Course Name	<b>7. Community health nursing and Basics of epidemiology</b>	<b>180 Hours</b>
Components	7.1. Basics of epidemiology. 7.2. Socially significant infections. HIV, tuberculosis, hepatitis, STD. 7.3. Basics of infectious diseases. 7.4. Role of nurse in public health services. Concept about the society and social groups. 7.5 Social problems of public health services and a way of their decision.	



## Appendix F (Continuation)

### The Curriculum of the MD-Nurse Diploma at MAPS, St. Petersburg, Russia

	Courses	# Hours
Course Name	<b>8. Nursing of old people-Geriatric nursing</b>	<b>60 Hours</b>
Components	8.1 .General principles of geriatric nursing care. 8.2 Common problems of the frail elderly.	
Course Name	<b>9. Nutrition</b>	<b>15 Hours</b>
Components	9.1. Basics of nutrition. The general principles of diet therapy. 9.2. Therapeutic diets. Diet therapy of various diseases. 9.3 Enteral nutrition-methods and devices –nursing care . 9.4 Parenteral nutrition – nursing care.	
Course Name	<b>10.Sociology and Economics</b>	<b>15 Hours</b>
Components	10.1. Basics of sociology. Sociology as a science. Society as a social and cultural system. 10.2. Basics of economy. Micro-economics. Economy and its basic problems.	
Course Name	<b>11. Methods of laboratory data analysis</b>	<b>15 Hours</b>
Components	11.1. Rules of preparation of the patient for laboratory analysis. 11.2. Role of the nurse in reception of authentic results of research.	

*Note.* Information obtained from < <http://www.mdnurse.com/CGFNS.html>>

## Appendix G

### Case-Level Display of Partially Ordered Meta-Matrix: Factors Identified from Media Stories that Influenced Foreign-educated Physicians to Pursue Nursing

Media Story (Case #)	Factors that Influenced Pursuit of Nursing
<p>Case #1 Bulgarian MD and Cuban MD (Rexrode, 2007)</p>	<ul style="list-style-type: none"> <li>▪ Build more promising future for family in the US</li> <li>▪ Cleaning hotels, washed dishes for a living</li> <li>▪ Other foreign-trained physicians drive taxis, stock groceries, work as security guards</li> <li>▪ Perceive being a doctor or being a nurse as both important</li> <li>▪ FIU five-semester program</li> <li>▪ Tuition coverage by HCA in exchange for 2 year work commitment</li> <li>▪ Pursuing medical license requires more time and money than could be afforded</li> </ul>
<p>Case #2 Chinese MD (Gunn-Lewis &amp; Smith,1999)</p>	<ul style="list-style-type: none"> <li>▪ Process to qualify for registration as a doctor in New Zealand (NZ) very long and difficult; comprised of three steps over three years—first two steps difficult but not impossible, but last step comprised of practical exam in the clinical setting was very difficult not due to lack of competence in diagnosing and prescribing, but due to language difficulties of the FEP</li> <li>▪ Possessed high scholastic adaptation abilities to train as nurse, but               <ul style="list-style-type: none"> <li>▪ Command of English very limited</li> <li>▪ Overall communication skills problematic</li> <li>▪ Belief that not qualified to become a doctor in New Zealand because of language and culture and lack of social knowledge</li> </ul> </li> </ul>
<p>Case #3 Colombian MD (Associated Press, 2003)</p>	<ul style="list-style-type: none"> <li>▪ Took odd jobs to support 5 children —cleaning floors, delivering pizza, and working as landscaper</li> <li>▪ Possessed medical knowledge just waiting to be used in more appropriate ways</li> <li>▪ Viewed nursing a way to re-enter medical field</li> <li>▪ Licensure as a physician in the US limited by lack of English abilities or by difficulty passing US medical board certification</li> <li>▪ FIU program [for foreign-educated doctors] reignited interest in medicine</li> </ul>
<p>Case #4 Colombian MD (Jimenez, 2003)</p>	<ul style="list-style-type: none"> <li>▪ Royal College of Physicians and Surgeons did not accept MD credentials. Colombia not one of the 13 countries whose medical education have been deemed acceptable in Canada</li> <li>▪ Required more than 2 years and \$3,000 to complete the Medical Council of Canada’s qualifying exam, and even if passed, has only a 10% chance of being accepted into residency program to retrain as doctor</li> <li>▪ Discouraged by the reality of the difficulty of not being able to requalify to become ophthalmologist again so retrained as nurse</li> </ul>

## Appendix G (Continuation)

### Case-Level Display of Partially Ordered Meta-Matrix: Factors Identified from Media Stories that Influenced Foreign-educated Physicians to Pursue Nursing

Media Story (Case #)	Factors that Influenced Pursuit of Nursing
Case #5 Colombian MD and Yugoslavian MD (Kelly, 2007)	<ul style="list-style-type: none"> <li>▪ Returning to careers as doctors impossible</li> <li>▪ Path to retrain as a surgeon is too long and expensive</li> <li>▪ Due to financial reasons, trying to retrain as doctor not an option</li> <li>▪ Although there is loss of status in going from a doctor to nurse, nursing is an opportunity to work in the medical field</li> <li>▪ Was a cleaner, mover, personal support worker; no room for advancement</li> <li>▪ This type of program [nursing] makes good sense and is grateful the government funding it (Canada)</li> </ul>
Case #6 Cuban MD (Hatcher, 2007)	<ul style="list-style-type: none"> <li>▪ Enormous challenges preventing transition from getting back to the healthcare field—language barrier, having to support family, passing difficult medical board exam</li> <li>▪ 10 years of wasting talent –working humble jobs</li> <li>▪ Open minded enough to realize that becoming a doctor is not the only alternative</li> </ul>
Case #7 Cuban MDs (Burnett III, 2006)	<ul style="list-style-type: none"> <li>▪ Unable to be licensed as MDs in the US</li> <li>▪ Difficult exams required by the ECFMG, followed by mandatory training under US standards, followed by 3-part licensing exam</li> <li>▪ Insight that knowledge deficient for exams which include math and English skills</li> <li>▪ Could not afford remedial classes, so gave up on MD careers</li> <li>▪ Worked in retail; worked in healthcare as medical recorder, medical records clerk, phlebotomist at a small clinic</li> <li>▪ Believe her situation is better here regardless of job when compared to being in Cuba</li> <li>▪ In Cuba as a doctor, one is lucky if earning an equivalent of \$30/month</li> <li>▪ As nurses, will not be physicians again but still recognizing dreams to work with people, with patients</li> </ul>
Case #8 Cuban and Romanian MDs (Mangan, 2007)	<ul style="list-style-type: none"> <li>▪ Series of minimum-wage jobs to support family—produce sorter, security guard, bellman, janitor, delivery driver, housekeeper, waitress</li> <li>▪ In order to practice medicine in US, must pass difficult 3-step licensing exam</li> <li>▪ Cannot pass tough medical licensing exams</li> <li>▪ FIU program give credit for medical expertise they already have</li> <li>▪ FIU has fast track program (18 months)</li> <li>▪ Evening and weekend classes</li> <li>▪ Found a way to work in the medical field</li> <li>▪ Nursing allows working with patients and families and is being appreciated</li> <li>▪ Beginning salary of a nurse in Miami is \$45,000.00</li> </ul>

## Appendix G (Continuation)

### Case-Level Display of Partially Ordered Meta-Matrix: Factors Identified from Media Stories that Influenced Foreign-educated Physicians to Pursue Nursing

Media Story (Case #)	Factors that Influenced Pursuit of Nursing
<p>Case #9 Filipino MDs (Contreras, 2004)</p>	<ul style="list-style-type: none"> <li>▪ Job market for medical graduates [in the Philippines] not good</li> <li>▪ Doctors pay [in the Philippines] not commensurate to the profession</li> <li>▪ A nurse in the US can work in two hospitals at the same time, three days at each hospital per week; by comparison, resident doctors in the Philippines can be on call 24 hours a day, especially in government hospitals</li> </ul>
<p>Case #10 Filipino, MDs (Gatbonton 2004)</p>	<ul style="list-style-type: none"> <li>▪ Disenchantment with the medical profession               <ul style="list-style-type: none"> <li>▪ Paltry HMO-driven consultation fees</li> <li>▪ Long wait for checks (payment)</li> <li>▪ Threat of compulsory malpractice insurance</li> <li>▪ High income tax</li> </ul> </li> <li>▪ High monetary investment to practice in a hospital               <ul style="list-style-type: none"> <li>▪ Requirements to buy stocks, rights to practice, and clinic and parking space (ranging from 800,000 to 1.5 million Philippine Pesos. This is approximately equivalent to US\$20,000.00 to \$37,500.00 at a 40-peso-per-dollar exchange rate)</li> </ul> </li> <li>▪ Most doctors earn between US\$300.00 to 1,000.00 a month               <ul style="list-style-type: none"> <li>▪ High level of charity work, not always by choice but by societal expectations</li> <li>▪ Fees are paid with promissory notes; only one in ten comes back to settle professional fees owed</li> </ul> </li> <li>▪ Escalating cost of living (in the Philippines)</li> <li>▪ Enticement of the dollar</li> <li>▪ Greener pastures in the US, London, Canada, and Ireland</li> <li>▪ Poor peace and order and political climate in the country</li> <li>▪ If a doctor cannot stay a doctor by force of circumstances, nursing is the next best thing. “Nursing is as much about caring for a patient’s well being, lessening pain or suffering, and bringing comfort as doctoring is” (last ¶).</li> </ul>
<p>Case #11 Filipino MDs (Ruiz, 2004)</p>	<ul style="list-style-type: none"> <li>▪ Low salaries for self-employed physicians (estimates from the Bureau of Internal Revenue database)               <ul style="list-style-type: none"> <li>▪ Median gross annual income in 2002 was 230,347.75 Philippine pesos (US\$4,189.00 at the prevailing P55.00 per peso that year)</li> </ul> </li> <li>▪ Nursing like medicine is a noble profession</li> <li>▪ Some Physician-Nurses are optimistic that (nursing) will serve as stepping stone to becoming physician assistants or licensed doctors abroad</li> <li>▪ Issue of buying stocks in big hospitals to obtain privileges to practice</li> <li>▪ Feeling of hopelessness related to               <ul style="list-style-type: none"> <li>▪ political uncertainty</li> <li>▪ stagnant economy</li> </ul> </li> <li>▪ Fears of increasing malpractice suits and mandatory malpractice insurance</li> </ul>

## Appendix G (Continuation)

### Case-Level Display of Partially Ordered Meta-Matrix: Factors Identified from Media Stories that Influenced Foreign-educated Physicians to Pursue Nursing

Media Story (Case #)	Factors that Influenced Pursuit of Nursing
<p>Case #11 Filipino MDs (Ruiz, 2004)</p>	<ul style="list-style-type: none"> <li>▪ Low salaries for self-employed physicians (estimates from the Bureau of Internal Revenue database)               <ul style="list-style-type: none"> <li>▪ Median gross annual income in 2002 was 230,347.75 Philippine pesos (US\$4,189.00 at the prevailing P55.00 per peso that year)</li> </ul> </li> <li>▪ Nursing like medicine is a noble profession</li> <li>▪ Some Physician-Nurses are optimistic that (nursing) will serve as stepping stone to becoming physician assistants or licensed doctors abroad</li> <li>▪ Issue of buying stocks in big hospitals to obtain privileges to practice</li> <li>▪ Feeling of hopelessness related to               <ul style="list-style-type: none"> <li>▪ political uncertainty</li> <li>▪ stagnant economy</li> </ul> </li> <li>▪ Fears of increasing malpractice suits and mandatory malpractice insurance</li> </ul>
<p>Case #12 Russian MDs (Mosqueda, 2006)</p>	<ul style="list-style-type: none"> <li>▪ Physician can go to the USA with a green card to initially work as a nurse, earning more than \$4,000 per month</li> <li>▪ While in the US legally working and earning as a nurse, physician can take required MD exams, Steps 1 &amp; 2 of the USLME, and Step 3 which is only given in the US</li> <li>▪ If all required MD exams passed, Physician-Nurse can apply for residency in a US hospital</li> <li>▪ Physician-Nurse can accept any residency because possess legal work authorization (a green card by virtue of being a nurse)</li> </ul>
<p>Case #13 Nicaraguan MD (Thrall, 2008)</p>	<ul style="list-style-type: none"> <li>▪ Fled war-torn home country in 1987</li> <li>▪ Unable to overcome physician licensure exams, language and financial barriers</li> <li>▪ Underemployed for many years: worked in a bakery and insurance office; then as X-ray technician and scrub technician in healthcare facilities</li> <li>▪ Innovative program that retrains FEPs to nurses</li> </ul>
<p>Case #14 Cuban MD (Ojito, 2009)</p>	<ul style="list-style-type: none"> <li>▪ Defected from his home country when he was 28 years old</li> <li>▪ Unable to pass medical licensing exams in the US</li> <li>▪ Language barrier: he was taught Russian in his military school in Cuba</li> <li>▪ Salary for physicians in Cuba equivalent to \$25.00 a month</li> <li>▪ Lured by a life of freedom and opportunities in the US</li> </ul>

## Appendix H

### Content Analytic Summary Table:

#### Motivating Factors That Influenced FEPs to Pursue Nursing

Factor Clusters	Aggregated Elements from Case-Level Display
<p style="text-align: center;">1</p> <p>Economic factors</p>	<ul style="list-style-type: none"> <li>▪ In the US and Canada, returning to medical career has enormous challenges. Medical retraining too long, expensive, and impossible</li> <li>▪ In Canada, even if FEP passes Medical Council of Canada’s qualifying exam, not assured of acceptance to a residency program</li> <li>▪ In the Philippines               <ul style="list-style-type: none"> <li>▪ Feelings of hopelessness related to stagnant economy, escalating cost of living, inadequate resources to perform functions as a doctor such as facilities and patient income</li> <li>▪ High monetary investment required to practice in big hospitals: buying stocks, rights to practice, and clinic/parking space</li> <li>▪ Disenchantment with the medical profession— HMO-driven low consultation fees; long wait for payment of services</li> <li>▪ Threat of the Malpractice Law and mandatory malpractice insurance</li> <li>▪ High income taxes imposed</li> </ul> </li> <li>▪ In developed countries, better financial security and higher standard of living because of higher salaries and compensation [as nurses]. Beginning salary of a nurse in Miami, Florida is \$45,000.00. In contrast, in Cuba as a doctor, one is fortunate if can earn an equivalent of \$30/month. In the Philippines, doctors’ low salaries not commensurate to professional status. Most doctors earn between US\$300.00 to 1,000.00 a month with a median gross annual income for self-employed physicians in 2002 of P230,347.75 (US\$4,189.00)</li> <li>▪ Tuition coverage to attend MD-to-Nurse retraining in exchange for work commitment</li> </ul>
<p style="text-align: center;">2</p> <p>Socio-Cultural factors</p>	<ul style="list-style-type: none"> <li>▪ Enormous challenges preventing transition to medical career in new country because of language barrier, cultural differences, and lack of social knowledge of new country</li> <li>▪ Poor working conditions in home country</li> <li>▪ Peer pressure: everybody else is doing it in the Philippines</li> </ul>
<p style="text-align: center;">3</p> <p>Political factors</p>	<ul style="list-style-type: none"> <li>▪ Lack of faith in home country and feeling of hopelessness related to political uncertainty; poor peace and order; corruption in home country</li> <li>▪ Lure of freedom and opportunities in the US</li> <li>▪ More socio-politico-economic security abroad; situation better here [in US] regardless of job when compared to being in Cuba</li> </ul>

Appendix H (Continuation)

Content Analytic Summary Table:

Motivating Factors That Influenced FEPs to Pursue Nursing

Factor Clusters	Aggregated Elements from Case-Level Display
<p>4 Factors related to immigration</p>	<ul style="list-style-type: none"> <li>▪ Easier to get a visa as a nurse than as a doctor</li> <li>▪ FEP can go to the USA with a green card to initially work as a nurse. While in the US legally earning as a nurse, FEP FMG can take required MD exams</li> <li>▪ Some MD-RNs are optimistic that (nursing) will also serve as stepping stone to becoming physician assistants or licensed doctors abroad</li> </ul>
<p>5 Factors related to the availability of nursing education program for FMGs</p>	<ul style="list-style-type: none"> <li>▪ The Florida International University offers an 18-month/five-semester accelerated program with evening and weekend classes; gives credit for medical expertise they have</li> <li>▪ Canada has MD-to-RN program funded by the government (Kelly 2007)</li> </ul>
<p>6 Factors related to regulatory requirements for MD licensure in host country</p>	<ul style="list-style-type: none"> <li>▪ In the US, difficult exams required by the Educational Commission for Foreign Medical Graduates (ECFMG), followed by mandatory training under US standards, followed by 3-part licensing exam</li> <li>▪ In Canada, non-acceptance of credentials of Colombian doctor by the Royal College of Physicians and Surgeons because Colombia is not one of the 13 countries whose medical education have been deemed acceptable in Canada; not being able to requalify to become ophthalmologist again so retrained as nurse</li> <li>▪ In New Zealand (NZ), process to qualify for registration as a doctor very long and difficult</li> </ul>
<p>7 Medicine and nursing viewed as professions of equal value</p>	<ul style="list-style-type: none"> <li>▪ Perceive being a doctor or being a nurse as both important; both noble professions; nursing is as much about caring as doctoring</li> <li>▪ View nursing as a way to re-enter a field left behind in homelands; an opportunity to work in the medical field that allows fulfillment of dreams to work with patients, families, and other people</li> </ul>
<p>8 Better job opportunities in the US as nurses</p>	<ul style="list-style-type: none"> <li>▪ In the Philippines               <ul style="list-style-type: none"> <li>▪ Job market for medical graduates are not good</li> <li>▪ A nurse in the US can work in two hospitals, three days at each hospital per week</li> </ul> </li> <li>▪ In developed countries, more employment, training, and career growth opportunities; better working conditions</li> </ul>

Appendix H (Continued)

Content Analytic Summary Table:

Motivating Factors That Influenced FEPs to Pursue Nursing

Factor Clusters	Aggregated Elements from Case-Level Display
<p>9 Factors related to family dynamics</p>	<ul style="list-style-type: none"> <li>▪ Build more promising future for family in the US; higher standard of living overseas</li> <li>▪ Motivating factors related to family include desire to bring or petition family and relatives to the US and reunion with loved ones</li> </ul>
<p>10 Underemployment and wasted medical talent</p>	<ul style="list-style-type: none"> <li>▪ Possess medical knowledge just waiting to be used in more appropriate ways</li> <li>▪ Possessed high scholastic adaptation abilities to train as nurse</li> <li>▪ Wasted talent. In new country, had series of minimum-wage jobs to support family: bellman, delivery driver, dishwasher, floor/hotel cleaner, grocery stocker, housekeeper, janitor, landscaper, mover, personal support worker, pizza delivery, produce sorter, security guard, taxi driver, waitress. Also worked in healthcare as medical recorder, medical records clerk, or phlebotomist</li> </ul>



## Appendix I

### Needs and Problems of Non-US Native Nurses and Nursing Students: A Summary of Studies

Studies/Purpose	Sample	Needs and Problems	Solutions
Amaro, Abriam-Yago, and Yoder (2006) Nursing education focus: to determine educational barriers	Ethnically Diverse Nurses N = 17 (African = 3) (Hispanic=6) (Asian = 8)	Lack of resources to meet personal, academic, language, & cultural needs: finances; time; family responsibilities; culture; language and communication. Perceived prejudice and discrimination at different levels from patients, hospital staff, classmates, and teacher in isolated cases.	Self-motivation and determination; teachers who value cultural diversity and respect cultural differences; peer support; ethnic nursing associations; English classes and tutoring; Medical terminology classes communication; assertiveness.
Bond, Gray, Baxley, Cason, Denke, and Moon (2008) Nursing educ.focus: describe perceived barriers and supports for Hispanic BSN students	Mexican American Students N =14	Lack of finances and advising; Gender stereotypes. Females were not expected to succeed. Tension between family values and commitment necessary to succeed in nursing school.	Financial support from family; cried and laughed together with families and classmates; classmates were second family; presence of Hispanic role models who offered mentoring and encouragement; sought support and developed personal relationships with faculty.
Caputi, Englemann, & Stasinopoulos(2006) Nursing educ.focus: Project [conversation circles] assess & help non-native English speaking students	Non-native speaking Students N = 7 (Polish, Romanian, Mexican, Chinese, & Filipino)	Grappling to learn a new culture and new language in addition to learn challenging nursing content. Participants did not feel format used for EAL program helped them academically.	Faculty to change EAL format to have combined nursing/EAL course focused on reading, writing, speaking, & listening in nursing context.
DeLuca (2005) Work-Life-Study focus: explored the meaning of crossing cultures	Jordanian Graduate Nursing Students N = 7	Anxiety not wing what to expect; loneliness due to missing separation from families; Language and communication barriers; cultural clashes and learning challenges (writing papers, acquiring adequate computer skills; meeting expectations of faculty)	Participants went through a process of ‘metamorphosis’ which allowed them to integrate into the US culture; they adapted by overcoming language barriers and by crossing cultures
DiCicco-Bloom (2004). Work & Life focus: describe work & life experiences in different culture	Indian Nurses N = 10	Displaced culturally: belonging to two places at one time yet not fully belonging to either; alienated by racism, oppression	Persistence. Work resilience.

## Appendix I (Continuation)

### Needs and Problems of Non-US Native Nurses and Nursing Students: A Summary of Studies

Studies/Purpose	Sample	Needs and Problems	Solutions
Evans (2007) Nursing education focus: to assess influence of workforce diversity grant (ALCANCE) on student retention	N=14 (3 American Indians; 2 Hispanic/Latinos; 10 Hispanic/Latinas/one <i>attrition</i> )	Felt isolated despite specific grant services to help students. No role models for American Indians. Profound sense of family obligation.	ALCANCE provided financial support and services for the students which they found very helpful in their nursing studies.
Gardner (2005) Nursing education focus: described experiences of minority students enrolled in a predominantly white school	Racial and ethnic minority students N = 15	Loneliness and isolation; differentness (peers lack respect and are aggressive, lacked fluent English); peers' lack of understanding of differentness due to peers' limited cultural knowledge (felt ignored, discounted, devalued, misunderstood); desiring support from teachers (emotional support, teacher to take personal interest, treat as unique individual)	Determination; coping with insensitivity; Ignore other's behavior; chose their battles; tried to be other than they are; determined to build a better future (striving to improve life)
Malu and Figlear (1998). Language development focus: case study on language development in as ESL student	Immigrant Nursing Students. Case focused on one.	Low degree of language development; vocabulary	Faculty help students with academic language fluency. ESL[English as a Second Language]students to immerse self in English .
Rivera-Goba & Nieto (2007) Explore meaning and significance of mentoring for Latinos/Latinas in nursing	Various Hispanic ethnicities. Students and recent graduates N = 17	Socio-economics; marginalization	Family, perseverance and mentors

## Appendix I (Continuation)

### Needs and Problems of Non-US Native Nurses and Nursing Students: A Summary of Studies

Studies/Purpose	Sample	Needs and Problems	Solutions
Sanner, Wilson, & Samson (2002) Nursing education focus: explore perceptions & experiences of international nursing students	Nigerian ESL Students N = 8	Social isolation: feelings of non-acceptance; antagonistic attitude; Language problems (accents)	Verbal retreat (language problems); cohesive group formation; international student network; accept and endure antagonistic attitudes; willingness to adjust; achievement of overall goal[becoming a nurse] is most important
Sherman and Eggenberger (2008) Work- & Life focus: Investigate educational & support needs of international nurses	Various: Australia, England, India, Jamaica, Philippines, Scotland, and Zambia N = 21	Differences in nursing practice Transition challenges: fear of lawsuits and litigation; computerized documentation; differences in cultural and religious beliefs; difficulty understanding accents, idioms, and phrases; orientation needs	Supportive nurse leaders critical to successful transition of international nurses (work environment that respects and values diversity); workplace transition program
Taxis (2006) Nursing educ.focus: explore perceived influences of institutional & interpersonal factors on retention & grad.	Mexican Nursing Students N = 9	Family and financial limitations; bicultural functioning—difficulty with living in two worlds; cliques; feeling isolated or lonely in campus.	Helpful/accessible staff and faculty; Supportive academic setting: felt safe, cared for, and connected. Family and financial support overwhelmingly helpful.
Villaruel, Canales, & Torres (2001) Nursing education focus: identify barriers and bridges to educational mobility	Hispanics 6 Focus Groups with total N = 37	Finances; Language; perceived discrimination and lack of support by faculty; cultural barrier related to prescribed gender roles within the Hispanic culture advisement/mentors	Family as motivators and provide major support; professional aspirations
Xu, Gutierrez, & Kim (2008)	Chinese	Communication inadequacies; conflicting professional values, roles, and expectations between US and China (differences in nursing practice); experiencing marginalization, inequality, and discrimination	Clinging to hope and adapting through (un)learning and resilience. Worked on enhancing self confidence, strength, assertiveness, persistence, and determination; valuing education and life-long learning; taking initiative; never giving up; and managing experiences, perspectives, and perceptions in a savvy manner.

## Appendix I (Continuation)

### Needs and Problems of Non-US Native Nurses and Nursing Students: A Summary of Studies

Studies/Purpose	Sample	Needs and Problems	Solutions
Yi and Jezewski (2000)	Koreans	Culture shock; language barrier; difference in nursing practice (in the context of role of family members)	Worked hard English classes Support from host members in the hospital unit Empathy from co-workers Support from hospital administration Teaching USA-style problem-solving strategies
Yoder (2001) Nursing education focus: describes the bridging pattern to teach ethnically diverse students	Nurse Educators N = 26 and Ethnic Minority Nurses N = 17	Instructor attitudes that are generic, mainstreaming, non-tolerant, and struggling; personal, academic, and language needs; cultural needs (invisibility, cultural isolation); unrecognized needs; pressure for conformity; devalued cultural perspectives; increased responsibility; unacknowledged barriers	Cultural awareness of bridging faculty

## Appendix J

### Letter of Approval for Period March 14, 2008 to March 13, 2009 (page 1)



March 19, 2008

Liwliwa Villagomez  
1119 Dockside Drive  
Lutz, FL 33559

RE: **Expedited Approval** for Initial Review  
IRB#: 106637 G  
Title: *Shifting Paradigm: The Development of Nursing Identity in Foreign-Educated Medical Doctors Re-Trained as Nurses Practicing in the United States*  
Study Approval Period: 03/14/2008 to 03/13/2009

Dear Ms. Villagomez:

On March 14, 2008, Institutional Review Board (IRB) reviewed and **APPROVED** the above protocol **for the period indicated above**. It was the determination of the IRB that your study qualified for expedited review based on the federal expedited category number six (6): Collection of data from voice, video, digital, or image recordings made for research purposes.

Also approved under category seven (7): Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. (NOTE: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45 CFR 46.101(b)(2) and (b)(3). This listing refers only to research that is not exempt.

Also approved is the Informed Consent Form.

Please note, if applicable, the **enclosed informed consent/assent documents are valid during the period indicated by the official, IRB-Approval stamp located on page one of the form**. Valid consent must be documented on a copy of the most recently IRB-approved consent form. Make copies from the enclosed original.

**Please reference the above IRB protocol number in all correspondence** regarding this protocol with the IRB or the Division of Research Integrity and Compliance. In addition, we have enclosed an Institutional Review Board (IRB) Quick Reference Guide providing guidelines and resources to assist you in meeting your responsibilities in the conduction of human participant research. Please read this guide carefully. It is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB.

OFFICE OF RESEARCH • DIVISION OF RESEARCH INTEGRITY & COMPLIANCE  
INSTITUTIONAL REVIEW BOARDS, FWA No. 00001669  
University of South Florida • 12901 Bruce B. Downs Blvd., MDC035 • Tampa, FL 33612-4799  
(813) 974-5638 • Fax (813) 974-5618

Appendix J (Continued)

Letter of Approval for Period March 14, 2008 to March 13, 2009 (page 2)

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-9343.

Sincerely,



Paul G. Stiles, J.D., Ph.D., Chairperson  
USF Institutional Review Board

Enclosures: (If applicable) IRB-Approved, Stamped Informed Consent/Assent Documents(s)  
IRB Quick Reference Guide

Cc: cd/Trudy Wittenberg, USF IRB Professional Staff

SB-IRB-Approved-EXPEDITED-0601

Appendix J (Continued)

Letter of Approval for Period February 13, 2009 to February 12, 2010 (page 1)



DIVISION OF RESEARCH INTEGRITY AND COMPLIANCE

Institutional Review Boards, FWA No. 00001669  
12901 Bruce B. Downs Blvd., MDC035 • Tampa, FL 33612-4799  
(813) 974-5638 • FAX (813) 974-5618

February 16, 2009

Liwliwa Villagomez  
College of Nursing  
MDC 22

RE: **Expedited Approval** for Continuing Review

IRB#: 106637 G

Title: *Shifting Paradigm: The Development of Nursing Identity in Foreign-Educated  
Medical Doctors Re-Trained as Nurses Practicing in the United States*

Study Approval Period: 02/13/2009 to 02/12/2010

Dear Ms. Villagomez:

On February 13, 2009, Institutional Review Board (IRB) reviewed and **APPROVED** the above protocol **for the period indicated above**. It was the determination of the IRB that your study qualified for expedited review based on the federal expedited category number six (6) and seven (7).

Also approved with the informed consent form.

Please note, if applicable, the **enclosed informed consent/assent documents are valid during the period indicated by the official, IRB-Approval stamp located on page one of the form**. Valid consent must be documented on a copy of the most recently IRB-approved consent form. Make copies from the enclosed original.

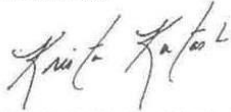
**Please reference the above IRB protocol number in all correspondence** regarding this protocol with the IRB or the Division of Research Integrity and Compliance. In addition, we have enclosed an Institutional Review Board (IRB) Quick Reference Guide providing guidelines and resources to assist you in meeting your responsibilities in the conduction of human participant research. Please read this guide carefully. It is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB.

Appendix J (Continued)

Letter of Approval for Period February 13, 2009 to February 12, 2010 (page 2)

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-9343.

Sincerely,

A handwritten signature in cursive script, appearing to read "Krista Kutash".

Krista Kutash, Ph.D., Chairperson  
USF Institutional Review Board

Enclosures: (If applicable) IRB-Approved, Stamped Informed Consent/Assent Documents(s)

Cc: Anna Davis/cd, USF IRB Professional Staff  
Mary Evans

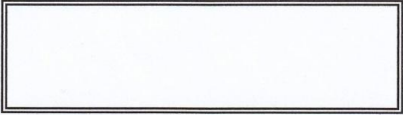
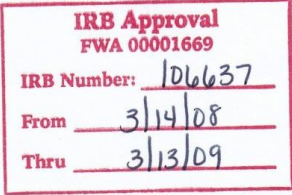

SB-IRB-Approved-EXPEDITED-0801



## Appendix K

Consent Form for Study Period March 14, 2008 to March 13, 2009 (page 1)

*Informed Consent*



**Informed Consent to Participate in Research**  
**Information to Consider Before Taking Part in this Research Study**

---

Researchers at the University of South Florida (USF) study many topics. To do this, we need the help of people who agree to take part in a research study. This form tells you about this research study.

We are asking you to take part in a research study that is called:

**Shifting Paradigms: The Development of Nursing Identity in Foreign-educated Medical Doctors Re-trained as Nurses Practicing in the United States**

The person who is in charge of this research study is Liwliwa Villagomez. Other research personnel who you may be involved with include: Faculty Mentors.

The research will be done at University of South Florida.

---

**Purpose of the Study**

The purpose of this study is to explain the process that influences the development of nursing identity in foreign-educated medical doctors who have been re-trained as nurses and who are now practicing in the United States of America (US). You have been asked to take part in this study because you have shown interest to participate and that you possess the requirements we are looking for this study. You were a doctor in your native country and you are now practicing as a registered nurse in the US.

**Study Procedures**

If you take part in this study, you will be asked to participate in one interview session with the researcher. The interview session consists of 10 questions with additional questions for clarification, if needed. In addition, the researcher will communicate with you via telephone or e-mail after the interview session if she has further questions. The estimated length of the interview is 1.5 to 2 hours. The interview will be done at a time and day that is convenient for you at a location agreed upon by you and the researcher. If the interview is done at the University of South Florida, it will take place in one of the small conference rooms at the College of Nursing. The interview will be audio-tape recorded which will then be transcribed on paper.

## Appendix K (Continued)

Consent Form for Study Period March 14, 2008 to March 13, 2009 (page 2)

### Alternatives

You have the alternative to choose not to participate in this research study.

### Benefits

We don't know if you will get any benefits by taking part in this study.

### Risks or Discomfort

There are no known risks to those who take part in this study.

### Compensation

We will pay you for the time you volunteer while being in this study in the form of a \$50.00 stipend.

### Confidentiality

We must keep your study records confidential. No participant identifier will be used. Code numbers will be assigned to your taped and transcribed interview. The tape will be destroyed after the accuracy of the transcription is verified. The electronic copy and the paper copy of your interview will be stored in a secure computer file and locked file cabinet, respectively, in the researcher's home for a period of 3 years.

In addition to the person in charge of this research, certain people may need to see your study records. By law, anyone who looks at your records must keep them completely confidential. The only people who will be allowed to see these records are:

- The researcher's faculty mentors.
- Certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety. These include:
  - the University of South Florida Institutional Review Board (IRB) and the staff that work for the IRB. Other individuals who work for USF that provide other kinds of oversight may also need to look at your records.
  - people from the Department of Health and Human Services (DHHS).

We may publish what we learn from this study. If we do, we will not let anyone know your name. We will not publish anything else that would let people know who you are.

### Voluntary Participation / Withdrawal

You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study, to please the investigator or the research staff. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study.



Appendix K (Continued)

Consent Form for Study Period March 14, 2008 to March 13, 2009 (page 3)

**Questions, concerns, or complaints**

If you have any questions, concerns or complaints about this study, call Liwliwa Villagomez at 813-810-6246.

If you have questions about your rights, general questions, complaints, or issues as a person taking part in this study, call the Division of Research Integrity and Compliance of the University of South Florida at (813) 974-9343.

If you experience an adverse event or unanticipated problem call Liwliwa Villagomez at 813-810-6246.

**Consent to Take Part in this Research Study**

It is up to you to decide whether you want to take part in this study. If you want to take part, please sign the form, if the following statements are true.

**I freely give my consent to take part in this study.** I understand that by signing this form I am agreeing to take part in research. I have received a copy of this form to take with me.

\_\_\_\_\_  
Signature of Person Taking Part in Study

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Person Taking Part in Study

**Statement of Person Obtaining Informed Consent**

I have carefully explained to the person taking part in the study what he or she can expect.

I hereby certify that when this person signs this form, to the best of my knowledge, he or she understands:

- What the study is about.
- What procedures/interventions/investigational drugs or devices will be used.
- What the potential benefits might be.
- What the known risks might be.

I also certify that he or she does not have any problems that could make it hard to understand what it means to take part in this research. This person speaks the language that was used to explain this research.

This person reads well enough to understand this form or, if not, this person is able to hear and understand when the form is read to him or her.

This person does not have a medical/psychological problem that would compromise comprehension and therefore makes it hard to understand what is being explained and can, therefore, give informed consent.



Appendix K (Continued)

Consent Form for Study Period March 14, 2008 to March 13, 2009 (page 4)

This person is not taking drugs that may cloud their judgment or make it hard to understand what is being explained and can, therefore, give informed consent.

\_\_\_\_\_  
Signature of Person Obtaining Informed Consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Person Obtaining Informed Consent



## Appendix K (Continued)

Consent Form for Study Period February 13, 2009 to February 12, 2010 (page 1)

*Informed Consent*



<b>IRB Approval</b> <b>FWA 00001669</b> <b>IRB Number: 106637</b> <b>From 2/13/09</b> <b>Thru 2/12/10</b>
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### **Informed Consent to Participate in Research**

#### **Information to Consider Before Taking Part in this Research Study**

Researchers at the University of South Florida (USF) study many topics. To do this, we need the help of people who agree to take part in a research study. This form tells you about this research study.

We are asking you to take part in a research study that is called:

#### **Shifting Paradigms: The Development of Nursing Identity in Foreign-educated Medical Doctors Re-trained as Nurses Practicing in the United States**

The person who is in charge of this research study is Liwliwa Villagomez.

Other research personnel who you may be involved with include: Faculty Mentors.

The research will be done at University of South Florida.

#### **Purpose of the Study**

The purpose of this study is to explain the process that influences the development of nursing identity in foreign-educated medical doctors who have been re-trained as nurses and who are now practicing in the United States of America (US). You have been asked to take part in this study because you have shown interest to participate and that you possess the requirements we are looking for this study. You were a doctor in your native country and you are now practicing as a registered nurse in the US.

#### **Study Procedures**

If you take part in this study, you will be asked to participate in one interview session with the researcher. The interview session consists of 10 questions with additional questions for clarification, if needed. In addition, the researcher will communicate with you via telephone or e-mail after the interview session if she has further questions. The estimated length of the interview is 1.5 to 2 hours. The interview will be done at a time and day that is convenient for you at a location agreed upon by you and the researcher. If the interview is done at the University of South Florida, it will take place in one of the small conference rooms at the College of Nursing. The interview will be audio-tape recorded which will then be transcribed on paper.

*Note.* Page 2 to 4 are unchanged from previous approval period; hence, they are not included.

Appendix L

Letter of Approval for Request for Modification (page 1)



DIVISION OF RESEARCH INTEGRITY AND COMPLIANCE  
Institutional Review Boards, FWA No. 00001669  
12901 Bruce B. Downs Blvd., MDC035 • Tampa, FL 33612-4799  
(813) 974-5638 • FAX (813) 974-5618

July 20, 2009

Liwliwa Villagomez  
Nursing  
1119 Dockside Drive  
Lutz FL 33559

RE: **Approved Modification Request**

IRB#: 106637 G

Title: *Shifting Paradigm: The Development of Nursing Identity in Foreign-Educated Physicians Re-Trained as Nurses Practicing in the United States*

Study Approval Period: 02/13/2009 to 02/12/2010

Dear Ms. Villagomez:

On July 17, 2009 the Institutional Review Board (IRB) reviewed and **APPROVED** your Modification Request. The submitted request has been approved **from July 17, 2009 to 02/12/2010** for the following:

**1. Change in study title from "Shifting Paradigms: The Development of Nursing Identity in Foreign-educated Medical Doctors Re-trained as Nurses Practicing in the United States" to "Shifting Paradigms: The Development of Nursing Identity in Foreign-educated Physicians Re-trained as Nurses Practicing in the United States".**

**2. Change in study population: Participants changed from registered nurses to registered nurses and RN-board eligible licensed practical nurses.**

Please note, if applicable, **only use the IRB-Approved and stamped consent forms for participants to sign**. The enclosed informed consent/assent documents are valid during the period indicated by the official, IRB-Approval stamp located on page one of the form. Make copies from the enclosed original.

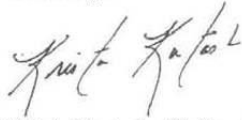
**Please reference the above IRB protocol number in all correspondence** to the IRB or the Division of Research Compliance. It is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB.

Appendix L (Continuation)

Letter of Approval for Request for Modification (page 2)

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-2036.

Sincerely,

A handwritten signature in cursive script that reads "Krista Kutash".

Krista Kutash, Ph.D., Chairperson  
USF Institutional Review Board

Cc: Anna Davis/cd, USF IRB Support Staff  
Mary Evans

## Appendix M

### Sample Introductory Letter to Nursing Leaders

1119 Dockside Drive  
Lutz, Florida 33559

February 10, 2008

Mrs. Ma. Teresa Ebrada, RN, BSN  
President, Philippine Nurses Association of Tampa Bay  
The James A. Haley VA Hospital  
13000 Bruce B. Downs Blvd.  
Tampa, FL 33612

Dear Tess,

I would like to seek your help. I am a doctoral student at the College of Nursing, University of South Florida. My research project aims to offer theoretical explanations about the development of nursing identity in MD-Nurses practicing in the United States. MD-Nurses are defined as foreign-educated medical doctors who have returned to school to become registered nurses. This study may assist employers in planning and implementing strategies for their socialization, adaptation, and support which will subsequently impact their nursing practice.

I am looking for MD-Nurses who are willing to be interviewed. Please disseminate the attached recruitment flyer through your website and through your organization's local and national e-mail network.

Thank you very much for your assistance.

Respectfully yours,



Liwliwa (Liw) R. Villagomez, MS, RN  
PhD in Nursing Student  
College of Nursing, USF  
813-810-6246 (cell number)  
lvillago@health.usf.edu



Appendix N

Recruitment Flyer

1. Are you a physician in your home country?
2. Are you a registered nurse in the US?



If you answered YES to both questions, I'd like to invite you to call or e-mail me. I am looking for foreign-educated MDs who have become RNs in the US who are willing to help me describe the process by which you transitioned from being a doctor to being a nurse. I look forward to your call or e-mail. Thank you!

**My Contact Information:**

**Liw R. Villagomez, MS, RN**

**Doctoral Student**

**Cell phone: 813-810-6246**

**E-mail: <lvillago@health.usf.edu>**

*Note.* The actual flyer was in color and printed on an 8.5 x 11 paper.

## Appendix O

### Demographic Data Collection Form

*Demographic Data*

<sup>01</sup> Native Country	01
<sup>02</sup> Gender <sup>03</sup> Age <sup>04</sup> Marital Status	02                   03                   04
<sup>05</sup> Number of Children <sup>06</sup> Ages of children	05                   06
<sup>07</sup> Year graduated as MD in native country	07
<sup>08</sup> Specialty as MD in native country	08
<sup>09</sup> Years of MD experience before going to nursing school	09
<sup>10</sup> Location where training as nurse obtained	10
<sup>11</sup> Year graduated as nurse	11
<sup>12</sup> Degree obtained	12
<sup>13</sup> Location where NCLEX taken	13
<sup>14</sup> Location of first US Employer	14
<sup>15</sup> Years of nursing experience <b>outside</b> the US	15
<sup>16</sup> Years of nursing experience <b>in</b> the US	16
<sup>17</sup> Specialty as nurse in the US	17
<sup>18</sup> Date of arrival to the US (month/year)	18
<sup>19</sup> Type of US Visa on entry to the US	19
<sup>20</sup> Visa processing (by employment agency or by self)	20
<sup>21</sup> Examinations taken before given permit to take NCLEX (Please list)	21

## Appendix P

### Interview Guiding Questions

*Semi-structured Interview Questions*

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Interview Guiding Questions

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1. What were the factors and experiences that influenced your decision to pursue nursing?
  2. Tell me about how nursing school was for you. *(Describe your emotions when you were training as a nurse. Describe instances, if any, when you felt uncertain about your decision to shift professions.)*
  3. Describe how your colleagues, friends, families, and patients reacted when they learned you were in nursing school? *(Describe also your reaction to their reaction.)*
  4. Tell me about how NCLEX was for you. *(Describe to me the obstacles you encountered as well as those that facilitated your licensure process.)*
  5. Share with me your personal experiences as a new immigrant in the US. *(What challenges and positive experiences did you encounter during your transition and adaptation as a new immigrant in the US?)*
  6. Share with me your work experiences as a new nurse in the US. *(What challenges and positive experiences did you encounter during your transition and adaptation period as a new nurse in the US?)*
  7. Tell me about your support system during your transition and adaptation period in the US, both within your personal social circle and within your work setting. *(How receptive were you to the support offered to you during your transition and adaptation period?)*
  8. Describe how you were able to shift from your identity as a medical doctor to being a registered nurse. *(Share with me instances when you struggled with your professional identity and describe to me how you overcame such struggles.)*
  9. What professional view do you have of yourself now?
  10. What else can you share with me that can help me explain and describe the process that helped you transition from the identity of a medical doctor in your native country to the identity of a registered nurse in the US?
-

Appendix Q

Consent to Audio Tape

UNIVERSITY OF SOUTH FLORIDA  
COLLEGE OF NURSING

CONSENT TO AUDIOTAPE

I, \_\_\_\_\_, hereby give consent to \_\_\_\_\_, a graduate student at the College of Nursing, University of South Florida, to audiotape an interview. I give my permission willingly and I understand that, should I become uncomfortable with being taped, I can ask to have the tape recorder stopped at any time. I understand that the contents of the interview will be transcribed and printed for purposes of research. I understand that I may call the faculty advisor at the phone number listed below. I understand that all audiotapes will be erased upon completion of the course. I understand that the content of the transcripts is confidential and no identifying information will be used on the hard copy of the transcript. All transcripts will be shredded after three years.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Participant Printed Name

\_\_\_\_\_  
Principal Investigator Signature

\_\_\_\_\_  
Principal Investigator Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Faculty Advisor Phone Number



## Appendix R

### Example of ATLAS.ti Output

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**Code-Filter: All**

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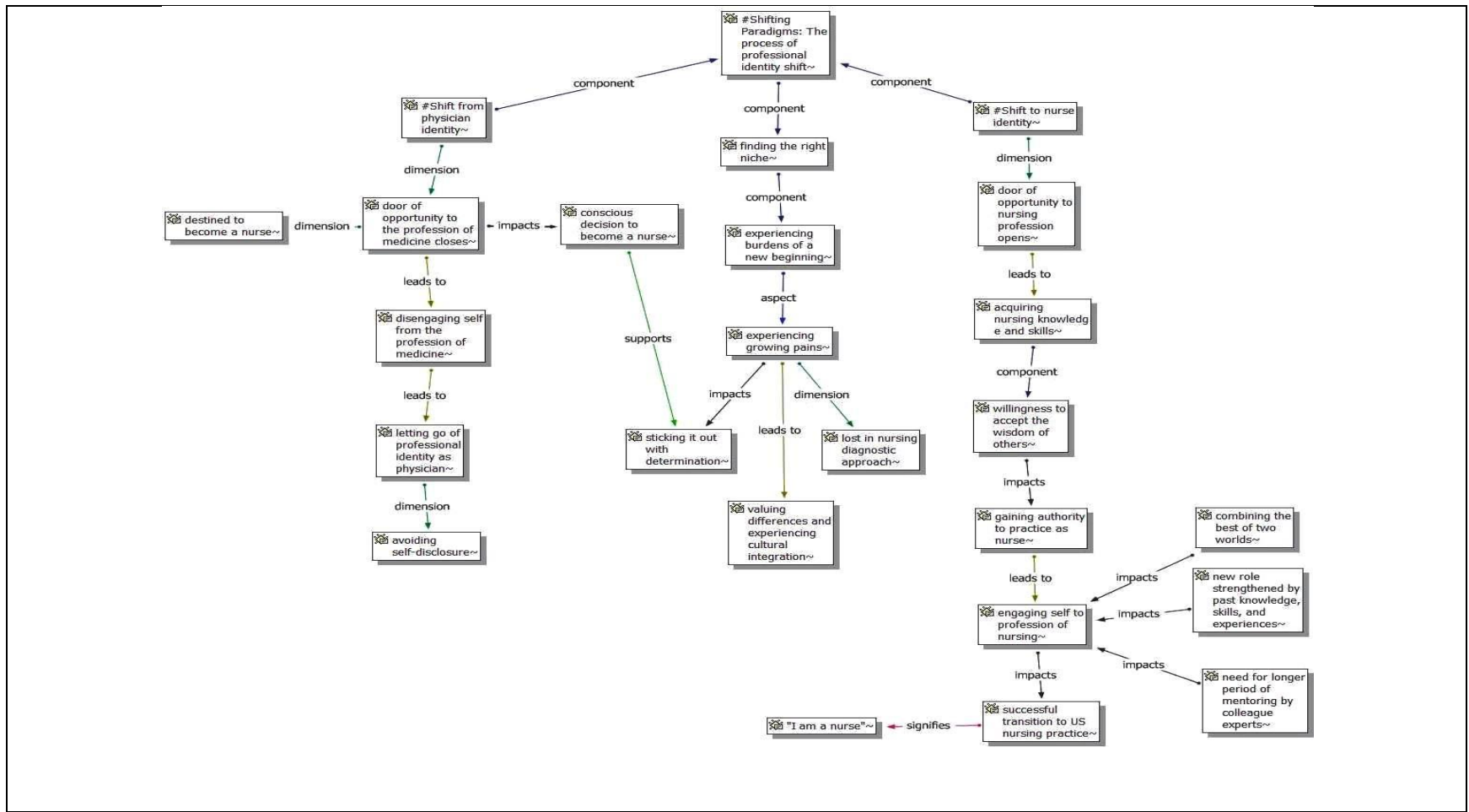
HU: MD to nurse transition  
File: [C:\Documents and Settings\HOME\Desktop\Villagomez Di...\MD to Nurse Transition.hpr6]  
Edited by: Super  
Date/Time: 06/30/09 07:07:01 PM

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#Barriers  
#Catalysts  
#Extrinsic barriers  
#Extrinsic catalysts  
#Intrinsic barriers  
#Intrinsic catalysts  
#Process of identity shift  
#Shift from physician identity  
#Shift to nurse identity  
acquiring nursing knowledge and skills  
appeal of nurse autonomy  
boredom with the basics  
combining the best of two worlds  
conscious decision to become a nurse  
cultural differences  
desire to reinvigorate self  
diminished social status  
disengage professional self from medicine  
door of opportunity to medical profession closes  
door of opportunity to nursing profession opens  
empowered to make a difference  
experienced burdens of a new beginning  
experienced caring nurse behaviors  
experienced cultural integration  
experienced culture shock  
experienced growing pains  
experienced role of patient  
finding the right niche  
gaining authority to practice as nurse  
gaining respect for past status as physician  
joining a bandwagon  
keeping the skeleton in the closet  
lack of control in life's events  
letting go of past status as physician  
letting go of sheltered past life  
need for longer period of mentoring by colleague experts  
new role strengthened by past knowledge, skills, and experiences  
new venture upheld by significant people  
nursing and medicine have same purpose and are equal  
nursing as an easier route to healthcare  
nursing as diminished professional status  
nursing as energizer  
nursing as saving grace  
nursing as way to economic gain  
nursing associated with humility and service  
nursing minimizes use of knowledge and skills  
physician in control of clinical decision making  
playing catch up in all aspects of life: profession, economics  
powerless to win over conflicting ideology  
professional integration to nursing  
reality shock  
shift in diagnostic approach  
shift to nursing seen by others as a failure  
significant impact of nurse  
sticking it out with determination  
successful transition to US nursing practice  
tug-of-war in desire to become a nurse and remain a physician  
valuing differences and blending-in  
victim of negative stereotyping  
willingness to accept the wisdom of others

## Appendix S

Screenshot of ATLAS.ti Network View Manager to Illustrate Early Conceptualizations by Researcher



## Appendix T

### The Initial Nine Core Categories

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#### Core Categories

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Experiencing burdens of a new beginning

Letting go of professional identity as physician

Experiencing growing pains

Nursing as saving grace

Gaining authority to practice as nurse

Successful transition to US nursing practice

New role strengthened by past medical knowledge, skills, and experiences

Valuing differences and experiencing professional integration

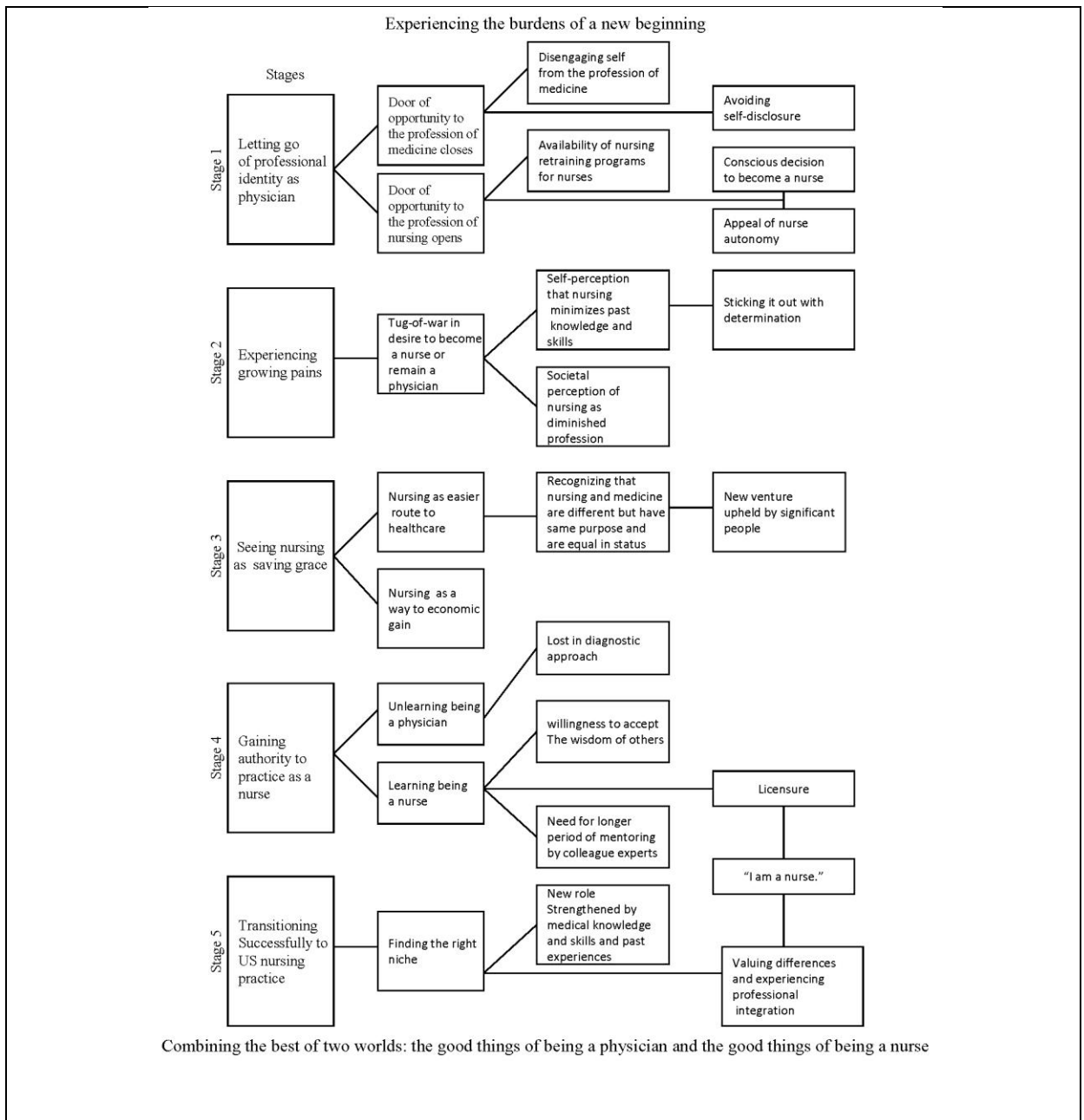
Combining the best of two worlds

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*Note.* With further theoretical coding, this initial set of nine core categories was reduced to seven. *New role strengthened by past medical knowledge, skills, and experiences* and *valuing differences and experiencing professional integration* were combined with *combining the best of two worlds*.

## Appendix U

### Initial Clustering of Core Categories



*Note.* As analysis and interpretation progressed with the iterative process of constant comparison, the name of Stage 5 was modified from transitioning successfully to US nursing practice to engaging self to nursing and asserting “I am a nurse.” (This was the phase in the analysis when the researcher was just starting to conceptualize relationships among the concepts. Relationships among the concepts are defined in Figure 5.2).



### About the Author

Liwliwa R. Villagomez received her BSN degree from St. Luke's College of Nursing, Trinity College of Quezon City, Philippines in 1980. She immigrated to the US in 1982. She began graduate studies at the University of South Florida College of Nursing in 2003 and obtained her Master in Science Degree with Academic Role Concentration in Nursing in 2005. While in the program, she was a recipient of scholarships from the CampusRN-AACN and the Philippine Nurses Association of America. She was also the recipient of the 2008 Dissertation Award of the Southern Nursing Research Society. Liw's other interest is the domain of spirituality and health. Two of her works pertaining to spirituality and spiritual distress have been published. Currently, Liw works at Pepin Heart Hospital, Tampa. In Spring 2010, she will begin her responsibilities as Nursing Director of the Foreign-Educated Physician-to-Nursing Program at the Biscayne Bay Campus, Florida International University, Miami.