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Strangers in Strange Lands
A Metasynthesis of Lived Experiences of Immigrant Asian Nurses Working in Western Countries

Yu Xu, PhD, RN, CTN

Nurses from Asian countries make up the majority of immigrant nurses globally. Although there are a limited number of studies on the lived experiences of Asian nurses working in Western countries, the development of nursing science will be impeded if the rich understanding gleaned from these studies is not synthesized. Using Noblit and Hare's (*Meta-ethnography: Synthesizing Qualitative Studies*. Newbury Park, Calif: Sage; 1988) procedures, a metasynthesis was conducted on 14 studies that met preset selection criteria. Four overarching themes emerged: (*a*) communication as a daunting challenge; (*b*) differences in nursing practice; (*c*) marginalization, discrimination, and exploitation; and (*d*) cultural differences. Based on the metasynthesis, a large narrative and expanded interpretation was constructed and implications for nursing knowledge development, clinical practice, and policy making are elaborated. **Key words:** *adaptation*, *Asian nurses*, *foreign nurses*, *lived experiences*, *metasynthesis*

NURSE SHORTAGE is a global issue.[1,2] Asian nurses from the Philippines and India have been the major targets of international recruitment.[3] For instance, internationally educated nurses made up 3.5% of the estimated 2.9 million US nurse workforce in 2004 and among them 50.2% were from the Philippines alone.[4] Buchan reported that India and the Philippines were the top 2 source countries for internationally recruited nurses (IRNs) in the United Kingdom during 2004–2005.[5]

Author Affiliation: *University of Nevada, Las Vegas.*

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Corresponding Author: *Yu Xu, PhD, RN, CTN, University of Nevada at Las Vegas School of Nursing, 4505 Maryland Parkway, Las Vegas, NV 89154 (mailto:yu.xu@unlv.edu).*

Both published literature and anecdotal evidence suggest that Asian nurses working in Western countries encounter unique challenges that profoundly affect their relationships with their patients, coworkers, physicians, supervisors, employers, and the host country at large. In addition, these challenges impact their relationships with peers from their home countries, their own immediate and extended families, and most importantly, their inner most selves. Because these challenges and associated issues are intertwined with gender, race, and culture, the dynamics of the interactions among these factors significantly affect the work and life experiences of Asian nurses and deserve a serious and rigorous examination.

As early as the 1970s, researchers started documenting and examining the experiences of Asian nurses working in the United States.[6–9] Most of the early studies were concentrated on Filipino nurses in the United States, primarily because they were the predominant subgroup of international nurses. In the last decade and particularly in recent years, qualitative studies on Asian

nurses working in Western countries have flourished.[6,10–20] These studies not only "renewed" the previously little-heard voices of Asian nurses but also expanded the geographical boundary beyond the United States.

However, systematic searches revealed no scholarly efforts to synthesize the available research except one systematic review that evaluated studies on black (African and Caribbean) and minority ethnic (Asian) nurses in the United Kingdom.[21] Essentially, this review concludes that the experiences of black and minority ethnic nurses is "generally poorly researched"[21(p50)] and there is a "lack of comprehensive literature concerning experiences of overseas black and minority ethnic nurses in the UK."[21(p54)] In addition, it identifies "a notable lack of empirical studies with gaps in knowledge, theory, and methodology"[21(p54)] and suggests a need for "rigorous, high-quality research."[21(p53)] However, the limitations of this review in context of the purpose of this metasynthesis are apparent: (*a*) its focus on how to conduct a rigorous systematic review rather than the substantive issues encountered by black and minority ethnic nurses; (*b*) its exclusion of studies conducted outside the United Kingdom; and (*c*) its inclusion of nonresearch literature.

The absence of a metasynthesis of the experiences of Asian nurses working in Western countries indicates a cross-disciplinary knowledge gap. The purpose of this metasynthesis is to provide cumulative insight into the collectively lived experiences of these Asian nurses in order to advance nursing knowledge and to inform practice, policy, and future research. For the purpose of this study, *Asian nurses* are defined as nurses whose home countries are in Asia.

METHODS

Metasynthesis is a method of synthesizing findings from qualitative studies. According to Sandelowski and colleagues, metasynthesis refers to "the theories, grand narratives, generalizations, or interpretative translations produced from the integration or comparison of findings from qualitative studies."[22(p366)] Specifically, metasynthesis refers to translating qualitative studies into each other so that a grand narrative or interpretation can emerge that is more than a sum of the parts.[22] Unlike meta-analysis where the purpose is to reduce findings (ie, data), the purpose of metasynthesis is to allow for an enlarged interpretation.[22]

Procedures

Systematic searches through the Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, PsychINFO, Sociological Abstracts, and ERIC were performed in consultation with an experienced health sciences librarian. To minimize bias against nonpublished research literature, a search through ProQuest Dissertations and Theses was also conducted. The following terms and their variations and combinations were used as search terms: "Asian nurses," "foreign nurses," "foreign-born nurses," "internationally educated nurses," "internationally recruited nurses," "international nurses," "immigrant nurses," and names of a half dozen Asian countries or regions such as Korea and Taiwan. These electronic searches did not set any specific cutoff dates; the last search was performed in July of 2006. In addition, ancestral searches (ie, tracing relevant studies through references in qualified studies) were conducted. Finally, targeted journals that had published studies on the topic were handsearched. Two criteria were set for inclusion in this metasynthesis: (*a*) empirical studies published in English that had a qualitative research design or contained qualitative data and (*b*) studies that focused on the experiences of Asian nurses working as clinicians in Western countries.

Types of qualitative research designs had no effect on selection. For a qualified study using a mixed method design or an overall quantitative design with a qualitative component, only data from the qualitative portion of the study were included for synthesis. For studies that included both Asian nurses and nurses from other countries, only data

specifically identified from Asian nurses were incorporated. When the nationalities of included nurses could not be determined, efforts were made to contact the primary author of the original study for clarification to make an inclusion or exclusion decision. As a result, a few qualitative studies had to be excluded because of the inability to separate the qualitative data among groups of international nurses, even though the author(s) had a blanket statement indicating nurses from Asian countries made up part of the samples. For one study, the primary author refused to disclose the national origins of participating nurses because of concern with confidentiality since the sample was very small.

Sample

Sampling in the real world is rarely simple and clear-cut. For this metasynthesis, studies based on the same sample but reporting different aspects of research findings were counted separately; however, they were grouped together in analyses to conserve space. This situation applied to several studies.[9–11,20] When it was impossible to differentiate data from Asian nurses and data from nurses coming from other countries in the original report of 2 studies,[10,11] an inquiry was made. Based on an e-mail reply from the primary author (O. Alexis, [oalexis@brookes.ac.uk] e-mail, July 28, 2006) indicating the applicability of all the identified themes to Asian nurses, both studies were included in this metasynthesis. Despite repeated efforts, one master of science thesis study from the University of Birmingham in the United Kingdom could not be obtained to evaluate for inclusion. The final sample for this metasynthesis included 14 studies.

Data analysis

The established 7-phase procedures proposed by Noblit and Hare[23(pp26–29)] were employed in this metasynthesis. In phase 1, this researcher determined the studies to include on the basis of the above 2 selection criteria. In phase 2, the researcher identified what was relevant to the purpose of this metasynthesis. In phase 3, the researcher read and re-read all the selected studies to become engaged with the results and contexts. In phase 4, how the selected studies were related to one another was examined. Several procedures were undertaken in this phase: (*a*) making a list of key metaphors (ie, "themes," "concepts," or "phrases") from each study; (*b*) identifying relations among these metaphors (ie, "reciprocal," "refutational," or presenting a "line of argument"); and (*c*) making initial assumptions of the relationships among the selected studies. After comparing all the metaphors from the selected studies, it was determined that the relationships among these metaphors were reciprocal because they were about similar things in similar "directions." In phase 5, the selected studies were translated into each other by juxtaposing the key metaphors. "Translations are especially unique syntheses, because they protect the particular, respect holism, and enable comparison. An adequate translation maintains the central metaphors and/or concepts of each account *in their relation to other key metaphors or concepts* in that account" (original emphasis).[23(p28)] In phase 6, the translations were synthesized. This involved "putting together" a whole that was more than what the each individual study implied. In phase 7, this researcher expressed the synthesis through written word. During the working process of the 7 steps, the advice from Sandelowski and colleagues was kept in mind:

> Qualitative metasynthesis is not a trivial pursuit, but rather a complex exercise in interpretation: Carefully peeling away the surface layers of studies to find their hearts and souls in a way that does the least damage to them. Synthesists must analyze studies in sufficient detail to preserve the integrity of each study and yet not become so immersed in detail that no useable synthesis is produced.[22(p370)]

RESULTS

Demographic and methodological characteristics of all the studies included in this metasynthesis are provided in Tables 1 and 2.

Table 1. Demographic characteristics of the participants of individual studies in the metasynthesis[a]

Study	Sample size	Age	Marital status	Gender	Time in host country	Religion	Type of program graduated from	Nationality of Asian nurses
Alexis & Vydelingum (2004, 2005a)	12[b]	...	...	F = 7 M = 5	...	...	...	Philippines
Allen & Larsen (2003)[c]	67 (11 Asians)	25–61	...	F = 58 M = 9	Mean = 3.8 y	...	...	Philippines India Pakistan
Daniel et al (2001)	24	...	...	F = 23 M = 1	Group 1 = 3 mo Group 2 = 2 wk	...	...	Philippines
Davison (1993)	10	42–59	...	F = 10	5–24 y	Mainly Catholic	BSN = 6 MSN = 2 PhD = 2	Philippines
Dicicco-Bloom (2004)	10	40–50	M = 10	F = 10	20–25 y	Christian	Diploma	India
Lopez (1990)	10	...	M = 7 S = 3	F = 9 M = 1	<2 y = 4 4–6 y = 3 >10 y = 3	Catholic	Mostly BSN	Philippines
Matti & Taylor (2005)	12[d]	...	...	7 M = 5	9 mo—2 y	...	...	India Philippines
McGonagle et al (2004)	10	...	...	F & M	>3 mo	...	...	Philippines
Miraflor (1976)[e]	405	21 to >60	M = 205 S = 190 Sp = 3 W = 6	F = 384 M = 21	A few mo	Mainly Catholic	5-yr BSN = 112 4-yr BSN = 53 4-yr diploma = 238	Philippines
Spangler (1991)	26	25–51	...	F & M	<5 y = 14 5–10 y = 7 >10 y = 5	Mainly Catholic	BSN = 23 Diploma = 3	Philippines
Withers & Snowball (2003)[f]	45	25–39	...	F = 31 M = 12	3–18 mo	...	...	Philippines
Yi (1993) Yi & Jezewski (2000)	12	25–57	M = 8 D = 1 S = 3	F = 12	1–23 y	Christian = 10	MSN = 3 BSN = 5 Diploma = 4	Korea

[a]Under "Marital Status": M = married; S = single; Sp = separated; D = divorced; W = widowed. Under "Gender": F = female; M = male.
[b]This figure included an unspecific number of nurses from South Africa, the Caribbean, and Sub-Saharan Africa.
[c]The demographical profile reported here is for the total sample ($N = 67$) due to the unavailability of specific demographical data on the 11 Asian nurses.
[d]This figure included an unspecified number of non-Asian nurses.
[e]Sum of subcategory figures under "Marital Status" is not equal to 405 due to missing data in the original study.
[f]Sum of subcategory figures under "Gender" is not equal to 45 due to missing data in the original study.

Table 2. Methodological characteristics of included studies in the metasynthesis

Study	Discipline published in	Country	Data analysis method	Research design and data-collection method
Alexis & Vydelingum (2004, 2005a)	Nursing	United Kingdom	Thematic analysis	Phenomenology (focus group)
Allen & Larsen (2003)	Nursing	United Kingdom	Thematic analysis	Phenomenology (focus group)
Daniel (2001)	Nursing	United Kingdom	Thematic analysis	Phenomenology (focus group)
Davison (1993)	Asian American studies	United States	Thematic analysis	Oral history (interview)
Dicicco-Bloom (2004)	Nursing	United States	Content analysis and critical case analysis	General descriptive design (interview)
Lopez (1990)	Education	United States	Thematic analysis	General descriptive design (interview)
Matti & Taylor (2005)	Nursing	United Kingdom	Thematic analysis	General descriptive design (semistructured interview)
McGonagle et al. (2004)	Allied health	Ireland	Thematic analysis	Phenomenology (focus group)
Miraflor (1976)[a]	Education	United States	Thematic analysis	Quantitative design with qualitative component (open-ended questions in questionnaire)
Spangler (1991)	Nursing	United States	Leininger's Ethnonursing Phases of Qualitative Data Analysis (Thematic analysis via induction)	Ethnonursing (ethnonursing interview, observation)
Withers & Snowball (2003)[b]	Nursing	United Kingdom	Thematic analysis	Mixed method design (semistructured interview)
Yi (1993) and Yi & Jezewski (2000)	Nursing	United States	Constant comparative method	Grounded theory

[a]Only qualitative data from this quantitative study were included for analysis.
[b]Only qualitative data from this mixed method study were included for analysis.

Out of the 14 studies, 4 were doctoral dissertations, 1 was master's thesis, and the rest (9) were research reports. The disciplines or fields represented by the selected studies were nursing, education, Asian American studies, and allied health. These studies took place in 3 countries (United States, United Kingdom, and Ireland), involving nurses from 4 Asian countries (India, Korea, Pakistan, and the Philippines). The most frequently used research design was phenomenology ($n = 5$) and general descriptive design (ie, qualitative descriptive studies without identifying a specific research design) ($n = 3$), followed by grounded theory ($n = 2$), ethnonursing ($n = 1$), oral history ($n = 1$), mixed method design ($n = 1$), and quantitative design with a qualitative component ($n = 1$). In addition, a detailed table of metaphors, themes, and concepts from the 14 studies was constructed and translated into each other, using Noblit and Hare[23] as outlined above (Table 3). What follows is a descriptive and interpretive report of the lived experiences of Asian nurses under 4 overarching themes.

Theme 1: Communication as a daunting challenge

Communication is critical in healthcare settings, especially for nurses who work with patients around the clock to conduct assessment, plan, coordinate, and deliver care, and evaluate interventions. By definition, communication is the creation of *shared* meaning and understanding. However, because of a variety of factors, Asian nurses encounter an array of difficulties that hinder their ability to communicate.

Unfamiliarity with accents and informal language usage

All of the included studies except one[16] documented language difficulties of Asian nurses, including agonizing experiences, especially during the initial period following their arrival in a new country. No matter how well Asian nurses thought they were prepared linguistically, they still found themselves not prepared enough to meet the communication needs in a foreign country. For many Asian nurses, language was a major obstacle for survival, both at work and in other aspects of their lives, particularly during the initial time after arrival.

The communication difficulties came from unfamiliar accents; usage of slang, idioms, jargon, abbreviations; recorded shift reports; and idiosyncratic physicians' handwriting.[6–12,15,17,19,20] Difficulties also rose from differences between the "book English" they learned formally in their home countries and the "street English" used in the new country.[7] For instance, to newly arrived Filipino nurses, the euphemistic use of "potty" (for "bedpan") was new; the British use of "theater" for "operating room" was unheard of; and the idiomatic use of the words such as "hell" as in "You are a hell of a good worker" was seemingly paradoxical and puzzling to their linear interpretation. Another example was the response "Uh-huh" because different tones had different and even opposite meanings.

Frequently, communication difficulty was compounded by frustration, stress, and psychological breakdown, and prevented Asian nurses from performing at their best, especially with regard to patient care, leaving them with a deeply saddened feeling of inadequacy, shame, and self-pity. From time to time, they questioned their ability to "handle" the new job and wondered "Why am I here?" Somatic symptoms were also reported from the associated distress.[9] At its worst, communication deficiency led to downward psychological spiral such as depression and resulted in job termination.[7]

Communication deficiency not only affected the effectiveness and efficiency of care delivery to patients but also impacted patients' families and the healthcare team in a variety of ways. In extreme cases, patients refused care by Asian nurses merely because of their inability to create mutual understanding.[7] Such incidents were painful, humiliating, and devastating because such

Table 3. Individual study metaphors as related to 4 overarching themes[a]

Study	Communication challenges	Differences in nursing practice	Marginalization, discrimination, and exploitation	Cultural differences
Alexis & Vydelingum (2004, 2005a)	Communication difficulties with patients and peers	Organization of care and its delivery; not prepared to provide ADLs for patients; focus on paperwork rather than delivery of care	Being seen as "other"; feeling unwelcome, not appreciated, and not belonging; no one would listen to complaints; lack of support from British peers & training opportunities; unfair treatment; lack of equal opportunity for promotion; had to prove self; being bullied & fear of being reported and reprisal	Lack of cultural preparation for United Kingdom and what to expect; feeling of being displaced and thrown into a different world
Allen & Larsen (2003)	Communication compromised by dialects, accents, colloquialism, intonation and style of talking; communication issue as stigma; being labeled "different" and "difficult" due to language deficiency	Nursing qualifications unrecognized; narrower scope of practice leading to feeling of being deskilled; humiliated to provide ADLs; different legal framework; focus on paperwork rather than care	Language barrier as vehicle for discrimination; felt exploited during induction and adaptation period; continuing exploitation after registration when negotiating employment status; being paid for one grade while being asked to take on responsibilities of a higher grade; undesirable working hours; backstabbing and policed by carers; not being accepted by patients—lack of appreciation, respect & trust; feeling of discrimination; manipulated & bullied by care assists	Negative UK attitude and treatment of the elderly; unaware of existence of care homes; tiers of bureaucracy to get registered; high living cost and tax
Dicicco-Bloom (2004)			Discrimination for being immigrant nonwhite female nurses in a gendered profession; alienation at work; marginalization, exploitation, and racism at workplace	Culturally uprooted; valuing family less by Americans; struggle to retain women's traditional role in Asian family

(continues)

Table 3. Individual study metaphors as related to 4 overarching themes[a] *(Continued)*

Study	Communication challenges	Differences in nursing practice	Marginalization, discrimination, and exploitation	Cultural differences
Davison (1993)	Communication barriers; language as an area of tension		Marginalization/discrimination as "foreigners": substandard wage, undesirable shifts, passed over for promotion; not allowed to speak Tagalog during work break, treated with hostility and retaliation, demotion for speaking Tagalog; nursing as a gendered profession: Asian women as exotic and sexual objects; constant fight against stereotyping	Hard-to-understand "American way of life" and culture: elderly abandonment, loose moral, lack of discipline, and "crumbling" of families; culture as another area of tension
Daniel (2001)	Difficulty understanding jargons, medications, abbreviations, and accents of staff and patients	Different role of family; nursing physically demanding; common use of verbal orders; different names of medications; different procedures for dispensing medications; specialization in nursing; legal issues in nursing practice.		Low social status of the elderly
Lopez (1990)	Communication deficiency: slang, "street English" vs "book English," fear of phone conversation; difficulty expressing self	Differences in nurses' role: bedside care vs paperwork; doing vs talking; respect and gratitude vs disrespect and lack of respect from patients; rejection from patients; risk of being sued	No one at airport to meet newly arrived Filipino nurses; lack of trust; frustration with "testy" US nursing aides; suffering quietly; had to earn right to be heard; differential treatment; hostility toward foreign nurses; jealousy; favoritism; rejection by patients and physicians	Lack of understanding of US culture, social skills, and assertiveness; hard to admit "Don't know;" speaking up as challenge

(continues)

Table 3. Individual study metaphors as related to 4 overarching themes[a] *(Continued)*

Study	Communication challenges	Differences in nursing practice	Marginalization, discrimination, and exploitation	Cultural differences
Matti & Taylor (2005)	Language and communication deficiency as a 2-way issue: due to colloquialism and accents	Not used to providing basic care to patients; feeling devalued and deskilled: skills not being recognized or utilized	Feeling not being trusted for performing some clinical procedures	Cultural differences between UK and home country; induction not specific to foreign nurses' needs
McGonagle et al. (2004)[b]	Difficulties with language, documentation & terminology (ie, abbreviation and jargon)	Irish nurses less autonomous; less focused on patients' physical needs; confusion regarding intellectual disability and mental illness		Little family involvement in care of sick family members; perception of institutionalization of elderly as uncaring and unjust
Miraflor (1976)	Language and communication ranked as top issue: taking phone orders, intonation, accent, and physician's handwriting	Learning to use modern equipment, machines, and supplies	Being taken advantage of by nursing aides; not respected as team leaders by nursing aides	Buying on credit, fast pace of life; "Dutch treat"; concept of "first come, first served"; American concept of time; open expression of affection; pervasive exposure of sex in media; disrespect for the elderly; direct communication style

(continues)

Table 3. Individual study metaphors as related to 4 overarching themes[a] *(Continued)*

Study	Communication challenges	Differences in nursing practice	Marginalization, discrimination, and exploitation	Cultural differences
Spangler (1991)	Language difficulties: slang, accent; had to talk in native language	Heavy workload; inability to provide adequate care; reducing care to technical tasks and its contribution to noncaring behaviors; impact of bureaucracy, standards and policies of regulatory agencies.	Mistrust by US nurses; had to prove self; had to "put up with a lot"; had to settle for less desirable shifts; prohibited from speaking Tagalog in work area; abuse; manipulated by patients; made to float to other clinical areas more frequently; frustration with heavier work load	Conflicts resulting from cultural differences; differences in interaction and relational style; differences in lifestyle
Withers & Snowball (2003)	Communication issues: idioms, abbreviations, slang, unfamiliarity with British accent	Differences in nurse's role; not allowed to perform certain procedures	Unfair treatment from colleagues and patients; cultural imposition: not allowed to speak own language; exploitation and bullying; fear to report abuse	Unassertiveness
Yi (1993) and Yi & Jezewski (2000)	Language deficiency as most challenging for successful adaptation	Different role of nurse and family; focus of care: needs of patients (Korea) vs diseases (United States)	Difficult relations with patients, peers, nurse aides, and supervisors; not being respected and accepted as leader by nursing aides; nonassertiveness and kind nature being taken advantage of; emotions over unfair treatment affecting health; being reported to supervisor behind back	Difficulty dealing with interpersonal conflicts; different communication styles

[a]ADLs indicates activities of daily living; Tagalog, most frequently spoken native language of the Philippines.
[b]Study took place in a learning disability service clinical setting.

refusals were interpreted by the involved nurses as incompetence to fulfill the basic duties for which they were hired. Moreover, Asian nurses tended to take such events personally because of their cultural upbringing and socialization. What made this feeling of inadequacy even worse was the cognitive dissonance with their self-perceived image as caring, compassionate, and competent professionals.[7,9,24]

Telecommunication as most challenging

Verbal communication over the telephone was reported as the most nerve-racking experiences for Asian nurses. Fear of making medical errors from communication mistakes and from other situational factors such as a medical emergency or talking to an awakening on-call physician at an early morning hour could magnify the experienced stress due to absence of nonverbal cues for validation as evidenced by the following reflexive reaction: "During the first few days on the job, I ran to the bathroom when the phone rang."[9(p93)]

Domino effects of communication deficiency

Language barrier virtually affected every other aspect of Asian nurses' experiences. First, it affected their confidence in themselves and stripped them of their dignity in extreme cases when they felt embarrassed because they could not express themselves adequately.[8–10,24] To save "face," Yi[9] documented that a Korean nurse was too frightened to ask questions, which could potentially cause harm to her patients. Second, it further reinforced the stereotype of Asian nurses that they were shy, unassertive, and not tough enough to be leaders. However, when a Filipino nurse did not fit into the stereotype, she was labeled as un-Filipino because she was "not quiet."[6(p31)] Third, language deficiency had a vicious cycle: the less Asian nurses spoke because of fear of making mistakes, the longer it took for them to develop a command of the language. Furthermore, language improvement was inherently associated with improvement in professional knowledge and interpersonal skills.[9] Unfortunately, some Asian nurses never overcame the language barrier and had to take a lower level position, quit nursing, or even return to their home countries.[7] These outcomes were regarded not only as catastrophic failures to the involved nurses but also as bringing shame to the nurses' families and even home countries.

Accent and communication deficiency as grounds for discrimination

Language was a key factor for distress to Asian nurses because accent was unjustly used as a "social marker" for stigmatization.[12] The intense emotions were palpable in the following comment by a Filipino nurse working in a New Jersey hospital: "They [American nursing staff] hate our accent. That's why they don't want to work with us. Although they don't say that, you just sense it."[7(p84)] Although some Filipino nurses lived and worked in the host country for more than 10 years, they still encountered "accent discrimination."[6(p30)] Being labeled "different" or "difficult" because of an unfamiliar accent or language deficiency was frequently used as a vehicle for discrimination. In some cases, this also gave their Western peers a "legitimate" excuse for not trying to understand.

Clashes between Asian nurses and their Western peers regarding language were constant. In an extreme case, a Filipino nurse had to resort to litigation to regain her civil rights to speak her indigenous language in the staff lounge during breaks.[6] On the surface, communication medium appeared to be the concern; in fact, these conflicts revealed deeper issues—intolerance, imposition, and the seemingly paradoxical coexistence of superiority and insecurity on the part of American nurses.

Lack of communication proficiency also negatively affected Asian nurses' ability to fight for their own rights: "Some people tell us, 'Why don't you speak up?' Maybe because we have a hard time in speaking in

English, that's why."[24(p185)] On the other hand, learning to "speak the same language" facilitated the acceptance of Asian nurses by their Western peers, and hence, their socialization and integration. It also served as an indicator of their acculturation level. For example, when a Filipino nurse expressed frustration with "Oh my god," her American peer was very excited to tell her that she "had become Americanized."[7(p90)]

Theme 2: Differences in nursing practice

Role of the nurse

One of the first differences Asian nurses discovered was the autonomy granted by laws and regulations as well as the accountability in Western nursing.[15] Initially, it was surprising for them to learn that nurses in Western countries functioned much more independently. However, they were also appalled that family members did not provide or assist with activities of daily living (ADLs) at all and depended completely on the nursing staff for meeting such needs.[9–12,15,19,20] Both professionally and culturally, they were not used to providing ADLs because those basic needs were taken care of by families in Asian countries. Asian family members regard providing such basic and intimate care for their loved one as their privilege. Consequently, many Asian nurses perceived providing ADLs as being deskilled, humiliating, demoralizing, and a waste of their education as evidenced by the following statements: "I feel degraded and frustrated having to wash patients"[10(p15)]; "I did not expect that life as a nurse would go around words like pee, loo, and poo."[19(p285)]

In addition, many Asian nurses were not prepared for the physical and psychological demand in taking care of heavy and dependent Western patients, referring to their weight and high acuity.[15] Furthermore, they were highly critical of the approach to nursing where the focus was perceived to be on the disease process rather than on the needs of patients and holistic care. They were frustrated to see nursing being reduced to technical tasks that contributed little to bedside care. To them, the most important role of the nurse was to provide bedside care that incorporated the hands, mind, heart, and soul.[9,24] Nursing was to give hands-on care with compassion, relieve suffering, and help with the healing process. It should never be merely a series of mechanical tasks. For instance, the sampled Filipino nurses in Spangler's study[24] felt an "obligation to care" and emphasized patients' physical comfort as their central concern. To them, caring was expressed by "doing," especially spending time with patients.

Meanwhile, Asian nurses were shocked by the amount of paperwork required institutionally and legally. Not surprisingly, such emphasis on documentation was perceived as "putting the cart before the horse" as criticized by a Filipino nurse: "Nursing is bedside care, not paper work. Here in the U.S. the prestige is when you are away from the bedside. Actual patient care is relegated to the nurses' aide."[24(p206)] Because of fast work pace, heavy paper work, and understaffing, many Asian nurses felt torn between providing quality patient care and getting everything done on time, which often lead to stress, job dissatisfaction, changing job, or even leaving the profession once for all.

Scope of practice

Quickly, Asian nurses learned that some routinely performed procedures in their home countries such as cannulation, venipuncture, and collecting arterial blood might not fall within the legal practice in some Western countries such as the United Kingdom.[15] Consequently, they felt that patients under their care suffered needlessly because of procedure delays. Such restriction also affected their job satisfaction because of the perception of being treated less like professionals.

Technological and legal environment

Asian nurses had to get to know quickly the 3 Ps: protocols, procedures, and policies,

as well as new healthcare technologies to adapt to a more automated healthcare environment.[8] While the use of advanced technology was largely true in America, it was disappointing to find that healthcare technologies in some Western countries such as the United Kingdom were not as advanced as expected.[12] On the other hand, the legal framework within which Western healthcare operated was dramatically different.[7,15] For example, the emphasis on documentation took on added legal importance because "If it is not charted, it didn't happen." Given the prevalence of litigation, many Asian nurses quickly learned to practice what this researcher called "defensive nursing" to minimize the margin of error and thus liability for both themselves and their employers. However, during the process, fear, stress, and distress could take their toll: "You have more at stake here. If you administer a medication a doctor ordered and it's wrong, you are liable since you are the one that gave it."[6(p33)] The Western notions of legality and accountability were unfamiliar and even foreign to them at the beginning of their first job.

Theme 3: Marginalization, discrimination, and exploitation

Nursing as a gendered profession

The vast majority of Asian nurses were females (Table 1). Because of the social perception of women as the weaker and less powerful gender, stereotypes of Asian women, and the simple fact of being in a foreign country, Asian nurses were exposed to a host of vulnerabilities and frequently became targets of marginalization, discrimination, and exploitation.[6–7,10–12,16–17,19] On a cultural level, Asian nurses collectively felt "otherness" or a lack of sense of belonging because of cultural differences or lack of sufficient cultural knowledge to fit in; hence, they felt disfranchised from their coworkers.[6,10,11,16] For instance, one Indian nurse related a disheartening experience: "Nobody learned my name for 4 months when I first came, and when they did it. . . they shortened it and pronounced it wrong. I finally stopped correcting them."[16(p26)]

To some degree, the unassertiveness of Asian nurses contributed to what this researcher termed "professional silence and invisibility"—the lack of professional representation and leadership positions in the healthcare hierarchy, and hence the lack of perceived political clout in the collective consciousness of the host country. Asian nurses (and Asians in general) as a group were taught in their home cultures not to challenge authorities or "rock the boat."[7,9,24] They also had high expectations of others and of themselves and expected that their preceptors and supervisors would take on a maternal role, treating them like a *parang kapatid* (like a sister) or an "adopted mother." These "messages" internalized through primary socialization were incongruent with dominant Western values and norms. The following excerpt from a Filipino nurse demonstrated how long she had to suffer needlessly before feeling accepted enough to request what she needed to do her job adequately:

> I am only 4′11″ and the operating tables were almost at the level of my neck. Even with the use of a stool I could hardly see what was going on with the surgery. I could not anticipate very well the instruments that the surgeons needed. They were frustrated and so was I. After the surgery I would go to the bathroom and cry. It was after 3 years that I felt I really belonged to the OR and therefore I had the right to ask for a higher stool.[7(pp87–88)]

Unfair treatment and lack of equal opportunity

Asian nurses were frequently passed over for career opportunities and believed that race determines promotion.[6,16] In addition, in some situations Asian nurses were paid substandard wages,[6] or unfairly compensated for a lower position while being asked to take on responsibilities of a higher one.[12] Moreover, they felt that they were discriminated against because of their skin color and "foreignness": "We can change some of our outlook, our values, but we cannot change our looks, our accents. No matter how egalitarian

Americans claim to be, we know that they are not color blind. . ."[24(p208)] Although many Asian nurses wanted to fight against injustice, they felt powerless and uncertain about the outcome. Some did fight, but at the expense of personal health.[9]

Bullying and sexual harassment

At times, Asian nurses were taken advantage of by their Western employers, coworkers, and even subordinates.[6–7,9–12,19] Receiving the "worst" patient assignment, being given the most undesirable work shift, and being assigned to work during holidays were not uncommon. In extreme cases, Asian nurses were targets of bullying by prejudicial patients, physicians, peers, supervisors, and even their subordinates. Furthermore, there was outright harassment as Asian nurses were perceived as exotic and sexual objects. One Filipino nurse encountered a white patient who asked whether he could bring her home as a maid with a sexual overtone and profound ignorance that the Philippines was so backward that the entire country was connected by dirt roads. This Filipino nurse fought back courageously by replying with a laugh: "You cannot afford to hire me."[6(p22)] At other times, Asian nurses told stories of being backstabbed such as being reported to management without their knowledge, being policed by their white peers, intentional withholding critical information by white peers, and a lack of appreciation and recognition for what they could contribute.[12] *We Need Respect,* the title of a recent report on the experiences of IRNs in the United Kingdom commissioned by the Royal College of Nursing, projected the voices of these nurses, including those from Asia—loud and clear.[12]

Having to prove self

Asian nurses believed they had to prove themselves to their patients, peers, and supervisors in order to win their trust and support.[10–12,17] Until then, there was frequent doubt about their worth and competence. Such apprehension and suspicion were particularly hurtful when patients under their care were dubious about the medications given to them and checked with their white peers behind their back.[12]

Theme 4: Cultural differences

Cultural displacement

Asian nurses felt "uprooted" culturally and "being thrown into a different world," especially during their initial transition after arrival.[10–11,16] Meanwhile, they experienced mounting pressure to "re-root" in the new culture. The feeling of being torn between 2 cultures was best captured by the metaphor from an Indian nurse as "a foot here, a foot there, a foot nowhere"[16(p28)] and as a "rupture"[16(p29)] with her homeland. The sense of cultural displacement was frequently made worse by the fact that a majority of Asian nurses left their close-knit families behind. Lopez reported that one Filipino nurse spent an average of $500 monthly on telephone fees to relieve her nostalgia.[7]

Asian nurses were challenged to understand the host culture and adjust to new ways of life.[6–9,24] During this adaptation process, their own values, beliefs, and cultural norms unavoidably clashed with those of Western societies as the 2 systems of thinking were likened to "oil and water."[14(p57)] These cultural differences ranged from different concepts of time (ie, "American time" equaling to "punctuality") to different communication styles, foods, and ways of life and customs such as "Dutch treat" and buying things on credit. In addition, they were not used to the "loose morality" (eg, being naked in the street, permeation of sex in the media), lack of discipline, and the "crumbling" of the family in Western societies.[8]

Negativity toward the elderly

Asian nurses were not prepared culturally for the perceived lack of respect for the elderly such as "Calling elders by their first name"[8(p75)] and for the perceived maltreatment of the elderly.[15] Moreover, they resented

what they perceived as the "elder abandonment" when frail parents were institutionalized in nursing homes with few visitations from their families or without family members being at the bedside when they were hospitalized. This perceived lack of family obligation and compassion was regarded as the ultimate shame and social evil of Western societies.

Interpersonal challenge

To a large extent, interpersonal challenge had its "roots" in the cultural upbringing of Asian nurses, who were taught to avoid conflicts at all cost in order to maintain harmony.[7] Culturally, Asian nurses came from collectivistic cultures where "we" and "us" came before "I" and "me." Therefore, to say "No" was socially unacceptable, especially to people with seniority and authority. To challenge physicians when necessary was expected in the Western nursing culture, but very hard to learn for Asian nurses, even though they realized that it was a legal and professional requirement.

In addition, Asian nurses quickly found out that their "all-yes" habitual mentality frequently brought them unnecessary work and even trouble in the real world because their kindness and tendency to accommodate were taken advantage of and even abused. Interestingly, the most intense conflicts were with nursing aides, especially those of African American background, rather than with their peers, supervisors, or physicians.[7,9] Asian nurses were particularly resentful if their subordinates refused to follow their directions because obedience to authority was expected according to the ways they were brought up.[6–9,24]

Inadequate training on leadership and management skills such as delegation and conflict resolution[8] was another barrier to building productive working relationships. In addition, many Asian nurses operated under their culture-based assumption that every employee was motivated, who was willing and ready to carry out duties as specified in one's own job description. Moreover, the cultural belief that it was an insult to someone if he or she had to be told to perform his or her regular duties also affected Asian nurses' management behaviors. However, frequently this culture-based expectation proved to be a un-starter at Western workplaces, particularly with many less motivated or unmotivated nursing aides.

DISCUSSION

Gender, race, culture, and interpersonal dynamics

Gender, race, and culture are at the crux of one's identity and impact interpersonal interactions profoundly; therefore, they are salient categories of analysis. The lived experiences of Asian nurses working in Western countries cannot be fully understood without looking through these 3 different lenses simultaneously. Essentially, their experiences were framed by these 3 dimensions of one's identity and humanity as well as their intricate interactions in the ever-changing physical, technological, legal, and interpersonal contexts in Western countries. It is from this framing that meanings of their experiences are defined and dynamics of relationships understood.

What Asian nurses went through was a *gendered* experience. Such experiences are crystallized in the metaphoric advertisement: "Your cap is your passport."[14(p61)] The socially constructed image of women in general and Asian women in particular affected not only the perceived status of Asian nurses but also treatment by their Western employers and the people they interacted with. This metasynthesis suggested that as women, Asian nurses were more vulnerable to social injustice and sexual harassment. Moreover, Asian nurses perceived that they had little power to change the status quo, particularly given the foreign contexts. The gendered experiences of Asian nurses in this metasynthesis validated similar experiences by minority foreign nurses documented in numerous Western countries.[11,14,25] Moreover, their gendered experiences were furthermore compounded by race and culture. As Thurston and

Vissandjee pointed out: ". . .gender interacts with other Symbolic Institutions—in particular race, class, and sexuality—to form hierarchies of inclusion and exclusion, is never seen alone, and is essential to understanding the organization of society."[26(p232)]

What Asian nurses went through was also a *racial* experience. They reported sabotaging attempts aiming to set them up for failure; documented double standards, exploitation, and abuse; witnessed intolerance and unrelenting discrimination; and encountered the "glass ceiling," all because of their skin color. Perhaps, the worst example racial discrimination was against 2 Filipino nurses who were convicted of poisoning, murder, and conspiracy at the Veteran Affairs Hospital in Ann Arbor, Mich, in 1976 and later were acquitted in a sensational national trial. Consequently as a group, Filipino nurses suffered from public suspicion about their professional intentions and even death threat.[14]

Furthermore, the glass ceiling effect was validated by longitudinal data in a study indicating that the vast majority of internationally educated nurses in the United States held staff nurse positions, which increased from 71.2% to 76.7% during 1977–2000, while their proportions in management positions declined from 6.2% to 2.7% during 1984–2000.[27] Hawthorn also found that immigrant nurses from non–English-speaking countries were not only much less likely to advance beyond the entry-level registered nurse position but also disproportionately concentrated in stigmatized geriatric units.[28] The documented experiences of Asian nurses in this metasynthesis revealed that racial equality in Western countries remain merely a myth. In light of the increasing reports of discrimination against nonwhite foreign nurses in Australia, Canada, the United Kingdom, and the United States,[3,12,14,16,25,29,30] one has to conclude that institutional racism still exists.

Lastly, what Asian nurses went through was also a *cultural* experience. The cultural heritage of Asian nurses was a mixed blessing, serving as both a barrier and a resource to their transition. Frequently, Asian nurses were puzzled and frustrated as to what part of "themselves" to give up and what part to retain during the adaptation process. This was an intense, and frequently agonizing, intrapersonal process involving soul searching, resolution of values conflicts, and even self-negation to seek and establish a new personal, professional, and cultural identity. Data indicated that Asian nurses had to change *who they were* in varying degrees in order to adapt successfully to the new culture and work environment. However, changing oneself was a challenge that was at least formidable to some but monumental to others.

Language is one of the most important carriers and exemplars of culture. Essentially, language functioned as both a symbol and a tool for Asian nurses. As a symbol, language and its associated properties such as accent gave away their "foreignness" and frequently served as a social marker, thus offering a handy vehicle for prejudice and discrimination.[28] As a tool, language served as a fundamental instrument for survival and adaptation both at work and in daily life in a new culture.

The meanings and dynamics of the precarious relationships between Asian nurses and African American nurse aides in the US healthcare environment cannot be fully understood unless the frequently cited conflicts are put into the sociopolitical, economic, and cultural contexts.[31] Control of the work environment is at the core of these conflicts. The underlying factors go far beyond the simple explanations of different accents, language use such as "Black English," and ways of relating to one another,[8] as well as cultural differences such as work ethics.[24] On the one hand, African Americans find themselves at the bottom of the American society. The position of African Americans nurse aides in the US healthcare system reflects their socioeconomic status in the American society at large. They often have the most physically challenging jobs but the lowest pay. Many of these African American nurse aides are single parents with limited education and work at multiple jobs to make ends meet. Their work and daily struggles are vividly portrayed in Diamond's classic ethnography of American

nursing home care—*Making Gray Gold*.[32] Compounding the situation is the ingrained memory of slavery and the painful fight for civil rights in US history. The feeling that the system has failed them can be overwhelming, often accompanied with a sense of powerlessness and hopelessness. Frequently, a spark is all that is needed to trigger an explosion of their frustration and anger. A simple, delegated task from a newly arrived Asian nurse, who is a "foreigner" with less-than-fluent English and a hard-to-understand accent but a higher position and salary, could well be "the last straw on the camel's back."

On the other hand, several factors on the part of Asian nurses also contribute to the surfacing and development of these conflicts. First, brought up in hierarchical cultures, Asian nurses expect obedience from subordinates. Furthermore, culturally Asian nurses avoid interpersonal conflicts if at all possible. However, oftentimes such avoidance behaviors enable African American nurse aids to become more testy and demanding. Second, they are thrown into the preexisting, predominant black-white racial politics that play out in the workplace daily. However, unaware of the interpersonal dynamics that are affected by the racial politics beyond hospital walls and situational factors, Asian nurses are caught completely unprepared and clueless as to how to effectively handle disobedience and subsequent conflicts. Third, Asian nurses are perceived as having multiple vulnerabilities and weaknesses that have further contributed to their ineffectiveness as team leaders: language deficiency, status as "aliens," job insecurity as contracted foreign nurses, less seniority as new comers, soft voice, and the small physical stature.

Implications for knowledge development, clinical practice, and policy making

Implications for nursing knowledge development

Asian nurses working in Western countries encounter a host of unique challenges that ultimately affect their adaptation as reported above. Consequently, the experiences and adaptation of Asian nurses in Western countries are likely to be different from those of non-Asian nurses, at least in some aspects. Consequently, this metasynthesis provides a starting point for the development of a midrange theory regarding Asian nurses' adaptation to the Western healthcare environment. This theory is expected to provide the foundation for theory-based interventions to improve the integration of Asian nurses into the Western healthcare environment. In addition, such theoretical advancement will contribute substantively to the knowledge base related to "transition" as one major area of inquiry in nursing research.[33] Finally, the research on the lived experiences of immigrant Asian nurses has opened new areas of inquiry into the dynamics of interpersonal relationships: How does the "failure" of some Asian nurses affect other immigrant nurses? What are the relationships between native-born Asian nurses and immigrant Asian nurses? How do immigrant nurses from different countries interface with each other? Is there any "reverse discrimination" against white nurses, especially in healthcare settings where immigrant nurses concentrate?

Implications for practice

In light of this metasynthesis, several issues need to be addressed regarding the current orientation and transitional programs for IRNs. First, apart from the general facility orientation, there should be a tailored transitional program for IRNs that specifically addresses their needs such as the differences in nursing practice, with detailed elaborations on legality, policies, and procedures and their implications. The importance of explaining these differences cannot be overestimated because they directly affect patient safety and quality of care. Second, Western healthcare employers need to develop and implement support mechanisms to facilitate the adaptation and integration of IRNs. Such measures should include mentoring programs such as the "buddy system," which proved effective in enhancing the adaptation of Asian

nurses, and hence, their retention and success. Third, cultural competence training that facilitates mutual understanding of culture-based values, beliefs, expectations, and behavioral and communication patterns is also needed. For Asian nurses, such training needs to be included in their prearrival recruitment programs.

However, how to prepare Asian nurses to handle inevitable interpersonal conflicts remains a serious challenge, especially when such conflicts are rooted in history and framed by socioeconomic forces that are beyond institutional control. At the minimum, Asian nurses should be made aware of the potential conflicts arising from racial tension in the new country prior to their arrival. In addition, exercises such as role-play to practice how to handle these emotionally charged situations in a high-stress environment will be helpful. A working knowledge of the history, people, and sociopolitical system of the host country and building a repertoire of interpersonal skills will certainly help in dealing with the unavoidable conflicts.

Meanwhile, Western employers need to understand that language acquisition is a lengthy process that takes years of learning and practice. Asian nurses have varying levels of language skills that differ from individual to individual and from one source country to another. For nurses from the Philippines and India, the language issues might be less profound since English is one of the official languages and most nurses from these 2 countries were trained in English nursing programs. However, for nurses from non–English-speaking Asian countries such as Korea, language barriers could be more challenging. Similarly, acquisition of a working knowledge about a new culture also requires years of immersion and accumulation through persistent efforts.

Implications for policy making

The documented experiences of Asian nurses in this metasynthesis underscore the central issue of social injustice and the imperative to address it head-on. The included studies reported widespread discriminatory practices and behaviors in one form or another. Oftentimes, discrimination was covert and subtle; other times, it was explicit and outright. To a large extent, the prejudice and discrimination against Asian nurses reflect the deeply rooted intolerance for, and injustice against, racial and ethnic minorities in Western societies and nurses from these groups. Although the eradication of racism is a long-term goal in nursing, both Western governments and employers need to determine what more can be done at the societal and institutional levels. Could Western governments make and implement policies on recruitment, credentialing, employment nondiscriminatory to immigrant nurses, including those from Asia? Although many of these policies are already in place, they exist merely on paper in many cases, with wide variations in their interpretation and execution. At the institutional level, can Western employers implement programs on cultural diversity and competence to cultivate a more tolerable, welcoming workplace environment and to facilitate the communication between Asian nurses and those they work with? More importantly, could specific measures be institutionalized to prevent or minimize discrimination in hiring, performance evaluation, compensation, and so forth so that antidiscrimination is not merely empty lip service or calculated political tactic?

CONCLUSIONS

Asian nurses constitute the largest group of immigrant nurses working in Western countries. For the foreseeable future, the number and share of Asian nurses in the global migration of nurses are likely to continue to increase. This metasynthesis of the lived experiences of Asian nurses working in Western countries encapsulates their challenges, agonies, and struggles for personal and professional identity and social justice. To a large extent, the story of Asian nurses is an integral part of the collective experiences of international nurses from other parts of the world

and parallels those of immigrant women. The lived experiences of Asian nurses must be first documented and examined before any effective interventions can be designed and implemented to facilitate their adaptation and integration. However, when gender, race, and culture intersect, the dynamics of relationships of the involved groups will inevitably be complex, and defies simple, linear explanations and easy solutions.

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