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The Experiences of Indian Nurses in America

Munira Wells

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THE EXPERIENCES OF INDIAN NURSES
IN AMERICA

BY
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It takes a village and my village was amazing.

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Abstract

Background: Nurses educated in India make up one of the largest groups of internationally educated nurses in America. Few studies have examined their experiences in the American workplace. An understanding of their experiences will be beneficial to those who work with them.

Objectives: The aim of this study is to understand what it means to be a nurse in America from the perspective of those who have practiced nursing in India. The question being asked is “What are the experiences of nurses from India as they adapt to the practice of nursing in America?”

Method: A phenomenological approach was used to gain insight into the lived experience of being an Indian nurse in the United States. Interviews were conducted with six nurses, from two different states in southern India. Interviews were audio-taped, transcribed and analyzed using traditional qualitative techniques. Patterns were identified and presented through the use of story telling and narratives.

Findings: Nurses who migrate from India to the US undergo both socio-cultural and workplace adjustments. They deal with loss, change and sacrifice. Workplace adjustments include communication issues, dealing with a new healthcare system and adapting to an expanded role of nurses.

Implications: Practice implications include recommendations for administrators, preceptors and staff working with Indian nurses as well as for those Indian nurses who may seek to migrate to the US. Research implications are also presented.

Chapter I

INTRODUCTION

“Where are you from? I mean, originally from?” or “You don’t have an accent” or “You seem so American compared to the other Indians I know.” I have often had these and similar remarks directed at me. As a person of Indian origin, living and working in America, I am often identified as different. I am different. I was born, raised and educated in India prior to immigrating to the United States as a young adult. The process of moving from one country to another is not without significant challenges and adjustments and I had my share of both. In the midst of learning to adapt to a new country, I was thrown into the new role of student nurse as well. I learned to adjust and soon I had completed my education and was a registered nurse working the night shift in a gritty urban intensive care unit. I was the only Indian nurse on the unit and one of a handful in that hospital.

Several years later, as a graduate student, I interviewed a number of foreign educated nurses who had migrated to the United States from their homes in the Philippines and Trinidad and Tobago. Their stories resonated with me. I understood their frustrations regarding food, clothing, weather, communication and a myriad of other issues that one takes for granted. Most interesting to me was that these nurses, seasoned professionals in their own countries, complained of the difficulty of being

nurses in the United States. I had assumed that immigrant nurses would experience the social, personal and cultural challenges faced by all immigrants but did not expect their unanimous expression of professional difficulty. Is it really that cumbersome to transfer one's nursing expertise from one country to another? This question was answered by a nurse who said to me, "*They failed to recognize that I am like a new nurse coming into the system because I did not know the American system of living... they didn't realize well, it's just a totally new experience.*" In a profession that is embedded in interacting with and caring for people, professional adjustment becomes contingent upon knowing "the system of living." So, how do foreign educated nurses, some with limited knowledge of American culture, transition into practice here in the US? How does one transplant a nursing career from one country to another? Are there differences in professional values, expectations, roles and daily functions? These questions led me to become intrigued by the experiences of foreign nurses, specifically the experiences of those nurses who are now increasingly becoming a part of the American workforce: nurses from India.

Aim of the study

The aim of this study is to explore the professional experiences of Indian nurses in the US with the goal of understanding what it means to be a nurse in America from the perspective of those who have practiced nursing in India. For the purpose of clarity, the term "Indian nurses" will refer only to those nurses who practiced nursing in India.

Research question

The research question is “What are the experiences of nurses from India as they adapt to the practice of nursing in America?”

Phenomenon of interest

Internationally educated nurses or IENs are nurses who have received their initial nursing education outside of the United States. They have migrated to the US since the 1900s, often being used as a means to alleviate nursing shortages within this country (National Foundation for American Policy, 2007). Nurses educated in India made up the third largest group of IENs in the American nursing work force in 2008, accounting for about 16,000 nurses actively employed within our healthcare systems, with a substantial portion located in the northeastern tri-state area of the country (Health Resources and Services Administration [HRSA], 2010). As Indian nurses migrate to the US, they will bring with them their cultural values, beliefs and life ways. A deeper understanding of their experiences is important, especially for the health care providers who will work with them.

Justification for the study of the phenomenon

Considerable research has been conducted internationally to examine experiences of a variety of Asian nurses. However, there are several reasons why a study that focuses solely on the experiences of Indian nurses in the United States is warranted. First, it is important to note that many international studies related to IENs

are rooted in systems of healthcare that are vastly different from that in the US.

Second, while it may be tempting to consider all Asian nurses as one similar group, it is important to recognize the ethnic and cultural diversity within this group. Much as the term “European” encompasses a variety of cultural groups (e.g. the Nordic and the Italian), so too does the term “Asian”. In recognition of these ethnic and cultural differences, the US Census bureau has in fact differentiated Asian from Asian Indian. Thus, it would be erroneous to assume that studies about Asian nurses, in healthcare systems different from our own, can effectively and completely speak to the experiences of Indian nurses in America. Existing literature points to the challenges that foreign nurses experience, both personally and professionally, when practicing nursing in a country other than the one they were trained in. However, there is no work that examines what it is like to be a nurse in America from the point of view of a nurse educated in India.

Relevance for nursing

Despite an otherwise grim economy, the nursing shortage is not a thing of the past. The healthcare sector continues to grow with analysts projecting continuing nursing shortages as we move towards 2020 (Auerbach, Beurhaus & Staiger, 2007; Bureau of Labor Statistics, 2011). The current rate of enrollment in nursing programs will not produce enough domestic supply to offset the demand created by new nursing opportunities coupled with anticipated nursing retirements (American Association of Colleges of Nursing [AACN], 2011). Indian educated nurses are

likely to continue to migrate and become employed by US healthcare organizations. They may be required to incorporate new knowledge, unlearn old knowledge, change behavior and redefine their personal and professional personas.

Research in the field of multicultural work environments and IENs indicates that orientation programs designed to meet the particular needs of foreign nurses result in increased job satisfaction and decreased turnover (Burner, Cunningham & Hattar, 1990; Eaton & Lowe, 1991; Martin, Wimberly & O'Keefe, 1994). With Asian Indian nurses becoming a growing section of the workforce, research specific to their experiences, values and nursing practices has an important role to play in the development of educational, institutional and regulatory policies. Such policies and programs would work to enhance the professional and personal wellbeing of Indian nurses by addressing barriers and facilitators to their adjustment to the US healthcare system. Programs targeted at improving the communication patterns and teamwork between IENs and American staff would have a favorable impact upon patient outcomes.

Successful integration of Indian nurses would assist in addressing the underrepresentation of racial and ethnic minorities in the health professions (Smith, Nsiah-Kumi, Jones & Pamies, 2009). This becomes particularly relevant when we consider the changing demographics of the US. Asian Indians are one of the fastest growing minority populations in the US. Like other minority populations, they are likely to benefit from having culturally and linguistically similar healthcare providers (United States Department of Health and Human Services Office of Minority Health,

2001). Further, it is believed that an increase in the diversity among health care providers will have a beneficial impact upon health care disparities in this country (Agency for Healthcare Research and Quality [AHRQ], 2000).

Given the paucity of information, a qualitative study that examines the phenomenon of being an Indian nurse in America is appropriate. In order to capture the essence of the experience of being a nurse in America from the perspective of nurses from India, it is critical that the voices of those nurses be heard. A phenomenological approach, using interview data, will allow a deeper understanding of the nurses' experiences.

Chapter II

LITERATURE REVIEW

The movement of people from one place to another is a story as old as time. Sociologists, anthropologists and psychologists have long been examining this process of migration and its impact upon the migrating individual. People moving from one cultural context to another bring their beliefs and practices to the new (host) culture and are tasked with adapting to a set of value systems and behaviors that is different from their own (Isaacs, 2010). This process of adapting to a different culture is called *acculturation* and involves a process of conflict and negotiation that individuals undergo as they attempt to accommodate to a different culture (Graves, 1967). Direct and continuing interaction with people from a culture different from their own results in sociocultural, psychological and cognitive changes in the migrating individual or immigrant (Abe-Kim, Okazaki & Goto, 2001; Berry, 1997; Padilla & Perez, 2003; Redfield, Linton, & Herskovits, 1936).

Transnational migration has become commonplace in the twenty first century with approximately 3% of the global population, or roughly one out of 33 people, currently residing outside their place of birth (International Organization for Migration, 2011). The international migration of skilled healthcare workers such as nurses is not new (Stilwell et. al, 2004). Western nations such as the United States

have historically supplemented their nursing workforce with internationally educated nurses or IENs (Brush, Sochalski & Berger, 2004; Kingma, 2008; National Foundation for American Policy, 2007; Xu & Kwak, 2005). Early immigration occurred largely from Europe, but immigration policy changes, such as the Exchange Visitor Program after the Second World War and the Hart-Cellar Act in 1965, opened the doors for an influx of non-European nurses from Asia, the Caribbean and Africa (Brush, et.al, 2004; Mosisa, 2002; Reddy, 2008). IENs from Asian and African countries have since then become an integral part of the American healthcare system.

For international nurse migrants, adjustments to the larger cultural milieu are compounded by changes in workplace and professional identities (Ea, Griffin, L'Eplattenier & Fitzpatrick, 2008; Hayne, Gerhardt & Davis, 2009; Spangler, 1992; Xu, Gutierrez & Kim, 2008). Internationally educated nurses in Canada, Australia, Iceland and the UK reveal that the process of transitioning into life and nursing practice in a foreign country is difficult with particular challenges in communication and adaptation to the nursing role (Alexis & Vydelingum, 2004; Allan & Larsen, 2003; Daniel, Chamberlain, & Gordon, 2001; Hagey et al., 2001; Omeri & Atkins, 2002; Sochan & Singh, 2007; Walters, 2008; Withers & Snowball, 2003; Zizzo & Xu, 2009). However, the system of healthcare as well as the immigration processes in these places are vastly different from that of the United States. Thus, while these studies may speak to the various adjustment difficulties of these nurses, they may not accurately reflect the experiences of IENs in their migration to the US or their experiences within US healthcare systems.

Internationally educated nurses in the United States

According to the 2008 National Sample Survey of Registered Nurses, an estimated eight percent of the 3 million licensed registered nurses in the United States are international nurses who have received their initial nursing education outside of the United States (HRSA, 2010). Since a majority of the IENs come from the Philippines (HRSA, 2010), much of the research on IENs in the US has focused upon the experiences of Filipino nurses.

Spangler (1992) conducted one of the earliest studies on the experiences of IENs in the US. This ethnonursing research study examined the nursing care values and practices of 26 Filipino nurses and the impact of US residency on these values and practices. All the participants identified differences in nursing practice particularly in the area of physical care of patients with Filipino nurses equating caring in nursing with attentiveness to the physical needs of their patients. These differences in practice still hold true as evidenced by Vestal & Kautz (2009) who conducted focus groups with 22 Filipino nurses in an attempt to examine differences and similarities between American and Filipino nurses. The nurses in this study further expressed the need to constantly “prove themselves” to both their colleagues and their patients. This is similar to the experiences of IENs in Europe who express a devaluation of their professional status and competence by their peers (Alexis, Vydelingum & Robbins, 2007; Allan & Larsen, 2003; O’Brien, 2007; Buchan, 2003; Hagey et. al, 2001; Omeri & Atkins, 2002; Sochan & Singh, 2007). It is significant to note that all these studies examined the experiences of immigrant nurses, often

women of color, calling into question the role of racism and discrimination in the immigration experience.

Job satisfaction and occupational stress among Filipino nurses in the US has also been studied. Ea, et. al (2008) examined the relationship between level of acculturation and job satisfaction among 96 Filipino RNs. Nurses with an “American” outlook were more likely to have higher levels of job satisfaction than those with a “Filipino” orientation. Greater length of stay in the US was positively associated with job satisfaction.

Research on other groups of IENs in the US has explored issues related to adjustment to US healthcare systems and perceptions of professionalism in non-American nurses. Yi and Jezewski (2000) used a grounded theory approach to conduct an exploratory study of the adjustment process of 12 Korean nurses working in a US hospital. Much like IENs in Europe, Korean nurses in the US also struggle with overcoming language barriers especially related to verbal communication as well as negotiating differences between US and Korean nursing practice, such as role of family members, nursing assistants and other ancillary personnel in patient care activities. Korean nurses struggle to adapt to and adopt US styles of interpersonal interactions, problem solving and conflict resolution. The Korean nurses in this study, much like the Filipino nurses in Spangler’s study (1992), also perceived American patients as more demanding and self-centered than Korean patients.

Kim-Godwin, Baek & Wynd (2010) examined the commitment that Korean nurses had to their careers as nurses by measuring professionalism. Hall's

Professionalism Inventory (HPI) scale was mailed to 221 Korean nurses. High levels of professionalism were associated with membership in a professional organization while nursing education outside of the US was associated with lower levels of professionalism.

Xu, et. al (2008) examined the lived experience of nine Chinese nurses in US healthcare. The nurses in this study experienced cultural dissonance as they tried to reconcile to the multiple differences in their lives, resulting in an“(un) learning” of traditional behaviors in order to successfully integrate into the workplace.

Studies of IENs in the US confirm that adjustment is an iterative process that often presents many challenges. Difficulties such as communication challenges and adaptation to US nursing practice ease over time, but feelings of marginalization, discrimination and cultural displacement persist, and act as deterrents to successful integration.

Indian IENs in the US

Nurses educated in India account for a significant percentage of internationally educated nurses in US healthcare organizations (HRSA, 2010). The number of Indian nurses passing the Commission on Graduates of Foreign Nursing Schools (CGFNS) screening and the National licensure examination (NCLEX- RN) is increasing, suggesting that Indian nurses remain interested in migrating to the US if demand persists (Mozumder, 2010). Since nursing workforce trends suggest that the number of nurses educated in the US will be unable to meet the growing needs for

practicing nurses (AACN, 2011), it is not unreasonable to believe that nurses educated in India will continue to be part of the solution.

As nurses from India become a bigger part of the US healthcare system, a few studies have begun to examine this population. Given the relatively small number of Indian nurses in the workforce, a number of these studies have included nurses from India in their sample of South Asian nurses rather than focusing solely on the Indian nurse. Edwards & Davis (2006) measured perceptions of clinical competency among 3,205 nurses preparing to migrate to the US. Ninety two percent of the respondents, including 962 Indian nurses, felt that their education had prepared them adequately to work in the US. They identified language and medication administration as their top two areas of weakness. While this study provides data that can assist in the creation of staff development and orientation programs, it does not shed any light on the actual experiences of IENs within US workplaces since the surveys were conducted prior to employment in the US.

Liou (2007) conducted a correlational, descriptive study among 120 Asian nurses, including 5 Indian nurses and found that Indian nurses were satisfied with their work environments ($M = 107.80$ SD 21.27) and exhibited low intention to leave their current jobs ($M = 35.00$ SD 5.79).

An in depth study of the overall experience of internationally educated nurses was conducted by Ryan (2010) who used naturalistic inquiry to examine the process of adjustment of foreign nurses and included one nurse from India in her sample of 12 IENs. Themes of loss, doubt, and unhappiness at working below their level of

experience emerged. Communication challenges, differences in US nursing practice and feeling devalued made adjustment difficult.

While these studies all contribute to our knowledge of the IEN experience in the US, studies that include a few Indian nurses as a portion of the sample, do not adequately describe Indian nurses as a specific cultural subset of American nurses. Combining nurses from the different South Asian countries into one group serves to reinforce stereotypes related to Asian minorities and further marginalizes each ethnic group.

Three studies have exclusively examined the experiences of Indian nurses in the US. Hegde & DiCicco-Bloom (2002) used a phenomenological approach to describe what it is like being a female immigrant nurse of color, living and working in the US. Participants (n = 9) were married, Keralite (South Indian) Christian women, aged 42 to 55 years old, living in the tri state area, recruited through a snowball technique. Interview transcripts were reviewed on an on-going basis to isolate “critical episodes” related to race, gender and immigration. Participants described their journey to migrate to the US in some cases starting with family resistance regarding choice of nursing career. Upon arrival to the US, participants’ questioned their decision to migrate when faced with a sense of *personal or cultural displacement* which resulted in, at times, a feeling of belonging in two places and at other times belonging nowhere. Participants also expressed a sense of alienation and isolation from colleagues or the “*other at work*” which stemmed from observations that other minority nurses seemed to maintain relationships along racial lines, leaving

these nurses feeling disconnected.

Dicicco-Bloom's study highlights the differences between traditional female Indian immigrants who accompany their spouses to the US versus nurses who are the primary migrants (Reddy, 2008). They face tremendous pressure to "do well" while juggling traditional roles in a different cultural context. While this research represents the typical demographic make-up of Indian nurses who have traditionally migrated to the US (women, married, Christian, from the state of Kerala), it is of note that this demographic is changing (Khadria, 2007). Although this study does address issues of personal and cultural displacement, it does not explore specific professional experiences related to the work of nursing.

Jose, Griffin, Click and Fitzpatrick (2008) conducted a descriptive correlational survey research study to examine the demands of immigration (DI) among Indian nurses who had relocated to the US more than three years ago as compared with those who had migrated more recently. The *Demands of Immigration Scale (DI)* was administered to 105 currently employed RNs who had obtained their basic nursing education in India and had immigrated to the US between 1985-2005. Like Hegde and DiCicco-Bloom's sample, this group of nurses was fairly homogeneous: primarily baccalaureate prepared (57%), married (98%), Christian (94%) women (98%), all from the south Indian state of Kerala. All participants reported feelings of preoccupation with one's homeland (*loss*), feeling like an outsider (*not feeling at home*), dealing with unfamiliar routines, people and things (*novelty*), and feelings of being treated differently (*discrimination*). In comparing the

two groups, demands of immigration were higher for the group that migrated less than 3 years ago compared to the group who had been in the US for a longer time period. This is not surprising in light of prevalent acculturation literature that associates greater duration of stay with higher levels of acculturation. However, feelings of not belonging and being treated differently persisted over time and were reported by both groups. An overall finding of low demands of immigration may be reflective of low scores on the occupational adjustment sub scale. This sub-scale, which measures difficulty in obtaining suitable employment, does not appropriately capture occupational stress for a group of immigrants who typically have a secure job prior to leaving their home countries.

George (2005) conducted an ethnographic study to explore the role of gender and class in transnational migration. Her study, conducted over a period of more than two years, in both India and the US, examined the lives of thirty couples where the wife-nurses migrated to the US first, bringing their husbands and families over later. This work focused on the sociocultural implications of migration, especially for the male spouses of the Indian nurses. It also addressed the stigma related to nursing in India and revealed that such stigma often carried over to the US among small tightly knit immigrant communities. While it is a fascinating work, offering much insight into the challenges of migration to the US, it has little input to offer with regard to the experience of being a nurse in the US from the standpoint of the daily difficulties experienced by nurses as they negotiate their work day.

Summary

International and US based research on IENs indicates that adjustment is an iterative process that often presents many difficulties for foreign nurses. Although these difficulties ease over time, feelings of marginalization, discrimination and cultural displacement persist. It is evident that nursing care practices and values differ among various countries, creating work place difficulties for IENs.

Three US based studies have explored the experiences of Indian nurses. Hedge and Diccio Bloom (2001) explored professional adjustment experiences through the lens of gender and racism. While gender and race are relevant to any discussion involving female immigrants of color they may not represent the whole of the experience. Jose et al. (2008) tried to quantitatively capture the stressful experience of immigration; however, the occupation subscale, which was not appropriate for this population may have falsely lowered scores and provided a less-than-accurate picture of the demands of acculturation in this sample of Indian nurses. George (2005) examined changes in social roles and family hierarchy that occur as a result of nurses from Kerala immigrating to the US ahead of their husbands.

None of these studies explore the basic question of what the experience of being a nurse in America is like for the nurse from India. This question transcends issues related to personal adjustments relating from migration, as well as viewing the entire nursing experience in the US through a race and gender perspective. A study aimed at understanding, in the broadest possible sense, the experiences of nurses from India will provide a fuller understanding of what it means for these nurses to be an

American nurse. An exploratory study that examines the phenomenon of being an Indian nurse in America, that captures the essence of the experience of being a nurse in America and allows a deeper understanding of the nurses' experiences could play an important role in the development of educational, institutional and regulatory policies that enhance the professional and personal wellbeing of Indian nurses as they become an integrated part of the American workforce. This study gives voice to the experience of nurses from India as they move their practice across continents and oceans and become American nurses.

Chapter III

METHODOLOGY

The term “phenomenology” literally means the act of “giving an account... (of) remembered events” (Sokolowski, 2000, p. 13). It is a human science aimed at describing and “explicating the meaning of human existence” (van Manen, 1990, p. 4). It seeks to understand that which is essential to making the phenomenon what it is (van Manen, 1990). According to phenomenology reality is subjective and made up of the multiple truths as experienced by different people (Munhall, 2010). The reality of any experience is inextricable from the individual undergoing that experience (Creswell, 2006).

Phenomenology is concerned with the lived experience making it a perfect fit for a study exploring the journey of immigrant nurses who are placed in a new professional and social milieu. The uniqueness of human experience is rooted in the *situated context* of that individual so that subjective perceptions develop as a result of past experiences and form the context for that person’s current experience (Munhall, 2010; van Manen, 1990). This is particularly relevant in an examination of the experiences of immigrant nurses whose past experiences bring a unique meaning to their professional practice.

A hermeneutic phenomenological approach was used. Hermeneutic

phenomenology is both descriptive and interpretive. The stories of Indian nurses practicing in the United States of America were heard through face-to-face interviews and then analyzed for themes that capture what it means for these nurses to be nurses in America.

Researcher's stance

Phenomenologists believe that it is impossible for any human to approach something as *tabula rasa*. It is understood that the researcher's personal experiences color his/her perceptions and interpretations of the world and thus, has some influence on the research process. So, how do my experiences color my research lens?

I am an immigrant and a nurse. I was born and raised in India and moved to the United States as a young adult. Like many young women from India, my upbringing was rather sheltered. My arrival to the United States twenty-three years ago to attend nursing school was my very first experience of leaving home for any extended period of time. I remember landing at the airport on a warm and sunny August afternoon, bursting with excitement at the thought that I had finally "made it"! For many of us growing up at that time in India, migrating to America was the ultimate dream.

The first few weeks went by in a whirl of activity. I was fortunate to have an uncle who housed me for my first two weeks in this country. He and his family acted as a buffer so that my transatlantic relocation felt like a vacation. I met their

neighbors and friends and basked in being in a foreign land filled with the promise of exotic experiences. Mundane daily activities such as a trip to the grocery store evoked wonder. How could there be so many different types of cheeses? Everything was neatly wrapped and shiny. No baskets of fruits and vegetables that were weighed on an old fashioned scale by a vendor who changed his prices if you let your inexperience show. All these new experiences made my adventure loving soul soar with happiness.

School started and I moved into the dorm. The reality of living away from home for the very first time in my life started to sink in. Like other immigrants before me, I realized that once the novelty was gone, it was not all that easy. The logistics of daily living caught up with me. Grocery shopping and other simple tasks now filled me with anxiety. Shelves of myriad cheeses no longer thrilled but instead created indecision and feelings of inadequacy. Just getting to the grocery store was a challenge. I had no car and the bus stop, several blocks away, was located in a less-than-desirable neighborhood. Then there was the language. I, who prided myself on my English fluency, spoke a different English from those around me. My accent, the cadence of my words and the phrases I used all marked me as an outsider. My appearance too, identified me as different. I had never before experienced this feeling of so identifiably being different from the social environment around me.

Fall deepened into winter and my warm clothes from India proved to be woefully inadequate in the harsher elements I now had to face. Not having immediate family and dear friends near by was especially difficult. The absence of the

supportive network that I had spent a lifetime building brought about bouts of sadness. I began to question my decision to leave home. Luckily, school and a part time job kept me occupied and ultimately allowed me to make new connections.

After graduating from nursing school, I started my nursing practice in a large urban hospital center where I encountered just a couple Indian nurses. Unfortunately, apart from a significant age difference between us, the wide differences in our socioeconomic, linguistic and cultural contexts made it almost impossible for us to form anything but the most superficial of connections. Most of the immigrant nurses I worked with were Filipino. I remember being envious of their camaraderie. The long-standing employment history of Filipino nurses in this country had at least given them the advantage of having a critical mass.

Later, as part of my Master's degree, I became involved in an acculturation program developed to assist foreign nurses to adjust to America. I investigated the initial acculturation of Filipino and Trinidadian nurses to US healthcare. This research was quantitative but had a qualitative component. It was the qualitative component that soon grew into a substantial part of the research and yielded rich, thick data. I pored over interview transcripts and identified themes speaking to the personal and professional difficulties experienced by these nurses. Many of their stories resonated with me and validated my own experiences of migration. There was a certain catharsis in listening to their stories and transcribing their words. Presenting my findings at conferences, I was amazed at the response I received from foreign nurses. They heard their own stories in the words of my participants. It was a

tremendously moving experience that brought home to me the power of qualitative research.

Over the years I have seen the healthcare landscape become more diverse. I interact with more Indian born nurses and patients than ever before. It is clear that the face of this nation is changing and therefore I am drawn back to my master's research. I am intrigued by the adjustment of nurses from India to the American workplace. Are their experiences similar to other foreign nurses'? I am fascinated by the processes involved in leaving behind one's practice in India and starting a whole new practice as nurses in America. What is the transition like? Are there differences in daily practice? How does the status of nurses in America impact upon their practice?

Moving to another country is shocking. Certain elements are refreshing and liberating and other elements are much more trying. It is my own process of change and redefinition that has piqued my interest in the process of acculturation.

Assumptions, biases, and beliefs in phenomenology

Since many researchers are drawn to topics rooted in their own experiences the challenge is to study the familiar "without the blinders that familiarity often attaches us to" (Ely, 1991, p. 17). Recognizing one's assumptions and beliefs and then "bracketing" or putting them aside so as to become more receptive to what is being studied is a critical component of the qualitative research process (Ely, 1991).

Explicitly recognizing, clearly articulating and setting aside one's preconceptions through the process of "decentering" allows the researcher to see data in a manner that is not clouded by one's own meanings (Munhall, 2010). In order to decenter I described the journey that has brought me to my research question and articulated my stance.

I had to engage in bracketing throughout the process. During the interviews, my shared cultural background with the participants was useful in establishing rapport but also allowed me to instantly and intuitively understand many of the things they mentioned about their "Indian lives".

I knew immediately what was meant by "high class" and "low class". I am horrified that I could actually picture in my mind's eyes, what they meant when they said low class. I could see these poor, dark skinned, local-language speaking speaking, sari-clad, oiled hair women, sweeping houses. I could picture my "kaam-wali" (servant)...I am starting to wonder if the "you know" that all my participants are fond of saying, is merely a speech idiosyncrasy or whether they actually believe that I know (Reflective memo, 2012).

At the same time, I acknowledged that there was much to separate me from my participants. The price of this self-awareness was often learning unflattering truths about myself and my attitudes.

A woman of my class and economic standing would not have gone to nursing school in India... what I am trying to say is that in one sense, I am able to distance myself from them because truthfully this (the nurses) was not a group

of people that I actually noticed. Much like any other servant, I relegated them to a group of people who served and their relevance to me was only in terms of the service they provided (Reflective memo, 2012).

Personal assumptions, biases and beliefs

This is what it is about: looking at it through their eyes, not through the lens of my expectations (Memo, 2012).

Researchers need to acknowledge those things that may potentially bias the findings prior to initiating the study. A disclosure of those factors may affect or influence the research process (Ely, 1991; van Manen, 1990). I entered this study with the pre-knowledge that the immigration experience is stressful. This has been substantiated by my personal experiences as well as the acculturation literature (Miller & Chandler, 2002; Padilla, Wagatsuma & Lindholm, 1984; Sodowsky, Lai & Plake, 1991; Sodowsky & Plake, 1992). I expected that the transition involved feelings of loss, homesickness, and communication difficulties. However, I also believed that there would be unique aspects to the experiences of Indian nurses in America. I was curious about issues related to self worth and professional pride. Indian society for the most part holds nursing to be a less-than-desirable occupation for its women (Nair & Healey, 2006). Indian nurses' decision to migrate is influenced by prevailing social attitudes towards nurses in India (Thomas, 2006).

I also believed that having limited opportunity to network with other immigrant Indian nurses has some bearing upon the experience of Indian nurses in the

US. Meeting others of similar ethnic/ racial backgrounds can be tremendously supportive but given the relatively smaller number of Indian nurses, such meetings were scarce. Until recently there was no organization that represented Indian nurses as a unit. The National Association of Indian Nurses in America (NAINA) was established in 2007 and all the participants arrived to the US prior to that time.

While my intent was to capture the experience of being a nurse in America, I believed it quite possible that the data would shed light on factors that facilitate and hinder the adjustment of Indian nurses. This information, along with information related to practice differences, may be used to guide decisions related to recruitment and retention of Indian nurses by informing the development of procedures and policies that improve the quality of life for immigrant Indian nurses.

Trustworthiness

Lincoln and Guba (1985) use the term “trustworthiness” to indicate that the research findings reflect the experiences of the participants. Trustworthiness implies that the researcher has engaged in research practice that is both ethical and an accurate reflection of the participants. The four criteria of *credibility*, *transferability*, *auditability* and *confirmability* may be used to evaluate that this has been accomplished (Guba & Lincoln, 1989; Lincoln & Guba, 1985).

Several measures were embedded in the research design in order to ensure that the findings of this study are credible, that they are close representations of the reality as experienced by the participants. Participants who expressed interest in speaking

about their experiences were invited.

Lincoln and Guba (1985) suggest the use of prolonged engagement and persistent observation in order to increase the truth-value of findings. More than one interview was conducted with each participant. Having more than one interview provided the opportunity to clarify, confirm and obtain further information as necessary. Multiple interviews also allowed for informal *member checks* so that participants had the opportunity to acknowledge whether or not their stories had been accurately represented. As the study unfolded, impressions of both the data collection process as well as the data itself were recorded as *reflective notes*. Debriefing sessions with the dissertation chairperson were sought to ensure that analysis was rooted in the data.

Since the premise of qualitative research is that each person's reality is unique to them, generalizability is not a concern. However, transferability speaks to the ability of the research to so effectively capture the phenomenon that other researchers are able to apply the findings to broader contexts (Guba & Lincoln, 1989; Lincoln & Guba, 1985; Shenton, 2004). Detailed descriptions of the phenomenon as well as the accompanying context are provided through the use of different literary devices such as narrative, storytelling and anecdotes. The use of multiple methods to present data allows the readers to best determine the applicability of the findings within their own contexts.

Dependability, which addresses the stability of the research over time, is a more complicated issue in qualitative research (Guba & Lincoln, 1989; Lincoln & Guba,

1985; Shenton, 2004). Details related to research design, data collection and analysis are provided so as to allow a replication of the study process by another researcher.

Participants

Phenomenological research necessitates the inclusion of participants who have experienced the phenomenon under investigation (Sokolowski, 2000; van Manen, 1990). Thus, a theoretical and purposive sample of six immigrant nurses from India who are currently employed as Registered Nurses within US healthcare organizations was recruited in order to obtain the rich, thick descriptions necessary to vividly evoke the phenomenon under the study. These nurses were able to speak to the experience of being nurses in the US as well as the process of transitioning from practice in India to their experiences in US healthcare systems.

Van Manen (1990) alludes to the temporal nature of lived experience. Keeping this in mind, participants were selected who had some time to reflect upon their experiences, and included those who had practiced nursing in the US for at least one year. This was particularly fitting when one considers that the first year after immigration to a new country is often seen as the “honeymoon” period wherein it is more likely that positive events are highlighted and negative ones ignored (Pilette, 1989). All participants were fluent in English as this would assist in the articulation of their experiences.

Participants were invited through word of mouth and referrals from participants and colleagues. In order to encourage complete candor, nurses with whom I share a personal or professional relationship were excluded. Gatekeepers

within the National Association of Indian Nurses of America (NAINA) referred nurses who were interested in participating. I attended several events hosted by NAINA and its New Jersey and New York chapters in order to recruit participants. A flyer with contact information (Appendix A) was posted at these events and other nursing conferences as well. Six women, all from the southern part of India, were interviewed before data saturation was reached.

Data Collection

Close examination of the stories of those who have experienced a particular phenomenon allows the researcher to capture the phenomenon in a way that is meaningful (van Manen, 1990). An effective method used to assist people in recounting their stories and the meaning they give to these stories is by using in-depth interviews. In-depth interviews “encourage people to reconstruct their experience actively within the context of their lives” (Seidman, 2006, p.14). Multiple interviews that combine taking life histories along with focused questions aimed at assisting participants’ to make meaning of their experiences with regard to the phenomenon of interest are a critical part of this methodology. They are a necessary part in the process of establishing the situational context that will add meaning to the experiences of the participants (Munhall, 2010; Seidman, 2006). Further, social conventions in India dictate that parties engage in some small talk and polite conversation before getting to the business at hand. Thus, a three-interview method was used.

In the first interview participants were asked about their experiences in India and how they arrived at the decision to embark on a career in nursing. Participants were asked to recount their early experiences related to the phenomenon under study (Seidman, 2006). During the second interview, the focus shifted to participants' current lived experiences. They were asked to share their experiences in the US, with specific reference to their professional lives. Participants were encouraged to share details about their work experiences and the meaning these experiences had for them. All participants consented to the first two interviews. Each interview lasted from forty minutes to ninety minutes and was conducted four to eighteen days apart for five of the participants. The interviews were spaced so that a connection with the previous interview was maintained while allowing participants the time to reflect upon their experiences in each country distinctly from the other (Seidman, 2006). Due to scheduling constraints, the sixth participant faced a 2½ month interval between interviews. Such variations in spacing are acceptable as long as the structure established by the researcher allows participants adequate time to reflect upon their experiences (Seidman, 2006).

A third interview was conducted three to five months after the second interview had been completed with all participants and data analysis was underway. The purpose of this interview was two-fold. The interval allowed participants' to reflect upon their experiences and gave them an opportunity to add to their stories (Munhall, 2010). From the researcher's perspective, it allowed me to perform informal member-checks by seeking clarification and confirmation for findings. All but one

participant agreed to this third interview. These interviews lasted from twenty-five to forty five minutes.

A tentative interview guide (Appendix B) is attached. This guide contains the queries that were used to initiate and guide the conversation. Broad queries allowed the participants to share that which they considered most salient to their experiences without a directional prompt from the researcher. Questions were added or modified depending upon the interview and participants. Field notes, logs and reflective memos were recorded prior to and after each interview.

Data saturation was reached after interviewing six participants. Declaring that data saturation had occurred was a particularly hard step to take.

Probably all novice researchers obsess about data and when you stop collecting it. Have I really captured it all? The pressure of doing justice to research makes you feel like you cannot miss a thing...I have arrived at the conclusion that the essence of her experience is the same as the others. I am, in fact, getting the same story. The stories are on a continuum but the elements are the same!
(Reflective memo, 2012).

Protection of human subjects. IRB approval from Seton Hall University was obtained prior to data collection. Initial contact with participants was established via a phone call or in person. Each participant was provided with a letter of solicitation (Appendix C) explaining the study purpose, protocols and nature of participation required. Upon indication of their interest in participation, a schedule for interview was arranged and verbal or telephonic consent was secured. Written consent was

obtained at the first meeting. Participants were informed that their participation was voluntary and refusal to participate would incur no penalty. They were free to decline to answer any questions and withdraw from participation at anytime during the process.

Interviews were conducted in a place that was mutually agreed upon by the researcher and the participant. Only in one case was the interview not at a participant's home. Participant confidentiality was assured by assigning a numerical code to each participant and their accompanying interviews. Use of full names was avoided during the interview process. Any accidental use of names was redacted from the interview transcripts. I transcribed each tape personally to ensure accuracy of transcripts as well as to refresh myself on any nuances during the actual interview. Audio recordings and interview transcripts were accessible to my dissertation committee Chairperson and myself. However, only I had access to each participant's name and contact information.

All data, including but not limited to field notes, memos, journals, interview transcripts, and audio recordings, are being kept in a lock box in my home. Electronic data is stored on compact discs and USB memory keys. All research related materials will be kept in my possession for at least three years after the completion of the project. All written material will be discarded by shredding prior to disposal. All electronic data will be stored for at least three years.

Data Analysis

Data analysis in qualitative research is an iterative process (Ely, 1997; Munhall, 2010; Seidman, 2006). Several authors have recommended ways in which data may be organized however they all agree that interview transcripts must be read several times in order to get a feel for what is going on (Ely, 1991; Strauss & Corbin, 1990; Tesch, 1990). The first step entailed a careful reading of the first two or three transcripts in their entirety with the intent of getting a sense of what they were about (Tesch, 1990). Thoughts and ideas about the data were noted as I read. The next step involved a more focused reading, with an attempt to begin preliminary coding. The question I asked as I read was "What is this about?" (Tesch, 1990). The topic of what I had just read was written in the margin as a tentative label. Ely (2006) suggests beginning with "the smallest, most literal descriptions" (p. 87). Transcripts were read again and relabeled as necessary. Similar labels from several transcripts were clumped to form categories (Ely, 2006; Tesch, 1990; Strauss & Corbin, 1990). Labels were compared and contrasted. Commonalities were developed more fully into themes. The process of reading, reflection and analysis continued in a loop until the data were organized.

At the end of the data analysis, a detailed outline was created to get a sense of the whole. Based upon this outline, I selected anecdotes and created stories and narratives that provide a glimpse into the experience of being an Indian nurse in America.

Chapter IV

INTRODUCING THE PARTICIPANTS

Six nurses participated in this study. All six women are from South India. Three women are from the state of Kerala, known in India for its “production” of nurses, while the remaining three nurses are from the neighboring state of Tamil Nadu. The women arrived to the US between 1994 and 2007, most as primary migrants and a couple as a consequence of their marriage.

A brief history of nursing in India

In order to provide context for understanding the experience of being an Indian educated nurse in the US it is important to know something about the history of nursing in India. Nursing as a profession can be traced back to ancient Ayurvedic texts dating to 100 BCE. Only men of good character, skilled in cooking and cleaning, and willing to provide gentle care were permitted to become nurses. However, by the early 20th century it was predominantly young women who became nurses (Gill, 2011). This change may be partly attributed to the British influence in India as well as religious and cultural strictures within Indian society.

As a colony of the British Empire for three centuries, India was the recipient of a number of English influences, one of them being a healthcare system. Florence

Nightingale has widely been credited with bringing professional nursing to India in the mid to late 1800s (Gill, 2011; Healey, 2008; Reddy, 2008). Prior to this time, the care of patients in hospitals was relegated to untrained or minimally trained personnel, most often orderlies, ward-boys and lay-midwives or *dais* (Healey, 2006). The first trained nurses in India were European nurses who arrived in India under the auspices of the British Medical services (Gill, 2011). These nurses functioned within the precepts of their Victorian upbringing so that "...To the doctor, she brought the wifely virtue of absolute obedience. To the patient, she brought the selfless devotion of a mother. To the lower level hospital employees, she brought the firm but kindly discipline of a household manager accustomed to dealing with servants..." (Ehrenreich & English, 2010, p. 90). In 1914, recognizing the need for an indigenous work force, the British Medical Services under the tutelage of Florence Nightingale, recruited the first Indians into the Indian Military Service (George, 2005). These nurses were indoctrinated into the same rigidly held ideas about hierarchy and the role of women as their Victorian teachers. The ideal of nursing as an extension of a woman's natural duties was propagated and remains part of the nursing image.

"They (Christians) are born nurses." A major influence upon the development of nursing in India is the role of Christian missionaries (George, 2005; Healey, 2006). Nursing education in colonial India was conducted in hospital-based training schools and was often undertaken by "medical missionaries" or medically qualified female missionaries who provided medical care along with their proselytization (Reddy, 2008). In fact, one of India's most renowned nursing schools

(and one attended by some of the participants of this study) Christian Medical College in Vellore, Tamil Nadu, was started by Dr. Ida Scudder, an American missionary whose experiences in India led her to understand the need for trained healthcare professionals, particularly women, in India (Reddy, 2008). Nurse training was largely attended by European women, Anglo-Indians and Indian Christians, in part because nursing came to be identified as a largely Christian calling (Gill, 2011; Healey, 2008; Reddy, 2008).

“It’s not a good profession for ladies.” Another reason why nursing became the domain of largely Christian women in India is that the nature of nursing work violated two beliefs widely held by Indian society. The first of these was the “polluting nature” of nursing (Reddy, 2008, p. ix). The handling of bodily fluids was relegated to the lower castes or “the untouchables” (George, 2005; Healey, 2006). Members of the higher caste would not deign to be in a position that involved such “dirty work”. The second deterrent to nursing was the gender taboo related to the touching, often intimately, of strangers of the opposite sex (Healey, 2006). Respectable women did not interact publicly with men who were not related to them, so the idea of touching strangers was relegated to women of loose moral values. This was complicated by the fact that nurses were required to work and live in such terrible conditions that nursing came to be viewed not as a profession, but rather as menial labor to be performed by members of a lower caste and/or class. This belief was, and in large part remains, prevalent among many sections of Indian society even today (George, 2005; Healey, 2006; Reddy, 2008).

“It is competitive to get into the program.” All students in India who complete twelfth grade must appear for a statewide examination. The results of this single examination will determine their eligibility to apply for higher education in certain fields. Students who score below the pre-determined “cut-off” scores are not eligible to apply to certain schools. Given the large number of students, and the relatively few institutes of higher education, this makes the admission process into any school of higher education in India intensely competitive. Students who want to pursue coveted fields such as healthcare and engineering need to excel.

Likewise, entry into a nursing program is a competitive business. A career in nursing is a viable option for those seeking secure employment since India has been experiencing a nursing shortage since the 1940s (Gill, 2011). This coupled with the lure of possible migration overseas as a nurse, makes nursing an attractive option, especially among those who are financially underserved. The number of nursing schools in India has been too low to successfully accommodate those seeking admission (Khadria, 2007), thus making entry into the program competitive even among the pool of applicants who are able to overlook the negative connotations of nursing.

Participant stories

The following pages introduce the participants. They share the stories of their journeys, first becoming nurses and then migrating to the US. The purpose of these stories is to provide a glimpse into the nurses’ lives prior to migration with particular

emphasis on their decisions to become nurses and the subsequent decision to migrate to the US. These two decisions provide critical context to their personal and professional experiences in America.

The stories are based upon interview data with italics representing the actual words and phrases used by participants' during their interviews. These phrases were chosen because they contributed uniquely to the voice of the participant or to their story in a manner that could not be duplicated by the researcher's voice. Pseudonyms have been used to protect their anonymity.

Viji. I was raised in a small village in Tamil Nadu, South India. I grew up in the time when there was little electricity and no transportation to school. Our village school only went up to fifth grade. After that we had to walk 2-3 miles to and back from school everyday. My parents did not finish school but they valued education so *they wanted their kids to have it*. In those days, if you were lucky, tenth grade was considered a big deal but I wanted more. Girls were discouraged from going out of town to study but luckily my father's dream was that I become a doctor. He was proud that I was very smart and brave, participating in all the school activities and coming first or second in class. So, despite everyone's objections, he sent me *to Catholic school where there are only girls because you know they worry about girls there. It was a well-known Catholic, well-disciplined school.*

When I graduated from 12th grade I did not know what I needed to do. I completed entrance exams for medicine but didn't even know how to apply for the medical schools. You have to understand, where I came from, especially in those

days, there was no TV, no Internet. No one in my family had gone to college so I had no idea of what to do. So I missed the opportunity to apply for medical college. Then I met a Catholic priest who became my mentor and guided me towards nursing. My parents, especially my father, were disappointed but no one else in my family had come so far. I wanted to go to a BSc nursing program but I was put on the waiting list. It was a Christian school and I am a Hindu. *If I had been a Catholic that day I would definitely have made it into the BSN program.* Ultimately, I went to another big city and got into a three-year diploma program over there. It was a hospital-based program run by nuns. *So all my life it is the nuns...It put me on track, helping people, learning the right things.*

After nursing school, I worked for a few years. The hospitals were run by Catholic nuns so they were well disciplined and everyone followed the rules. Then, of course, I got married. I continued working until I had my first child. At that point, I decided to stop. I liked my job but the hours were too long and the pay was nothing much. My husband was making good money and you know, over there, you have also family responsibilities.

I never intended to move to America and become a nurse. My husband's job brought us to America in 1995. *I didn't think at all about nursing.* I was busy with my family. The turning point came after my second son was hospitalized for several months. It was during this time that I got to see what nurses did over here. I spoke to my son's Indian pediatrician and to one of the Malayalee (from Kerala) nurses in the unit. She told me how things were here. *This is not what I experienced back home.* I

decided that I would do it. I bought books and studied for the NCLEX-RN. I had all the knowledge, solid base from my education in India. I just had to get used to this multiple-choice type of questions. A year later, in 1999, I became an RN in the US.

Rachel. I went into nursing because I saw the opportunities presented in a nursing career. You know, my state (Kerala) is very competitive so it was important to do something that had job opportunities. Initially, I wanted to get into medical school but that did not work out for me so I got my BSc in Chemistry. But in the meantime I was able to get into a nursing program in the neighboring state of Tamil Nadu. Many students from Kerala go there for nursing school. *My mom was not at all happy with me. She wanted me to work as a professor, teacher, something like that. Which is, she said, a very good profession for ladies.* My brother was an engineer and my sister had a BSc in math so my mother did not want hospital nursing for me. *None of the high-class families go into nursing. Either average or low class goes into nursing. Most of them want to get a job and help the family. That is the main intention – to make money for the family.* Luckily, my father travelled a lot to the Middle East and he saw the opportunities in a nursing career so he encouraged and supported me.

After completing the nursing program, I moved with some of my friends to Bombay. My sister was in Bombay so it was OK. We were very excited. It was a good experience there. It was difficult to get a job initially because of the difficulty in getting certified to work in another state. I had my certificate in Tamil Nadu but now the Maharashtra state nursing council has to approve and give us a certificate to

work. This took a very long time but once it was done, we got good jobs. I started in the OB department in a very big hospital but in 2-3 months they asked me to teach in the diploma program because they don't have any instructors. I took it. *I liked it.*

They moved us to a brand new building. The people respected us a little more.

Unlike the staff nurses, we worked only one shift (8am to 4pm). We did not have mandatory rotation. *It was really, kind of easy job. Not stressful.* The money was not good but they provided food, housing and *everything is taken care of.* Of course,

moving to Bombay, we had to deal with lots of different people from all over India.

They are all speaking different languages and we have to learn Hindi as well. *Bombay*

has better hospitals, better opportunities. You get more exposure and you get

opportunities to go out of state, meaning out of country. Like Middle East. All the

people for interviews come to Bombay. My initial interest was to go to the Middle

East and make some money. *I did not have much interest in coming (to America).*

From what I am hearing, Indians who come here they don't have good jobs.

However, things don't work out like you plan.

I got married and my husband was in the US so the Middle East was no longer an option. While I waited for my US visa, I moved back to my state and worked there.

I also passed the CGFNS exam. In August 1995, I finally came to the US. I took the NCLEX-RN in October and soon thereafter I was a licensed RN in America.

Vincy. I believe I was destined to be a nurse. I was born in a big hospital, very close to my house and this is where I eventually started my nursing career. Both my parents were in the healthcare industry so I was always comfortable in that

environment. I didn't really know much about nursing but *I had a good impression about nurses*. I see how some nurses have gone abroad, *brought things home so I see that it's a good life*. In Kerala, the education is very competitive and it is very difficult to get the 4-year program. We were all very disappointed when my sister failed to qualify for nursing school. So, I decided to try it *for my family's sake - she didn't get it, so at least I should get it*. After high school, I worked hard. Day and night I worked so that I could get through. And I did! But still, I had no clue about nursing. My turning point came in my first year of college, when my father had a heart attack and died. That's when I realized that this was a serious thing, people's lives. *It was not just to go and earn but also going to handle life. So that's when I got serious about it*.

I completed the 4-year BSc program. Like all nursing and medical students, even though my house was close by, it was mandatory to stay in the hostel so I did. The school I went to followed the same books that are used here in America – same authors, same subjects. Because it was a big medical college where they were training doctors, we also had access to autopsies, equipment etc. The school was in English but often we had students who had studied in other languages up to that point so we had to help them out. We had intense clinical training – 2 weeks of classes followed by 2 weeks of clinical, Monday through Friday, and 4 hours on weekends.

After graduation, I was assigned to work in community health for one year. After that I requested to work in a hospital so I could get acute care experience. I worked in a medical surgical/ spinal injury unit for 2 years before I was offered a

promotion to a new developmental pediatrics unit. *At the time I didn't know that a nurse should have a specific area for many years for that specialty to count* but I did it and I am glad because I love caring for children. Because it was a brand new unit, I was involved in the initial set up. The nurses worked as a team with doctors, therapists, OT and PT. We taught families how to care for their developmentally challenged children. We did research studies. It was fantastic.

During this time, I had gotten married and my husband and I had discussed the option of going to a foreign country. I had in my mind the long term plan of either going back to school for my master's or of going abroad, whichever would be better for my family. I had passed the CGFNS exam so I knew it was a possibility for me. It made sense to go to the US – *get a good education for my children and me*. And, financially it would be good too. So, I signed up with a recruiting company in India and sat for the NCLEX-RN. It was great to be able to do the exam right there, where I was working. When I passed, I had 3 job offers I could choose from. Having a company made it easy because they took care of all the paperwork and running around. I didn't pay them anything *because when they place me in a hospital, the hospital gives them an incentive*. Some nurses have a bad experience with the companies, but my company was very good. They made it easy for me. They processed our visa and helped to get Green cards for my whole family. So, in May of 2006, my family and I moved to the United States and two weeks later I had started working as a RN in Virginia.

Bindu. *None of my family members are nurses – father, mother, sisters, nobody. We are Hindus. High caste Hindus will not opt for nursing thinking that you have to touch the men, you have to wash people and you have to do those things. I was motivated to become a nurse because of my neighbor who was a doctor. My family initially refused but I was begging my father so despite my sister's objections, my father took me for an interview and I wrote the written exam and I passed. And, so like that I came into nursing. When I started school, I really thought I will quit because I could see that, I was not brought up in that surrounding, so it was not good. I was in my 3rd year of school when I started loving it. But the social stigma was there. For a long time my sisters would not tell people that I was in nursing school, only that I am in college. Even now, you can see, only 7% of Indian nurses in America are Hindu. Mostly they are Christian.*

After I completed my BSc, I worked in an ICU for a couple of years. Then I started to teach. I have always been driven to learn and do new things, so I then went on to get my Master's in nursing. At that time, not many people did it and only two people were allowed in one specialty- for example 2 students in pediatrics, 2 in psychiatric and so on, so it was very competitive. After I completed my MSc, I returned to my previous teaching job.

The life in India was really I can say it was very nice. Stress free. My husband and I lived very close to the school where I taught. My days were structured. I went to work at 9 am, came home for lunch, sometimes even had a quick nap, returned to school and was home a little after 4pm. I had domestic help for the daily

jobs of cooking, cleaning, and helping with all the household work. I was home before the kids got home. My husband had a good job and we were both socially and professionally successful and settled. It was simple.

The decision to move here was driven a little bit by peer pressure – many of our friends were moving to the US – but also by the desire for professional growth and doing what is best for our children. Coming to the US seemed like a good move for the whole family - *better for the children and better for me also basically in the nursing career*. Once we decided upon it, I contacted an agency and they guided us through the process of CGFNS, immigration visa, paper work, getting a job, everything.

The hardest thing was to leave everything behind. Both of us had successful careers and our extended families that we gave up to start fresh here. *We have to sell basically our house, sell all of our properties – some to our friends. All those things have to be disseminated and we have to come here. And it was really hard*. But we did all that for our future and in September 2003 I moved to the US and started my life as an RN in New Jersey.

Elsy. I am the youngest of 13 children. I was born in South India and I lived there until I finished 12th grade. After school *I wanted to go into medicine actually but I was a little laxed in my studies so it was little hard to go so I decided to go to nursing*. My parents were OK with my becoming a nurse but they did not like it that I was moving north. In India, most children, especially girls, do not go away to college

and I was moving far away - from one end of the country to the other. I could go there only because my brothers lived in that city.

As the baby of the family, I was always cared for. Moving so far away from home, and it was my first time leaving my parents and going away, was very hard. It was very different from where I grew up. The language was different so that was difficult. There were all different people from many parts of India – different languages, different food. At school they put us in dorm rooms with people who were from different states so that *you would learn the language*. At school it was only English and living in Delhi, I had to learn to speak Hindi. *I speak Hindi very well.*

I liked Delhi very much. It was a 4-year BSc program, with a very good college life. The school was not in a hospital environment so we had only 2-3 hours of hospital time every day otherwise we are in the college. Weekends were off and summers were free. It was very nice! Many of our teachers were foreign trained and we used British textbooks so the education was very thorough. The teachers helped you a lot. My college was not like some other schools. We did not have long hours of classes and clinical with lots of hospital work. It was a great college experience.

After I graduated, I worked in Delhi for a year and half. It was a nice place. Everyone was friendly and willing to teach you. I was not planning on leaving India but when the chance came to go to a foreign country, I decided to try it. Saudi Arabia is very close to India so my friends and I decided to try that. My family was not

happy that I was going so far again but at the *time Saudi was not very, very strict so it was good.*

Life in Saudi was very different from life in Delhi. You have less freedom there. They give you everything – food, accommodation – but you cannot go anywhere by yourself. And, of course, the language is different so you have to learn. Their customs are different so that is scary but the people were nice, friendly. The work was very similar to India so it was fine. I did not have any trouble with that. I was the only Indian in my unit at that time so I made friends with the Filipino nurses who worked there. To this day, we stay in touch.

Then I got married. My husband travelled a lot so initially I stayed in Saudi and then moved back to Delhi when we decided to start a family. My husband's job was good but he was transferred every 3 years and we didn't like that. And then, in between the transfers, he had to go away also. When our son was born, I wanted us to be settled in one place, together. In India, with his job, we could not do it. In America, I could get a good job and we could settle down. *Initially I didn't want to come. My brothers were here and I knew about America. They are always busy. I did not want to be a so-busy person.* But we wanted a life together so we decided that we should move to America.

I did CGFNS and I passed and so I came to America in November of 1994. By February of 1995 I passed the NCLEX-RN and started the long process of finding a job without any "American experience". It took six months but finally I was a practicing RN in America.

Susan. I never wanted to be a nurse. I come from an upper class, Christian family in Tamil Nadu, South India. We are a family of professionals – doctors, teachers, engineers. I wanted to go to medical school. Unfortunately, I missed the eligibility criteria by just a few points. You know, in India we have a quota system for the lower castes so the upper class seats are restricted. I was very disappointed. A last minute conversation with a friend persuaded me to try nursing. Still I am not very clear why I chose nursing. I think it was basically a good financial option for me because at that time, with my high grades, essentially I went to nursing school for free. My parents would never push me to a particular career but nursing was not what they wanted for me. The upper middle class families, they don't want their daughters to go in for nursing. My father said, "OK, you can complete the BSc nursing and become a lecturer in the college". So my goal was to complete nursing and become a lecturer.

I had no clue. I did not know how nursing would be. My very first day in clinical I had to make a bed. The patient was a colleague of my mother. I was so embarrassed to be there, doing this kind of work in front of him. I wanted to quit right away but one of my professors counseled me. She was very kind and she helped me. Slowly I made friends, did very well in school, even won a gold medal, so I started to like it.

School was very hard. My school was attached to the medical school so after our nursing classes (8 am to 4pm every day) we went to anatomy and physiology classes in the medical school until 7-730pm. We barely got a chance for dinner and

then we had mandatory study class from 8pm to 10pm. I liked the academic side so I enjoyed it. *The education is very good. It covers all the areas.* In my class there were not too many local students like me. Most of my classmates were from Kerala. You know, in Kerala everyone wants to become a nurse.

I finished nursing school and I worked in the same hospital for 2 ½ years, mainly as a clinical instructor. After graduation I also got married. My parents did not mention that I was a nurse, only that I was going to teach. My husband was well aware that I would only get married to him if he supported me to go back to school and get my Master's. So, after marriage I got my Master's in Mental Health nursing. I had become interested in psychiatric nursing during my clinical rotation in school. *I had a passion to become a psych nurse. For some reason I had a feeling that psych nurses are more independent and you don't have to touch and all those things.* As a Masters prepared nurse I could move from being a clinical instructor to a full-fledged professor. This was what I truly enjoyed. It had been my goal from the very beginning so I was very happy. Also, not too many people were into psych nursing in India, especially not at the Master's level, so it was a small group of us and we all knew each other and were recognized for our work. I took a break from school after my MSN to have children and then I returned to school for an M.Phil. This is like a precursor to the PhD program here. I wanted to do research.

The decision to migrate to the United States was because of I wanted learn sound research. I came here not to work at the bedside but to teach and get my PhD and learn correct research methodology. Like many nurses, I had also done the

preparation exams like CGFNS but my husband and I were very well settled and did not want to move. The decision was made suddenly. In the space of a week, we packed our bags, and with \$2000 in our pockets we moved to the US. In 2007, we left our comfortable lives and moved to Virginia. I became a bedside nurse in a pediatric psychiatric unit so that I could fulfill my dream of getting a PhD in Nursing in the US.

Summary

It is estimated that a large majority of migrant Indian nurses in the US come from South India, specifically the state of Kerala (George, 2005; Gill, 2011; Khadria, 2007). All participants in this study were from South India, with half of the nurses ($N= 3$) from the state of Kerala and the other half ($N=3$) from Tamil Nadu. This geographical distinction is relevant because current research related to Indian nurses in the US up to this point has focused on Keralite nurses (Hegde & Diccico-Bloom, 2002; Jose et. al, 2008). The regional difference is also relevant in exploring attitudes towards nursing and status of nurses in India. As one of my participants said, "*In Tamil Nadu, even though there is only 50 kilometers between our states, it is a huge difference in the attitudes of people in sending their children, their daughters for nursing*".

Due to societal and religious constraints associated with the physical care of patients, nursing was not encouraged among well-to-do Hindu and Muslim women (Gill, 2011). This is expressed by one of the participants, "*The upper middle class*

families, they don't want their daughters to go in for nursing." In fact, nursing was considered a Christian profession and the majority of nurses in India belong to the Christian community of Kerala (George, 2005; Gill, 2011). The nurses in this study reflect that demographic with only 2 of the immigrant nurses being Hindu, a religion that is followed by roughly 81% of the population (Census of India, 2001) and the remaining 4 nurses being Christian. There were no Muslim women in this study.

As shown in Table 1, the participants arrived in the US over a period spanning about fifteen years, ranging from 1994 to 2007. All but one nurse migrated with the intention of continuing their nursing career here in the US.

Table 1

Participants' migratory information and work experience

Name	Year of migration	Age at migration	Years of practice (India)	Years of practice (US)
Elsy	1994	34	1.5	18
Rachel	1995	26	3	18
Viji	1995	24	2.5	14
Bindu	2003	35	11	10
Vincy	2006	30	8	7
Susan	2007	32	12	6

Reasons for migration included those most often cited by the literature, financial gain and hope for a better future for themselves and their families. Two nurses in this

sample moved to the US as a function of their marriage while the remaining four nurses all migrated with the specific intention of seeking employment or and/ or furthering their professional growth. This distinction is important since it affects their experience here in the US with some in the sample believing that these nurses have it easier than they do. It is one of these nurses who had not planned on resuming her nursing career since she felt that her financial situation was comfortable enough wherein the stress of a nursing career was not worth the bother. It was only after her exposure to the work-life of nurses here in the US did she reconsider her decision to give up nursing. She states that in India "*the profession wasn't giving the right stuff that I was looking for*" and acknowledged that her decision was not based solely upon salary.

All the nurses started at the bedside as staff nurses. This is related to the employment contracts that allow them to migrate here. At the time of this study, only two remain exclusively at the bedside, and three are either nurse practitioners or on their way to obtaining NP and DNP certification. One nurse, with post Masters credentials from India, is a clinical instructor with a desire to continue onto a doctoral program. This desire to continue their education and progress in their careers may well be a reflection of the high value placed by Indians upon education (George, 2005; Gill, 2011) or a consequence of the snowball sample technique used to recruit participants. It is likely a function of both.

Four of the six nurses admit that nursing became a career option only when they were unable to pursue a career in medicine. Only Vincy was able to embrace a

nursing career with no family resistance or any negative perceptions of nursing. She was the only one to have exposure to a family member who was a nurse. For her, nursing was associated with a life outside of India and financial stability. She states, "...*They brought good things home so I see that it's a good life. They went abroad so it's a good thing*". Her middle class Christian upbringing reinforced traditional ideas of service and nursing.

All the other participants ($N=5$) discuss their own experiences with existing Indian stereotypes related to nursing. They were all privy, in varying degrees, to the idea that nursing was not a "respected profession" for some Indian women.

Attitudes towards nurses and nursing: Participant experiences

To be frank none of my family members are nurses – father, mother, sisters, nobody. We are from Hindu culture. Basically Hindus will not opt for nursing thinking that you have to touch the men and you have to do those things.

All my family, cousins, they all work in college. They are all professors, doctors, Indian Administrative Service officers so I was the first one to become a nurse. My father said, OK, you can complete the BSc nursing and become a lecturer in the college.

My mom was not at all happy with me. She wanted me to work as a teacher – that's what she wanted... Work as a Professor, teacher, something like that. Which is, she said, a very good profession for ladies.

Nursing remains an undesirable profession for many Indians. The nurses in this study were no strangers to these feelings and attitudes. In fact, for all but two, the choice of nursing was the fallback option when they were unable to get admission into medical school. Attitudes about what nursing entails and the lack of respect accorded to nurses and nursing means that most families are not overjoyed to have a nurse in their family. Although these attitudes are changing, especially as immigrant nurses bring financial gains, the notion of a career in nursing is still viewed as a dubious choice. Some nurses faced family resistance. One nurse, granted admission into the program during her interview, was encouraged by the principal to stay at the college while her father returned home to bring back her things. She was afraid that her mother would forbid her from returning if she were to go home. Her father was supportive of her decision since his travels with the military had given him an understanding of the benefits of a nursing career.

The idea that nursing involves menial work remains part of the Indian psyche, along with its accompanying stigma. Another nurse was categorically told by her family that a career that involved washing people and dealing with body waste was not to be pursued. She obtained the support of a physician, a person who carries great weight in Indian society, to persuade her parents to agree with her choice. Even this nurse, so steadfast in her resolve to be a nurse, had second thoughts early in her

student days as she dealt with the reality of working in a government hospital that served a socioeconomically lower clientele than she was used to. She said, “*I really thought I will quit...I could see that I was not brought up in that surrounding. It was not good*”. The same nurse spoke about her orthodox background wherein gender segregation was the norm, resulting in her hesitance when washing patients. “*I was doing it with like two fingers,*” she said. It was the motivation of her teachers and their ability to engage her that kept her going.

Yet another nurse relates her embarrassment at having to make the bed of her first clinical patient – a colleague of her mother’s. He was surprised to find her there and asked her “And how come you are doing all this?” She was afraid that he would tell others that he had seen her performing the menial act of making a bed. She said, “*I was so shameful.*” Her own feelings about nursing were less than positive and the physical aspects of care were, and remain to this day, particularly distasteful to her. In fact, she agrees that terrible as these thoughts may be, one of her reasons for seeking psychiatric nursing was her aversion to this aspect of nursing.

Only two nurses did not face family resistance upon embarking on their nursing career. One nurse was actively encouraged by her family as their own experiences working in healthcare as well as having other family nurses led them to a positive view of nursing as a career. The other nurse, while not encouraged to pursue nursing, was at least supported by her family. She believes that as the well loved youngest child, her parents were willing to let her follow her own path, whatever she chose.

Nurses continue to experience stigma in India. Even the families of highly successful nurses in this study, some who are advanced practice nurses (APNs) and others who provide much by way of financial and healthcare support to their communities in the US and back home, continue to keep their career choice a secret. One nurse' sisters will not acknowledge that she is a practicing bedside nurse, instead preferring to tell others about her faculty position.

In marriage conscious India, nurses may have trouble finding a husband. For every family that seeks a nurse-bride for their son with the hope that she will be his ticket to foreign lands, there is a family that will rule out any bride who is a nurse. *"No one wants to marry a nurse. I am not from Kerala where everyone wants to become a nurse"* says one nurse. The state of Kerala in Southern India has long been known for its education, training and emigration of nurses (Nair & Percot, 2007; Simon, 2009). Another nurse is reminded to this day by her mother-in-law that but for her son's insistence, she would never have sought a nurse for a daughter-in-law. Movies and television shows in South India continue to portray a nurse daughter-in-law in a negative light, leading to the impression that these are not "good women" (George, 2005).

Nurse emigration outside of India has brought about some changes in attitudes. Nursing is now viewed as an opportunity to be upwardly mobile. Some nurses accept lucrative work assignments in the Middle East, becoming a source of foreign income for their families. Others use nursing as an opportunity to migrate to countries, which are prepared to offer them and their families permanent residence. One effect of the

increased number of people choosing to be nurses coupled with foreign nurse migration is an increasing awareness within India about the poor working conditions that nurses tolerate. This has led to some major upheaval in recent years, even a series of unprecedented strikes, in an effort to bring awareness to the plight of nurses, particularly those who are employed in the private sector. It is to be hoped that as working conditions for nurses improve, the profession will attract people from different segments of society, thereby challenging the age-old beliefs that stigmatize nursing.

Chapter V

FINDINGS: BEING A NURSE IN INDIA

This chapter describes the experience of being a nurse in India. In the first section the participants describe what being a nurse means to them. The nurses discuss what the profession of nursing means to them and what they believe to be vital to the essence of nursing. Later sections describe the experiences of being a nursing student and a nurse in India.

The Nightingale way of nursing

Over there we did old fashioned, Nightingale way of nursing. We took care of the patient, prevented infection. We made sure the environment was clean. There was no evidence-based nursing, no education focus and there was no autonomy for nurses or advocating for nurses. The profession was designed in a certain way that's what was followed over there. I am glad in a way for what I took away. There was discipline, more discipline, respect for others, care for others. That's again because I worked under nun sisters and I think that attitude came to me- "your profession is all about giving to others", and "do the best to your consciousness" and "do no harm." In all those values that is the best thing I learned.

Florence Nightingale kind of things. As a nurse you are there to serve, you always have to be there to help others.

“The Nightingale way of things” or “Nightingale nursing” was mentioned several times by the participants. These terms, as one participant was quick to point out, do not mean that nursing in India is technologically backward or medically lagging. Rather, it signifies the values and practices of nursing and nursing education in India. It evokes images of caring and duty towards one’s patients.

Florence Nightingale was largely responsible for bringing the concept of organized professional nursing to India (Gill, 2011; Healey, 2008; Reddy, 2008). Nightingale nursing has become synonymous with the Victorian ideals of nursing and reflects the strict moral and disciplinary code that became part of nursing education and subsequent practice in India. It also has become representative of the Christian missionary ideals of duty, charity and caring. The following sections describe the participants’ experiences of Nightingale nursing in their lives as students and practicing nurses in India. These experiences cover a period spanning from 1978 to 2007 and may not reflect changes of recent years.

The following story describes what it was like to be a nursing student in India. Using the stories of the participants, and on several occasions their own words (in italics) I have tried to present a narrative that captures the essence of their experiences. In some instances, they were able to discuss similarities and differences between

education in the US and in India since all but one of the participants have had personal encounters with US schools of nursing as either students or faculty. This exposure to nursing education in the US gave the nurses the advantage of evaluating their own educational experiences in India from a different lens.

There are several categories of nursing and nurse training in India. The two categories that are comparable to the Registered Nurse in the US are that of a 4-year baccalaureate Nursing degree (BSc.) and the 3-year General Nursing and Midwifery (GNM) diploma. Five of the participants graduated from the BSc program and one nurse attended a diploma school. However, for each one the journey into nursing education started well before the first day of school. Given the extremely competitive nature of higher education and the relatively small number of nursing institutions in India, especially during the time that the participants in this study lived there, all participants had to work hard in order to gain admission into schools of nursing.

“It is like a military rule”

Nursing school was very stressful and I had to work very hard. There were a lot of things I had to get used to. First of all, it is a residential program so even though my house was not far, I had to stay in the dorms. *You cannot leave the college.* Most of the students in my school were from Kerala. Secondly, it is very structure-oriented. *Four years you will go to college, study and come back. You cannot work and study there. Learning is very structured, very systematic.* Classes are held every day from 8am to 4pm. After that we had special classes like anatomy

and physiology. This was taught to us by the doctors in the medical college until 7-7:30 pm. It was hard but it was also very exciting. *It was a big medical college. They were training doctors too. They had every type of equipment. All the autopsies and all the parts, they would show...I was able to look at every bone of the human body.* Then we had mandatory study class from 8pm to 10pm. So it was a long day but I made many friends so I liked it.

We had a semester system and each semester was six months long with block classes. For example, for pediatrics, we had 2 weeks of class alternating with 2 weeks of clinical for six months. The syllabus and courses were based on Western education. We had the same subjects that nursing students here have – fundamentals, pediatrics, psychiatric, medical-surgical, community health and so on. We even use the same books –*same Brunner, same Luckman, Potter and Perry!* So, all our textbooks are Western but we have to adapt it to Indian ways. *Here you have a disposable gauze. There it comes in a big roll and has to be cut into the pieces. Of course Potter and Perry will not tell you that! You won't get all the stuff (from the text book) in the clinical area so we have to work with what we have.* Now I think one of the Indian authors has written a simple procedures book for the Indian way of doing certain things.

We had a very strict system for clinical. First we had to do a procedure in skills lab. We can do the procedure on a patient only after the teacher has signed off on the skills lab. Then we have to repeat on as many patients until the teacher is satisfied. *There was one teacher who wanted us to do it 6 times. Whatever it is –*

open bed, closed bed, mouth care, whatever it was, 6 times. Then we have to make a appointment and take the signed logs to the faculty. Now again they question us and if we cannot answer then they will not sign the book. Once I had to come back nineteen times because I could not remember every component of the answer! *The teachers being very tough on (us) - like a military rule. (We) learn. (We) gain the confidence. (We) become assertive. (We) can dive into the situation.* So it was good even though it was very stressful.

Oh yes, nursing school is strictly in English. Until tenth grade I studied in my local language but after that I went to English schools. And, in nursing school you cannot speak in any language except English. In fact, they will put you into dorms with students who cannot speak your language so you are forced to speak English or learn another language. If you don't know English, you have to take English classes.

We had examinations at the end of every year that were graded across the state. My school always did well. Over here it is all multiple choice but in India we had to write essays – pages and pages of answers! It felt like we were learning so much information.

What I liked was that because we worked so much with patients – *there we never had any patient bill of rights, patient suing – we become very skilled. But many of the things we are blindly studying...You learn the role of the nurse – independent, authoritative but the opportunities for that in some areas is very limited...You learn everything but you don't get to practice everything.* As a student you become very

filled with the passion to do everything so it is difficult when you work and it is different.

In terms of the college life itself, there were many rules. Everything is monitored – *our uniform, our behaviors, our hygiene*. It was a Catholic school, run by nuns. *It is good you know. It put me on track - helping the people, learning the right things. Nursing school was like the military. We were not even allowed to get out of the campus for anything. So all you do is go to work in the hospital, and then you come back.* You are not allowed to marry or have boyfriends. Most of the girls were very serious in their studies but a few, especially those who came from far away, used it as an opportunity to go out, meet boyfriends, have love affairs and so on.

Despite all the rules and the work, I would say that it was an excellent education. When I moved here I felt like I knew everything people were talking about because I had studied it in India.

An important aspect of all their experiences was the structure of the systems they encountered. The phrase “it was like a military rule” was used to convey the rigor of their education in both academic and moral matters. Whether the institution was a Christian institute or a secular one, rules regarding the behavior of students were universal. This was confirmed by a nurse who mentioned that although her institute was not a Catholic one, her Dean was “of a similar mind set” so that many aspects of students’ lives, both personal and in school were strictly monitored and controlled. The monitoring of students’ correspondence, for example, was

commonplace, as were rules related to leaving the campus and engaging in unladylike behavior. The consequences of lapses were severe and could result in expulsion, especially where morality was thought to have been compromised. This level of intrusive supervision and oversight of student behavior are reminiscent of Victorian mores and harken to the severe attitudes towards nursing and the morality of young women, unchanged from colonial times. This strict discipline was not viewed negatively. One nurse believed that her father allowed her to go to a Catholic school because these rules provided a safe and protected environment for a young girl. Another nurse was glad for the morals and values that were provided within this environment. It is possible that given the stigma attached to nursing, these young women were happy to have an environment that was indicative of their good behavior.

Despite the strictures upon their social lives, all of the nurses were very proud of the education they received. They attribute their ability to work in the US (or any other country) in a “confident way” to the structured and disciplined education they received. They are quick to point out that their early timidity as RNs in the US is a result of the nursing role in India rather than a lack of academic know-how. “*We were (educated to have a lot more responsibility) but it was not needed there,*” said one nurse. This sentiment was echoed by the other participants. It was clear that the Western textbooks were read and learned as best as could be given the constraints of their practice environment. This is reminiscent of their stories of adapting procedures to the “Indian way of things” because of equipment availability.

None of my participants spoke about having male classmates. One nurse said that she knew that men were getting into nursing now but did not know anyone personally when she was in India who was a male nurse. Another nurse, who was one of the last to immigrate to the US, states that there were male nurses but they were few in number and were diploma prepared since there were no nursing baccalaureate programs for men at that time.

Although this story is representative in some way of all participants, one nurse had a different academic experience. This nurse is different from the others in that she embarked upon her nursing education more than ten years before any of the others. She is the only nurse in this study who obtained her education in the northern part of India. Another significant feature is that her school of nursing was the only one that was not physically situated in a hospital environment. It is likely that all these factors account for her experience being different from those of the other participants. While the structure of her coursework was similar to the others, she lived in a "college environment". Clinical experience was limited to 2 or 3 hours daily compared to the longer hours faced by the other nurses. This experience is unusual in that typically both baccalaureate and diploma programs in India rely heavily on clinical experience, using student nurses as apprentices in hospital wards.

Transition from nursing student to nurse. When students graduate from the nursing program, most have the opportunity to work or intern at a hospital connected to their school of nursing. They can choose to work there for a stipend that covered some of their costs, or they might choose to seek employment elsewhere. Similar to

the early tuition reimbursement schemes offered by diploma schools here in the US (where a year of employment forgave a comparable time of school loans), this program allowed nurses to get assured employment but they were then at the mercy of their employer with regard to unit or specialty placement, for the first year at least. Vincy now regrets the ease with which she transferred from one area to another at her hospital's request, *"At that time I didn't know that a nurse should have a specific area for these many years for that specialty to count so now I feel like I'm all over the place. But I enjoyed it."*

"Admission, discharge, assessments, medications"

In India we have private and public or government hospitals. A government job guarantees good benefits but then you have to deal with the poor working conditions. I worked in a private hospital. They have more money so we have better staff and more doctors and services than the government hospitals. We don't have any health insurance or anything like that. Since the patients have to pay for everything, we get a higher class of patients. The poor people only come when they are really sick. *If they can move a little bit they will not come because they have to pay out of pocket.*

The morning shift starts about 7:30 a.m. We have a short prayer after which we get our assignments. The patient assignment depends upon the unit and the hospital.

Some hospitals will have one nurse covering the whole floor. That could be 20 patients or even 50 patients! If you work in a good hospital then it is better. Then the

patient acuity is taken into account. If the patients are total care e.g. in a spinal cord unit, then you get about 6 patients.

We go to every bed side – the charge nurse, the bedside nurse, the night nurse. The night nurse would give report on what happened last night, and the previous day, and any major events. This report time gives us an opportunity to prioritize and organize ourselves. Every shift will start with an assessment. The assessments are usually focused, especially if you are in a low acuity unit with many patients. Then you do only a simple assessment. For post-operative patients you check the site and make sure the pain is managed.

After we finish rounds, we set up our patients for breakfast. Then it is medication time and then all the doctors come for rounds. After they are done with rounds, we have to go through the orders and do whatever is required. We walk the patients that need to be walked, and make them sit in a chair if they are fresh postop. At this point the day is half done, and it is time for the nurse to take her lunch break. Then it is afternoon medications and dressing changes followed by calling the specialty consults. There is also a certain time when the doctors are called with test results.

The relationship with doctors was mainly okay. Of course, nurses are subordinate to the doctors. *The doctors are up there and nurses down here.* But it depends on the doctor and the nurse. You can have a rapport, especially if they know you from school. It depends. A colleague of mine was asked by a physician about a patient's CT Scan. When she told him what the result was, he got really mad and responded with, "I didn't ask you for the result. I just asked you if you got it". Some

physicians don't want nurses to know any more than doing the tasks and walking behind them.

During the day (and also the night) the patients' family members are in the hospital. At least one person is always there. They are mostly very helpful in caring for the patient. If the doctor orders any medicine then they must go get them and give them to us so we can administer them to the patient. Sometimes they can get it from the in-house pharmacy but sometimes the family has to go outside the hospital to get these medicines. That is their responsibility. If they cannot afford them then we cannot do anything. Sometimes the doctors will order a test that we cannot do in the hospital. The family has to take care of it. They call and make all the arrangements. They are responsible for getting the patient there and bringing them back. Even if they need an ambulance, they have to get it and be there to help the patient. We cannot take care of the patient so well if the family member is not there taking care of all this. They will sometimes ask some questions to us but mostly they ask the doctors. They trust the doctors so they are satisfied.

As long as we do our job, the families are good to us. They do not confront or question us. Sometimes the upper class families can be difficult. They have their own private wards and think they can treat us like servants. The middle class, the lower class people, they are nicer. They know that we are there for them.

In the afternoon the nursing students arrive. We know who is assigned to our patients and depending upon what year they are, we know what they can do. So we assign them things but we also teach them things.

Some days are overwhelming. We have to stay to finish everything but there is no overtime pay. We get a monthly salary so it is what it is. We have to work six days a week. On day shift it is eight hours but we also must do mandatory night shift rotation and that is twelve hours. It is very tiring to do that. It would be nice to have more money and more respect.

The major part of the nurses' job was to administer medications, start intravenous lines and change dressings. Given that each ward could have up to fifty patients, these tasks alone could take up half the nursing shift. Nursing care was focused on getting tasks done for a large volume of patients. Nursing practice was often limited to "following doctor's orders."

Although family members may not have much understanding of medicine or healthcare, they are crucial partners in the care of hospitalized patients. It is not unusual to see entire families camped in the lounge, with food, change of clothing and mattresses. These family members are not there simply to stay near to their dear ones, they perform critical functions for the patient. Family members may provide physical care such as toileting, feeding and ambulating. They are responsible for obtaining the medications ordered by the physician. Some hospitals allow family members to purchase medications from the in-house pharmacy. Other hospitals require family members to purchase the prescribed medications from local retail pharmacies and bring them to the hospital. Only controlled substances like narcotics are kept in the hospital. These medications are then turned over to the nurse who will administer

them. If they are unable to afford medications, bearing in mind that there is no healthcare insurance and services are provided based upon cash payments, the patient will not receive medications. In fact, family members' presence is critical when there are decisions to be made about any interventional, diagnostic or surgical procedures. Families are required provide payment prior to the services being rendered as well as, in most instances, arrange for and transport of the patient to and from the testing site, even if said site is not located within the hospital. Another function that family members perform is that of keeping extended family and friends updated about the patient's condition. Nurses from India remark that the time spent on phone calls is considerably less in India than in the US because of the family's role in patient care. Hospitals, realizing the indispensability of family members, will accommodate them with far more sangfroid than what we are used to in American hospitals. I was told about families that bring portable stoves and radios into cramped waiting areas, settling in for their stay: "*Just like a house they will set up in one corner and each family will take up one corner*".

Nurses also talked about the way they are perceived by the families and patients. Most believe that the way they were perceived was a function of not only their own abilities but of the class of patient the hospital catered to. Most agreed that poorer patients viewed them positively and were appreciative of their help while wealthier patients were more likely to regard them as menials. "*It depends upon the class of people that we get...when the upper class people come...we will be one more servant or maid for them...Nurse, bring this, Nurse do that. And you have to respond*

to them, immediately. Of course, the middle class people, the educated people, the lower classes they do look up on you”.

Interactions with physicians are predicated upon the understanding that nurses are subordinate to physicians and not partners in care. Those participants who functioned as faculty expressed that they had a good relationship with physicians. They believed that their role as teacher put their interactions with physicians on a different level than that of staff nurses since teachers are more respected than nurses.

Working hours are long and the pay is not commensurate with work load. Mandatory shift rotation is part of bedside nursing in India, with no room for over time payments.

The practice of nursing is slowly evolving. Vincy, the last nurse to leave India describes her job as a nurse rather differently. She points out that she worked in “a very Westernized unit” so that her practice more closely resembled nursing in the US than that of the other nurses.

I got the opportunity to start and manage a brand new unit. This was very exciting because it was a very new concept. I worked with patients who were chronically ill and received treatment and education over a number of days. A team of MDs, OTs, PTs and nurses worked together to plan and care for the pt. We even got to do some research studies initiated by the nursing staff. *It was fantastic teamwork.*

“People respected us more (as teachers)”

There weren't enough teachers to teach...so we were kind of forced to do it because they couldn't find anyone who was prepared to teach these nursing students. So they took all these BSN nurses to work in the school. We have a semester of nursing education theory and practicum in our last year of nursing school, so we are comfortable dealing with nursing students.

Three of the six participants were teachers at the time of their migration. One nurse was able to teach as a clinical instructor with a baccalaureate degree. Unlike the US, in India the minimum level of education required to be a nursing tutor in a diploma program is successful completion of a baccalaureate education (Indian Nursing Council, 2013). Teaching nursing school was enjoyable. One of the immediate benefits was the increased status that teachers enjoyed. Those who taught also felt that physicians treated them differently from the staff nurses. Other perks included a less stressful lifestyle because they were guaranteed one shift, generally some variation of a 8a-4p shift and in some cases the provision of accommodations and food. This, coupled with a higher salary than that of staff nurses, made teaching a very desirable option.

Besides the better status that teachers enjoy as compared to nurses, being a nursing instructor had other perks as well. Rachel, who worked as a clinical instructor in a big city in Western India, describes her job as “a good experience”

which provided food, accommodation and a decent salary considering that her other expenses were taken care off. This almost preferential treatment underscores the difference in attitudes towards teachers versus nurses in India. However, due to the extensive migration of experienced nursing faculty, India struggles to recruit and retain expert faculty (Rao, Rao, Kumar, Chatterjee & Sundaraman, 2011).

Since students were full time, teachers felt that they were dedicated to their studies. All content was delivered via lectures. University wide exams were held, comprised of essay type questions rather than multiple-choice questions. Hierarchy is a very important factor in the teacher-student relationship, *as a teacher, whatever you say, the students are totally going to accept it*. This is important to note because when the two Master's prepared nurses started to teach in the US, they had to make yet another transition in learning not just how to be an American nurse but also how to be an American teacher.

Chapter VI

FINDINGS: LIFE IN AMERICA

I landed in NY, May 1995...It is still very chilly for us in May. Then we are in the hotel, looking at all the food...We didn't even touch any of the food. We couldn't even eat that kind of stuff. So we ate the apple.

When I came here it was very hard. That was the time that nurses had a hard time getting a job...I stayed for 6 months with no job... I have my RN license also over here but still wherever you go, they used to ask, "do you have any American experience?" I don't have so... I had good experience actually. I was head, charge nurse in Saudi Arabia so it was really hard for me. I was crying everyday. Even though I have my friends to support (me), I have my brother here. It was still bad.

The first thing was that it was a culture shock...US should be a Christian believing country but no. My son doesn't pray in school. So whatever we teach them at home is what they grow up with. I was in a Catholic based institution until I finished my 12th. They taught us so much values, morals and spiritual health

I was looking at the window and I could not hear any noise. That was bothering me. Because I used to get a lot of noise in India - from the horn sounds and the cars and the people walking, talking. And I don't hear nothing. Then it was really kind of depressing kind of thing.

Never knew until I came here how difficult. I was in for a rude awakening. I was always in and around where I was born and brought up so I didn't know how it was going to impact.

This chapter describes the reactions of the nurses and their families upon their arrival to the United States as well as their ongoing experiences in this new country. Their struggles to establish a new life for themselves and for some, new careers for their spouses, while negotiating environmental, financial and sociocultural changes are presented. There are some differences between those nurses who were primary migrants ($N=4$) versus those who are not ($N=2$). Primary migrants are those whose nursing career provides the impetus for the immigration to the US. They arrive to the US as the breadwinners of the family. Their spouses and children may accompany them as part of family reunification laws. These spouses then have to find employment in the US. Those who are not primary migrants, arrive to this country either as a result of their spouse's migration ($N=1$) or as a consequence of their marriage to a US resident ($N=1$). Differences in food, weather and currency are

mentioned in passing as these have been identified as adjustment stressors for all immigrants and have been well documented in the literature.

“He could see only the snow. Only the snow”

All the nurses arrived either in the spring or late fall and were struck immediately by difference, starting with the temperature. The weather was significantly cooler than what they were used to in India. Except for one nurse, all others had lived and worked in the southern part of India and had little exposure to chilly climates.

One participant used the phrase “He could see only the snow. Only the snow” to describe her husband’s first sight from their apartment window. It seemed an apt metaphor for the losses that they sustained to come to the US, with the blanket of snow representing a blank slate; a vast emptiness. The loss of everything known and starting over is one of the major themes that resonates in their stories. The most significant loss was that of family and friends. Some of the primary migrants initially left behind their spouse and children so that they could secure employment prior to bringing dependents over to a new land. This was a source of much heartache for them, especially when things at work were not going quite as anticipated. One nurse left her infant son and husband behind. It took her six months to find employment, something she had not planned on. She confesses to crying everyday, despite staying with close friends. For those who migrated with their immediate family, they felt acutely the loss of their extended families. The distance from loved

ones is complicated by the fact that family and friends are an integral part of family life in India, often assuming the role of parent, caregiver, or helper where needed. One nurse missed not only her mother's company but also those things that had become a part of her life – a meal already prepared after a long day at work, someone to watch the children and a confidante with whom she could share a hot cup of tea. Given the extended kinship networks that exist among most Indian families and communities, these nurses lost not just their immediate family but also a wide network of support structures developed over years of connection.

The nurses and their families also had to deal with the loss of their previous lifestyles, especially those nurses who were primary migrators. There were the physical losses. In order to move here, most of the nurses sold their homes and many of their belongings. This was a financial necessity as well as a function of the sheer volume of things that they could bring with them in this transatlantic journey. Thus, upon their arrival they were faced with a near bare apartment, with little resource to purchase large items. During an interview, one nurse pointed out two chairs in her living room. They stood out as ill fitting in the otherwise impeccably decorated room. These were her first purchases in the US. She retains these “ten dollar chairs” as a memento of those first difficult days when her possessions consisted of a mattress on the floor, her bags from home, and the stove and refrigerator that came with the apartment.

Unlike India there was no easily available and cheap domestic help. Indian families rely upon an array of domestic helpers or “servants” to assist with chores of

daily living such as cooking, cleaning, and laundry. The lack of domestic help and familial support further stresses the delicate balance in the lives of these nurses adjusting to a new country and a new job. One nurse said, *“You have more help (in India) because you have all your family around. It’s easy to get somebody to help, from outside even, to help in the house. It’s not like here.”*

There were emotional connotations of performing household chores associated with the work of the lower classes and lower castes. One nurse poignantly shares her emotions as she trudged home from the store with her new bucket and broom in hand. She questioned the decision to leave behind a comfortable lifestyle and prestigious career. Her husband was a high-ranking executive and she was a well-established teacher in India. They were used to returning home from work to a clean home and a hot cup of tea already prepared. Now, they were emotionally and physically drained by the demands of their new lives. She recalled:

One day we went to the store to buy some things. So we had no car so on the way back in the bus with the brooms and everything, we are feeling like a successful professor for so many years, he is having a good job and people to bring coffee tea when you press the bell – and being now here with the broom in the bus, it was breaking your heart. The way that struggle was! (Bindu, 2012).

Loss of established careers was difficult to adjust to. One nurse said, *“They knew me. They respected me”*. Here they were new nurses, and worse, new foreign nurses. Their experiences outside of the US were disregarded and successful careers

minimized as they searched for jobs or dealt with transition from their own specialties to what was available. Nurses who had worked day shifts, some as professors and others as charge nurses or managers, were now working in staff positions on night shift. The two nurses who were faculty in India particularly felt the financial burden of moving. Professors not only garner more respect, but also make significantly more money than staff nurses. This combined with the unfavorable exchange rate made their financial situation weaker than before. One nurse talks about this sudden financial setback, *"You have to build up slowly because how much ever money you bring from India, it is nothing when you convert to the dollar...if you convert it, it is one month, maybe 6 months rent."* The cost of living expenses, especially in the first few months, consume their life savings. *"It goes like that,"* said one nurse, snapping her fingers. For another nurse this was her first experience in budgeting and paying attention to cost. As she explained, *"We never knew when we spent so much money, no second thought of what is left in the bank but now it became like that. Till then money was never a problem."* Expecting the windfall of higher salaries in the US, the nurses had failed to take into account the higher cost of daily living as well as the financial burden of starting over.

These financial constraints had other repercussions as well. In order to attain or maintain financial stability, the nurses had to sacrifice social situations that involved spending money. Thus, nurses who would have benefitted from being in social settings, especially with non-Indians, found these opportunities to be burdensome and unaffordable. For those nurses whose husbands were working, the

nurses worked opposing shifts to meet childcare needs, so that spouses rarely got to see each other or spend time in leisure activities. *“Totally there is no social life. For 3-4 years just to build up your family in a better shape. So it is stress.”*

For secondary migrants there were losses associated with friends and extended families, but not the same financial strain that the others experienced. They were also in the position to negotiate for jobs more suited to them since they were not primary breadwinners. However, losses were experienced, in some manner by all the nurses.

“We didn’t know where to go. For anything”

For primary migrants, with no previous contacts or relationships in the US, it was difficult in the beginning. There was a complete lack of knowledge regarding the very basic things and services. One nurse recalled that the men, used to going to a barber shop in India “to shave and to cut” were at a loss as to how to negotiate this very simple transaction. How is it done? How much does it cost? Where does one go? Learning about their new environment was critical, but was often hampered by their lack of transportation. For some there was also a fear of the environment in which they resided. One nurses recounts, *“They put me in a hospital place, like the quarters...they put a person in charge and she came and said, please don’t go out because people will shoot you because that is the way... She said that. First thing.”*

Lack of a credit history was a significant and unexpected financial hurdle. One nurse talks about her frustration after being repeatedly denied a credit card. This frustration turned to a feeling of accomplishment when a letter to the company

yielded results and she was given her very first credit card. *How are we expected to get a credit history*, she asked, *when no one would let us build one up?* This early victory was an important turning point for her because it taught her that her struggles were not for naught. It also sowed the seeds for her philosophy that “speaking up” is an important part of survival in America. To me, it also marks her transformation from bystander to active participant in her new life. Although there were many struggles, there were also victories. These accomplishments, however seemingly minor, fostered feelings of empowerment as the nurses realized that it was their hard work was paying off. *“I am really proud of myself and my family to be able to swim with all the struggles.”*

Things were slightly different for the nurses who came here through marriage. These nurses did not have the pressures of being the primary provider. One nurse’s husband had been a US resident for several years. Although she had to deal with the loss of her family and adapt to new surroundings, her transition was aided by her husband’s previously established co-ethnic support at work and outside of work. This nurse was able to secure employment at the same hospital as her husband and even establish a mentee relationship with other Indian nurses who had been in the US for a decade or more. Unlike the other nurses, she was able to fit into her new surroundings with somewhat greater ease.

“Basically I will be more comfortable where I am brought up”

Adjusting was the big thing, said one nurse. There were numerous adjustments to be made – weather, food, people, currency and language. These adjustments, typical to most new immigrants, are well chronicled in the literature so this section will address the socio-cultural issues that were most challenging for the new immigrants.

Moving to a whole new and different cultural setting required a great deal of learning. One of the first things that these nurses learned was to adapt to a new social conventions. *“They would ask me if I have children and then the next question would be are you married? I thought that was the other way round.”* Family was redefined as they were exposed to blended families, single parents, and unmarried mothers at work. *“Back home you have a father and mother living together. Here, the family system itself is different”*. The nurses agree that while it may be different from their own upbringing, this is the American way and must be accepted as such. They had anticipated a new environment but not how this new environment would affect them:

We thought we would still be who we are. And we still are who we were but it does, the outside world, where we live, and the environment, who we socialize with, everything has an impact on me, on my family, on my children.

Although the nurses were startled and sometimes shocked, there were positive moments in their learning. One nurse found this new culture fascinating. She said, *“When you take the family history, I will be thrilled and amazed listening to their histories. Everyday I will have a long talk at home after coming home from my*

clinical areas, my experience of things.” Learning about and acceptance of the sociocultural mores was critical to transitioning successfully to their new lives.

“You say RAAH-way, they say ROH-way”

Communication was a significant source of early discomfort both in daily life and at work. One participant put it succinctly by saying “*there is a lot of communication issues.*” For some language itself was problematic. While all nurses in India are required to learn English, their fluency is in British English. The American accent was initially difficult. “*When I came to this country I had to listen to what people say... The accent was a problem.*” Communications with multi-ethnic staff and patients was even more difficult. One nurse who initially lived in Virginia noted, “*That was a lot of African American culture so their language was even more fast and unpredictable. Very quick, difficult to understand.*” The nurses had to attune themselves to many variations of “American”. Over time, the accent got easier to understand. These nurses recommend that new nurses coming to the US watch a generous amount of television and listen to the radio as much as possible in order to improve their comprehension skills as quickly as possible. Interestingly enough, none of the nurses felt that their own accents were very difficult for Americans to understand. When asked, they admitted that most people were able to easily identify their country of origin from their speech and that occasionally they were asked to repeat things.

Physical gestures and touch, especially between different genders, is not the norm in India, making this aspect of non-verbal communication disconcerting to the nurses. One nurse said, “*I learned to nod my head, different from the way we nod our head*”. She pantomimed the more American (and North Indian) up-down nodding of her head as compared to the sideways nod typical of South Indians (Jain & Choudhary, 2011). Another described her unfamiliarity with greeting people:

The formal things like you do over here. When you see somebody, you say good morning but you shake hands with them as a nurse. Those kind of things are not much in India. So those things are a bit embarrassing for me.

The ability to understand the unspoken rules of communication are important when trying to make new connections and fit into a new social and professional milieu (Spangler, 1992; Yi & Jezewski, 2002). Nurses struggled with what information is considered appropriate to share. “*People (here) will talk very openly*” about personal lives compared to a more reserved sharing in India. When coworkers or patients discuss those subjects about their personal lives deemed as intimate details, with relative strangers, Indian nurses were taken aback. “*Back home you may have it but you will not show it out,*” said one nurse, referring to issues such as divorce, children out of wedlock, and different fathers for one’s children. Their prior image of Americans being reserved clashed with this new reality and created dissonant expectations related to information sharing, resulting in greater uncertainty related to communication.

The last area of communication difficulties relates to assertiveness.

An initial hesitance to not create waves or to be misconstrued as pushy, coupled with a lifetime of conditioning to avoid conflict, led nurses into keeping silent and opting out of confrontational situations. “*When you come, you are new. You are submissive,*” said one nurse. To her it was only natural that one keeps a low profile in a new environment. According to another participant, the art of “speaking up” is a critical skill to develop in order to improve one’s work environment. She said:

You will know many things but you don't open up your mouth because you are thinking what will everyone say. So I had to learn to do that. You have to learn to speak up. That is the main thing. Once you learn to speak up then your surroundings, your work, a better atmosphere will be there...unless you say it no one knows what the issue is... That is most important.

She advises all nurses new to this country that it is all right, in fact, encouraged in the US to express one self verbally. Direct communication is far more valued than the indirect, subtle communication prevalent in collectivistic societies such as India, especially in the work environment where clear and direct communication is synonymous with patient safety. It was only after a period of observing others interacting, and becoming more comfortable within their environments, that the nurses begin to assert their own personalities and learn the art of speaking up.

Sacrifice and “the Dependent Variables”

Nurses expected to make adjustments and sacrifices in order to successfully re-establish themselves in their new country. However, they were blindsided by what

one nurse aptly termed, “the dependent variables” when referring to their families, in particular, their children. “*After coming here, one of the hard part is the children...(in India) I could do my job and my kids and it was very nice*”. Nurses discovered that childcare was not as easy or as affordable as what they were accustomed to. One nurse wondered at the value of working when a significant portion of her salary went into childcare. There was also the dilemma of leaving their children with strangers rather than family members. Some nurses worked evenings or nights so that between husband and wife they had 24-hour childcare coverage. This meant that some couples saw each other only in passing, as one arrived home from work, the other would be leaving. Some nurses were fortunate enough, and some continue this practice, to have parents or in-laws visit for extended periods of time in order to have someone share the burden of childcare.

Raising children in a cultural environment very different from the one in which they were raised creates some anxiety for the nurses. They struggle with allowing their children to grow up as Americans while keeping some non-negotiable aspects of Indian culture such as respect. “*We don’t blame the children. They are also in a dilemma. They also don’t know whether it is this culture to be followed or the peer culture,*” says one nurse. Another nurse tries to temper her own philosophy of unquestioning obedience to elders as she struggles to allow her child to learn to question everything and to think independently. Balancing Indian values with American ways is difficult but important to these nurses as they raise their multi-cultural children.

Although children often became an unexpected burden, the nurses had yet another dependent that they hadn't planned on: their husbands. Nurses who were primary migrants discovered that their own secure employment was not accompanied by a similar situation for their husbands. Some of the nurses found that their husbands were unable to obtain any employment at all and others found employment not commensurate with their past experience or education. One long time engineer eventually obtained employment as a technician. He had to adjust to life as a labor technician. Such a change in job status sometimes had health ramifications, causing more stress to the nurses as they dealt with the numerous issues of becoming primary breadwinners as well as providing emotional support to their spouses. For some nurses, an additional conundrum was whether or not their husbands should seek employment. A husband who was not working was the perfect childcare solution for those with young children. One spouse opted to be a stay-at-home father. He not only took over the childcare duties but also all matters related to the home. In hearing her friends' horror stories about their childcare and housekeeping woes, this nurse was grateful for a spouse who was willing to put his career on hold for hers.

Summary

Moving to the US had many challenges, some anticipated, but many that they had not expected. Nurses and their families had to struggle to negotiate everyday activities that one takes for granted in one's life. However, the nurses all eventually adjusted and are at varying levels of comfort in their lives – both financially as well

as in terms of satisfaction with the move. Among the primary migrators, those who have been here longer seem to be more financially well off. There is a marked contrast in the homes of those nurses who have been here longer than those who arrived to the US more recently. It appeared that the nurses' early struggles and sacrifices do reap rewards in the long run.

Chapter VII

FINDINGS: BEING A NURSE IN AMERICA

Compared to India, it was like starting a new job, a new nursing job...I had the knowledge but the practice and the way of doing things everything was new.

It was very over whelming for me.

*It is a little different from what I used to do. Nursing is the art of caring for the patient but here it is the art of caring for the patient, the family and everything so!
It's much different.*

They expect you to know everything.

The differences was mostly family involvement and their cultural background.

Being a nurse in America was, and sometimes continues to be, a daunting challenge for the participants. This chapter examines the experiences of the study participants as they adjust to nursing practice in the US. Interestingly enough, the

professional challenges faced by the first nurse migrant in this sample are similar to those of nurses who arrived in the mid-late 2000s. This could mean that the nature of nursing practice in India has not changed significantly over that time period or it could reflect our inability to tailor orientation specifically enough to meet the needs of these nurses.

This chapter is divided into seven sections examining the nurses' experiences being nurses in the US: the role of nurses, elements of healthcare systems and practice that are new to Indian nurses, social and cultural differences that affect their nursing practice, experiences of racism, and those things that facilitated the transition to their new lives.

“Nurses here do everything”

There, the doctors are more the ones working with the patient than us. Here you have to be (the) more responsible one

The extensive scope of nursing practice in the US was a surprise to the nurses. The nursing role in the US involved far more responsibility than they were used to. They were overwhelmed by all that was expected from them by patients, families and other members of the healthcare team. Discharge instructions, medication reconciliation, customer service, and patient advocacy were new to their vocabulary and added to their responsibilities. In India, their roles, especially as staff nurses were task driven with the “basic nursing care” referring to medication administration,

starting intravenous lines, changing dressings and assisting physicians where needed. They expressed that nursing is far more complicated in the US than in India. The ability to practice more independently, to question physician's orders and to advocate for patients is new to these nurses. Nurses must not only provide quality care to their patients, but are also responsible for coordinating care and being vigilant about errors in care, even care that is not strictly in their own province. All these things are new to them and take away from what they consider to be their primary objective, being with the patient. One nurse puts it this way:

And here, there are so many things to worry about...There are a lot of things you are supposed to do...Being a nurse I am in charge of everyone's mistake sometimes. I have to make sure, fix it before I leave.

Despite their unanimous agreement that the nursing role in the US encompasses far more than they had anticipated, they do not view these added responsibilities negatively. One nurse appreciates the "holistic" approach of American nursing. According to her, nurses in the US look at the patient more completely and thoroughly. She believes that nurses here must be more holistic since patients rely on them more whereas in India it is the family that fills in the gaps in care. Another nurse, currently an advanced practice nurse (APN), says that she is able to fully see now, the degree to which nursing practice was mechanical and order-driven in India and is appreciative of being able to participate so proactively on behalf of her patients here in the US. She believes that it is the ability to affect patient outcomes that brings the passion into nursing.

These nurses believe that the lack of family involvement in the care of patients has an impact upon their nursing duties, giving them more responsibilities. Used to family members practically living in the hospital with the patient, it comes as a surprise to them that American patients are left alone. One nurse remarked that, *“They (the families) even give bedpan to the patients sometimes. They don’t even come and bother you...here we get called constantly.”* Another nurse believes that because patients’ families are less involved in their care here in the US, the patients tend to rely more on the nursing staff to meet their physical, social and emotional needs. Not having a family member present makes the nurse the patient’s lifeline to communication and social interaction. Tasks such as organizing and transporting patients to and from tests, arranging for transfers to other care facilities and even obtaining medications from the pharmacy if necessary, were completed by families in India so these are seen as added responsibilities that they did not expect to have to attend to. One nurse remarked that, *“So I think they are doing more of other things than our practice of being with patients.”*

This lack of presence at the bedside coupled with the questioning nature of American families’ and their need to be kept fully informed leads to the perception that patients and family members are more demanding here in the US. In hierarchy driven Indian society the nurses’ position within the hospital as care providers afforded them a certain status so that they were not used to patients or families questioning them. Being questioned by families and patients here is perceived as confrontational. One nurse felt that *“In India you were respected by the patient’s*

family. Meaning no one questioned you. If you know the work, everyone is happy and thankful.” She was surprised that patient’s and their families asked so many questions about their care. Another said, *“You have to be able to answer their questions, give them the right direction. Otherwise they look at you like you are stupid.”*

Another aspect of care that was new to the nurses was related to interactions with patients and their families, particularly where it relates to patient teaching. One nurse expressed this viewed extension of her nursing role as, *“Here you have to teach the patient, you have to teach the families. You are more involved in the patient’s education and the family education”*. While some cursory patient education was part of their practice in India, for most part, patient education was largely the realm of physicians and not nurses.

Nurses had mixed feelings about time spent with family members. For one nurse, the constant interaction with family members is a detractor from patient care activities. This nurse views the emphasis on nurse-family communication as burdensome and the least enjoyable part of her job. Another nurse, who had worked in a “more Westernized unit” in India felt that time spent with family is the most valuable part of patient care. Yet another nurse, who has recently dealt with her mother’s hospitalization in India, agrees that communication with family members is crucial and a necessary nursing function. Because of her own experiences regarding the lack of information she received from nursing staff, she is greatly appreciative of the level of communication that nurses must engage in here in the US.

Although all these responsibilities were and sometimes are overwhelming, the fact that their input has an impact upon patient care, often resulting in a positive outcome, is very gratifying. One nurse describes her feelings about her current nursing career as:

I used to think that I will have to quit bedside nursing. I may not be able to do it as I age but there is something that is capturing me there. No, it's not just the running around, its more than that, dealing with humans holistically. That is giving me a lot of fulfillment.

“I did not have this in India”

There are many aspects of professional practice in America that are different from what they experienced in India. The healthcare culture in the US is very different from that in India resulting in some basic differences in the way things are done.

Things are “legally tied up.”

They have questions, and rights and a lot of legal and ethical issues that we have to be aware of.

You know all those years as a student and a nurse, I never encountered one legal issue, family problem or patient problem over there. No people getting upset and all that.

One major cultural change was dealing with the level of regulatory systems in the US. In India, part of the patient role is to accept the word of the healthcare professional as gospel so that lawsuits related to malpractice are almost unheard of. Further, the judicial system in India is such that lawsuits may take decades and are not a financially viable option for most people. Because of this, the ease with which lawsuits occur here was disconcerting. “*Legal demands are high,*” said one nurse, referring to workplace and outside-the-workplace incidents. At work, dealing with patient rights, confidentiality and HIPAA were new experiences.

However, it was the “*suing stuff*” that was intimidating to handle. Nurses here are held more personally accountable for patient care. According to one nurse, this greater legal burden acted as an incentive to remain constantly vigilant. She did not believe that it hampered her practice, instead she believed that, “*where there is more law there is more perfection*”. The lack of liability in India was seen as a disservice to patients there because nurses and doctors “*take everything in a relaxed way.*” Another nurse felt that the focus on legal issues did make her cautious and sometimes tentative because, “*Even though, you know, you talk about the scope of practice, I was always afraid of malpractice and someone who will sue you.*”

Yet another nurse felt that while her patient care had not changed, the time spent in vigilance did mean that all aspects of patient care were not always completed. In particular, nurses talked about the extensive documentation required in the US. They believed that the numerous documentation requirements detracted from actual

patient care, in terms of time spent with patient and the quality of time while with patients. As one nurse put it:

The part I like most in India is that nurses spend a lot of time at the bedside. And it's patient oriented, less paperwork. So we invest a lot of time with the patients, to teach them, to get to know them, for them to get comfortable with us.

The participants also felt that the legal culture here has created one major drawback and that is in the area of clinical nursing education. Nurses who have had experiences, either as students or faculty in American nursing schools, agree that students here get far less hands on patient care time than Indian students. Due to the legal constraints of nursing practice in America, students here are not permitted to practice to the extent that Indian nursing students are able to, thus, missing out on the kind of intense clinical training that Indian students must undergo in order to graduate.

“Nurses are treated better in America.”

You come here and you are able to appreciate the differences. That the Indian nurses are not being treated very well (in India).

One of the biggest draws for nurses who migrate to the US is the salary of American nurses. In India, a bedside nurse may expect to earn the equivalent of fifty to sixty dollars per month and an educator would earn upwards of roughly eighteen hundred dollars per month. For them, a nursing career in the US is far more lucrative than the one they left behind. All the nurse participants were generally pleased with their salaries but those who were primary breadwinners pointed out that despite

earning more than they did in India, their household income had initially decreased as their spouses were either unemployed or underemployed when they first arrived to the US. This coupled with an increase in their cost of living meant that at first they did struggle financially. One thing that was a surprise to at least one of the nurses was the comparatively lower earnings of nursing faculty. She was disappointed that teaching was less lucrative than clinical practice. As a well-established educator in India, she had expected the same pay hierarchy to hold true here in the US as well.

The labor practices in the US are seen as generally favorable. Forty hour work weeks and overtime pay were new to them since hospitals in India do not pay an hourly wage and a six-day work-week is common. Perhaps the most appreciated thing was the concept of a permanent shift. In India, all nurses are mandatorily expected to rotate to night shift every so often. The participants were pleased that they could work just one shift unless they chose to do otherwise. One nurse, whose husband worked a full time, demanding job during the week, was amazed to have her own full time career as a Baylor nurse.

Other advantages of working in the US include the ability to call in an unplanned absence over the phone. Barring a serious personal injury, nurses in India are required to report in person to fill out a written request for a sick/ family day. The ability to call out for a family emergency over the phone was a welcome change. One nurse said that it she never realized how unfairly nurses were treated until she came here. This nurse had chosen to stop working after having her first child and decided to be a stay-at-home mother when her husband's job brought them to the US. It was

only after she realized that working as a nurse here would allow her to balance her home life as well that she decided to re-enter into nursing practice. Higher pay scales plus better working conditions made nursing a more family friendly option.

“Technology was a big shift.” The extensive use of computers and the level of technology were new to the participants. None had any experience with computerized charting or automated medication administration systems. However, they did not find these to be problematic since their hospital orientations covered these areas. Since some of these nurses were already practicing here during the time when these technologies were becoming more main stream in the US, they were no different than their American nurses in terms of their exposure to the increasing technology at the bedside. However, the nurses who moved here in the mid 2000s felt that learning about technology was a critical piece in their orientation.

“Here everything is available.”

The suture removal kit, after they are done, I was hesitating to throw (it away) basically. I was thinking such a shiny thing, shining brand new and he just cut one suture and now he is asking me to throw it out.

Dealing with so many disposable items was novel. Since the nurse participants practiced in India over a span of about 20 years, they had varying degrees of experience with disposable supplies. Like many domestic nurses, they too remembered a time of glass bottles and reusable syringes giving way to greater numbers of disposable items.

Medical insurance systems are a novelty as well. For one nurse the obligation to provide care to patients, regardless of their ability to pay upon admission to the hospital, had a “*major, major impact*”. Unlike India where medical care is contingent upon a patient’s financial state, here practice guidelines are uniform regardless of patient’s economic status. She used the example of a school where all children wear the same uniform so that the teacher treats everyone in a similar manner because she cannot isolate who has the wealthy influential parents and who does not.

“Opportunity is open.” One of the most unique things about working in the US is the availability of opportunity. Despite the difficulties the nurses faced and some continue to struggle with, there is no doubt that the ability to work hard makes many things possible in the US. As one nurse said several times in our conversations, “*Opportunity is open for talented, skillful, bright people who will be willingly working hard.*”

“Here you can’t force anybody”

In India we all belong to where we belong. We have our roles and we have to stick to those roles. Not everybody is equal...In the US I learned that a managerial job needs (long pause). It is a hazard, a hazard for my health I would say. When I had the managerial job I had to deal with PCTs and nurse. When I tried to discipline them they would talk back and argue. They know

what they are supposed to do, but they don't do it. -There is no respect for higher roles and authority.

The managers, charge nurses, head nurses, they all know when people are not doing their jobs. But here in America they don't force people or anything like that. If the in-charge people don't tell them anything then you feel that if you say anything no one will like it. So you avoid it.

Nurses who are used to strictly prescribed roles and hierarchies are unable to effectively manage the more egalitarian approach of Americans. Hierarchy, obedience and “knowing one’s place” are part of social and professional interactions in India. When the nurses’ requests to patient care technicians (PCTs) are not adhered to, nurses from India are often taken aback and not quite sure how to handle the situation. They feel that their authority is not respected. They are surprised by what they perceive as a lack of discipline. According to one nurse, without adherence to rules and discipline, nursing care suffers:

(In India) you pretty much follow the rules. Rules means rules. And you don't deviate from that and that kind of helped for better patient care. And that is a big difference that I see from here to there. Nursing has to be very disciplined and everyone has to do their best.

Disciplinary issues are believed to be the realm of managers and supervisors, people with official titles that gave them the authority to lay down the law. One nurse

observes, *“I do see some very inappropriate behaviors especially from the PCTs but I’m not their manager so I keep quiet.”* This area, problematic even for American nurses, is even more difficult for these nurses to address. Adherence to the rules is a given and failure to do so seems inconceivable, leaving them somewhat paralyzed when confronted with the situation.

These nurses realize that they must approach delegation differently than what they were used to in India. One nurse said, *“You have to be a little tactic in managing them”* when discussing her dealings with PCTs. She quickly realized that framing her requests for help as questions implied a choice. She found that requests affirmatively stated, *“Please do it”* were far more effective in getting the job done. Learning to move from an authoritative setting to the more laissez-faire American setting is often challenging and while some ultimately develop the skills for more effective delegation, others quickly learn to avoid it if possible.

“Where you have to talk back, you have to talk back.”

We don't fight, we don't argue

You come to any place, when you are new, you are submissive

You know, coming from another country you are more polite... She is having no confidence (in me)... My politeness is working against me.

New Indian nurses are hesitant to confront or challenge others. This hesitance to avoid confrontation and maintain harmony is a philosophy that the nurses grew up with and it is intensified by the inhibitions imposed by a new and strange environment. This often had an impact on the nurses' work environment and ability to perform their jobs to their fullest capacity. One nurse recalls being put in charge of a 30-bedded unit in a nursing home shortly after starting her new job. Although she had no experience taking care of a geriatric population, "*Whatever they want me to do, I did it*".

As the nurses become more comfortable, and gain a better understanding of communication styles in the US, they find themselves becoming more eager to speak up and be heard. Learning to be more assertive is a critical step in improving delegation skills and in becoming more effective participants within their workplaces. Bindu remarked that the only way to improve one's work environment and situations that are distressing is to "*speak up*". She is vocal in letting other new nurses know that they must learn to communicate more effectively.

"Sometimes you feel so small"

Back home I was wanted.

I don't think Americans know the value of (my degree)

Nurses who are able to migrate to the US are typically the cream of the crop – the better educated and more seasoned nurses (Rao et. al., 2011). The participants in this study were no different. Arriving from a somewhat exalted position and becoming yet another one of the foreign nurses who don't have American experience is a humbling experience. The transition from veteran nurse to novice is difficult, particularly for those who had been clinical instructors or faculty in India. The little things were sometimes the most difficult to deal with. One nurse relates the story of being confronted with a new digital thermometer. She felt intense shame that she had no idea what to do with it. She eventually figured it out but was frustrated that even such a little task had become more problematic than she expected. Another nurse talks about her humiliation when someone complained about her lack of skill. She understood that she had much to learn yet but felt that as a new nurse she should have been given a little more leeway.

Having years of experience and education not being recognized and appreciated is frustrating but at the same time it may be the lesser evil. Susan disclosed her level of experience and credentials to coworkers, upon arrival to her small unit. She was certain that letting people know about her advanced degrees (post Masters), extensive teaching experience in India and goal to obtain her PhD would be appreciated by her peers. She found the opposite to be true. She was then isolated by the others to the point that it impacted upon her practice as nurses were unwilling to assist her or co-check high risk medications with her. This was very traumatizing for someone who believed that the US was the ideal place for highly educated people.

According to her, *"We read all the American books ...so when you read these things you think the people they all just welcome you...some of the nurses didn't like it. (I was) I don't know the word – differentiated, segregated."* The only other nurse who arrived to the US with a Masters degree had chosen not to reveal this to her coworkers initially, largely because she was uncertain about her clinical skills after being away from the bedside for a number of years. This may have been a prudent choice because she was able to establish herself as part of the team prior to disclosing her advanced education.

Learning to gain entrée into an already established group of IENs can also be intimidating. Bindu, looking to transfer to a specialty unit, realized that the entire unit was staffed by another group of international nurses. She was told by others outside the unit, as well as those inside the unit to reconsider her decision to transfer. She felt that as the sole Indian to apply for this position, she was seen as less-than-able to handle the job requirements. Her preceptors were hard on her, often reminding her how difficult it was and asking if she truly wanted to continue. She persevered and has since successfully integrated into the unit. Her success inspired her to encourage other Indian nurses to seize the opportunity and seek challenging positions, and not be intimidated by other IEN enclaves.

“Knowing the rules is important.”

When I came here, uh, I lost my confidence, first thing. I didn't have my confidence because I wasn't aware of what is right or what is wrong. What I can do and what I cannot do.

Indian nurses have spent a lifetime being driven by rules and now the rules have changed. Having a thorough orientation and an understanding preceptor was important for nurses to learn how to do “*things the American way*”. Most nurses felt that given all the differences, it was important to have things, especially nursing protocols and legal requirements, spelled out so that they had clarity related to those major issues. However, the nurses realized that it was the unspoken rules, such as those governing communication, those dealing with cultural nuances that they would have to observe and learn where possible. One nurse firmly believes that *the preceptor has to be of a different culture...if you are put up with an Indian, culture wise you will not be learning much*. According to her, a diverse workforce is ultimately beneficial for the patients as multicultural nurses learn from each other and can use each other as resource when needed.

“I don't want to say racial because it is not just that”

I recognized that she was not treating me right.

It looks like there are no hindrances – I have the right to apply. So I did my interviews good, that I know, but I have never gotten an explanation from anybody why they wouldn't take me. So it looks like I am given the freedom but at the same time are they being fair to me? It's still a question. I don't know the answer to it

I don't want to use any big words because when you say that way, you see it everywhere. In your own country you have it – the caste, the favoritism...I thought it would be totally different here. I thought people are very broad-minded and they would treat you very well. So it was kind of shocking.

For some nurses the experience of being treated differently began before they even left India, most often as a consequence of religion or caste. One nurse believes that as a Hindu, she was denied a place in a prestigious Christian institute due to her religion. She said, *“If I had been a Catholic that day I would definitely have made it into the BSN program”*. Another nurse complained that she lost her entry into medical school because of the preference given to the lower castes due to India's reservation system, similar to the American system of affirmative action. This nurse was particularly surprised to experience racism here in the US because her textbooks led her to believe that such a behavior did not fit in with American ideals.

Nurses were at first hesitant to talk about racism or discrimination. Only one nurse had an incident where a patient refused to be cared for by a “black nurse” but all others felt that their dealings with patients were generally fine. Their experiences

with possible racism or discrimination are associated with co-workers and supervisors. The nurses were hesitant to label the difference in treatment as racism or discrimination, especially at first. Because they were not fully confident about what they bring to the plate, these nurses look inward to evaluate their own shortcomings before looking to their ethnicity or skin color as a possible cause for the difference in treatment. *I don't want to say racial because it's not just that. Maybe I have to work more to get there.* However, they have all experienced at least one situation which they could not explain away as anything else.

When instances of racism or discrimination occur these nurses are not quite sure how to address them. Once again, they believe the onus lies with their superiors. They are hesitant to respond directly because past experience has led them to believe that their own responses are more likely to be the cause of disciplinary action than the inciting incident itself. Most of the nurses believe that if they continue to “do the right things” that they will be able to meet their goals and continue to be reticent about discussing racism.

“This made it so much easier”

There are several factors that made the transition to their new lives smoother. Contracting with a reputable recruiting agency that provided suitable placement and accommodations upon arrival to the US was critical in ensuring a good start. Early employment provided both financial stability and a distraction from the acute sense of losses they experienced at first.

Previous migratory or travel experiences was helpful in dealing with cultural and linguistic differences. Rachel, who moved to a big city in Western India after graduating from nursing school in South India, compared those experiences to her move here to the US. For the first time, she came into contact with co-workers and patients who were from many different parts of India, speaking many different languages. Her current practice in New Jersey is reminiscent of that as she interacts with coworkers and patients from a variety of backgrounds. Elsy's education took her from South India to North India, a move akin to transplanting someone from the rural south into New York City. Even though she was still in India, she was dealing with differences in food, weather, language and even the appearance of people. Her subsequent work experience in the Middle East immersed her in yet another cultural environment, dealing with patients who spoke none of the several languages she was fluent in, and working with staff that were largely American or Filipina. These experiences prepared her in dealing with difference and, more importantly, allowed her to establish networks with other IENs. These friendships provided her with entrée into the Filipino nursing network here in the US. Unlike many other IENs who struggle to integrate, she found social and occupational support almost immediately, making her transition to her new job and life less stressful.

Although any form of social support was appreciated, co-ethnic support was even more critical.

I came with a large group, maybe 15 other families, all of the same culture, same language. This made it so much easier because we all shared our

struggles as well as our resources. If one person got something, however simple, they would let everyone know and share it. The children thought that it was a wonderful outing and they enjoyed having so many friends, like them, in this new place. They didn't feel any of the stress and anxiety that we felt.

(Bindu, 2012)

Having similar others, those who viewed the new world through the same cultural lens as they did, was helpful in making sense of new shared experiences and allowed the nurses to learn from each other. For some being in a diverse setting with different cultures, languages, and people, was preferable as it meant that they were not alone in their difference. For others being in an ethnic enclave was comforting. One nurse, who moved from Virginia to New Jersey, remarked, *"This looks so much like India, oh my goodness. Almost. That's how my mother, mother in law could survive when they are staying here."*

At work an American preceptor is preferable. Such a preceptor is fluent in "American ways" and is able to teach these new nurses both the occupational and social skills that they need to survive in their new surroundings. One nurse believes that having a co-ethnic preceptor is not helpful since it prevents the new nurse from being exposed to a different culture and the American way of thinking. Having a preceptor who makes an effort to have a social relationship with them is especially helpful in building trust and rapport.

Support from superiors at work is crucial in bolstering their confidence and in addressing issues with other staff members. Unfortunately, the nurses felt that this

was not always the case and when managers were supportive they were not consistently so resulting in confusion regarding what was expected of them.

The demanding education and intense clinical experiences in India prepared them for the more challenging aspects of being nurses in America. However, a thorough institutional orientation was invaluable in providing practical experience, especially for Elsy whose orientation involved one month of classroom instruction followed by 2 months of supervised clinical. This orientation period was critical in helping her to learn new skills as well as in allowing her to practice those skills that she had only read about in India such as setting up a Swan Ganz catheter. On-going educational offerings available in the US help with the acquisition of new knowledge, and increase the nurses' confidence.

Perhaps the most important factor in making the transition easier is something that occurs prior to the migration. Knowing what to expect is crucial in order to adequately prepare for the social, cultural, economic and professional changes. As one nurse said, "*Expect it will be hard.*" Migrating without a clear understanding of financial considerations and childcare needs makes the transition difficult. One's expectations prior to moving are important. Susie expected to obtain a lucrative, full time faculty position upon arrival to the US based upon her educational accomplishments in India. The failure to have these expectations met continues to color her experiences here in the US. She admits, "*It is about my expectations. I know all the people, who came here with me, they are all teachers there and over here they are bedside nurses. Its not like that is low but its not what I want.*" She also

points out that as a long time teacher in India, she failed to prepare herself for a new clinical role. In retrospect, she understands that preparing herself for this role change would have eased her transition to life as a nurse in America.

The passage of time eases transitional stressors. Living and working in the same environment over a period of time allows the nurses to rebuild personal and professional connections. As their knowledge and self - confidence increase, their professional and personal lives become less stressful.

Summary

Becoming an American nurse is a journey filled with many learning experiences, some pleasant and some more difficult. Each of these nurses is in a different place in their journey. Those nurses who have been here longer, are more secure in their personal lives and professional identities as Americans while others, especially the last two nurse immigrants, are still finding their niche. For nurses from India, learning to adapt to an expanded practice and embracing the differences between their two practice experiences has been empowering. Although they have questioned their decisions at times, most agree that migrating to America to become a nurse was a very good move indeed.

Why did I come? Why? What made me choose this? That was the feeling I had in the beginning. Really, really terrible feeling. But later on I felt that this is the place for me to come. Because if you really want to go up in your profession, this is the best place.

I am getting addicted to the profession. I can't think of anything else I could have been than being a nurse. Now I'm looking for more challenge now – challenging situations, challenging areas.

Chapter VIII

SUMMARY AND DISCUSSION

This chapter summarizes the purpose and findings of this study. The findings are discussed in the context of current literature. The discussion includes the contribution of the findings of this study to the literature and implications of the findings for practice and research.

Summary of the study

The purpose of this study was to understand the experience of Indian nurses who are now nurses in America. The question “What are the experiences of nurses from India as they adapt to the practice of nursing in America?” was addressed by considering the nurses’ lives at work and outside of the workplace. Six nurses, from two different states in southern India were interviewed to gain insight into what being a nurse in the US is like for these nurses. The experiences are best understood within the context of their lives as nurses in India hence those stories were also examined. The findings include both socio-cultural experiences as well as workplace adjustments.

Methodology. A phenomenological approach was used to gain insight into what the lived experience of being an Indian nurse in the US is like. Six nurses, who

were educated in India and had practiced as nurses, shared their experiences. Initial referrals were obtained from two gatekeepers. The remaining participants were obtained through snowball sampling. Data saturation was met after six sets of participant interviews.

A three-interview method was used. The first interview elicited information about their life and work experiences in India. This allowed participants' to start from a safe place and provided the context for their experiences. The second interview focused on the lives of the participants in the US. The goal of this interview was to gather data about the nurses' work and life experiences in America. Points that needed clarification from the first interview were also addressed in this interview. All the participants agreed to the first two face-to-face interviews. Each interview lasted approximately forty-five minutes to ninety minutes. The third interview was used as an informal member-check for data obtained in the previous interviews. This interview also provided an opportunity to ask the participants to clarify, verify and add to the findings. One participant was not available for the third interview.

Data were analyzed throughout the data collection process. Transcribed interviews were read and re-read for commonalities and differences. Transcripts were coded and recoded. Analytic memos and reflective memos were written to organize thoughts and findings. Transcripts were reviewed several times. After all data were collected, the process of final coding and thematic analysis was begun.

Findings. Nurses who migrate from India to the United States undergo a period of adjustment during which they must adjust to daily differences in weather, food, currency, people, and the culture. Prior to their move, these nurses had meaningful personal lives, surrounded by friends and family within a cultural context that they have socialized in since birth. Their professional lives also unfolded within this familiar milieu.

What it was like to move to the US. There was the loss of family, friends and known support systems. There were financial losses, lifestyle changes, and sacrifices made to start over in this new world. The nurses were confronted with dealing with the logistics of daily life such as where to find a barber, how to establish credit and, most importantly, how to learn all the new rules that must govern their new lives. Spouses of primary migrants dealt with loss of successful careers as, at least initially they had to settle for employment for which they are over qualified.

Communication presented difficulties despite knowledge of, and varying levels of fluency in the English language. This is best illustrated by the following story:

On my first day, I had to help a patient order food. So I asked him what he wanted and he said "dog meat". I asked him to repeat it but every time he said it, I heard "dog meat. So I came out of the room thinking these people eat dog also? When I repeated the request, in the same tone as the patient, he seemed to think this was perfectly normal. He said, "OK, I will order it."

When the tray came, first thing I ran to see was what is this dog meat. Then

when the tray comes there is the list of food – potato, chicken – and next to that it said “dark meat!” Oh, the accent! And, of course, in India chicken is chicken. We don’t say dark meat or white meat. (Bindu, 2012)

Communication issues stemmed from not just language but also accent, knowledge of colloquialisms and the cultural nuances that are part of growing up within a culture, such as what information is appropriate to share and what is not. Because of these initial missteps, some nurses found it easier to keep interpersonal relationships formal and business-like.

What it is like to be a nurse in the US. There were numerous professional adjustments. Besides getting used to a new healthcare system where services were not solely provided on the basis of cash-at-hand, the single largest theme that describes their impressions of what nursing in America is like, is that “*Nurses here do everything.*” Nursing practice in the US encompasses far more than what they are used to, with many new responsibilities that were part of physician practice and family function in India. For example, patient education and family communication was a physician role more than a nursing responsibility. Family members were responsible for obtaining the ordered medication, arranging for diagnostic testing, transporting patients and often providing food and participating in the physical care of the patient. This extended role was somewhat intimidating at first, but most nurses came to enjoy their ability to participate more wholly in patient care. They appreciate their contribution to patient outcomes and are glad to be equal members in the healthcare team.

Indian nurses struggled with delegation, and were unable to reconcile the egalitarian mindset of American culture with their own authoritarian upbringing. Disciplinary issues were believed to be the responsibility of their managers and when these are not handled decisively they concluded “*you can't force anybody over here*”. They worked hard to understand the legal issues involved in healthcare. Patient rights and customer satisfaction were new concepts, requiring new ways of approaching patient care. Most nurses were not averse to the idea of personal accountability for patient outcomes, believing that it allowed for greater vigilance in practice. They were however, concerned that too much time is spent on such legal requirements as documentation rather than on actual patient care.

The stress of settling into a new life here did have some impact upon their confidence and job performance. As one nurse put it, “*So I couldn't be what I needed to be, what I wanted to be is to be a quality nurse.*” It was only once the initial stress of settling down had lessened, were the nurses able to focus on professional development.

The nurses were hesitant to speak about racism and discrimination. This was particularly interesting since informal group conversations with Indian nurses as well as other immigrant nurses of color had led me to expect this to be a significant part of their experience here in the US. Some nurses were very clear in expressing that they had been at the receiving end of racist remarks and actions while others did not want to use the word discrimination. Susan described a previous workplace as a “skin dominated area” where non-white nurses were excluded from opportunities to grow

whereas Vincy reflected that perhaps her failure to obtain desirable shifts and positions when competing with those of lesser experience and education was indicative of the need to improve her skills and education. However, she remains perturbed by the illusion of open opportunity which is thwarted for reasons she cannot fathom. For the most part these nurses acknowledged the existence of racism as part of their experience but were focused on moving beyond that and defining their careers through their clinical expertise and educational accomplishments.

Despite the specter of racism, the nurses agreed that America is indeed the land of plenty, with opportunities for professional advancement open to all who are willing and hardworking. The work environment and employment conditions (such as better pay, shorter work weeks, better schedules and over time pay) were all far more attractive than what they experienced in India, resulting in a general satisfaction with their jobs. This confirms Liou's finding that Indian nurses are generally satisfied with their work place (2007). The move to the US was marked by opportunities for upward mobility in their careers.

The longer the nurses lived here, the more satisfied they were with their lives. As they adjusted to the many changes, the stress decreased and they were able to more fully enjoy their new lives (Hegde & DiCicco-Bloom, 2002). Only one nurse expressed a desire to return home to India. Susan, ambivalent from the very start about even becoming a nurse, moved to the US with the primary objective of completing her doctoral studies so that she could teach. The inability to achieve this goal was been a bitter disappointment leading to a general dissatisfaction with her life

here in the US. The other nurses all made significant progress in their careers and are proud of their accomplishments. Some continue to pursue educational and/or clinical challenges while others are satisfied with their current situation. Despite all the challenges, both professional and social, most of these nurses agreed that the migration was a positive move.

Comparisons to the existing literature on internationally educated nurses

Much of what this study revealed is supported by the existing literature. IENs from countries such as the Philippines, Africa, India and the Caribbean, working in Canada, Australia and the UK reveal that the process of transitioning into life and nursing practice in a foreign country is difficult with particular challenges in communication and adaptation to the nursing role. Communication difficulties are not restricted to merely English language fluency but also encompass nuances of communication related to accent, use of colloquialisms, and rules of engagement such as the ability to delegate. Adaptation to nursing role is influenced by the nursing practice differences between country of origin and the new country. Scope of practice issues, documentation concerns, technological skills and physical care of the patient are most cited as areas of difference (Alexis, et. al, 2007; Allan & Larsen, 2003; Daniel, et. al, 2001; Hagey et al., 2001; Omeri & Atkins, 2002; Sochan & Singh, 2007; Walters, 2008; Withers & Snowball, 2003). Similar findings have been obtained in studies of IENS in the US (Ea. et. al, 2008; Ibitayo, 2009; Kim-Godwin, et. al, 2010; Spangler, 1992; Vestal & Kautz, 2009; Xu et.al, 2008; Yi &

Jezewski, 2000). These findings are mirrored in this study as well. Given that all these studies examined the experiences of nurses from Asian and African countries to Western nations, it is clear that cultural differences between these worlds have an impact upon the work of international nurses.

Filipino, Chinese, and Korean nurses who migrate to the US share additional similarities with Indian nurses (Kim-Godwin, et. al, 2010; Spangler, 1992; Vestal & Kautz, 2009; Xu et.al, 2008; Yi & Jezewski, 2000). They are also surprised by the lack of family involvement in patient care and have similar difficulties with delegation, especially to ancillary personnel, as do the Indian nurses in this study (Spangler, 1992; Vestal & Kautz, 2009; Xu et.al, 2008; Yi & Jezewski, 2000). American patients and their families are perceived as being more needy and demanding than patients from their home countries (Spangler, 1992; Xu et.al, 2008; Yi & Jezewski, 2000).

One difference between this study and the existing literature is with reference to physician-nurse interactions. Doctor-nurse communication is often identified as difficult (Kim-Godwin, et. al, 2010; Spangler, 1992; Vestal & Kautz, 2009; Xu et.al, 2008; Yi & Jezewski, 2000). However, for the nurses in this study, while initially intimidating, nurse-physician interactions are perceived positively. The role of nurses as patient advocates and equal members in the healthcare team, allow for communication that is not fettered by hierarchical mandates. As one nurse put it, *“I would say it (communication) is more easier here because it is the job description of the nurse to give her input to the team members.”*

Another area of some difference relates to the issue of the devaluation of previous professional knowledge and skills by domestic RNs. This feeling was overwhelming echoed by IENs in the UK and Canada (Alexis, et. al, 2007; Allan & Larsen, 2003; O'Brien, 2007; Buchan, 2003; Hagey et. al, 2001; Omeri & Atkins, 2002; Sochan & Singh, 2007). The nurses in this study seemed to have varying experiences with this. On the one hand, they did feel that their previous experience was not counted when trying to seek employment in the US, as is the case of Elsy who could not get a job despite a decade of critical care experience in the Middle East and of Susie, who is unable to get a full time faculty position despite a successful academic career in India. On the other hand, they acknowledge that as new nurses, they have to be treated as such until they are able to do things the "American way".

Comparisons to existing literature on Indian nurses in the US

US research on internationally educated nurses has focused largely on Filipino nurses. Few studies have examined other populations of internationally educated nurses such as nurses from Korea and China. Some studies, examining the experiences of Asian IENs have included Indian nurses in their sample.

Edwards and Davis (2006) measured perceptions of clinical competency among 3,205 nurses who were in the process of meeting requirements prior to their possible migration to the US. About a third of their sample self-identified as Asian Indian, with a majority of the respondents believing that their education and work in their home country provided good preparation for their nursing careers in the US.

This was confirmed by the present study in which all participants credit their education for the confidence and ability to adapt to US nursing practice. This study further confirms that Edwards and Davis' finding that IENs have an interest in educational offerings in their American workplace that will enhance their learning.

The study, perhaps most similar to the current study, is Ryan's naturalistic inquiry examining the process of twelve IENs' adjustment to US healthcare systems (2010). Several of Ryan's findings were reflected in the current study as well. These findings included the following: a sense of loss of family and friends, doubting their decision to migrate, struggling with communication challenges, differences in nursing practice and differences in the culture of US healthcare. While this study was able to capture the experience of IENs in the US, it included only one Indian RN in the sample. The current study focuses exclusively on Indian nurses.

A phenomenological approach was used by Hegde & DiCicco-Bloom (2002) to answer the question, "How do South Asian nurses in the United States negotiate meanings about self in the multiple cultural contexts in which they live and work?" (p. 91). While this study used a similar methodology and participants included exclusively female nurses from Kerala, its aim was to examine the race and gender issues in transnational mobility. Thus, some of the findings of their study are mirrored by the findings of this study. For example, some participants in both studies faced family resistance regarding the choice of nursing as a career. Facing challenges at work and at home, participants in both studies questioned their decision to migrate to the US. However, Hegde & DiCicco-Bloom's study did not examine the specific

details of the participants' experiences as nurses. Their interest was to look at the workplace difficulties from a race and gender lens.

Another study that examines the lives of Keralan nurses in the US is Sheba George's ethnography (2005). This work looks at the role of gender and class in the migration and adjustment of female nurses from Kerala and their spouses. While this work describes some of the issues that immigrant nurses face –losses (of family, friends, domestic help and social status), upward mobility of nurses accompanied by downward mobility of their spouses, and the stigma that nurses experience in India – it does not describe the work of the nurses.

Jose et. al (2008) examined the demands placed by immigration upon 105 nurses from Kerala using a descriptive correlational methodology. This study examined the immigration experience as a whole rather than the experience of being a nurse in a different country in particular. Feelings of loss, dealing with unfamiliar routines, people and things and feelings of being treated differently are common to the participants in both studies.

What this study adds to the dialogue

Existing research has examined the socio-cultural and professional adjustments that IENs undergo in the US. Some research has also specifically examined some aspects of the experience of Indian nurses in the US. This is the first study that explores the experience of being a nurse in America from the perspective

of nurses from India, with a specific emphasis on the professional adjustments that must be made to become an American nurse.

This study confirms the numerous financial and professional benefits Indian nurses enjoy in the US. They are hesitant at first but soon become accomplished American nurses, seeking academic and clinical advancement. The extended role of American nursing is initially intimidating but later welcome as they develop into equal members of the healthcare team. The study brings to light the fact that Indian nurses are pleased to find that interactions with physicians are easier due to both relaxed hierarchical structures as well as the role of nurses in the US. At the same time, the relaxed hierarchy makes for difficulties in delegating to subordinates. Indian nurses are initially confounded by the legal issues that surround life and healthcare in the US but ultimately believe that greater vigilance leads to better practice, which is beneficial for patients. They agree that racism exists but choose to minimize it as part of their professional experience, preferring instead to focus on personal growth.

Thus, although many of the findings of this study mirror those of existing literature, this study confirms that Indian nurses have similar adjustment issues that other internationally educated nurses to the United States experience.

Implications

According to van Manen (1990) phenomenological questions seek to provide a deeper understanding of phenomenon rather than to problem solve. However, the findings in this study do offer some valuable implications for practice and research.

From a practice perspective, study findings may be helpful to both the organizations that hire Indian nurses and Indian nurses planning to migrate to the US. Nurse administrators and educators in the clinical setting should consider planning orientation programs that include and highlight the differences in practice between the US and India. Understanding that communication is a particular challenge, an orientation program for nurses from India that includes delegation skills and assertiveness training would be helpful. Detailed information about legal issues and training specific to patient advocacy and customer service will provide knowledge that is new to Indian nurses. Hospital equipment and computers need to be reviewed thoroughly as Indian nurses have varying levels of familiarity with technology.

The study findings are meant to provide bidirectional guidance. Not only do we learn about Indian nurses, but there is much to learn from the Indian nurses as well. This study allows us to understand the strengths that Indian nurses bring to nursing in the US, particularly to bedside nursing. This knowledge can assist administrators in placing Indian nurses more strategically within the organization. This knowledge also suggests that preceptors should teach Indian nurses new skills without minimizing their past experiences. Lastly, it is important for institutions, managers and co-workers to bear in mind that these IENs are undergoing several life

altering adjustments simultaneously. These extensive changes may have an impact, at least initially, on the professional lives of these nurses. Given time, they are likely to regain their confidence and this will be reflected in their performance at work.

Nurses who plan to migrate to the US from India can also learn from the findings of this study. The findings provide insight into the kinds of adjustments Indian nurses who migrate to the US can expect. As one nurse shared in her interview, preparation and expectations can define the experience. The stories of the nurses in this study serve to inform other nurses about what awaits them, allowing them to better prepare for the journey.

This study has implications for further research as well. Given the homogenous nature of the sample (i.e. all south Indian women), research including participants from other parts of India might bring to light regional differences. As more males enter nursing in India, a study including male nurses would allow us to see whether there are gender differences in the adjustment of Indian nurses to US nursing.

One issue that did not emerge in this study relates to the status of Indian nurses within Indian communities in the US. Does the stigma attached to nursing in India carry over to Indian communities here in the US? A research study that examines this issue might help address the recruitment issues related to nurses of Indian descent in America.

Lastly, it is important to remember that as our country's population changes, so must our country's nursing workforce. The American Association of the Colleges

of Nursing (2011) advocates a nursing workforce that mirrors our increasingly diverse population. Given that Asian Indians are a rapidly growing group in the US, it is hoped that Indian nurses will become a larger presence in our nursing workforce, allowing Indian patients to benefit from culturally and linguistically similar healthcare providers. This study provides a deeper understanding of issues relevant to Indian nurses and allows for the exploration of strategies to recruit and retain Indian nurses within the American workforce.

Chapter IX

REFLECTIONS

As a novice to research, I found qualitative research to be as much about the journey as the findings. In this chapter I share my reflections about the research process and some concluding thoughts about the journey I have been on. Also included is a section about some of the surprises I encountered.

Reflections on method

"Go back?" he thought. "No good at all! Go sideways? Impossible! Go forward? Only thing to do! On we go!" J. R. R. Tolkien (The Hobbit)

Throughout the research process, I was plagued by doubts. Should I have stayed in my comfort zone and done a quantitative study instead? I wanted the comfort of numbers. The time taken to conduct the interviews, transcribe them and then analyze data seemed interminable at times. The process itself left me confused, aggravated and unsure of myself on more than one occasion. I dreamed of hitting the analyze button in SPSS and seeing the order out of chaos! In the end though, I find myself glad for the road I took.

Interviews. The interviews were intense. The work of active listening is just that, work. I found myself exhausted after the interviews. The long drives to get to

my participants, sometimes in poor weather, made me anxious before I even got there. Then there was the awkwardness of meeting a person for the first time and setting ourselves at ease. I began to wonder whether it might have been easier to interview people whom I actually had a social relationship with! And then there was the listening. Prior to the first interview I believed that I could try and schedule more than one interview a day, if possible. However, I discovered rather quickly that was not feasible.

I found it very difficult to remain focused by the time the hour was done. I had too many thoughts shooting around my brain and was having trouble not interrupting the speaker. I can see why sixty minutes might be a good length. It is exhausting! (May 24, 2012)

Being completely open to the stories of the participant is also harder than it seems as first. Yes, I believed myself to be bracketing effectively and arriving to each interview ready to listen however on one occasion I caught myself actively not listening and allowing preconceptions to guide my responses. The first interview with the fourth participant I remember quite clearly:

I am interviewing her and the first interview is going kind of slow. She seems hesitant to talk, and needs a lot help answering questions. Her answers are short and I feel like I am asking her only close-ended questions, making the situation even worse. I am annoyed: doesn't she know that she agreed to talk to me? Why isn't she answering questions more completely? Then I realize that she is telling me her story. I am not listening. I am waiting to hear the

things I expect to hear or want to hear. When I didn't get that, I stopped listening. Once I realized that, I started to pay attention again: I mean really listen, not just say "uh-huh" in the appropriate spots. That's when I really began to see her story, her life and her experiences. Either she got more relaxed and was revealing more or I became more open and was listening more. Either way, the dynamic changed and I swear I could sense the exact moment when we both settled into the interview. (June 28, 2012)

One eventuality that I was not prepared for was having a negative reaction to what a participant was sharing. This is what I noted after that first interview with one of the participants:

Listening to her was annoying. There. It is out there. She tried my patience. She made me want to smack her...She is having a terrible time here. I think that she hasn't been able to give up her fantasy of the perfect world she left behind. Dealing with the real America was not part of her plan...I guess part of me wants to say to her, buck up, get over it! We all went through it, why can't you? (August 2, 2012)

I had to struggle with my feelings. I had to address the fact that I dislike women who paint themselves as victims of circumstance. I have struggled so hard not to accept the status quo in my life. When women seem to do so, I find it difficult to understand them and worse, don't have the desire to do so. I understood immediately that I needed to acknowledge and overcome this.

Further, I realized that perhaps the nurse needed to do this interview because it gave her a safe avenue to verbalize her feelings and give meaning to her experiences. Seidman (2006) talks about the “meaning-making experience” of stories. In choosing the details that people share about their lives, they are reflecting on their experiences and trying to make sense of them. This is what she had chosen to do by telling me her story. She was, in essence, trying to come to terms with an obviously difficult time in her life.

Once again, as soon as I was able to re contextualize the way I approached the interview, I was able to open up to the interview process and accept what she had to share. After her second interview I discovered that she confirmed many of the experiences that the other participants shared and that she added valuable insight to the findings. I also have a sense that the recounting of her life story has allowed her to move forward in some ways. Recounting your story to someone else may be the catalyst that provides clarity amidst chaos. I received a phone call from another participant that validated the interview process and the meaning it can have for the participant. This is what I wrote about it:

The best moment. Vincy spoke with me over the phone...She said that talking about it all made her think about where she had come from and where she needed to go. It was the highest compliment she could have paid me. It is personal validation and so much more. The interview process works! She thought deeply about her responses, reflected about what she had experienced

and shared with me things that were of meaning to her. I am getting teary-eyed thinking about it. (November 16, 2012)

On Writing. Writing is the essential element of qualitative research. There is the writing of logs, reflections, and memos. There is transcription and coding. And then of course there is the writing of findings. I have prided myself on being a good writer. I am able to synthesize material rather quickly. Writing academic papers has never been problematic for me. This was not the case for this study. Initially I found that words came begrudgingly, like coins from a miser's purse. I needed to coax them out, tease them out and force them onto paper. In retrospect I understand where that initial hesitance came from. It was borne out of doubt. Words have power and I did not want to wield my power unfairly or unwisely. The words I chose would represent what it means for the participants to be nurses in America. I recalled what van Manen (1990) said about the interpretive nature of hermeneutic phenomenology. According to him, the words used to describe phenomenon reflect the storyteller's decision to represent or interpret the phenomenon in a certain way. Capturing lived experience via stories implies an interpretation of the experience by the storyteller in the words he/she uses to describe that experience. With the iterative process of coding, I began to see their stories very clearly. Their stories emerged. Their voices began to play out in the themes that developed. The words began to flow. Scrooge had arrived at Christmas morning.

What surprised me

Given my personal experience with migration, I did have some notion about what their initial experiences in America would entail. There is also ample evidence in the literature to support their stories. But there were some surprises along the way.

Prior to this study I had little knowledge about nursing education in India. Given the stigma attached to nursing, nurses' lack of social status and their poor working conditions, I was surprised to find that students struggled for entry into nursing programs, especially a baccalaureate nursing program. I now know that this is related to the relative paucity of nursing programs in India, although this is changing given the proliferation of nurse migration (Khadria, 2007).

Another surprise related to the issue of education is the complete confidence and pride all the participants had in their nursing education in India. They described the rigor of the program both in terms of the discipline it instilled in them as well as the knowledge they gained. Having studied in India, I had no doubt that they would have been required to learn massive amounts of information. I was surprised that despite the more restrictive role of nurses in India, that these nurses felt adequately prepared for their nursing roles here in the US. I was convinced that Davis and Nichols' finding that Indian nurses overwhelming felt prepared to work in America was a result of those nurses never actually having practiced in the US. It was my supposition that had they worked here, they would realize that their confidence was misplaced. In fact, I was wrong. One of the participants put it into perspective for me.

According to her, the discipline and intensity required to complete nursing school in India prepared her for further learning experiences, however difficult they might be.

I was also surprised that four out of the six participants had initially sought admission into a medical school. I see nursing and medicine as two wholly different careers, involving very different paths, so it is inconceivable to me that someone who was unable to become a doctor would automatically opt for nursing. This could well be because my own nursing education occurred in the US, giving me a different perspective on nursing and medicine.

I was surprised at the high level of achievement orientation that these participants possessed. Four out of the six seized the opportunities provided to them for higher study and APN roles, with one waiting for greater financial stability before returning to school. It could be a function of my sample although anecdotally I can say that a show-of-hands at the biennial national convention of the National Association of Indian nurses in America, indicated a large percentage of Masters and doctorally prepared Indian nurses, indicating that this is a group that values achievement and education and is likely to strive for both given the opportunity to do so.

Personal note

At the very start of this project I had asked myself several questions. What is this journey like for other immigrants? Are their experiences similar to mine? Will listening to their stories add meaning to my own? I believe that at journey's end I

have an answer to all these questions. The journey for immigrants is scary and exhilarating, anxiety-provoking and liberating, terrible and wonderful. Each of us has our own blend of emotions and experiences as we adjust to life in a new and radically different cultural milieu. We share many similar experiences but each of us has distinct and novel events that make each of our experiences unique to us alone. And, yes, listening to others' stories, did add meaning to my own. I hope that immigrant nurses who read this study find, in the voices of my participants, a little bit of themselves, and that through their stories, other Indian nurses can find meaning in their own.

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Appendix A

RECRUITMENT FLYER

ATTENTION INDIAN NURSES!

Did you begin your nursing career in India?

Have you been a practicing RN in the US for at least one year?

I am interested in your experiences of being a nurse in India and in the US.

If you would like to share your experiences or get more information about my study, please contact me, Munira Wells, at muniwells@gmail.com

Munira Wells, MSN, RN is a doctoral candidate at the College of Nursing, Seton Hall University, South Orange, NJ.

Appendix B

INTERVIEW GUIDE

Interview One

Tell me about your life in India. How did you decide to become a nurse?

Describe your life as a nurse in India.

Can you tell me what a typical day at work was like?

Interview Two

Tell me what it was like when you first came to the United States.

Describe your experiences as a nurse in the US.

How do your experiences when you first arrived compare to your experiences now?

Interview Three

Looking back on your experiences, is there anything you would do differently?

Is there anything else you would like to share with me?

Appendix C

LETTER OF SOLICITATION

I am a doctoral student at the College of Nursing, Seton Hall University, New Jersey. I am recruiting participants for a research study.

The purpose of my research study is to examine the experiences of nurses from India who are currently practicing as registered nurses in the US.

Participation in this study will involve two, perhaps three face-to-face interviews, each lasting approximately 60 minutes. All interviews will be audio taped and transcribed verbatim. The interviews will take place at a place that is mutually convenient for the participant and researcher. This place cannot be the participants' workplace.

In order to participate in this study you must be a registered nurse who meets the following criteria and are willing to share your experiences in interviews with me:

- You have received your basic nursing education in India
- You have practiced as a nurse in India for at least one year
- You have been a registered nurse in the US for at least one year
- You are a registered nurse in current practice in the US

During the interviews you will be asked to describe your experiences as a nurse in India as well as in the United States. Broad questions will be asked such as "Tell me about your life in India. How did you decide to become a nurse? Describe your experiences as a nurse in the US". Additional questions will depend upon your responses during the actual interviews.

Participation is completely voluntary. You may choose to withdraw from the study at anytime without penalty.

Although participants will not be anonymous to me, your name will be changed so that you will be anonymous to everyone but me. Participants' real names will not be connected to the data and will only be known to me.

Information about your identity will be kept completely confidential. Although some identifying information such as participants' names and contact information will be collected, you will not be mentioned by real name in the research materials. There will be one master list that connects you to the alias assigned to you for the purpose of this study. This master list will be kept in a lock box separate from all other research material. Only the researcher will have access to this lock box.

All data (audiotapes and written material) will be kept in a lock box in the researcher's home. Electronic data will be stored on compact discs or USB memory keys as needed. All research related materials will be kept in the researcher's possession for at least three years after the completion of the project. All written material will be discarded by shredding prior to disposal.

If you are interested in participating or you have any questions about the study please reach Munira Wells, MSN, RN, at munira.wells@shu.edu or at 973-761-9266.

Appendix D

INFORMED CONSENT

Researcher and Affiliation

Munira Wells, M.S.N., R.N., a doctoral candidate at the College of Nursing, Seton Hall University. She is conducting a study entitled: "Experiences of Indian nurses in the United States. "

Purpose of the Study

The purpose of this research study is to understand the experiences of Indian nurses working in America. The researcher seeks to gain an understanding of what it means to practice nursing in America from the perspective of nurses who have practiced nursing in India and are now practicing in the US.

Procedure and duration of the study

Participants will participate in two, perhaps three, face-to-face interviews. During these interviews the researcher will ask participants to describe their experiences as a nurse in India as well as in the United States. Each interview will last approximately 60 minutes. The third interview, if necessary, will be determined when the first two interviews are completed.

The interviews will take place at a location that offers privacy so that the participant can describe life experiences without interruption. Participants will select a location that will be mutually convenient for both parties.

Interviews

The researcher will conduct the interviews. Broad questions will be asked such as "Tell me about your life in India. How did you decide to become a nurse? Tell me what it was like when you first came to the United States". Additional questions will depend upon what participants' share during the actual interviews.

Audio Tapes

All interviews will be audiotaped. Audiotaping will allow the researcher to accurately document participants' words during the interviews. It will also allow the researcher to study the content of the interviews at a later time during the study. The participants will not be anonymous to the researcher but names will be changed to preserve anonymity to others. Each participant will be assigned a fictitious name that will be used to identify and label any material associated with that participant. Only the researcher will have access to the audiotapes. The researcher will listen to and transcribe all audiotapes verbatim. Audiotapes and the accompanying transcripts will be stored in a locked filing cabinet, in the researcher's home. Only the researcher will have the key to the filing cabinet. All materials related to the research including

audiotapes will be kept for at least three years after the study ends.

Voluntary Nature of Participation

Participation is completely voluntary. You may choose to decline participation and/or withdraw from participation at anytime during the research study. There will be no penalty for doing so.

Anonymity

In order to ensure that no one will be able to link data to any individual, participants will not be identified by name on any of the audio recordings or transcripts. Previously assigned aliases will be used to identify participant data. These aliases will be used to report study findings.

Confidentiality

Information about participants' identities will be kept completely confidential. Although some identifying information such as participants' names and contact information will be collected, participants' names will not be connected to any of the research materials. Participants will not be mentioned by real names in the research materials. There will be one master list that connects each participant to the alias assigned to them for the purpose of this study. This master list will be kept in a lock box separate from all other research material. Only the researcher will have access to this lock box. All research material will be stored on a compact disc and/or a memory key. These will be kept in a lock box at the researcher's home.

Access to research records

Research material will be accessible to the researcher and the researcher's Dissertation Committee members only. In the event that research data is presented in publication or at conferences, no identifying information about the participants will be used.

Risks or Discomforts

There are no foreseeable risks to the participants. It is possible that participants may become distressed during the recounting of their experiences. If this should occur, participants may choose to suspend the interview until they regain their equilibrium or they could terminate the interview entirely.

Benefits of the Study

From a personal standpoint, participation will provide an opportunity for reflection, which may bring the participants a deeper insight and meaning to their experiences. From a research perspective, participation will provide a truer understanding of what it means for a nurse from India to practice nursing in America and could assist in the development of programs that aid transition of Indian nurses to practice in the United States.

Compensation

There is no compensation or payment for participating in this study.

Injury

Participation in this study is not expected to cause any physical or psychological harm requiring professional assistance.

Alternative procedures/ treatments

N/A

Contact Information

Researcher/ Principal investigator: Munira Wells, M.S.N., R.N. The researcher may be contacted by e-mail at Munira.Wells@shu.edu. A message may also be left at (973) 761-9273.

Dissertation Committee Chairperson: Dr. Judith Lothian, R.N., Ph.D. She may be contacted at 973-761-9273, or via e-mail at Judith.Lothian@shu.edu

Director of the Institutional Review Board at Seton Hall University: Dr. Mary F. Ruzicka, Ph.D. She may be contacted at (973) 313-6314.

Copy of Informed Consent

A signed and dated copy of the Informed Consent form will be given to each participant before the first interview.

Participants may request a copy of the research findings upon completion of the study.

Name (please print)

Signature

Date _____