

2009

## Filipino physician-turned nurses: A phenomenological study

Victor Rey Cui Vapor  
*University of Nevada Las Vegas*

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FILIPINO PHYSICIAN-TURNED NURSES: A PHENOMENOLOGICAL  
STUDY

by

Victor Rey Cui Vapor

Bachelor of Science in Nursing  
Brokenshire College (Philippines)  
1992

A thesis submitted in partial fulfillment of  
the requirements for the

**Master of Science in Nursing  
School of Nursing  
Division of Health Sciences**

**Graduate College  
University of Nevada, Las Vegas  
December 2009**

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THE GRADUATE COLLEGE

We recommend that the thesis prepared under our supervision by

**Victor Rey Cui Vapor**

entitled

**Filipino Physician-Turned Nurses: A Phenomenological Study**

be accepted in partial fulfillment of the requirements for the degree of

**Master of Science**

Nursing

Yu Xu, Committee Chair

Alan Jauregui, Committee Member

Jennifer Kawi, Committee Member

Emily Lin, Graduate Faculty Representative

Ronald Smith, Ph. D., Vice President for Research and Graduate Studies  
and Dean of the Graduate College

**December 2009**

## ABSTRACT

### **Filipino Physician-Turned Nurses: A Phenomenological Study**

by

Victor Rey Cui Vapor

Dr. Yu Xu, Examination Committee Chair  
Professor of Nursing  
University of Nevada, Las Vegas

Foreign nurses have augmented the United States nursing workforce. The Philippines has remained the world's leading exporter of nurses, including the United States. More recently, a new phenomenon has emerged involving Filipino physicians who went back to school to take up nursing in the Philippines in order to migrate to foreign countries to work as nurses. The purpose of this study was to describe and to interpret the lived experiences of Filipino physician-turned nurses in the United States. Phenomenology was used as research design, with data obtained from a purposive sample of eight (8) self-identified physician-turned nurses in Las Vegas, Nevada. Participants were interviewed using a single, open-ended central question. The audio taped responses that described their lived experiences were eventually transcribed verbatim. To interpret their experiences, clusters of themes were then generated using the Colaizzi's (1978) method of Phenomenological Inquiry. The results of the study revealed that the experiences of Filipino physician-turned nurses involved multidimensional issues, both in the contexts of emigration and a professional shift from physician to nurse. Being the first of its kind, this study will enlighten society of the lived experiences of Filipino physicians who compromise professional integrity by working as nurses just to emigrate to the United States. 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.

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## ACKNOWLEDGMENTS

The writing of this thesis was truly a remarkably challenging experience. The study would not have been possible without the support of a number of people. I would like to thank my friends, colleagues and family for the words of encouragement as I struggled through graduate school and work, both on a full-time basis.

I wish to thank the respondents of the study, the Filipino physician-turned nurses, for allowing a stranger into their lives to capture a glimpse of their thoughts and experiences. Their collective input was instrumental to the fruition of this research inquiry.

My gratitude also goes to the UNLV graduate nursing faculty for believing in my capabilities and to my peers for reinforcing my ideas. I was also tremendously fortunate to work with such an inspiring group of scholars: Dr. Emily Lin (UNLV Department of Curriculum and Instruction), Mr. Alan Jauregui, MSN, APN and Ms. Jennifer Kawi, MSN, APN-BC, who served as members of my thesis committee.

Finally, this thesis would not have been possible without the expertise of my esteemed advisor, Dr. Yu Xu, PhD, RN, CTN, CNE, for his patience during my personal and academic struggles. He has become a role model, a mentor, and most importantly, a friend.

# CHAPTER 1

## INTRODUCTION

Nurse shortage in developed countries has been a major global issue (Aiken, Buchan, Sochalski, Nichols & Powell, 2004). Many developed nations face a demographic dilemma; wherein there is an increasing trend of elderly people while their nursing workforce is also aging (Buchan, 2002; Buchan, Parkin & Sochalski, 2003). Foreign-educated nurses constitute 5 to 10% of nurse workforces in Australia, Canada, Ireland, the United Kingdom, and the United States (Kingma, 2007). Certain countries, such as New Zealand with 21% of its nurses trained abroad, have higher statistics (WHO, 2006). Buchan and Sochalski (2004) suggested that to maintain the supply of nurses, efforts must be directed towards improving retention or broadening the recruitment base. Despite prominent recommendations of policy-makers to focus on improving working conditions to facilitate retention, recruitment of international nurses has remained the dominant mechanism to address the staffing issue among developed nations (Buchan & O'May, 1999; Buchan & Sochalski, 2004).

The Philippines has been one of the major targets in global recruitment and has remained the world's largest exporter of nurses (Brush & Burger, 2002; Kingma, 2006). The demand for Filipino nurses may be attributed to the fact that they are primarily educated in college-degree programs and communicate well in English (Lindquist, 1993). In addition, the Philippine government supports overseas employment as a key source of economic growth as stipulated in its 2001-2004 medium term development plan (Bach, 2003). In the United States alone, Filipino nurses constitute 50.2% of internationally educated nurses in 2004 (Health Resources and Services Administration, 2005).

The relationship between American and Philippine nursing is linked to colonial

ties (Brush, 1995). In the early 1900's, Filipino nurses were sent to the United States for further training, as sponsored by philanthropic institutions like the Rockefeller Foundation, the Daughters of the American Revolution, and the Catholic Scholarship Fund (Brush, 1995).

In the 1920's, the Rockefeller Foundation played a major role in providing funds to internationalize American medical and nursing ideology (Abrams, 1993). The continued American influence and intervention, even after the Second World War, created an oversupply of Filipino nurses who were trained by Western standards (Brush 1995). Between 1956 and 1973, widespread unemployment enabled 12,526 Filipino nurses to enter the United States through the Exchange Visitor Program (Alinea & Senador, 1973). Over the past 60 years, the Philippines has led the world in preparing nurses explicitly for export to meet the demand for nurses in the United States and other developed countries (Brush, Sochalski & Berger, 2004; Choy, 2004).

#### Problem Statement

As a more recent phenomenon, physicians in the Philippines have retrained as nurses in order to seek overseas employment (Lorenzo, Galvez-Tan, Icamina & Javier, 2007). Although the exact number of these physician-turned nurses (a.k.a. “nurse medics”) was not initially reported, a study on the trends estimated approximately 2,000 doctors who became nurses in the year 2001, which increased to an additional 3,000 by 2003 (Pascual, Marcaida & Salvador, 2003). In 2005, the University of the Philippines College of Medicine in Manila, through the Philippines’ National Institute of Health, conducted a follow up study that revealed approximately 3,000 physicians were enrolled in more than 45 nursing schools that offer customized courses for physicians all over the country (Galvez-Tan, 2006). The same study also found out that the aforementioned physicians

come from a variety of specialties, with ages ranging from 25 to 65 years old, more females than males, and with physician practice experience ranging between 0 to 38 years. Since 2000, more than 3,000 doctors have left to work as nurses in developed countries predominantly in the United States (Galvez-Tan, 2006).

In 2005, the National Institute of Health in the Philippines, conducted focus groups among “nurse medics” or physician-turned nurses in two urban centers. The participants reported that their career shifts were attributed to the very low compensation and salaries in the Philippines, feeling of hopelessness about the current situation of political instability, graft and corruption, poor working conditions, and the threat of malpractice lawsuits (Galvez-Tan, Sanchez & Balanon, 2004). The “nurse medics” were also drawn to attractive compensation and benefits packages, more job opportunities, career growth, and more socio-political and economic security abroad (Lorenzo, Galvez-Tan, Icamina & Javier, 2007).

Migration is never an easy decision (Kingma, 2007), which affects the involved nurses and their families in every way possible. There is an array of challenges facing migrating nurses across national borders: economic, political, psychosocial and cultural (Allan & Larsen, 2003; Allan, Larsen, Bryan & Smith, 2004; Baumann, Blythe, Rheaume & McIntosh, 2006; Buchan, Withers & Snowball, 2003; Xu, 2007).

The above mentioned studies performed in the Philippines imply that the migration of physician-turned nurses has posed a major issue in the integrity of the country's overall health situation, as characterized by a ‘brain drain’ of skilled and specialized health workers (Asis, 2007). However, personal accounts of their experiences as nurses in the United States have never been a focus of inquiry or study, particularly in the context of a professional role shift.

Furthermore, the exploration of these experiences, positive or negative, will best describe the impact of the decision of a professional compromise, i.e. from physician to nurse, as well as migration to a foreign land. Becoming a physician in the Philippines is generally an achieved status. This implies that assuming the physician role in the Filipino society connotes stratification among the elite. An elite status in the Filipino context is largely determined by the possession of key values to be able to influence others in society. Wealth, skill, power, respect and enlightenment are often desired values (Simbulan, 2005). For instance, respect and power may be characterized by having multiple domestic servants to perform menial household tasks.

In the Philippines, medical education is not easily affordable. A vast majority of the medical colleges operate privately and consequently only wealthy people or families can afford to pursue a degree in medicine (Islam, 2005).

Without a template or guide for structure, the author of this study formulated an encompassing central research question that would best generate spontaneous and multi-dimensional ideas: "As a former physician in the Philippines, what are/were your experiences of working as a registered nurse in the United States?"

#### Purpose of the Study

The main purpose of this qualitative study was to describe the lived experiences of Filipino physician-turned nurses in the Las Vegas, Nevada area. Furthermore, the subjective accounts of their professional shift, from being former practicing physicians who underwent retraining as nurses in the Philippines to being staff nurses in the United States, were further explored through interpretive analyses, in the context of emigration.

#### Significance to Nursing

Globalization has increased the effects on the labor market, resulting in an increase

in migration of highly skilled professionals from developing to developed countries, with healthcare professionals forming the largest proportion (Martineau, Decker & Bundred, 2003). Kirk (2007) proposed that because emigration of nurses being the front line staff of most health care systems and essential for delivering services, the impact of their migration may compromise developing countries' healthcare delivery systems. In addition, it has been hypothesized that the magnitude of the losses and demands of immigration affects the immigrant's ability to develop mastery of new roles and responsibilities (Aroian, 1990). However, before final judgments can be made on the effects of nurse migration to either source or recipient countries, more research is deemed imperative.

As a recent phenomenon, Filipino physician-turned nurses are becoming an integral part of the workforce that is augmenting the shortage in developed countries, particularly the United States (Galvez-Tan, 2006). Hence, it is worthwhile to study this special subgroup of international nurses to determine the effects or consequences of the dual impact of professional compromise and migration. Through their lived experiences, insight may be obtained to possibly enrich the existing literature on the effects of professional compromise and/or migration in relation to patient safety, quality of care, job satisfaction and nurse retention. Also, this inquiry will further provide a deeper appreciation or understanding of the consequences of the decision to shift careers, and simultaneously going through them in a foreign environment.

## CHAPTER 2

### REVIEW OF RELATED LITERATURE

Using CINAHL, Academic Premier, Medline and PsychInfo databases, a thorough literature search of published and unpublished work was conducted using combinations of various keywords. The keywords used included “Filipino nurses,” “physician,” “nursing shortage,” “migration,” “Philippines,” “phenomenology” and “international nurses.”

The relationship of the United States and the Philippines began when Spain ceded the islands to the U.S. under the terms of the Treaty of Paris in 1898, which ended the Spanish-American War (U.S. Department of State, 2008). After four centuries of Spanish colonization, the presence of the U.S. in the Philippines was followed by a revolutionary war of resistance by native Filipinos, claiming tens of thousands of lives. The resistance gradually died with American efforts to facilitate conflict resolution. The Philippines eventually became a self-governing commonwealth in 1935 under the guidance of the Americans. On July 4, 1946, the Philippine islands became an independent republic in accordance with the terms of the Tydings-McDuffie Act (U.S. Department of State, 2008).

The Philippines has played an integral role in the economy of migration with an estimated 7 million (approximately 10% of the population) working or living abroad (Bach, 2003). According to a working paper published by the International Labour Office in Geneva, Switzerland, the Filipino overseas migration is reflective of the economic and socio-political situation in the Philippines. In particular, the perpetuating “brain drain” of health professionals in the Philippines may be attributed to a number of factors, namely: a colonial mentality, economic need, professional and career development, and the

attraction of higher living standards. Nurses represent the largest category of health professionals, followed by midwives and doctors (Institute of Health Policy and Development Studies, 2006).

The Global Commission on International Migration facilitated the acceleration of movement of health professionals from developing to developed countries (Carballo & Mboup, 2005). There are a variety of factors that are contributory to such movement: a) developed countries have not been able to adequately plan for and/or invest in expanding their own health human resources; b) demand for health care in these developed countries is now out-pacing the existing health professional capacity; c) some developing countries are producing health human resources that can be recruited; d) better opportunities for health professionals in developed countries; e) developed countries are now more actively involved in the international recruitment of health professionals from developing countries; and f) degree programs in both recipient and donor countries are interchangeable (Carballo & Mboup, 2005).

As previously mentioned, the relationship of American and Philippine Nursing is linked to the neocolonial ties of the two countries. The poor health conditions in the Philippines were attributed to contaminated water supplies and poor sewage systems, increased urbanization, inefficient basic health care and vaccination programs, and inept administration of services (Brush, 1995). In effect, American missionary workers and medical providers became involved in the nursing movement as well as hospital development immediately after U.S. possession of the islands, as part of its westernizing efforts (Brush, 1995). This move complemented the vigorous U.S. worldwide nursing and public health reform all over the world (Brush, 1995).

However, the U.S. met unintended consequences due to the impending shortage of



American nurses as early as the 1920's. As a result, rather than improving the health of the Filipino people, the introduction of American nursing methods and ideas gave rise to a series of events that may have facilitated the creation of a "ready-made workforce" for future under-staffed American hospitals (Stevens, 1989).

Brush (1994) analyzed the recruitment and employment of migrant Filipino nurses to U.S. hospitals between 1945 and 1980. Through historical research, the study unveiled the beginnings of the American nursing shortage, which was attributed to post-war healthcare expansion, technological advancement, and shifts in the consumer ideologies about health. Brush discussed that these changes prompted nursing leaders and policy makers to initiate temporary and expandable means to address the shortage, including the recruitment and employment of foreign nurses as posited by Stevens (1989). However, Brush's dissertation emphasized that this approach failed to address the shortage and instead contributed to the complex hierarchical nurse labor structure that divided nurses by race, class, ethnicity, and even geography. As a consequence, Brush deduced that nurses became socially and spatially segregated, paradoxically perpetuating the vicious cycle of the nursing shortage.

Also using a historical research approach, Choy (1998) studied the international migration of Filipino nurses as a post-1965 phenomenon. Throughout the study, Choy supported Brush's (1994) dissertation by arguing that the development of this mobile labor force is inextricably linked to the history of American Imperialism as well as the early-twentieth-century colonization of the Philippines by the United States. Moreover, this nursing labor force was brought to existence as a transnational process involving the collaboration of both Philippine and American nurses, government officials, and hospital administrators. Meanwhile, the number of nursing schools in the Philippines increased

from 17 in 1950, to 46 in 1965, to 88 in 1974 (Ortin, 1990).

As of 2005, there were approximately 470 nursing schools in the Philippines (Galvez-Tan, 2006). Conversely, the number of registered Filipino nurses dramatically increased from 7,000 in 1948 to over 57,000 in 1973 (Sotejo, 1974). In 2000, a study revealed that an estimated 163,756 or 85% of all Filipino nurses are working outside the Philippines in at least 46 countries (Corcega, Lorenzo, Yabes, De la Merced & Vales, 2000).

Asis (2007), of the Scalabrini Migration Center in Manila, presented a paper during the 17<sup>th</sup> General Meeting of the Pacific Economic Cooperation Council in Sydney, Australia. The presentation highlighted the surplus of nurses in the Philippines, with a stock of 332,206 nurses, as opposed to an existing demand for only 193,223 nurses based on the most recent population. By far, there is an oversupply of over 190,000 nurses in the Philippines who are anticipated to find employment abroad (Asis, 2007). Asis also emphasized that nurse migration does not lead to a Philippine nursing shortage per se, but that it has led to marked distortions in the health care delivery and human resource development of the country. As examples to the above implications, Asis mentioned the proliferation of nursing schools or programs that may affect the quality of Philippine nursing education and doctors becoming nurses because of the global need, as only two of the multiple consequences of the nurse migration problem (Asis, 2007), which reinforced Galvez-Tan's (2006) findings.

The plight of Filipino nurses who migrated to various parts of the globe has been anecdotally well highlighted (Berger, 2008; Dimapilis-Baldoz, 2007; Quisumbing, 2007; Kinderman, 2006). Berg, Rodriguez and De Guzman (2004) performed a descriptive demographic survey of Filipino American nurses, revealing that they were primarily

educated in the Philippines, held baccalaureate degrees in nursing, worked full time and had high job satisfaction. In a more recent study, Filipino registered nurses in the U.S. demonstrated moderate level of job satisfaction that was positively correlated to a level of acculturation that was more American than Filipino (Ea, Griffin, L'Eplattenier & Fitzpatrick, 2008). Other variables such as age, length of U.S. residency and acculturation play an important part in predicting perception of job satisfaction among this group of Filipino nurses. However, the above studies were purely descriptive of the profile of migrant Filipino nurses, and did not reflect deeper perspectives of their experiences as emigrants.

The acculturation of Filipino nurses to nursing practice in the United States was intensively studied by Lopez (1990) for doctoral dissertation. The study used a triangulation of quantitative and qualitative methodologies to describe the problems or issues, coping methods, and changes in the nursing practice among migrant Filipino nurses. Lopez discovered that the most common issues experienced by Filipino nurses include initial deficiency in technical skills, communication difficulties due to unfamiliarity of American expressions and slang, delegation of auxiliary staff members, and passing the nursing licensure examination.

Various studies attempted to describe the impact of migration on Filipino nurses working in other countries. For instance, Daniel, Chamberlain and Gordon (2001) performed focused group interviews of newly migrated Filipino nurses at a London hospital. The study identified equal opportunities to training and promotion and the use of culturally sensitive orientation program as factors that may promote successful adaptation and retention. However, the study also reported that differences emerged between their initial expectations and their actual experiences. Another qualitative phenomenological

study (Alexis, Vydelingum & Robins, 2007) was conducted in the United Kingdom. Although the same study only had two of the interviewees who were Filipino, it provided insight on the psychosocial consequences of migration. The study revealed six themes among the experiences of overseas minority ethnic nurses, namely: the devaluation process, concept of self-blame, discrimination or lack of equal opportunity, concept of invisibility, experiencing fear and benefits of being in the United Kingdom.

Grossman and Jorda (2008) studied the impact of a five-semester Baccalaureate nursing program specifically for foreign-educated physicians in Miami, Florida. The program emanated from a dire need for minority nurses in the area, and was proposed by a group of Cuban immigrants who were educated as physicians in their home country. However, the participants of the Baccalaureate program have undergone nursing education in the United States prior to obtaining licensure for nursing.

#### Summary

The literature has provided insight on the historical importance of Philippine nursing in the continuing struggle of the nurse labor shortage in the United States, as well as other developed nations. Studies had been performed that focus on the various aspects of the migratory experience of the Filipino nurse. However, the recent emergence of nurse medics or physician-turned nurses as a special sub-group has yet to be explored, particularly in their transition from working as physicians in the Philippines to functioning as staff nurses in the United States. There is nothing in the published literature, quantitative or qualitative, that focuses on the experiences of physician-turned nurses.

## CHAPTER 3

### THEORETICAL FRAMEWORK

Munhall (2001) stated that theoretical frameworks are not used in qualitative studies in the same manner as in quantitative studies, because the goal is not theory testing. In fact, Munhall (2001) explained that in some qualitative studies, theory development becomes one of the results. Burns and Grove (2005) summarized Munhall's logic of qualitative research as follows:

The qualitative approaches are based on a worldview that is holistic and has the following beliefs:

1. There is not a single reality.
2. Reality, based on perceptions, is different for each person and changes over time.
3. What we know has meaning only within a given situation or context.

The reasoning process used in qualitative research involves perceptually putting pieces together to make wholes. From this process, meaning is produced. Because perception varies with the individual, many different meanings are possible (Burns & Grove, p. 52).

Munhall (2001) also emphasized that qualitative research is guided by a particular philosophical stance considered a paradigm. This philosophical stance directs the questions asked, the observations made, and the data interpretation performed (Munhall, 2001).

Based on the multidimensional nature of the factors that affect nurse migration in the existing literature, the phenomenon (i.e. migration of Filipino physician-turned nurses to the United States) will probably be best understood through the dual perspectives of emigration as well as of the professional shift from physician to nurse. Hence, this

particular study will use both the International Migration Theory (Massey, 1994) to explain the act of migration and the Role Theory in Social Psychology (Biddle, 1986) to guide the interpretive discussion of results.

#### International Migration Theory

To underpin this relatively new theory, Massey et al. (1994) synthesized the key concepts of the neoclassical economic theory, the new economics of migration, the dual labor market theory (a.k.a. the segmented market theory), and the world-systems theory. This theory posits that individuals and families respond to the changing circumstances set in motion by social transformations of their societies, both political and economic. In moving, they seek to raise incomes, accumulate capital, and control risk by following international routes of transportation and communication to global cities where secondary sectors may be had (Massey et al., 1994).

Traditional neoclassical economics views international migration as a simple sum of individual cost-benefit decisions, which are made to maximize expected income through international movement (Massey et al., 1994). In essence, people migrate because they expect to gain higher net earnings abroad. According to the neoclassical view, flows of labor move from low-wage to high wage countries, and emigrants tend to move to countries in which they expect the highest net gain (Todaro & Maruszko, 1987).

More recently, Massey et al. (1994) described that a new theoretical paradigm has emerged to challenge the hypotheses and assumptions of neoclassical economics. This theory of the new economics of migration proposes that individuals relocate permanently to countries that yield the highest lifetime income and that they play a little role in the economic life of the source community thereafter. Furthermore, outmigration influences the local economy through its effects on prices and incomes, shifting labor supply inward

or outward, hence raising or lowering wages. According to Stark (1991), theorists of the new economics argue that individuals migrate not only to improve absolute income but also to increase their incomes relative to others in the source community.

Piore (1979) proposed that the impact of migration on the natives of the recipient countries is small because immigrants take jobs that natives refuse to accept. Piore explained that there are inherent tendencies in modern capitalism, which leads to a bifurcated labor market. This duality has given rise to the creation of primary and secondary sectors, the former with the capability to produce jobs with secure tenure, high pay, generous benefits, and good working conditions. Conversely, the secondary sector is typified by instability, low pay, limited benefits, and unpleasant or hazardous working conditions. Piore (1979) also purported that there are inherent tendencies within developed societies that tend to produce a shortage of workers willing to work jobs in the secondary sector since there are few economic returns attributed to experience, skill or education. In effect, employers seek to recruit immigrants to fill secondary sector positions rejected by natives.

In the dual labor market theory, Piore (1979) also discussed that migrants not only gain access to high wages and remittances to shift their position in the local income distribution but also move into a different society that constitutes a radically different frame of social and cultural reference. By this, Piore expounded that migrants initially do not see themselves as part of the destination society, and they view their work as a means of earning money to enhance their status at home.

For Immanuel Wallerstein (1974), “a world-system is a social system which has boundaries, structures, member groups, rules of legitimation, and coherence. Its life is made up of the conflicting forces that hold it together by tension and tear it apart as each

group seeks eternally to remold to its advantage. It has the characteristics of an organism, in that it has a lifespan over which its characteristics change in some respects and remain stable in others (Wallerstein, 1974). Life within it is largely self-contained, and the dynamics of its development are largely internal (Wallerstein, 1974). Wallerstein terms this system as a “world economy,” integrated through the labor market rather than a political center, wherein two or more regions are interdependent with respect to necessities, like food, fuel and protection (Goldfrank, 2000).

Furthermore, Wallerstein (1974) further explains the concept of the world-system as being a multicultural territorial division of labor in which the production and exchange of basic goods and raw materials are necessary for the everyday life of its inhabitants. This division of labor leads to the concept of two interdependent regions: *core* and *periphery*. Core societies refer to regions that benefit the most from a capitalist economy; with developed strong central governments as well as extensive bureaucracies and large mercenary armies (Wallerstein, 1974).

Peripheral regions are areas that lack strong governments or were controlled by other states, exported raw materials to the core, and relied on coercive labor practices as well as unequal trade relations (Goldfrank, 2000).

According to Zohlberg, Suhrke and Aguayo (1989), the global market relies on the existence of a stable international system conducive to capitalist social and economic relations. The process of capital accumulation that drives economic growth among core states tremendously benefits from unhindered access to markets and natural resources scattered around the world. In essence, core nations have pursued diplomatic and military means to preserve the integrity of the international system, thereby protecting overseas investments, ensuring continued access to natural resources, supporting military allies



and maintaining sympathetic pro-capitalist regimes (Zohlber, Suhrke & Aguayo, 1989; Rumbaut, 1991).

As preliminary synthesis of the International Migration Theory, Massey et al. (1994) arrived at the following hypotheses, based on the aforementioned economic theories:

1. International migration originates in processes of economic growth and political transformation within the context of a globalizing market economy (world systems theory).
2. The penetration of markets into peripheral nations disrupts non-capitalist modes of social and economic organization and causes widespread labor displacement, creating a mobile population that actively searches for a means of improving income, acquiring capital, or controlling risks (neoclassical economics and the new economics of migration).
3. In core nations, postindustrial development leads to a bifurcation of the labor market, creating a secondary sector of jobs with low pay, unstable conditions, and few opportunities for advancement (dual labor market theory). Because natives shun secondary sector jobs, employers rely on immigrant workers; at times initiating the immigrant flows directly through recruitment (dual labor market theory).
4. International movement is further caused by foreign policy and military entanglements that reflect the need of core nations to maintain international stability and security (world-systems theory)(Massey et al. 1994, pp 740-741).

### The Role Theory

Role theory, in social psychology, concerns one of the most important characteristics of social behavior – “the fact that human beings behave in ways that are different and

predictable depending on their respective social identities and situation” (Biddle, 1986). Moreover, role theory concerns itself with a triad of concepts: patterned and characteristic social behaviors, identities assumed by social participants, and expectations for behavior. The concept of “roles” is a theatrical term and conveys the notion that normative expectations, such as culturally defined behavioral rules are attached to positions in social organizations, e.g. family, corporations, society, etc. (Goffman, 1959). In other words, as succinctly stated, a person occupies a status, but plays a role (Lindesmith & Strauss, 1968). Through the enactment of rules, static social positions are brought into life, wherein roles can be assumed to carry not only certain rights and privileges, but also duties and obligations (Bielkiewicz, 2007).

Key Concepts. One of the strengths of role theory is that its concepts are easily studied (Biddle, 1986). Furthermore, this has led to considerable research that focused on the various issues in role theory. Biddle (1986) identified the four key concepts in role theory as consensus, conformity, role conflict and role-taking.

Consensus is the term used by role theorists to denote agreement among the expectations that are held by various persons (Biddle, 1986, p. 76). Functionalists who believed that social roles appear because individuals in a social system can be counted on to support those norms with sanctions initially argued the significance of this concept. Hence, a social norm has been defined as a standard that is shared by members of a social group (Biddle, 1986).

Conformity connotes compliance to some pattern for behavior (Biddle, 1986). Others conceive this pattern as the modeling of behavior. In turn, modeling or imitation, invokes the concept of expectation. Conversely, others’ actions reflect or lead the persons to form expectations that induce conformity (Biddle, 1986).

Biddle (1986) defines role conflict as the concurrent appearance of two or more incompatible expectations for behavior. Biddle reiterates that in such cases, the person will be subjected to conflicting pressures, will suffer stress, will have to resolve the problem by adopting some form of coping behavior, and that the person and the system will both be disrupted. However, role conflict is only one of the several structural conditions that cause problems in social systems. Others have included *role ambiguity* (a condition in which expectations are ill-defined, incomplete or insufficient to guide behavior), *role malintegration* (when roles do not fit well together), *role discontinuity* (when a person must perform a sequence of malintegrated roles), *role overload* (when the person is faced with too many expectations) and *role incongruity* (when role expectations contradict the individual's values and self-perception) (Biddle, 1986; Lindesmith & Strauss, 1968).

Individuals also take on the role of others in order to anticipate their actions, which is termed as role-taking (Turner, 1956). As an outcome of these interactions, individuals identify themselves and are identified by others as holding particular positions or social statuses (Stryker, 1968).

One of the main limitations of the role theory is its difficulty to explain deviant behavior particularly when it does not correspond to a pre-specified role (Biddle, 1986; Michener & DeLamater, 1999). Also, role theory fails to explain how role expectations came to be what they are (Michener & DeLamater, 1999).

## CHAPTER 4

### METHODOLOGY

The study focuses on the lived experiences of Filipino physician-turned nurses. This particular chapter discusses the various aspects of the research methodology, namely: study design, sample selection, inclusion criteria, data collection procedures, data analysis process and measures to safeguard the study.

#### Study Design

Phenomenology is the research design for this study. It is rooted in early 20<sup>th</sup> century European philosophy as developed by philosophers Husserl and Heidegger (Johnson, 2000). Through examination of individual experiences, phenomenologists seek to capture the meaning or essence of an event or experience (Burns & Grove, 2005). The truth of that event, being an abstract entity, is subjective and can only be discerned through embodied perception (Starks & Trinidad, 2007). Grounded in this philosophic tradition, phenomenology is also a research method that aims to describe and examine phenomena that are consciously experienced as lived by study participants (Burns & Grove, 2005). This approach involves the assumption of multiple, situated realities in which both the participants' and the researchers' contexts give meaning to a particular phenomenon (Young, 2008). Various interpretations are considered with the acquiescence that there is no single or accurate interpretation, and that the researcher does not have a better understanding than the participant (Baker, Norton, Young & Ward, 1998).

In judging rigor in qualitative studies, including phenomenology, Burns (1989), Dzurec (1989) and Sandelowski (1986) stated that rigor is associated with openness, scrupulous adherence to the philosophical perspective, thoroughness in data collection, as well as careful consideration of all the data in the subjective theory development phase.

This study adopted the approach developed by Paul F. Colaizzi (1978) that involves the observation and analysis of human behavior within its environment to examine experiences that cannot be communicated. Colaizzi's method is derived from the assumption that the human experience is: (a) objectively real for one's self and others; (b) not an internal state but a mode of presence to the world; (c) a mode of presence that is existentially significant; and (d) a legitimate and necessary content for understanding human psychology (Colaizzi, 1978, p. 52). Because of the nature of the problem statement, the methodology must comprise both descriptive and interpretive elements to describe the lived experiences of Filipino physician-turned nurses, as well as interpret their experiences in the contexts of emigration to the United States and professional shift from being physicians in the Philippines to working as nurses in the U.S., hence the option of using the above method.

#### Sample Selection

A purposive sample of ten (10) self-identified Filipino physician-turned nurses in the Las Vegas, Nevada area was initially projected for this specific phenomenological inquiry. Through anecdotal reports from colleagues, there are a significant number of Filipino physician-turned nurses working in various hospitals in the area. In addition, their entry into the United States as nurses did not involve full disclosure of their background as former physicians in the Philippines. Thus, purposive sampling was used to ascertain consistency of resources to study the identified phenomenon. However, the actual number of respondents was determined largely by achieving data saturation. In other words, the interviews were completed when data saturation was appreciated after the 8<sup>th</sup> participant. The respondents were selected by referral from colleagues and acquaintances in the health sector.

## Inclusion Criteria

There was only one inclusion criterion for this study: each participant was initially a licensed physician in the Philippines and eventually obtained a nursing degree (i.e. Bachelor of Science in Nursing) prior to migrating to the United States to work as a registered nurse.

## Data Collection Procedures

Data collection occurred at the time each respondent agrees to participate in the study. This implied that each respondent had approved participation by signing the consent forms.

Human Subjects Review. The study, *Filipino Physician-turned Nurses: A Phenomenological Study*, was approved by the University of Nevada, Las Vegas' Office for the Protection of Research Subjects (Institutional Review Board). Possible participants, who met the above mentioned inclusion criterion, were initially contacted via telephone with an invitation to participate in the study. Then a personal interview was arranged at the place and time of each participant's choice and convenience. Prior to the scheduled interviews, the participants were then asked to sign the informed consent forms for both participation and audio-taping of the conversations. After giving each participant a copy of the purpose of the study, as well as copies of both consent forms, the interview began with questions pertaining to demographical data. Confidentiality was maintained by excluding personal identifying information in the protocols, data analysis and research findings. Then, each participant was asked to respond to one, single open-ended question: "As a former physician in the Philippines, what are/were your experiences of working as a registered nurse in the United States?" The interviews were conducted in English and there was no allotted time to limit the duration of the interview. The tape-recorded

interviews were then subsequently transcribed verbatim. To ensure completeness of the description of the phenomenon being studied, collection of data (i.e. interviews) continued until data saturation was ascertained.

#### Data Analysis Process

Each written transcription of the tape-recorded interviews was analyzed using Colaizzi's (1978) method of phenomenological inquiry. The methodology involved the following seven procedures:

1. All of the respondents' tape-recorded responses were repeatedly listened to and the written transcripts repeatedly read in order to acquire a feeling for them.
2. Significant statements that pertain to the lived experiences of the respondents were then extracted from each research protocol or transcript.
3. Meanings were then formulated from each statement extracted.
4. The aggregate formulated meanings were then organized into clusters of themes.
5. The results were then integrated into an exhaustive description of the investigated phenomenon.
6. Descriptive identification of the fundamental structure of the phenomenon was derived from the formulated exhaustive description.
7. Finally, validation was achieved by returning to the respondents, asking them of the results of the findings. There was no additional data recommended by any of the respondents that needed to be incorporated in the essential structure of the phenomenon.

#### Measures to Safeguard the Trustworthiness of the Study

During the interview process, "bracketing" was maintained, ensuring that the interviewer did not consciously influence the replies of participants. Bracketing was a

concept introduced by the phenomenologist Merleau-Ponty (1956). It refers to a reawakening of the researchers' own presuppositions to facilitate abstinence from them during the research process.

Aside from repeated listening to the tape-recorded interviews or reading of the verbatim transcription of the interviews, efforts were made to achieve *reflexivity*. During the analysis phase, researchers need to critically think through the dynamic interaction between one's self and the data occurring (i.e. taped interviews and/or transcriptions). Lamb and Huttlinger (1989) refer to these critical thought processes as reflexivity, which enables the researcher to explore personal feelings and experiences that may be integrated into his/her study to further understand the investigated phenomenon. In addition, researchers apply *intuiting* to examine the actual phenomenon, wherein the researcher focuses all awareness and energy on the investigated topic to allow an increase in insight. In essence, intuiting requires absolute concentration and complete immersion with the experience being examined (Oiler, 1982).

A "member check" was carried out wherein the study findings grounded in the interview data were shared with three of the interviewees. Also, direct quotes from the interviews were used in interpreting the results to help substantiate the emerging themes formulated.



## CHAPTER 5

### FINDINGS OF THE STUDY

This portion of the paper is intended for sharing the results of the study. The profile of the participants, the emerging themes identified and the essential structure of the phenomenon will be included in this section.

#### Profile of Participants

Of the eight respondents, two (2) of the Filipino physician-turned nurses were male, while six (6) were female, with ages ranging from 43 to 58. Four (4) or half of the respondents still held positions as staff nurses in different healthcare facilities, while the other half were employed in either middle-level management or nurse practitioner positions. The average number of nursing experience in the United States was 3 years. Six (6) or 65% of the respondents reported not having any nursing experience in the Philippines, one respondent with two years and the remainder with 3 years of nursing experience in their home country prior to emigration. Half of the respondents reported a baccalaureate degree in nursing as their highest nursing degree attained while the remaining half had completed master's degrees in nursing as family nurse practitioners.

As physicians in the Philippines, the respondents had varying medical specialties. One respondent was an ophthalmologist for 10 years. Another specialized in Internal Medicine for two years. Two of the respondents were Family Medicine practitioners, one practiced for 3 years and the other for 6 years. Two of the respondents specialized in Obstetrics and Gynecology, one for 10 years and the other for 14 years. Among the respondents, there was also a former gastroenterologist who practiced for 13 years. The remaining respondent specialized in Pediatrics for 24 years. When asked of their ultimate career goals, five (5) of the eight respondents wanted to become clinicians

as nurse practitioners; one respondent wanted to pursue a career as a nurse educator, one divulged intentions of becoming a Medical Director, while one respondent aspires a career in management.

### Emerging Themes

Thirty-seven (37) significant statements pertaining to the lived experiences of Filipino physician-turned nurses in the U.S. were extracted from the interview data. Meanings for each significant statement were then formulated. The formulated meanings were then organized into four clusters of themes.

Theme 1: Changing roles from physician to nurse as most challenging during their transition. The role change from physician to nurse involves a rather complex psychosocial dimension. Assuming the nursing role gives rise to new and occupation-specific issues, such as erratic work schedules, physical and emotional demands in caring for patients, less autonomy and control of the work environment, and inadequate work hours. The role change also bred negative perceptions in the work milieu, which the respondents translated as forms of debasement or demotion. Some of the respondents indicated that misconception was not uncommon while others clearly emphasized that peers, other co-workers and even physicians in the workplace directly and indirectly discriminated them against. The succeeding statements reflect that issue:

*“Some people here have that thinking that physician-turned nurses came to the U.S. because they were not good in their medical practice.”*

*“You have to swallow your pride and sometimes deny your new role as a nurse because people will look down on you. I have this feeling that it is better to be incognito.”*

*“I know of other doctor-turned nurses like myself who were discriminated or treated differently when they were found out to be former physicians. They either expect much*

*from you or even ridicule you.”*

Moreover, this shift from a predominantly “thinker” perspective in medicine to a “doer” role in nursing caused negative emotions in the transition process. A decrease in self-esteem may be attributed to various degrees of embarrassment, shame, despair, alienation, loneliness, frustration, dissatisfaction and disillusionment. On the other hand, as former physicians, the expectations of entering nursing practice in the United States were set unrealistically high because of their perceived strong theoretical and clinical backgrounds. As a result, U.S. healthcare employers provided them with limited transitional training and/or orientation as indicated by one respondent who stated that, *“The nurse manager only gave me two weeks of orientation with the knowledge that I was a former physician.”*

Different healthcare systems and climate also affected the transition of the Filipino physician-turned nurses. The respondents observed various differences in both nursing and medical practice in the two different countries and even noted the legal implications of unsafe and sometimes unacceptable care in the United States. In the process, these Filipino physician-turned nurses found themselves being socialized and even indoctrinated into “defensive practice.” Without proper orientation to the legalities and the scope of practice during the transition phase, the physician-turned nurses expressed initial feelings of uncertainty and even paranoia.

*“In the U.S., nursing involves a lot of documentation, covering one’s self in a shift, because of malpractice lawsuits.”*

The obtained data also divulged statements that reflect difficulty in letting go of the physician role while working as nurses. During the transition phase, the respondents openly commented on the differences in the professional conduct and expectation of

physicians between the U.S. and the Philippines. Denial was a common defense mechanism in their adaptation into the nursing role, which facilitated expression of the following strong statements:

*“I had experienced arguing with a doctor here (an anesthesiologist) because he was ordering something that I was not comfortable doing.”*

*“Sometimes, the physicians here look down on you even if you know that you are better than them.”*

*“I was initially shocked because it seems that physicians here do not spend much time with their patients; that’s why the nurses here have a more important role in managing the patients.”*

One of the respondents was an obstetrician in the Philippines who incidentally worked as a postpartum nurse. She openly expressed her struggles in her nursing practice.

*“I took care of a postpartum patient who I knew was bleeding. I knew she was having atony but I could not do anything. I wanted to give her Methergine or something...but I needed a doctor’s order. I was only a staff nurse.”*

Another respondent who worked as a part-time school nurse shared a similar predicament.

*“As a school nurse, it felt like being a doctor. The hardest part was that you cannot diagnose...I knew what students had [medical diagnosis]...but I could not fully address them especially with the parents because I was not allowed to diagnose.”*

The cumulative negative experiences in nursing in the United States have pre-empted feelings of yearning for their former professional roles as physicians. This difficulty of letting go largely explained their tendencies to recall former experiences as physicians in their home country, and comparing these experiences to physician counterparts in the

United States. The attempt to compare physician professional conduct becomes a vehicle that momentarily detached them from their individual realities as nurses. This effort of detachment then temporarily offered a subconscious escape. Not surprisingly, the respondents did not report major issues in communication, except for occasional clarification of slang terms and pronunciation.

Theme 2: Psychosocial support provided by fellow Filipino nurses providing a safety net in their transition. The transition process of international nurses working in a foreign healthcare environment was affected by the diversity of the workplace. Pre-existing organizational structures, the complexity of the healthcare system, workplace culture and the stressful atmosphere of bedside nursing practice propagated feelings of uncertainty and discomfort as the physician-turned nurses confronted the various changes in both their professional and personal lives. In this process, comfort was achieved with the received support by other Filipino co-workers. Identifying with co-workers of the same ethnicity decreased the burden associated with transition and facilitated a sense of belongingness that ameliorated some of the possible negative consequences of transition, such as alienation and isolation. Ventura (1991) describes the Filipino culture as a collectivistic society and that Filipinos desire social acceptance, group belonging and nurturing. Productivity and time efficiency are far less important than smooth interpersonal relations and awareness of other people's sensitivity to criticism.

*“My ego was really low in the beginning...Filipino nurses and other Filipino members of the auxiliary staff provided support.”*

*“Nurses are competitive if they belong to different races. Non-Filipino nurses may sometimes give you support but not all the way. I noticed that Filipino nurses really help each other.”*

*“I started in a medical-surgical department with 6 to 8 patients per nurse. I had so much difficulty...but I was very lucky to have Filipino co-nurses. It was very easy to work with them. They taught me a lot and made work look lighter.”*

Theme 3: Unmet preconceived high socioeconomic expectations before coming to the U.S. serving as bondage for transition. In addition to the challenge of the disciplinary shift from medicine to nursing, disappointment was pervasive stemming from their unmet expectations conceived before migrating to the U.S. One of the immediate reasons to work as a nurse in the U.S. was to improve the family’s standards of living. However, for some, their living standards in general went down instead. Many of the Filipino physician-turned nurses experienced disparity of the lifestyles from the before-after comparison. Although their income as a nurse in the U.S. was higher than what they earned as a physician in the Philippines, there was no comparison in terms of lifestyle and social status. The once comfortable and stress free work and home environments were now being replaced by increased involvement both at home and at work. Financial needs exponentiated as members of the family slowly assimilate into the American culture of consumerism, necessitating some of the respondents to find additional gainful employment. One respondent stated that,

*“I was forced to get another job to augment my income.”*

*“If you were a doctor in the Philippines and then work here as a nurse, the pay is not enough. You have to work 6 days a week to sometimes equal your income in the Philippines. But, I want my children to have all the options in life. For the first three months, I was dreaming...literally everyday...that I was still in the Philippines...being myself.”*

*“I do not regret coming here, but at home (the Philippines), we had helpers...and a*

*driver. Here, I have to do everything.”*

Furthermore, the failure to meet the socioeconomic expectations paved way to feelings of emptiness and lack of self-worth. By this time, some experienced resentment and regret from the career move from medicine to nursing, especially when the Filipino physician-turned nurses assumed the “doer” role. Performing basic nursing functions evolved into despicable acts that were least expected of individuals with higher educational attainment or stature in society. The following quotes reflected such a sentiment and frustration.

*“As a nurse, you are looked at as a servant. In the U.S., nurses are at the mercy of what doctors tell them to do.”*

*“As a nurse, you do menial tasks compared to working as a physician in the Philippines.”*

*“When I first came to the U.S., I really cried because of the adjustment. I was not used to collecting urine, emptying urine from the bag or cleaning patients.”*

Theme 4: Laborious demands of bedside nursing as the “last straw that broke the camel’s back.” The intensity of American bedside nursing caught the Filipino physician-turned nurses completely by surprise. The labor-intensive nature of bedside nursing was a reality shock to them and eventually got them out of illusionment. After assuming the nursing role in the U.S., many of them came to realizations that they had gone beyond their initial expectations of the role, inasmuch as nursing in the U.S. involved more complex responsibilities compared to their nurse counterparts in the Philippines. The Filipino physician-turned nurses collectively perceived nursing in the U.S. as physically, emotionally and mentally demanding. The participants once again attempted to detach by failing to accept the variations of practice between the U.S. and

the Philippines, subconsciously masking their compromised professional integrity.

*“It is hard [working as a bedside nurse] because of the schedule and the irregular hours. Aside from the shifting, we have to work weekends...and even get called in to work in the middle of the night if you are on call.”*

*“Working as a nurse in the U.S. is like being exploited. As a nurse, you do menial tasks compared to working as a physician in the Philippines.”*

*“Nurses here are like the medical residents in the Philippines, and the physicians here are very dependent on nurses.”*

Consequently, leaving bedside nursing for other career pursuits was their next logical step. The overall experience as nurses in the U.S. was unsatisfactory, from either socioeconomic or professional standpoint. The pursuit of other “better” career options was a likely consequence to re-live a more comfortable and more satisfying past. In fact, half of the respondents pursued the option of becoming advanced practice nurses and were employed as nurse practitioners while the other half disclosed plans to pursue other careers. One respondent stated that,

*“I cannot be a [bedside] nurse forever and I have to think further.”*

The Essential Structure of the Lived Experiences. The experiences of interviewed Filipino physician-turned nurses involved multidimensional issues and challenges during their transition process. The main reason for migrating to a foreign land and changing/compromising their professional roles was to provide perceived better educational and career opportunities for their children and families. There appears to be a consensus among the respondents that migrating from a Third World country to an industrialized nation, such as the United States, will open doors to improve standards of living and opportunities for their families as summarized and expressed succinctly in



*“I want my children to have all the options in life.”* Realization of the compensatory inadequacies of the labor-intensive nature of the nursing role in the U.S. is complicated by the unanticipated issues associated with the diversity and complexity of the American healthcare system. Furthermore, the shifting of roles not only poses economic, political, psychosocial and cultural challenges but also significant disciplinary adjustment in the overall adaptation process. In other words, they faced a double-whammy during their transition. Their strong theoretical foundation in medicine was viewed as advantageous yet intimidating, leaving them with inadequate periods of orientation and/or transitional exposure to nursing. This issue was compounded by the limited or even absence of working experiences as nurses before migration, a practice issue with implications for patient safety and nurse retention.

Preconceived expectations of practicing nursing in the United States were replaced by the painful realities of the role change. The laborious demands of nursing gave rise to negative emotions and experiences that triggered subconscious desires to re-live the past, including contentment and lifestyle achieved as former physicians, from either a financial or professional standpoint. Comparing delineated expectations of physicians and nurses in the U.S. and the Philippines further manifested the difficulty of letting go. Yet identifying with other Filipino co-workers provided a badly needed sense of acceptance and belonging to make the transition process more bearable. Failure to accept the U.S. healthcare system including nursing reflected a possibly inappropriate handling of the transition process, particularly in facilitating ways to appreciate the differences in expectations.

Eventually, dissatisfaction and disillusionment of the nursing role in the U.S. forced the Filipino physician-turned nurses to leave or consider leaving for other career pursuits.

Bedside nursing in the U.S. failed to meet their expectations; neither was it professionally rewarding. The physical and emotional demands of nursing paved way to move on with their careers to redeem their professional integrity and personal dignity.

## CHAPTER 6

### DISCUSSION

The challenges experienced by Filipino physician-turned nurses may be discerned in multiple dimensions: economic, political, psychosocial and cultural. The economic dimension of the challenges inherent in changing professional roles emanates from a conscious and culturally rooted desire to provide better lives for their families. Although some of the participants expressed that the financial gains from practicing nursing in the U.S. could not make up for the reduced social recognition and lost lifestyle as physicians in the Philippines, they perceived that such sacrifice was for the betterment of lives in the context of experiential, educational, and career opportunities for their families, especially for their children. From this perspective, the trade off was worthy.

Migration to the U.S. was also a political decision. In the post-Marcos era, the Filipino government failed to rid the country of political unrest, as the country evolved from an authoritarian to a democratic state (Rivera, 2002). Furthermore, this political instability can be best described in the politicization of the military, amidst worsening and blatant graft and corruption among government officials, as well as major economic decline. Migration, in this context, has become a ‘ticket out’ to spare their families from the effects of a nation in turmoil.

Lifestyle changes are anticipated consequences of living in a different country, including lack of hired domestic servants to assist in various menial household responsibilities. Having to work full-time while taking care of the daily needs of children facilitated role overload that in turn led to frustration and feelings of helplessness.

Data in this study revealed that this “new breed” of international nurses encountered far more complex transition issues and challenges than previously anticipated. The

overall nature of their transition into the nursing profession may be described as collectively unsuccessful. This is manifested by the respondents' decision or intention to leave bedside nursing (role discontinuity). This career trajectory defeated the ultimate goal of recruitment of international nurses to work as direct caregivers.

Theoretical Congruence. Through the lens of the International Migration Theory, the data in this study may somewhat be superficially explained through the act or intent of migration among the respondents. For instance, in the neoclassical view of international migration, the respondents clearly expressed the need for economic upliftment as divulged by the Filipino physician-turned nurses, and as supported by studies conducted by the National Institute of Health in the Philippines (Lorenzo, Galvez-Tan, Icamina & Javier, 2007). However, in the context of the new economics of migration, the relationship of the respondents' pursuit for improved economic life and that of the corresponding effects to the source country (i.e. the Philippines) cannot be established. This may be attributed to the qualitative nature of this study and the size of the sample. Also, based on the research protocol, the improvement of absolute income in the United States in comparison to counterparts in the Philippines cannot be supported by the data and/or results.

Another area that appears nebulous is Piore's (1979) proposal that the impact of migration on the recipient countries is small because immigrants take jobs that natives refused to accept. First, it is arguable to categorize nursing as a profession that belongs to the secondary sector because it does not generally typify instability, low pay, limited benefits or unpleasant or hazardous working conditions. Second, the nursing shortage is not by any means caused by rejection, and instead is a supply and demand repercussion that has resulted from an increasing trend in elderly people accompanied by an

unprepared health labor market that has failed to invest in nursing (Buchan, 2002).

Applying the dual labor market theory, Piore (1979) also proposed that migrants not only gain access to economic improvement but also move into a radically different society. The experiences of the Filipino physician-turned nurses reveal an astounding radical shift of social and cultural realities as evidenced by their negative experiences during the adjustment phase, difficulties of letting go of their previous profession, as well as yearning for support from Filipino co-workers.

Finally, the data also cannot be justified by Wallerstein's (1974) world-systems context, inasmuch as his theoretical concepts highlight relationships of donor and recipient entities. This lack of congruence implies that the International Migration Theory is a weak theoretical framework for this study simply because of its encompassing nature.

In contrast, the role theory suitably explains the bulk of the experiences of Filipino physician-turned nurses. The results of this study clearly magnify the issues that the respondents experienced, particularly during the professional shift from medicine to nursing. In the context of conformity, the Filipino physician-turned nurses expressed their difficulties during their transition process, involving negative affective consequences, such as alienation, disillusionment, disenfranchisement, anger, denial and frustration. This may be explained by unrealistic expectations from co-workers and employers alike that may have practically bred paranoia among the respondents. It also cannot be denied that there was a clash of perceptions in the workplace that generated unnecessary stress and indifference. The truth of the matter is: medicine and nursing are two separate disciplines or philosophies, with separate professional sanctions and rules. This may not be well understood by the respondents' co-workers because they are unable to fathom the differences between the above disciplines without experiencing the struggle themselves.

The Filipino physician-turned nurses internalized two incompatible expectations for behavior, which Biddle (1986) refers to as role conflict. The struggle involves a shift from a predominantly “thinker” role (as former physicians) to that of a predominantly “doer” role (as bedside nurses). As far as the other problematic structural conditions experienced by Filipino physician-turned nurses, there was also evident role ambiguity, as co-workers and peers expressed high expectations of the respondents because of their level of education and training. However, the physical and emotional demands of bedside nursing appeared to prevent if not slowed down the transition process by having difficulties in letting go of previous role expectations and responsibilities that were less laborious. In addition, role malintegration also occurred as the respondents compared themselves to the physicians in the United States as a consequence of the difficulties of letting go.

The shift from medicine to nursing also gave rise to role incongruity. There was a noticeable contradiction of their individual values and self-perception. The compromise from a “thinker” role to that of a “doer” role was now perceived as a form of debasement or demotion. Thus, the resultant aftermath was to leave bedside nursing for other career opportunities. In essence, role ambiguity and role incongruity pre-empted role discontinuity. Half of the respondents had already pursued careers as nurse practitioners, while the other half expressed serious desires to eventually leave bedside nursing.

Misconceptions. One of the major factors causing unsuccessful transition of Filipino physician-turned nurses was the anticipated misconception of the role shift by individuals or workers in various work settings. Subjectivism fostered indifference, judgmentalism and even discrimination. The notion that “just because they used to be physicians” was not in itself an adequate justification to exclude them from adequate orientation and/or

training. In fact, any existing nursing transition programs must be modified to accommodate the disciplinary role shift that physician-turned nurses go through, which may make the transitional process even more challenging than international nurses in general.

Misinterpreting the Filipino culture. Based on the lived experiences of the Filipino physician-turned nurses, it is evident that there is lack of knowledge of the Filipino culture. Ordonez and Gandeza (2004) state that physicians in the Philippines are among the most well respected professionals. Filipinos put value on achieved social status and professional achievements, which assures societal respect and reverence. This opens a different perspective in trying to understand the pursuit of role shift from physician to nurse. Regardless of the ultimate reason in pursuing this shift, it can only be generalized that these physician-turned nurses were willing to compromise their own professional integrity, their social stature, and their self-worth because their family needs supercede their personal needs. Additionally, this cultural orientation extends beyond kinship in foreign environments. Their colleagues, peers, and friends of Filipino descent essentially became their family members. The friendship, bonding, and other forms of psychosocial support effectively eased their “aches and pains,” and provided solace and a sanctuary/refuge during their transition in a new environment. The lived experiences of the Filipino physician-turned nurses indirectly highlighted a grave need to intensify efforts in promoting cultural sensitivity and/or competency in healthcare work environments.

Mishandled transition. The respondents’ negative experiences during their short-lived bedside nursing careers were compounded by their difficulties in letting go of the physician role, a probable manifestation of role conflict involving contradictory

expectations. On the one hand, they were truly experts in medical management (but unable to utilize function as physicians); on the other hand, they were also truly novices in nursing practice. Although their individual transition was not the exactly the same, dominant negative experiences and emotions, such as disillusionment, grief, disappointment, humiliation, shame, etc. confirm that the Filipino physician-turned nurses were unsatisfied at their job. In order to facilitate the transition and adaptation of these nurses, specifically tailored transitional programs must include, but not limited to, the following content areas: scope of practice, homogeneity of nursing practice, and clearly-defined expectations. Establishing these expectations from the perspectives of the physician-turned nurses, administration, peers and co-workers will ease their transition.

As aforementioned, the issues of a professional shift from physician to nurse are well explained by the role theory. A career move to retrain as nurses connotes that physicians are expected to alter their mindset and to assume the responsibilities inherent to nursing practice, i.e. involving direct physical care of patients (consensus). However, the transition from a ‘thinker’ to ‘doer’ role has affected the conformity among Filipino physician-turned nurses, giving rise to either role ambiguity or role incongruity, or both. In effect, dissatisfaction (role malintegration) resulted which eventually prompted them to look for or consider other career options (role discontinuity).

Miscommunicated expectations. The International Theory of Migration attempts to justify the unstoppable movement of people from developing to developed countries, wherein pastures are presumably greener and lifestyles supposedly better. However, it is quite clear that the experiences of the Filipino physician-turned nurses offer a different perspective in appreciating this phenomenon. It appears the added dimension of compromising professional integrity has not been duly rewarded with just compensation.



The data also revealed that physicians who underwent a disciplinary shift to nursing require careful processing of the career transition. Hence, countries with programs that allow this disciplinary shift must take into account the possible perils of role ambiguity or role incongruity. In addition, the data also revealed that six of the eight Filipino physician-turned nurses did not practice nursing prior to migrating to the United States. It will be advantageous for recipient countries if physician-turned nurses have some nursing experience before hiring, thus facilitating the internalization of the nursing role. Having discussed this, it is imperative to initiate inquiry into possible policies to apply more stringent criteria in hiring international nurses who worked previously as physicians.

Limitations of the Study. Aside from the reality that there is no previous study conducted on the lived experiences of Filipino physician-turned nurses, one of the limitations of this study is the fact that it revolved around one central question. Although the research protocol revealed involvement of a multitude of dimensions during the respondents' transition process, the economic, political, socio-cultural and other dimensions were not fully covered in depth, as the direction of the inquiry was more heavily focused on their professional shift. Also, the respondents were all located in Las Vegas, Nevada. This means that the data may not reflect experiences of other Filipino physician-turned nurses in other locales.

Nursing implications. The unique attributes of Filipino physician-turned nurses call for a transition plan that addresses specific issues for this particular sub-group. Careful processing of their transition process into nursing must also take into account the disciplinary shift from medicine. Their strong medical backgrounds make them excellent resources in any healthcare environment. However, there is no documented transition plan devised specifically for this subgroup. In addition, the implementation of such a plan

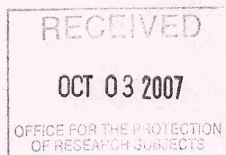
does not necessarily guarantee satisfactory performance, which implies that further investigation of its efficacy will need validation. Furthermore, with the inherent issues that can be anticipated in this particular subgroup, it is deemed necessary to further investigate if recruitment of physician-turned nurses from other countries will truly be beneficial to our society. With the worsening nursing shortage in the United States, one of the challenging strategies is that of retention. Employing physician-turned nurses may temporarily fix our numbers. But with the complexity of the consequences of a disciplinary shift from physician to nursing, it cannot be assured that their presence at the bedside will ensue.

## CHAPTER 7

### CONCLUSIONS AND RECOMMENDATIONS

As the first known study on Filipino physician-turned nurses in the United States, this phenomenological inquiry aimed to describe their lived experiences. As a unique subgroup among international nurses, their transitional experiences involved multidimensional issues and challenges. The data revealed that this special group of international nurses has been collectively dissatisfied with their current positions. Although survival during the completion of their nursing contracts was attributed to support given by other Filipino co-workers, Filipino physician-turned nurses have expressed intentions to leave bedside nursing for other career pursuits. As the number of this new breed of international nurses continue to increase in the foreseeable future, it is of economic, ethical, and practice imperative to further study this unique subgroup of international nurses. The successful transition and adaptation of these nurses not only benefits the involved nurses but also their employers and most importantly, patients and their families.

APPENDIX A  
INFORMED CONSENT



**INFORMED CONSENT**  
Department of Nursing



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**TITLE OF STUDY: Filipino Physician-Turned Nurses: A Phenomenological Study**

**INVESTIGATOR(S): Yu Xu, PhD, RN, CTN, CNE**

**Victor R. Vapor, RN, BSN, CCRN, CNRN**

**CONTACT PHONE NUMBER: 702-895-3175 (Dr. Yu Xu)**

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**Purpose of the Study**

You are invited to participate in a research study. The purpose of this study is to examine the lived experiences of Filipino nurses who were formerly practicing physicians in the Philippines.

**Participants**

You are being asked to participate in the study because you meet the inclusion criteria for this study. The inclusion criteria are: a) currently working as a registered nurse in the United States; b) ethnically identify oneself as Filipino; c) formerly practiced as a physician in the Philippines; and d) age 18 and over.

**Procedures**

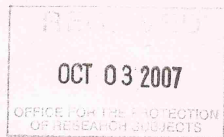
If you volunteer to participate in this study, you will be asked to participate in an audio-taped interview which will last approximately 1 hour. You may be asked about your experiences as a registered nurse working in the United States.

**Benefits of Participation**

There *may* be some direct benefits to you as a participant in this study. You find the interview process therapeutic. We hope to learn the lived experiences of Filipino physician-turned nurses working in the United States. In addition, we hope to gain insight into your adaptation process, particularly your experiences of role change, role transition, and role delineation in a different cultural and work environment in a new profession (i.e. nursing).

**Risks of Participation**

There are risks involved in all research studies. This study may have only minimal risks. It is possible that you may experience some discomfort or emotions when answering some of the questions.



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**Cost /Compensation**

There will not be financial cost to you to participate in this study. The study will take approximately 1 (one) hour of your time, which will not be compensated.

**Contact Information**

If you have any questions or concerns about the study, you may contact Dr. Yu Xu at 702-895-3175. For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted you may contact the UNLV Office for the Protection of Research Subjects at 702-895-2794.

**Voluntary Participation**

Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may withdraw at any time without prejudice to your relations with the university. You are encouraged to ask questions about this study at the beginning or any time during the research study.

**Confidentiality**

All information gathered in this study will be kept completely confidential. No reference will be made in written or oral materials that could link you to this study. All records will be stored in a locked facility at UNLV for at least 3 years after completion of the study. After the storage time the audio tapes will be erased/taped over while the written transcription will be shredded.

APPENDIX B

INTERVIEW SCHEDULE

Date\_\_\_\_\_

Respondent No.\_\_\_\_\_

Title of Study: FILIPINO PHYSICIAN-TURNED NURSES:  
A PHENOMENOLOGICAL STUDY

A. DEMOGRAPHIC DATA

1. Gender:     M     F

2. Age\_\_\_\_\_

3. Current Position in Nursing\_\_\_\_\_

4. Years of experience as a nurse in the Philippines\_\_\_\_\_

5. Years of experience as a nurse in the US\_\_\_\_\_

6. Highest Nursing degree attained\_\_\_\_\_

7. Clinical specialty as a physician in the Philippines\_\_\_\_\_

8. Years of experience in the above medical specialty\_\_\_\_\_

B. QUESTIONS

1. As a former physician in the Philippines, what are/were your experiences of working as a registered nurse in the United States? (central question; may require elaboration or follow up inquiry)

2. What are the issues that you have encountered of working as a registered nurse in the US?

APPENDIX C

EXAMPLES OF DERIVED SIGNIFICANT STATEMENTS

Table 1. Selected examples of Significant Statements of lived experiences of Filipino physician-turned nurses and their corresponding Formulated Meanings

SIGNIFICANT STATEMENTS	FORMULATED MEANINGS
1. It is difficult to work here because of the irregular schedule.	1. As a nurse, the schedule is more erratic and unpredictable compared to that of being a physician.
2. As a physician, I used to delegate or give orders to nurses, and here I am receiving orders from a colleague.	2. There is difficulty in accepting the role change which is internalized as debasement or demotion.
3. Working as a nurse is stressful, and is always physically and emotionally exhausting.	3. The labor-intensive nature of [bedside] nursing as a new role is perceived as a stressor.
4. My co-workers were easily intimidated by me, when they found out that I used to be a physician in the Philippines.	4. The achieved status as a former physician has strained relationships with peers and/or co-workers.
5. At first, it was difficult to accept that I am not a physician here.	5. There was an initial state of denial in the role transition process.

APPENDIX D

EXAMPLES OF DERIVED THEME CLUSTERS

Table 2. Examples of Two Clusters of Themes and their Subsumed Formulated Meanings

Changing roles from physician to nurse as most challenging during their transition.

- a. The initial denial of the new role as a nurse facilitated a recollection of own capabilities as a physician during the transition process. (10)
- b. There is difficulty with coming to terms in assuming the new role as a nurse. (18)
- c. The role change facilitated comparison and contrast of previous role (as physician) with U.S. counterparts. (26)
- d. Denying the former role as physician suppressed negative feelings, such as resentment, frustration and/or misery. (29)
- e. The limited capacity to make clinical judgments in patient care can be extremely frustrating. (33)

Unmet preconceived high socioeconomic expectations before coming to the U.S. serving as bondage for transition.

- a. Due to physical demands, the compensation for the nursing role is not comparable to the remuneration received as a physician. (6)
- b. There is an underlying compromise in assuming the new role as physician, aimed specifically at providing better lives for children. (7)
- c. Perseverance in succumbing to the consequences of role transition is influenced by the ultimate reason for eventually accepting the role change: the children's future. (11)
- d. The role transition brought out a sense of yearning for the more comfortable past. (37)

NOTE: The numbers in enclosed parentheses refer to the original numbers of significant statements of the protocol from which the formulated meanings were derived.



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VITA

Graduate College  
University of Nevada, Las Vegas

Victor Rey Cui Vapor

Degrees:

Associate in Science, Biological Sciences, 1986  
Santa Ana College

Bachelor of Science in Nursing, 1992  
Brokenshire College (Philippines)

Thesis Title: Filipino Physician-Turned Nurses: A Phenomenological Study

Thesis Examination Committee:

Chairperson, Yu Xu, PhD, RN, CTN, CNE  
Committee Member, Alan Jauregui, MSN, RN, APN  
Committee Member, Jennifer Kawi, MSN, APN-BC  
Graduate Faculty Representative, Emily Lin, PhD