

Adaptation and Transformation Through (Un)Learning Lived Experiences of Immigrant Chinese Nurses in US Healthcare Environment

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This phenomenological study examined the lived experiences of Chinese nurses working in the US healthcare environment. In-depth interviews with 9 self-identified Chinese nurses were conducted in English and transcribed verbatim. Using Colaizzi's (In: Valle RS, King M, eds. *Existential-Phenomenological Alternatives for Psychology*. New York: Oxford University Press; 1978:48-71) 7-step procedure, the narrative data were independently analyzed by a team of researchers. Five primary themes emerged from the data: (a) communication as the most daunting challenge, especially during initial transition of their first job; (b) different and even conflicting professional values and roles/expectations of the nurse between the United States and China; (c) marginalization, inequality, and discrimination; (d) transformation through clinging to hope, (un)learning, and resilience; and (e) cultural dissonance. To a large extent, this study supported the findings in the general literature on international nurses, especially those from Asia. It also documented the uniqueness of this group of Chinese nurses, namely their ingenuity to turn challenges into opportunities, their high-level job satisfaction in spite of adversity, their desire for learning and execution of strategic plans for performance and career enhancement through further education, and their proactive measures to adapt to workplace demands. In addition, this study revealed both real and potential risks to patient safety and quality of care during the transition of these Chinese nurses. In light of these findings, implications for both practice and future research are elaborated, particularly in the context of the accreditation standards of healthcare organizations and national agenda for patient safety research. **Key words:** *Chinese nurse, lived experiences, patient safety, phenomenology, quality of care*

MIGRATION of nurses is an international phenomenon.¹⁻³ In 2004, internationally educated nurses constituted 3.5% of the estimated 2.9 million US nurse workforce.⁴

However, other studies^{1,5} suggested much higher proportions, ranging from 12% to 15.2%, depending on how "international nurse" was defined and what database and methods were used. Migration of Chinese nurses to the United States is a post-Mao phenomenon after the policy of "opening to the outside world" was adopted in 1978 under Deng Xiaoping.⁶ Before that, Chinese nurses from Taiwan and Hong Kong had been migrating for some time. Modeling after the Philippines, China has adopted "training for export" as a national development policy regarding technical personnel, including nurses.⁷ This is a direct response to an increasing need for foreign exchange to fuel a booming economy, but more importantly, to a

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growing employment pressure from a *relative* surplus of nurses who are unemployed or underemployed, especially in urban areas. On the other hand, US healthcare employers and recruitment agencies have attempted both direct and indirect recruiting in China, with less than expected success primarily due to the general English language disadvantage and deficiency of Chinese nurses, as well as the convoluted visa process.^{6,7}

In 2004, 51 Chinese nurses came to California on tourist visas, marking the first time of an organized migration of nurses from China to the United States. Many managed to stay and work in local healthcare agencies after passing the National Council of Licensure Examination for Registered Nurses (Y. Ping, written communication, November 22, 2004). Since the Commission on Graduates of Foreign Nursing Schools (CGFNS) opened a testing center in Beijing in 2003, about 1500 Chinese nurses have taken the CGFNS certificate examination (B. Nichols, personal communication, August 6, 2007). However, the exact number of Chinese nurses migrating to the United States through CGFNS and other channels is unknown.

This study examines the lived experiences of a group of Chinese nurses working in the US healthcare environment. In light of the study's findings, implications for both practice and future research are elaborated, particularly in the context of accreditation standards for healthcare organizations and the national strategic plan and agenda for patient safety research. To the authors' knowledge, this study is the first of its kind on Chinese nurses, thus making a contribution to a growing knowledge base on international nurses.

REVIEW OF THE LITERATURE

Systematic searches through CINAHL, MEDLINE, ERIC, PsychInfo, ProQuest, and Scopus generated no studies focusing on the lived experiences of Chinese nurses working in foreign countries, using "China" or "Chinese" and "nurses" as search terms.

Although one study on 12 international nurses included Chinese nurses, its focus was on their experiences to obtain licensure in Ontario, Canada.⁸ The absence of research on the working experiences of Chinese nurses indicates a gap in the knowledge base concerning this subgroup of international nurses.

However, there is a growing body of literature on the lived experiences of international nurses working in foreign countries—Australia,⁹⁻¹¹ Canada,^{8,12,13} Iceland,¹⁴ Ireland,¹⁵ United Kingdom,¹⁶⁻²³ and the United States.²⁴⁻³¹ These studies focused on Asian and/or black nurses, although nurses from Western countries were also part of the samples in some studies. This picture was not surprising because nurses from Asian countries such as the Philippines and India, and black nurses from Africa and the Caribbean make up the vast majority of international nurses.¹⁻³ Of particular relevance are 3 systemic reviews³²⁻³⁴ and 1 metasynthesis³⁵ of studies on the experiences of black nurses from both Africa and the Caribbean, as well as immigrant Asian nurses. The major findings of these studies, including the 4 metastudies, are synthesized here.

Communication difficulty

Almost all of the studies documented the challenge of communication for international nurses and suggested it as the primary cause for a plethora of derivative issues both at work and in daily life. This challenge originated not only from the inadequacy of language preparation and the lack of knowledge regarding the host country's culture but also from the unfamiliarity with the slang, accent, and other language nuances.^{18,26,29} This challenge was particularly acute with telecommunication where nonverbal cues were absent. Language deficiency also impeded the ability of international nurses to advocate for their patients and speak for themselves.^{18,29} Yet learning to speak in the ways of native speakers was perceived as a positive indicator of adaptation.²⁶ Moreover, accent and language inadequacy affected negatively the

perception of the competence of international nurses by patients, peers, and supervisors, and was used as a convenient vehicle for mistreatment and discrimination.^{11-13,16-19} Lastly, language was frequently an area of contention and conflict between international nurses and host country nursing staff when the former was found to speak their indigenous languages at the workplace.^{27,28}

Differences in nursing practice

Differences in nursing practice include the role of the nurse, scope of practice, legal environment and requirement for accountability, use of more advanced healthcare technology, and the relationships between nurse and physician. For instance, providing activities of daily living (ADLs) such as bathing and feeding to patients was perceived by Asian nurses as deskilling^{18,21} and a waste of their education.²⁹ Also, they were physically challenged at providing ADLs and were emotionally frustrated at the norm that Western families were not involved in these activities.^{18,20,22,29} In addition, many international nurses were not accustomed to the legality and amount of time accorded to nursing documentation in Western healthcare systems.^{18,29} Some of these clinical differences are also, directly or indirectly, related to patient safety and quality of care.

Injustice and racism

Because of race, gender, culture, and language, international nurses encountered marginalization and lack of support from peers, supervisors, and employers. They also experienced unfair treatment and widespread racism, including stereotyping and rejection by patients and peers. Other times, such injustice was overt and outright, such as sexual harassment and bullying, being given the “worst” patient assignments and most undesirable shifts, being passed over for promotion and educational opportunities, and being paid for a lower position while performing duties of a higher one.^{11,18,19,28,30,31} Consequently, the feeling of otherness was common, which

negatively impacted their work performance and integration into the workforce. This perceived injustice was compounded by language difficulties in expressing themselves and advocating for their rights. In extreme cases, international nurses had to resort to legal actions against discrimination.^{12,13,28}

Cultural adjustment

Working and living in another country also presented cultural challenges to international nurses, which was likened to “cultural uprooting”—the perception and feeling of “a foot here, a foot there, a foot nowhere.”^{31(p28)} Cultural displacement ranged from learning new spending habits, such as buying on credit, to being challenged by the reality in host countries, such as interpersonal conflicts due to differences in culture-based values, norms, and assumptions. For example, Filipino nurses were not accustomed to calling patients by their first names; using “honey,” “darling,” or other colloquialisms to address their clients; or the “loose moral” (ie, permeation of sexual messages in mass media) in the United States.²⁵⁻²⁷ Moreover, they perceived the institutionalization of older parents as abandonment by their families and as a social vice. Conversely, Asian nurses were used to hierarchy and hard work. They were resentful if their subordinates were confrontational and rebellious, and perceived having to ask subordinates to do their jobs as an indication of a lack of good work ethics.^{25,29}

It was only until very recently that serious questions of patient safety and quality of care were raised in the literature on international nurses, given the national focus on patient safety following the Institute of Medicine’s report *To Err Is Human* in 1999.³⁶ The threat to patient safety and quality of care arose from a host of sources: language/communication difficulty; different expectations of the nurse and nursing training; different cultural values and behavioral patterns; and different healthcare systems, policies, and procedures, among other factors. However, language and communication deficit was believed to be the leading cause. For instance, the threat to

patient care due to communication inadequacy was implicated in Yi's study²⁹ when a Korean nurse was too frightened to ask questions. Similarly, Davis and Nichols³⁷ and Brush et al³⁸ raised the quality of care issue regarding foreign-trained nurses. Most recently, Xu³⁵ reframed this issue as a risk to patient safety and quality of care in the current US health-care context. This is a subject that deserves both public attention and scholarly inquiry. However, this area is grossly understudied.

METHODS

Study design and sample

Phenomenology was the research design for this study. Phenomenology is a philosophical tradition developed by Husserl and Heidegger. As a philosophy, phenomenologists are interested in knowing the essence of a given phenomenon, with the assumption that it has an essential invariant structure.³⁹ Phenomenology is also a research method grounded in this philosophic tradition. Phenomenologists "investigate subjective phenomena in the belief that critical truths about reality are grounded in people's experiences."^{39(p214)} Because a phenomenological inquiry intends to understand and interpret the meanings of the lived world through the eyes of informants, understanding rather than generalization is the primary purpose. As a qualitative research method, specific procedures of this inquiry have been advanced by such scholars as Colaizzi,⁴⁰ Giorgi,⁴¹ van Manen,⁴² and others.

A purposeful sample of 9 nurses in the northeastern US participated in the study. They were recruited by word of mouth and referral. No incentives were offered for participation. The central research question of this study was: *What are the lived experiences of this group of Chinese nurses working in the US healthcare environment?* Typical opening and probing questions were: *Could you tell me your experience of working as a foreign nurse in the United States?* and *What made you choose nursing?* The only inclusion criterion was that participants

must be working as registered nurse clinicians and identify themselves as ethnic Chinese, whether they originally came from Mainland China, Hong Kong, or Taiwan.

Data collection and analysis procedures

The study was approved by the primary investigator's institutional review board. After consent was obtained, an in-depth audio-taped interview was conducted in English with each nurse at the place of her choice. Each interview lasted from 45 to 90 minutes. Following each interview, a demographic information sheet was completed.

Once the interviews were transcribed verbatim, the research team members performed independent data analysis according to the 7-step procedures established by Colaizzi,⁴⁰ namely (a) reading all interview data; (b) extracting significant statements; (c) formulating meanings; (d) organizing aggregated meanings into themes; (e) integrating study findings; (f) formulating the description of investigated phenomenon; and (g) validating findings via member check. Essentially, the data analysis process involved: immersion in the interview data through reading and reflecting until an overall understanding was achieved; identifying significant statements and emerging meanings/themes; and arriving at coherent and consistent interpretations by resolving discrepancies among team members through discussion.

Measures to ensure trustworthiness of data

Several steps to safeguard data credibility were undertaken as indicated by Pilot et al.³⁹ First, "investigator triangulation" was used among the 3-member research team. Specifically, besides the primary investigator, both a Hispanic male research associate versed in qualitative research yet who had no prior knowledge of this study or any nursing experience, and a female Caucasian nursing graduate assistant who had some direct experiences with international nurses, conducted independent data analysis and interpretation.

Second, "bracketing" was undertaken in an effort to make the researchers aware of pre-conceived notions regarding Chinese nurses working in the United States. This was important because the primary author shared cultural and educational backgrounds and work experiences with the participants. Specifically, the following measures were taken during the interview process: (a) efforts were made to ask neutral questions and (b) the focus was to verify, clarify, and amplify instead of putting words into interviewees' mouths. During the data analysis stage, each research team member remained open-minded by listening to and challenging each other's interpretation of the data. Consensus was sought through discussion whenever discrepancies arose. Third, "intuiting" (ie, remaining open-minded) was retained during both the interview and data analysis. Fourth, "member check" was carried out whereby research findings were sent back to the participants for validation. Lastly, an "audit trail" (ie, records of decisions, field notes, and research team discussions) was maintained.

RESULTS

Demographics of sample

The final sample of informants included 9 Chinese nurses working in Connecticut and Massachusetts: 7 from Mainland China and 2 from Taiwan. All informants were women, with an average age of 40.4 (range = 32–51) years. The mean time of living in the United States was 12.7 (range = 7–20) years, and the average time of working as a registered nurse in the United States was 7.3 (range = 1–17) years. Regarding basic nursing education, 3 informants graduated from US associate degree programs, 3 from baccalaureate degree programs (2 in Taiwan and 1 in the United States), and 3 from secondary-level nursing programs in China and Taiwan (ie, nursing programs that admit graduates of junior high schools). The highest nursing degrees obtained by the informants were 2 associate, 5 baccalaureate, and 2 master's degrees. All of the informants worked in hospitals except 1 who was

employed in a nursing home at the time of this study. Regarding their current positions, 5 worked as staff nurses, 3 as clinical leaders (ie, advanced clinical nurses who served as resource nurses on the unit because of recognized clinical expertise), and 1 as a supervisor. In terms of their jobs before their arrival in the United States, 4 worked as nurses, 2 as teachers, 1 as a computer software engineer, 1 as a secretary, and 1 as a physician.

Emerging themes

Five competing themes emerged from the collected data. These themes are presented in the order of significance to the transition and adaptation of the participants as determined by the research team. In addition, chronological sequence and specificity-generality order are taken into account.

Theme 1: Initially, Chinese nurses experienced paralyzing emotions of communication inadequacy that affected both their work and daily life.

The obtained data suggested that communication was the first and foremost transition and adaptation issue and a daunting challenge to the Chinese nurses, especially during the first few months of their initial job. They felt frustrated, embarrassed, stupid, and fearful because of their communication deficiency. The communication challenge arose from a number of sources: language deficiency; unfamiliarity with English medical terminologies, slang, accent, and colloquial English; and lack of knowledge concerning American culture such as name brands, popular music, and sports. Communication was particularly challenging over the telephone. Consequently, language barrier was a severe constraint on "what you can hear, what you can speak, and how much you can explain."

A number of the Chinese nurses found it stressful to communicate with patients and families of diverse backgrounds, particularly when they could not get their ideas across or when the patients and families talked about matters beyond healthcare issues. Such situations were embarrassing and humiliating. One nurse found it psychologically painful

when physicians and coworkers failed to understand her after repeated efforts, but even more so when this situation occurred with her patients: "It is pretty hurtful because they cannot just get it." More importantly, the communication barrier was recognized as a patient safety issue when obtaining verbal orders from physicians and communicating with pharmacists: "When they order medications you don't know or are unsure about the spelling from the phone order, you need the right spelling so the pharmacist can give the right medication for patient safety."

In addition, the language and communication deficit made the Chinese nurses an easy scapegoat when things did not go well, influenced their employability, and affected their ability and comfort level to mingle with their American peers, to ask for assistance, to advocate for their patients, and to speak up for themselves when necessary. Improving language skill was also the most frequently mentioned advice the Chinese nurses gave to their newly arrived Chinese peers or those who wanted to come from China to work in the United States.

When your language cannot communicate better, you are the easy one to pick.

I was nervous because [of] the doctor's attitude. [The] doctor was directly picking on my language. But at first I didn't know where to complain, and then second, I didn't know how.

Theme 2: The diametrically different and often conflicting professional values, roles, and expectations of the nurse between China and the United States caused the Chinese nurses to directly compare the healthcare systems, including nursing, in the 2 countries.

The Chinese nurses noted significant differences in nursing between China and the United States. Nursing was perceived as commanding a much higher socioeconomic status, prestige, and respect in the United States because it was regarded as a profession that required independent clinical judgment with considerable autonomy and abundant opportunities as a *career*. In addition, it is the nurse who is responsible for coordinating

care among healthcare team members to achieve the best patient outcomes. In contrast, nursing in China was perceived by the public as a dead-end, no-challenge *job* that required little formal education/training, and nurses were best characterized as physicians' handmaids with no "brains." Consequently, these Chinese nurses did not enjoy working as a nurse in China and, in fact, were ashamed.

I just wanted to switch job [in China] because they don't think you are a professional. They think the nurse is just a kind of person to wash people, to put the bedpan on patients. And you come in contact with peoples' body waste almost every day. It is a dirty job.

The reason [why I didn't like to be a nurse in China] is because you didn't get enough respect.

Nursing is rewarding because in this country nurses are so much involved in decision making about patient care than in China. In China you mostly did tasks. Here you do a lot of analysis, interpret lab results and give advice to the physician. And you deal with patients and family from social aspect, spiritual aspect, and clinical aspect. You feel like you are somebody.

Also, clinical expectations were different. Independent clinical judgment backed up by critical thinking was one of the core expectations in American nursing. However, different care delivery models and staffing patterns reduced the need for critical thinking, thus presenting a challenge for Chinese nurses. Activities of daily living were another area of contention. Whereas ADLs were primarily performed by families who were at the bedside round the clock in China, these activities were the responsibilities of the nursing staff in the United States. Such "added" duties made nursing physically demanding. The increased acuity and the much higher proportions of obese American patients rendered ADLs even more exhausting.

Everybody thinks that as a nurse you only do what the doctor wants you to do; you don't have your own judgment. They [Chinese nurses] don't have a brain.

For the family, I think they all depend on the hospital personnel to take care of the patient. But back

in my country the family involved a lot; they do a lot of bedside care. But here, family doesn't want to get involved. I think that is a big difference.

Differences in values and beliefs regarding patient care in the 2 countries were also noted by the Chinese nurses. The difficulty to adapt to American nursing practices was further compounded by differences in healthcare systems and policies governing nursing practice. Patient-centered care was the philosophy of American healthcare, including nursing. This consumer-centered approach was not only emphasized in the mission and philosophy of healthcare agencies but also embodied in the daily actions of employees. Similarly, patient rights were respected and honored. In addition, patient education assumed a prominent role in the American nursing practice. The goal of nursing care was for patients to achieve independence at their earliest possible time. In contrast, consumerism was less prevalent and patient rights were not honored to the same extent in China. Interestingly, Chinese patients were allowed to regress developmentally during hospitalization.

I think patient teaching is emphasized here. And patient here is much more independent than back home. [For] Oriental people, [if] one family member gets sick the whole family is mobilized. They just treat the sick like a baby and don't want him or her to do anything.

Another area of difference was the nurse-physician relationship. In China, physicians worked side by side with nurses, handling patient medical treatment and crises. This staffing pattern made the nurse-physician relationship more like that of colleagues and less hierarchical. However, it also rendered nursing practice less autonomous, ultimately hurting nursing's public image and affecting its development as a profession and discipline.

Lastly, although not many clinical variations in procedures and skills were noted, the Chinese nurses revealed that their American peers functioned much more independently and were responsible for their own actions (and inactions). This was believed to have contributed to nursing's professional

status and nurses' job satisfaction in the United States. Such professional expectations underscored by critical thinking posed a formidable challenge to the Chinese nurses, especially during the initial months, because nurses in China had minimal expectations of independent clinical judgment.

Theme 3: Chinese nurses experienced marginalization, inequality, and discrimination, which perpetuated and amplified their perception of "otherness" based on race, culture, and language.

The Chinese nurses were plagued by loneliness in a workplace where no one truly understood their daily nightmares. Especially at the outset, the fear and distress from their desolation undermined their confidence, often crippling their performance in the workplace.

In the beginning some people didn't understand how hard [it] was [for me]. I was very nervous and I didn't want to make medical errors. Patients were asking for their medications at the same time and I would get distracted constantly. And I didn't have that much self-confidence. I needed to check the order several times before I really gave the medication. That made me slower than other people. . . . I tried to be careful, I tried the best I could, but I still made one or two errors. . . . I felt kind of isolated; I felt uncomfortable. I was working in Hell!

Lack of knowledge of the American culture and society also affected their ability to relate to their peers, which in turn, contributed to their sense of not belonging during the initial period. For example, the Chinese nurses indicated that they had trouble joining a conversation when it came to sports, popular music, or other social situations such as baby showers: "You feel you are different than your co-workers because you don't understand their daily life. And you couldn't really chat with them unless you talk about medical problems."

Moreover, the "otherness" afflicting these nurses also brought about painful feelings of alienation and lack of trust in the workplace. One nurse explained what happened on a snow storm night when the off-going nursing staff decided to sleep over on the unit: "They [American nurses] didn't invite you. 'You can

go home, we don't need you,' they told you. I didn't feel good. I don't know this kind of feeling . . . I can't describe [it]."

Furthermore, the Chinese nurses were sometimes frustrated at their subordinates because of their disobedience and apathy, because some American nursing staff could not or refused to work at their Chinese colleagues' level of standards and conscientiousness. These dilemmas intensified their feeling of loneliness because their American coworkers did not understand their work ethic and cultural upbringing, which in turn, led the American nurses, consciously or unconsciously, to alienate them.

For some [personal care assistants] they try to slide over their work. They didn't do their job and I had to cover them. This made you feel frustrated because they get paid to do their job.

You ask them [personal care assistants] to get this and that done. The person does not answer you and is sitting there doing whatever they were doing. They even don't talk—no response.

The Chinese nurses perceived that some patients were questioning their competence, although the patients acknowledged that they were experienced. They had to make additional efforts to prove themselves, which resulted in the perception of prejudice and discrimination.

I have to pull out the medications and explain every single one—what's the name, what for, what side effect. One day, the patient finally asked me, "Why you always do this? None of the other nurses do this." I gradually built up the habit because I've been challenged so many times.

At times during their daily work, the Chinese nurses were tormented and disgraced. Whether verbally or behaviorally, Americans, including patients, nurses, and supervisors, discriminated against "foreign" nurses. The prejudice and discrimination were manifested via unfair treatment and baseless remarks predicated on ignorance and bigotry. As a result, the Chinese nurses felt emotionally hurt and psychologically traumatized.

"You again? Where are those White nurses?" As a foreign nurse, we have to prove ourselves.

But in the beginning the nurse manager did something that really made me feel kind of disgrace. I made a med error. She told me that, "You got to be careful! You work for the United States!" But some other people made med errors almost every week. They were U.S. nurses; she didn't say anything. On another occasion, my Ukraine patient refused to take his medications. This manager said there was a war between China and Ukraine. She was suspicious that I abused my patient or did something that caused my patient to refuse his meds.

Theme 4: By clinging to hope and adapting through (un)learning and resilience, the Chinese nurses transformed into competent professional nurses and clinical experts, enjoyed their work, and pursued their career dreams.

Despite the seemingly insurmountable odds, the Chinese nurses remained hopeful and determined. They demonstrated dedication and resourcefulness to prevail at their chosen profession, converting ongoing negativity into opportunities. For example, by learning the English language and American culture, and by improving their clinical competencies, they compensated for the perceived loss of control over their environment and deflected negativity effectively. Once overcoming the transitional difficulties, they began to see the world around them in a different light, which in turn, affected the perception of their peers positively.

If I want to live in the U.S., I know I can't always [meet] nice people. So I got to be strong; I got to be tough; I got to overcome all the problems. Language is a big barrier, but you got to face it. You got to fit in with the rest and stand up for yourself. I think if you can survive in your working place you will also be happy in being here.

I think a lot of learning depends on yourself. If you find something you don't know, write it down, and then you come back to review. Because medicine is changing everyday you need to attend continuing education if you want to keep up. You just have to keep learning. Never stop learning.

The resonating messages in these statements are self-confidence, strength, assertiveness, persistence, and determination; valuing education and life-long learning; taking initiative; never giving up; and managing

experiences, perspectives, and perceptions in a savvy manner. To adjust to the culture-based norms and behavioral patterns in the US sociocultural context, (un)learning was integral to their adaptation and transformation. For example, one participant stated: "We should always take negative pressure into a positive way. If people laugh at your English you laugh with them." Phrases such as these epitomized the successful metamorphosis of these nurses from being timid, unsure "foreigners" to becoming competent, well-adapted professional nurses.

In addition, the Chinese nurses expressed an incredible sense of pride in their chosen profession, a high level of job satisfaction, and a fulfillment from caring for patients. Seven of the 9 participants rated their job satisfaction at or above 8 on a 0 to 10 scale, with 10 as completely satisfied. It was the genuine desire to help patients, the firm belief that they made differences in whom they cared for, and the derived joy that not only made their work meaningful but also sustained their careers in nursing.

This job is a rewarding job. Patients are very, very happy to see you because you are there to help them. That alone makes everyone happy. You feel you are needed and feel happy too. That's the best decision [going into nursing] I have ever made of my life.

When I come to work, people ask me questions, they respect me as a good nurse. I am satisfied when I see my patient get better. That's the part that's making me feel good. I don't know somehow you feel like you contributed something to society.

Once survival was secured, new development needs emerged for these nurses. Rather than simply voicing their intentions to improve their performance and advance their careers, most of them were already in the process of executing their strategic career plans. Not surprisingly, the nurses shared similar career plans, although they did not necessarily know one another.

I am an advanced nurse called Clinical Leader. Right now, I am in school for my nurse practitioner program.

I was a graduate of a 3-year diploma program [in China]. That's why I went back for my BSN. Then I continued and graduated with a master's degree in Healthcare Administration. And I'd like to go back to school for my PhD.

As the Chinese nurses gained more experience, and with it self-confidence and competence, they underwent a monumental transformation. Consequently, the self-fulfilling prophecy became a reality: they transformed into competent professional nurses and clinical experts. By this stage, the Chinese nurses became seasoned, successful, and respected by their peers. They felt that their input, expertise, and unique cultural identity were genuinely valued and appreciated by their American peers. Moreover, with this transformation, there was also a concurrent, positive change in the perception and attitude of patients, peers, and physicians who were now able to transcend Chinese nurses' omnipresent accent, previously held stereotypes, and cultural bias and accept them as equals and as superb, professional nurses with unique qualities. It was at this point in their long journey that the Chinese nurses began to become truly integrated.

The data suggested that it took at least 1 year before the Chinese nurses transitioned comfortably into their first jobs. However, the adaptation and integration process was far from over after the first year, as evidenced by the unease of a 17-year veteran Taiwanese nurse who still identified delegation as a challenge. To a considerable extent, the data indicated that adaptation and integration were a never-ending but ever-evolving process, whereby the involved nurses became increasingly, but perhaps never completely, at ease with their job demands and work environments. This process was dynamic and could be compared to a quest or journey for perfection where one moves ever closer to the ultimate goal but is never able to reach it.

Theme 5: Chinese nurses experienced profound cultural dissonance that compelled them to reflect on their identity as cultural beings, leading to (un)learning or reaffirming who they were.

There were significant cultural differences noted by the Chinese nurses that impacted their work and everyday life, which provided robust explanations for many of the themes presented above. The Chinese culture is collectivistic, whereas the US culture is individualistic. In the former, the interest of groups (ie, family and community) comes before that of the individual. In the latter, individual self-interest is supreme. In addition, the Chinese nurses were socialized to be humble—a virtue in the Chinese culture. However, the new experiences of living and working in the United States naturally catalyzed the nurses to rethink who they were as cultural beings.

We always help others first and take care of ourselves last. When I first got on an airplane in this country, the announcement said: “Get your oxygen on first and then help others.” If you can’t help yourself, you can never help others. But we grew up the opposite way.

I think a lot of Chinese people are very intelligent, very well-educated, and very knowledgeable. Just because they don’t speak out, they miss a lot of opportunities, and they are not well recognized as they should be. In this society you do a lot of work in the back stage. If you don’t take the credit for it, nobody will give it to you.

Yet, it was extremely challenging to *unlearn* the values, beliefs, and behaviors acquired through one’s primary socialization. In fact, unlearning was often more difficult because it involved having to first “erase” what had already been learned. Oftentimes, there were frequent conflicts between the “head” (cognition) and the “heart” (affect) that torn the Chinese nurses. Such real or perceived conflicts could be agonizing because maintaining inner peace and harmony with the external environment was another culturally based value of these nurses. However, through (un)learning, these nurses recognized the rationales of the “American behavioral patterns,” although they might not completely identify with or accept them.

On other occasions, the Chinese nurses chose to keep their traditional values after deliberation, which also demonstrated

learning—learning through affirmation:

So their [American] perception is: If you think you are the best, others will think you’re the best. But that’s not my culture. I will never think I’m the best. Always somebody else [is] better than me. That’s what I grew up with.

The culture [is] absolutely different. Take self-evaluation for example. For most Westerners, they embrace themselves. But for Asians, especially Chinese, we grew up with the Confucian philosophy. We feel very humble. People would put 5 on a 1–5 scale. I would put 2.5 or 3, thus impacting my merit pay increase. It’s just different. If I put myself 5, that means I have no room for improvement for next year. Nobody is perfect. You miss a lot of opportunities – absolutely. But I don’t regret it at all. That’s my philosophy. I’m not going to change it.

DISCUSSION

Of the 4 dimensions of lived experiences that are interesting to phenomenologists—lived space or spatiality, lived body or corporeality, lived time or temporality, and lived human relation or relationality³⁹—the narratives of the immigrant Chinese nurses in this study focused on relationality. Tentative explanations for this focus are 2-fold. First, the essence of their lived experiences in American nursing was their relationships with patients, families, staff, other healthcare professionals, and nurse managers/administrators that defined the meanings of their experiences. Second, it was relationality that appeared to have generated the most profound impact on their experiences, in both positive and negative terms.

Comparison with other studies

To a large extent, this study supported the general findings in the literature on immigrant Asian nurses working in the United States and other Western countries,³⁵ namely, communication challenges, differences in nursing practice, marginalization and unfair treatment, and cultural displacement. In fact, there was a remarkable parallel between the lived experiences of these Chinese nurses and those

immigrant nurses from other Asian countries such as the Philippines, India, Korea, and Pakistan, and black nurses from Africa and the Caribbean.^{11-13,16-19,23}

Conversely, these immigrant Chinese nurses also revealed unique aspects of their experiences that were rarely documented in other studies on immigrant nurses. First, in spite of loneliness, marginalization, and inequitable treatment, they managed to cling vehemently to hope, refusing to give up. They demonstrated motivation, perseverance, ingenuity, and conscientiousness that could be best characterized as “resilient” despite the wide range of seemingly insurmountable adversity. Moreover, these nurses managed to turn challenges into opportunities and excelled under trying circumstances. For example, 3 of them became “Clinical Leaders” on their respective units. Another had been promoted to off-shift supervisor of a large, prestigious teaching hospital.

Second, the Chinese nurses enjoyed a high level of job satisfaction in spite of adversity, genuinely felt pride in their work as a group, and were pleasantly surprised by their past and current achievements. At the first glance, this finding seemed paradoxical given the harsh reality encountered. A plausible explanation was that, because they believed in the value of their work (ie, making differences in patients’ lives on a daily basis, thus contributing to society), their sense of self-worth and self-actualization outshone the negative aspects of their experiences. Such positive feelings were further reinforced by affirmative feedback from patients, patients’ families, peers, and nurse managers. Furthermore, the professional status of nursing in the United States, the associated career advancement opportunities, and the challenges derived from the professional responsibility, autonomy, and accountability served as driving forces for their satisfaction and dedication to nursing. Although all of the participants from China had a negative image of the Chinese nursing profession, they were proud of their current chosen career. For instance, one participant had quit nursing in China, yet her com-

mitment to the profession was renewed after coming to the United States and comparing nursing between the 2 countries.

Third, these Chinese nurses expressed a keen desire for self-enrichment and performance enhancement, and consciously employed education as a vehicle to improve their career prospect and social mobility. In fact, 6 of them went back to nursing schools at the time of this study or were planning to do so, taking advantage of the tuition reimbursement policies of their employers. It appeared that the plausible explanation for such a yearning for learning as a group phenomenon might be linked to the Chinese culture that values education.

Lastly, these Chinese nurses took proactive measures to transform *who they were* in varying degrees through (un)learning to adapt to their new US work environment. As a result, they ultimately transcended themselves, getting ever closer to realizing their full potentials. However, transforming oneself was a challenge that was formidable to some and monumental to others, particularly when they had to *unlearn* some of what they had learned through the primary socialization during their formative years. It was the unlearning that was the most difficult and challenging, as well as the most time- and energy-consuming.

Challenge to patient safety and quality of care

This study revealed both real and potential risks to patient safety and quality of care. First, language deficiency could potentially affect the communication accuracy between the Chinese nurses and patients, families, physicians, pharmacists, and other healthcare team members, especially during telecommunication. Because of incorrect pronunciation and accented speech, the potential risk to patient safety and quality of care was evident from at least 2 of the study participants whose spoken English, at times, was less comprehensible or even incomprehensible during the interviews. The risk to patient safety and quality of

care was even greater when other situational factors were considered. Fear of making medical errors from communication mistakes, medical emergencies, or talking to an awakening on-call physician at an early morning hour could exponentially magnify the risk of miscommunication. Second, learning to ground clinical judgment in critical thinking was a “paradigm shift” for the Chinese nurses. Constantly, they had to consciously fight against the “no brain” mentality and learn to accept the notion of accountability along with the increased responsibilities and professional autonomy in American nursing. Finally, learning to challenge authority figures, such as physicians, to advocate for and protect patients was nerve-racking during the initial transition because such professional expectation was in conflict with their “cultural programming.” However, for healthcare agencies, it is imperative to minimize risks to patient safety and quality of care if they intend to seek license and (re)accreditation by the Joint Commission, whose mission is to improve quality and safety of care provided to the public.

Implications for practice and research

Implications for practice

Several measures are indicated from this study at the institutional level. First, this study demonstrated a need for an evidence-based transition program to facilitate the adaptation and integration of immigrant Chinese nurses. In addition to other components, this multifaceted transitional program should include training on language, cultural differences (beliefs, values, and norms), clinical differences in nursing practice and nursing as a profession, management/leadership skills such as assertiveness training, conflict management and resolution, and handling difficult staff. In addition, workshops on the US healthcare system, including legality and regulatory requirements, and psychosocial and logistics support, should also be provided. Second, US healthcare agencies should inform the peers of Chinese nurses, including managers and administrators, that their attitudes,

understanding, and support are critical to the success of the Chinese nurses. Third, efforts to enforce existing policies against inequality and racism need to be strengthened so that these policies do not sit on the shelf and collect dust. Fourth, facility-wide training for cultural diversity and competence should be implemented on an ongoing basis to create a positive work environment. The classic studies on Magnet Hospitals support the conclusion that a positive workplace climate is one of the leading factors impacting nurse recruitment and retention in the United States^{43,44} and other countries.⁴⁵

At the individual level, Chinese nurses should make continuous efforts to narrow the gap of job demands and their current competencies. First and foremost, they must seek every opportunity to improve their language proficiency. In light of the recent research identifying communication as the root cause for most medical errors and sentinel events,^{46,47} the urgency to improve communication effectiveness is even greater to ensure patient safety and quality of care. However, it should be kept in mind that it is impossible to overcome the communication challenge overnight. Nor can communication effectiveness be enhanced by merely improving linguistic skills because language requisition and communication also contain a sociocultural dimension (knowledge of idioms and figurative language; knowledge of culture, custom, and institutions; and knowledge of cultural references)⁴⁸ and personal dimension (attitude or personality, level of effort, etc) that make the process dynamic and nonlinear. Second, Chinese nurses need to obtain a working knowledge about American culture and society such as sports, popular music, politics, and racial dynamics. This knowledge will enable them to function more effectively both at work and outside the workplace. However, both language skills and cultural knowledge take time to accumulate and require diligent and persistent efforts for noted improvement. Third, a conscious effort to transform oneself in the new work and cultural environment is perhaps the most

important cognitive step toward successful transition, adaptation, and eventual integration. This entire process is nonlinear and challenging, and could be painful and even agonizing at times. Although this process does not mean that Chinese nurses have to give up who they are, it does require a keen awareness of the clinical and sociocultural differences to make informed, sound adjustment decisions.

Implications for research

Many research questions have been raised by this study. Why did the job satisfaction for these Chinese nurses remain high in spite of crushing adversity? If culture (ie, beliefs, values systems, etc) played a role in their adaptation, to what extent and in what fashion did it mediate or modify the process? Did the Chinese nurses have a different adaptation curve from that of other immigrant Asian nurses from the Philippines and India who have a considerable English language advantage? It appeared that those immigrant Chinese nurses who adapted faster and professionally excelled possessed a unique set of personality traits: highly motivated, adventurous, optimistic, self-confident, ambitious, eager to learn, persistent, and maintaining a sense of humor amid stress and chaos. So, how do different personality traits affect the transition, adaptation, and integration process? Finally, unlearning was frequently the "bottleneck" in the adaptation and transformation process of these Chinese nurses. However, this issue has not received the adequate scholarly attention it deserves.

More important clinically, how do challenges such as language and communication inadequacy and different role/expectations of the nurse affect patient outcomes? For instance, to what extent do these factors increase the risk to patient safety and quality of care? Was there any difference in the quality of care provided by the Chinese nurses compared with that by US nurses and other international nurses? Given the national strategic plan and agenda for patient safety research after the landmark Institute of Medicine³⁶ re-

port *To Err Is Human* in 1999 and the subsequently established National Patient Safety Goals by the Joint Commission that list "improve the effectiveness of communication among caregivers" as the second priority,⁴⁹ scientific inquiries along these lines are both warranted and timely. These research questions may be sensitive, but they are legitimate and clinically significant.

Furthermore, on the basis of the comparison with other studies on international nurses, this study appears to suggest that there may be differences in the length of transition as indicated by the comfort level among international nurses from English-speaking countries versus that among nurses from non-English-speaking countries. This is a reasonable possibility and a logical hypothesis in that it may take international nurses from non-English-speaking countries longer to adapt because language skills have been identified as the leading cause for adjustment issues.* However, this hypothesis needs to be empirically tested and taken into consideration when designing transitional programs for international nurses if research evidence confirms it.

CONCLUSIONS

It is predicted that, as the last frontier for international nurse recruitment, China will become a major player on the global nursing market in the foreseeable future.⁶ Given the global demand and the undesirable socioeconomic conditions of nurses in China, a growing pool of qualified Chinese nurses is likely to find its way to the global nursing market, including the United States. Although Chinese nurses do not have the same language advantage as international nurses from English-speaking countries, this study indicates that they do possess unique strengths that are appealing to and valued by Western countries, including the United States. A strong ethical

*References 11, 14, 16, 18, 19, 21, 23, 25, 28, 29.

and business case can be made to develop and implement an evidence-based transitional program to facilitate their adaptation to the new work environment and ultimately their

integration into the US nurse workforce. Such a program will benefit not only these international nurses but also US employers and, most importantly, the American public.

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