

The Pennsylvania State University

The Graduate School

College of the Liberal Arts

**THE LABOR MIGRATION OF CHINESE NURSES TO
THE UNITED STATES:
EXPERIENCES OF CHINESE NURSES**

A Thesis in

Human Resources and Employment Relations

by

Lili Xu

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Submitted in Partial Fulfillment
of the Requirements
for the Degree of

Master of Science

May 2009

The thesis of Lili Xu was reviewed and approved* by the following:

Paul Clark
Head and Professor of Labor Studies and Employment Relations
Thesis Advisor

Mark S. Anner
Assistant Professor of Employment Relations and Human Resources

Samanthi Gunawardana
Lecturer in Labor Studies and Employment Relations

Darlene Clark
Senior Lecturer in Nursing
School of Nursing

*Signatures are on file in the Graduate School

ABSTRACT

Most countries in the world today, including industrialized countries like the United States (U.S.), are experiencing a shortage of registered nurses (RNs). The recruitment of nurses from developing countries has become one of the primary means for developed countries to fill vacant positions. Although the number of Chinese nurses working in the U.S. is unknown, the evidence suggests that China will become a major player on the global nursing market in the foreseeable future.

This thesis investigated the experiences of Chinese nurses working in the U.S. by addressing the following questions. What factors cause Chinese nurses to immigrate to the U.S.? What is the process to immigrate to the U.S.? What challenges do they encounter in pursuing nursing careers in the U.S.? And how are their lived experiences as RNs mediated through race, gender and culture?

A sample of ten Chinese RNs working in the U.S. were recruited for the study. Data were gathered through in-depth, semi-conducted interviews.

The analysis of data demonstrated 1) that the Chinese nurses interviewed for this study emigrated due to low salaries, lack of jobs and educational opportunities. 2) that there are different migration paths taken by Chinese nurses, including migrating with family members, on government contracts, or with private agencies. 3) that Chinese RNs face significant barriers, including language deficiencies, cultural differences, and racial issues when pursuing nursing careers in the U.S.

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ACKNOWLEDGEMENTS

First of all, I would like to thank the ten women who participated in the study. Their honesty and sincerity in willingly sharing the stories that became the data for this project was invaluable. Without their participation this thesis would not have been possible.

I wish to thank my thesis committee for their guidance through various phases of the project. The unique perspectives contributed by each member of the committee enabled me to develop integrated critical approaches to analyzing the experiences of the participants. My thesis advisor Dr. Paul Clark, committee members Dr. Mark S. Anner, Professor Samantha Gunawardana and Senior Lecturer Darlene Clark contributed to the development of this thesis. Insights gained through discussions with them contributed to the refinements of my argument in writing the thesis.

CHAPTER 1

INTRODUCTION

The United States (U.S.) is a country built on and by immigrants. Immigrants have been credited with making this great nation. The image of the U.S. as a land of opportunity continues to attract immigrants, both legal and illegal, from all corners of the world.

This thesis focuses on the experiences of Chinese nurses who have emigrated to the U.S. and are now working in the American healthcare system. In particular, the research will focus on the emigration experiences of these nurses, as well as their acclimation to the U.S. healthcare system and to U.S. culture and living conditions.

A shortage of registered nurses (RNs) exists in most countries in the world. This shortage extends to all wealthy, industrialized countries, including Australia, France, and Germany. The nurse shortage in many countries has been “the result of increased demands outpacing the slower-increasing supply of nurses” (Buchan, 2001, p. 202). The recruitment of nurses from developing countries has become one of the primary means utilized by developed countries to fill vacant positions (Stewart, Clark, & Clark, 2007).

International nurse migration is defined as “the movement of nurses from one country to another to take up employment and establish residence, either temporarily or permanently” (Stilwell, Diallo, Zurn, Vujicic, Adam, & Dal Poz, 2004, p. 12). Traditionally, most of the world population lives in their country of birth. Only three percent participate in work-related migration (International Organization of Migration, IOM, 2005). However, the migration of foreign nurses to the U.S. has risen sharply in recent years (Brush, Sochalski, & Berger, 2004; Buerhaus, Staiger, & Auerbach, 2003 & 2004). The Immigration Policy Center (2004) indicates that

foreign-born nurses accounted for 12 percent of the total nurse work force in the U.S. in 2003. As the demand for RNs continues to grow, and the nurse work force in the U.S. ages and shrinks in size, hospitals and other providers will increasingly rely on foreign R.N.s (FRNs) (Buerhaus et al, 2004). The strong demand for RNs opened the nurse labor market to the world. From a global perspective, it is clear that the recruitment of nurses from other countries, to the U.S., has the potential to cripple the healthcare systems of the countries of origin. The loss of skilled nurses in developing countries has the potential to exacerbate the shortage in those nations from serious to catastrophic and could have ramifications for every aspect of global health.

In the last few years international recruitment of nurses has intensified, particularly in Australia, the United Kingdom (U.K.), and the U.S. Many studies have shown that developed countries are the primary recipients of migrant nurses. Australia, the U.K., and the U.S. received the largest number of such migrants (Bach, 2004; Brush & Berger, 2002; Buchan, Parkin, & Sochalski, 2003; Davis, 2002). Between 1995 and 2000, Australia received 11,757 foreign nurses (Hawthorne, 2001). The U.S. Citizenship and Immigration Services (USCIS, 1998) reported that more than 10,000 foreign nurses immigrated to the U.S. from 1995 to 2000. In addition, the U.K. alone received 59,885 foreign nurses from 1998 to 2004; most of them from Botswana, Ghana, India, Kenya, Lesotho, Malawi, Mauritius, Nigeria, Philippines, South Africa, Swaziland, Zambia, and Zimbabwe (UK Nursing and Midwifery Council, 2004).

I. Why study the immigration of Chinese nurses

The phenomenon and experience of Chinese immigrant nurses to the U.S. is an important issue for several reasons: 1) There has not been much written in the literature on the causes, barriers and lived experiences of this group of workers; 2) due to the Chinese nurses' current situation in China and the global nurse shortage, China will supply more and more RNs to

developed countries in the coming years; 3) the immigration of Chinese nurses coincides with the large numbers of nurse vacancies in the U.S.

The nurse shortage is one of the dominant concerns in healthcare today. As one of the main means to relieve the shortage, especially in developed countries, nurse migration from developing countries to developed countries is a hot topic for researchers. However, most of the research on nurse migration has focused on the Philippines (Lorenzo, Galvez-Tan, Icamina, & Javier, 2007; Perrin, Hagopian, Sales, & Huang, 2007; Brush, & Sochalski, 2007), India (Khadria, 2007), and Sub-Saharan Africa (Dovlo, 2007) including Zimbabwe (Chikanda, 2005). There are few studies on nurse migration from China.

The purpose of this thesis is to examine the phenomenon of nurse migration from China to the U.S., including the causes, the process, and the barriers involved. This thesis will also look at the experiences of Chinese nurses who choose to emigrate, as well as the challenges – professional, emotional, and cultural – they face.

China appears to be one of the few countries in the world that does not suffer from a shortage of nurses. In fact, because China has a very high patient to nurse ratio it actually has a surplus of RNs. According to Fang (2007), “there are over 18,000 hospitals, 2 million physicians, and 1.3 million working registered nurses in China, i.e., one nurse for every thousand people. Further, there are 0.4 registered nurses per hospital bed in China (Mao, 2004), and only 0.68 nurses for each physician in the hospitals” (Fang, 2007, p. 1419).

Due to limited budgets China hasn't provided enough job positions to the educated nurses. A lot of nurses either cannot find jobs or are worrying about losing the one they have. Meanwhile, many nurses older than 50 years have to give their jobs to younger ones due to competition (Liu & Sun, 2003). Therefore, a large number of Chinese nurses, especially those with bachelor or higher degree, are looking forward to changing occupations or working outside China.

On the other hand, the Chinese government has taken action to encourage and promote the migration of Chinese nurses. In 2002 the Commission on Graduates of Foreign Nursing Schools (CGFNS) and the Chinese Ministry of Education Examination Center reached an agreement and set a new CGFNS test center in Beijing. The first CGFNS exam was scheduled in July 2003. The Chinese government believes that this event will significantly promote the international mobility of Chinese nurses and stimulate China and Chinese nursing to integrate into the global community (Xu, 2003).

Because of language deficiency and differences in medical education and practices between China and the U.S. it would be hard for Chinese nurses to pass the CGFNS exam. However, it is expected that the number of Chinese nurses passing this exam will grow greatly due to their passion for learning and a strong work ethic. As a result, more and more foreign countries, especially wealthy, industrialized countries, will recruit Chinese nurses to alleviate their nurse shortage. And China will become the largest group of international nurses in developed countries.

II. Aim of the study

The migration of Chinese nurses to the U.S. is a post-Mao phenomenon that coincides with the policy of “opening to the outside world” adopted in 1978 under Deng Xiaoping (Xu, 2003). Prior to that time, Chinese RNs from Taiwan and Hong Kong had been migrating for some time. Using the Philippines as a model, China has adopted “training for export” as a national development policy regarding technical personnel, including nurses (Xu, 2006). This is a direct response to an increasing need for foreign exchange to fuel a booming economy, but more importantly, to a 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 engaged in both direct and indirect recruiting in China, with less than expected success primarily due to the English language deficiency of Chinese nurses, as well as the convoluted visa process (Xu, 2003, 2006).

In 2004, 51 Chinese nurses came to California on tourist visas, marking the first organized migration of nurses from China to the U.S. Many managed to stay and work in local healthcare agencies after passing the National Council of Licensure Examination (NCLEX) for Registered Nurses (Xu, 2008). Since CGFNS opened a testing center in Beijing in 2003, about 1,500 Chinese nurses have taken the CGFNS certificate examination (Xu, 2008). However, the exact number of Chinese nurses migrating to the U.S. through CGFNS and other channels is unknown.

This thesis examines the lived experiences of Chinese nurses working in the U.S. healthcare environment. The research will focus on the following questions:

- 1) What factors cause Chinese nurses to immigrate to the U.S.? The issue of Chinese nurse migration will be studied under the “push-pull” theory..
- 2) What is the process to immigrate to the U.S.?
- 3) How are the lived experiences of Chinese nurses working in the US mediated through race, gender, and culture? 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, themselves. 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 serious and rigorous examination (Xu, 2008).

4) What challenges do Chinese nurses working in the U.S. face in adapting to the fundamentally different culture they experience in the U.S.? Do they have difficulty adjusting to different living conditions?

5) What challenges do Chinese nurses who immigrate to the U.S. face in terms of the practice of nursing? Is nursing practice in the U.S. different from nursing practice in China? How much “retraining” is required for Chinese nurses to successfully practice in the U.S.? How difficult is it for Chinese nurses to adapt to the U.S. healthcare system, given the fundamental difference between the U.S. and the Chinese systems?

III. Organization of the thesis

This thesis is organized into seven chapters.

Chapter Two reviews the related literature on labor migration and discusses labor migration research, including work on Asian and Chinese labor migration.

Chapter Three discusses the pertinent immigration laws that impact nurse migration.

Chapter Four examines the nursing shortage in the U.S., its causes and proposed solution.

Chapter Five discusses the qualitative research methodology used in the study. This chapter provides a detailed discussion of the selection of participants, ethical considerations, and methods used in data analysis. A discussion of the demographics of the sample is also included in this chapter.

Chapter Six is devoted to an analysis of the narratives of the project’s participants. This chapter focuses on participants’ voices in relating the reasons for immigration, the immigration processes, and the barriers in navigating their careers as registered nurses.

Chapter Seven summarizes the thesis. This chapter discusses the implications of the research for nursing, and makes recommendations for change based on antiracism. Limitations of the research are also included.

CHAPTER 2

LITERATURE REVIEW

This chapter discusses labor migration theories and reviews the relevant migration literature.

I. Labor Migration Theories

A. Neo-classical Approach

Traditional neoclassical economics views international migration through the lens of the cost-benefit calculations of individuals (Massey et al., 1994). Individuals undertake migration in order to maximize their expected incomes.

According to the neoclassical theory, labor flows “from low-wage to high-wage countries and capital moves in the opposite direction” (Massey et al, 1994, p. 701). In other words, migrant labor usually flows from low-wage countries (third world) to more industrialized countries, while capital used for building offshore factories, for example, usually flows from industrialized countries to third world nations. “Migration exerts downward pressure on wages in destination countries and upward pressure on wages in sending countries until an equilibrium is reached.” (Massey et al, 1994, p. 701). This is what Portes and Walton (1981) called the equilibrium theory. Rist (1978) labels this same theory the modernization view. A primary assumption of this perspective is that there is an imbalance in the distribution of the factors of production such as land, capital and labor (Wood, 1981). People migrate in response to perceived economic imbalance. Migration, according to this theory, is a way to decrease the pressure of population

and economy in low-growth areas and simultaneously to provide labor for the needs of growing regions. The migration process achieves a balance between human and capital resources. Migration should continue until the gap between expected wages (minus migration costs) is closed (Massey et al, 1994). The process itself is thought to be self-regulating; that is, it will stop once an “equilibrium” state or balance is reached.

A variant of the equilibrium theory is modernization theory (Portes-Walton, 1981). Western-styles and values, and forms of consumption, having penetrated the backward regions, lead to the emergence of new aspirations between the active and dynamic sectors of the society. This exposure to “Westernism” produces a split in the backward areas’ population: those who adapt to the “new” trends are called ‘modern’ while those who cling to the old way are called ‘traditional’. Migration is the logical outcome – those who are more attuned to the new values go to advanced centers and leave the traditional population behind.

Closely resembling modernization theory is Piore’s (1979) cumulative causation theory. This theory refers to the tendency of international labor migration to continue and perpetuate itself over time, irregardless of the original factors or conditions that may have caused it. According to this theory, the prior experience of an individual migrant effectively changes his/her perceptions, motivations, expectations and values. As a result of these changes, people who migrate once are more likely to do so again (Massey et al., 1994). An international migration may begin as a short-term strategy for income generation. But as an individual makes repeated trips, he gains more experience of living and working in an advanced economy. He also gains valuable information about job-hunting, and getting around, thereby effectively reducing his costs and risks. As a result, what originally started as a short-term income generating strategy becomes a lifestyle.

Equilibrium and modernization theories are closely related to the neoclassical theory of human capital. The individual migrant worker is viewed as a rational, free utilitarian worker,

trying to maximize differential income opportunities (Borjas, 1989; Ball, 1990). In terms of international labor migration, people seek employment abroad mainly because of the huge differences between the real income at home and abroad (Straubhaar, 1986). Research conducted by the North American scholarly community relies heavily on the microeconomic model of migration (Wood, 1982).

B. Structural Approach

One of the sharpest contrasts between the neoclassical approach and new structural approaches is the conceptual shift from a view of international migration as the aggregate movements of individuals in response to differential opportunities, to a view of migration as a movement of workers encouraged by the “transnational capitalist economy” which also determine the “push” and the “pull” factors (Zolberg, 1978). This conceptual shift broadens the theoretical domain by encompassing the present experience of other countries.

The structural-historical approach was elaborated by Marxist scholars and other “dependency” writers. The main argument was that the flow of investment capital and trade relationships from the advanced to the peripheral countries did not lead to equilibrium between them but to the progressive subordination of the weaker nations. This is due to the continuous drain of the surplus from the peripheral countries which results in the stagnation of their economies. If there is any growth in their economies, it is slower than the central countries or in terms dictated by them (Portes-Walton, 1981). Ball (1990) summarizes the common theme among dependency theorists such as Myrdal (1957), Frank (1973) and Cardoso and Faletto (1979) as follows:

- 1) The most important obstacles to development are not lack of capital or entrepreneurial skills, but are external to the underdeveloped economy.

- 2) International transfers of labor through migration can be analyzed in terms of relations between two crude regions: the center and periphery.
- 3) Due to the fact that the periphery is deprived of part of its surplus, including human capital through labor migration, development in the center implied underdevelopment in the periphery (Ball, 1990, p.22).

The most recent form of historical-structural perspective is the world-system theory (Wallerstein, 1974). According to this view, labor migration and related exchange are not really externally processed between two separate entities but rather parts of the internal dynamics of the same world-capitalist system. Under the world-capitalist system, the peripheral nations satisfy resources, market and labor. Peripheral areas are “bound closer to the centers via a series of financial and trade mechanisms controlled by the latter” (Portes-Walton, 1981, p. 29). The net result is an ever growing interdependence between the different economic units of the system. Within this context labor migration is viewed as “an expression of, a response to, and a mechanism for, increasing inequality between core and periphery” (Ball, 1990, p. 24). In contrast with the dependency approach with its rigid determinism and unidirectional flow of power, the world-system approach recognizes the uneven development of capitalism and that it is more fluid and complex both between countries and regions within countries (Ball, 1990).

One example is Sassen’s (1988) study linking foreign investments to migration. According to the author, the cause of international labor migration can be traced to the direct foreign investments of countries like the U.S. Foreign investments into third world are used for large scale operations like huge factories. These operations generally disrupt the local labor patterns. Native farmers and young women are attracted to export processing zones. They become wage-earners and at the same time get immersed in new western culture. This immersion into the western culture subjectively shortens the distance between the developed country and theirs. They come to think that they can be useful in the developed country too. The next logical step therefore is to immigrate to this developed country. The U.S. is a special target of immigration because of several factors: 1) it has the image of an immigration country; 2) the 1965 Immigration Act which

advocated family reunification opened the door to millions of migrant laborers; and 3) the relocation of factories from the cities to the outskirts of the city to attract a cheap labor pool that caters to migrant labor. For Sassen (1988), labor migration is intimately tied with the capitalists' expansion into the third world economies.

C. Segmented Labor Market

Neoclassical theory views international labor migration as originating from the rational calculations of individuals and their families in response to market forces. Segmented labor market theories on the other hand, argue that labor migration is essentially demand-oriented and built into the economic structure of advanced societies (Piore, 1979). It is inherent in modern capitalism to promote a “bifurcated labor market, creating a sector that produces jobs with secure tenure, high pay, generous benefits, and good working conditions, and a secondary sector typified by instability, low pay, limited benefits, and unpleasant or hazardous working conditions” (Massey et al., 1994, p. 715). Local workers inherently shun working in the secondary sector since the economic return to their labor is generally low with regards to their experience, skill and education. Employers therefore have to recruit immigrant workers to fill the jobs in the secondary sector which are rejected by native workers (Piore, 1979).

1. Origins: Labor market segmentation arose during the transition from competitive to monopoly capitalism – the era between 1890 to the present. In the era preceding the period of competitive capitalism, labor market developments pointed towards progressive homogenization of labor forces and not towards segmentation. The factory system eliminated many skilled crafts while at the same creating large pools of semi-skilled labors.

The large pools of increasingly homogenous workers generated tensions manifested in the upsurge in labor conflict with the emerging capitalism. The needs of monopoly capitalism for

control were threatened. In order to meet the threat, the employers “actively and consciously fostered labor market segmentation in order to ‘divide and conquer’ the labor force” (Reich et al., 1973, p. 361). Monopoly capitalists’ strategy involved change in the internal relations of the firm. They used “Taylorism” and scientific management, the establishment of organizational structures, the use of industrial psychologies, and others to devise appropriate motivating incentives (Reich et al., 1973). With these internal changes, there is cost for an individual worker to leave a certain company. One may be skilled at a certain task in one company and yet be totally useless in the other company. Similar efforts of conscious segmentation were underway with regards to the firms’ external relations. The employers consciously exploited racial, ethnic, and gender antagonisms to achieve segmentation. These “efforts of monopolistic corporations to gain greater control of their product markets led to the dichotomization of the industrial structure” and consequently of the labor force (Reich et al, 1973, p. 361).

2. Primary labor market: Core firms have internal labor markets consisting of sets of positions within the firm. The jobs in these internal labor markets possess the following traits: “high wages, good working conditions, employment stability and job security, equity and due process in the administration of rules” (Althausser & Kalleberg, 1981, p. 123). The primary labor market can be further broken down into two tiers: the upper and the lower tiers (Althausser & Kalleberg, 1981). The upper tier jobs require stable working habits (Reich et al.), while offering more security, higher wages and status, autonomy, and greater opportunities for promotion (Montagna, 1977). These are the better professional and managerial jobs. The secondary tier occupational groups are salespersons, clerical workers, and skilled workers (craftsmen) (Montagna, 1977).

3. Secondary labor market: Periphery firms operate on the external or secondary labor market (Hodson & Kaufman, 1982). Jobs in the secondary labor markets are “characterized by low-pay, poor working conditions, and little chance for advancement”. There is also “a highly

personalized relationship between supervisors and employers giving latitude for favoritism and poor work discipline” (Montagna, 1977, p. 90). In contrast with the primary labor market, there are no barriers to movement into or out of position (Hodson & Kaufman, 1982).

The labor force which makes up the secondary labor market has the following experiences and characteristics: 1) persons with stable but low-wage experience (for example, adults, black female, and recent immigrants); 2) adults with a history of chronic turnover and poor work habits; 3) teenagers with little or no experience; 4) persons with “clearly defined obstacles to employment” like the aged, mothers with young children, alcoholics and the like; 5) those who are not in the labor force (Montagna, 1977).

A variant of segmented labor economy is split labor market theory put forth by Edna Bonacich (1979). Her emphasis is on the theory of race and ethnic relations and the subsequent arguments accounting for racial and ethnic antagonism.

In explaining ethnic antagonism, split labor market theory identifies the difference in the price of labor as the primary cause of the antagonism rather than ethnicity (Bonacich, 1972). The efforts of white workers to improve their position through militant trade unionism threatened to drive labor prices up (Bonacich, 1976) thereby creating a price differential. It must be noted that the emphasis is on the price differential more than the salary differential. Price differential means the gross difference to the employer in hiring one group of workers or another group. This includes housing, recruitment, training and discipline (Bonacich, 1976). The employers upon seeing the difference in the price of labor were motivated to displace high-price labor with cheap labor in order to maintain their profits.

Recruiters who come from poorer economies would tend to be induced to sell their labor cheaply. Immigrants may be pushed to sign a contract without knowing fully the prevailing wage rates in the new country. Generally, the wage-rate varies inversely with the amount of political

power that a group has. The weaker the group is politically, the more vulnerable it is to bargain or to no bargain at all (Bonacich, 1972).

Both theories lend themselves to international labor migration. Migrant labor is seen as a reserve army of labor for jobs which few local workers would take (secondary sector). Immigrant labor is also seen as a means to increase profits by labor substitution.

D. The push – pull theory of migration

“Migration is the result of the interplay of various forces at both ends of the migratory axis. These forces are political, social, economic, legal, historical, cultural, and educational.” (Kline, 2003, p. 108). These forces are “push” and “pull” factors. Push factors exist in the donor countries and pull factors in the recipient countries. The combination of both factors result in the national and international labor migration (Dovlo, 2007).

In 2005 Lorenzo and his partners organized 48 focus groups with Filipino health workers planning to migrate to other countries to investigate nurse migration in Filipina. The study showed the following push and pull factors for nurse migration:

Push Factors

- *Economic:* low salary at home, no overtime or hazard pay, poor health insurance coverage.
- *Job related:* work overload or stressful working environment, slow promotion.
- *Socio-political and economic environment:* limited opportunities for employment, decreased health budget, socio-political and economic instability in the Philippines.

Pull Factors

- *Economic:* higher income, better benefits, and compensation package.

- Job related: lower nurse to patient ratio, more options in working hours, chance to upgrade nursing skills.
- *Personal/family related*: opportunity for family to migrate, opportunity to travel and learn other cultures, influence from peers and relatives.
- *Socio-political and economic environment*: advanced technology, better socio-political and economic stability.” (Lorenzo et al, 2007, p. 1412)

II. Other Relevant Literatures

A. Racism

According to James, “race is significant as long as groups are identified and acquire status according to selected physical traits” (p. 25). He stated that race transcends the biological category and is significant because of social meanings that are attached to the concept. According to Anthias and Yuval Davis (1992), “racist practices do not require racist intentionality of structures which underpins so much of the work on institutional racism. Practices may be racist in terms of their effects” (p. 13).

The concept of racism relates to denial of resources based on power and privilege. Individuals and groups who have enough power can implement actions that deny privileges to individuals of other races who are seen as less worthy. Various forms of racisms may be manifested by individuals or groups, and become part of the normative functioning of societal institutions. Systemic racism maybe embedded in practices of social institutions. Everyday practices are taken as normal and accord privileges to some, while denying them to others (James, 1996). Historically, ideological categories such as skin color and facial features. Institutional

practices based on racial differentiation have been used to justify economic and social domination, where privilege is accorded to dominant groups, while nondominant groups are oppressed and denied privileges.

Individual racism is exhibited in the negative attitudes that individuals hold toward each other. When attitudes are translated into daily social interactions and consequent actions that deny privileges to members of some groups, these actions are expressions of racism. Essed (1991) characterized the taken-for-granted practices that underlie institutional norms and values as “everyday racism”. According to van Dijk (1993), “everyday mundane practices” that result in discrimination against minorities, “contribute to dominance of the White group and subordinate the positions of minorities” (p. 5).

Institutional or systemic racism is based on institutionalized rules and policies that dictate how societal institutions operate (James, 1996). Furthermore, James stated that race is not determined by outward biological categories, but by social meanings attached to the concept and how they are operationalized in society at the level of individual and group functioning.

B. Gender Oppression

Gender differences in the social lives of men and women are based on biological differences between the sexes. Gender is rooted in societies’ beliefs that the sexes are naturally distinct and opposed social beings (Reskin, 1984). These beliefs are turned into “self-fulfilling prophecies through sex-role socialization: the biological sexes are assigned distinct and often unequal work and political positions, and turned into socially distinct genders” (Reskin, 1984, p. 13).

Critical feminist scholars have provided useful frameworks to analyze the experiences of women color in nursing. Western feminist scholarship has traditionally put women’s experiences

of oppression under the umbrella of gender and thus negated those oppressions created through racial domination. Maynard (1994) noted that while it is important to focus on the experiences of women of color derived from race and gender, it is critical to go beyond differences to examine how power relations and the hierarchy of power are constructed and how women of color are situated in the hierarchy. In most institutions like government, the judicial system, education and the healthcare system, top positions that are associated with power and prestige are held by White males. Even in occupations such as teaching and healthcare, where there is a predominance of women. Administrative positions are frequently held by White males. Although significant numbers of nurses are drawn from minority groups, only a few people of color are represented in powerful and prestigious positions in nursing.

C. Migrant Networks

Migrant networks have a significant impact on labor migration in the world. This impact is particularly apparent when “migration involves large informational or psychic costs, such as when moving to a completely different culture or environment or if the destination labor market is hostile to immigrants” (Zhao, 2003, p. 500). For example, Chinatowns and Koreatowns in the U.S., which are the communities made up of international immigrants with the same ethnic background, are the products of migrant networks.

“Migrant networks are sets of international ties that connect migrants, former migrants, and nonmigrants in origin and destination areas through ties of kinship, friendship, and shared community origin” (Massey et al., 1993, p. 448). The most important effect of migrant networks is to reduce the cost of labor migration. It is well known that laborers have to spend a lot on migration, including material, informational, and psychic costs. Migrant networks can “reduce information costs by providing specific job information to potential migrants, reduce

psychological costs by providing supportive relationship to migrants in destinations, and reduce the probability of unemployment by providing direct job search assistance from fellow villagers” (Zhao, 2003, p. 500). Previous studies have demonstrated that migrant networks play an important role in facilitating sequential migration (e.g., Massey et al., 1993; Massey, 1987).

Migrant networks have played an important role in promoting labor migration in China domestically and internationally. In one study involving 706 migrant workers in the southeast of China, Zhao (2000) found that over 75.6 percent of the migrants were assisted by relatives or friends during their first migration. In another sample survey involving 15,000 migrants in Shangdong province, more than 70 percent of the migrants reported that they had prearranged jobs before migration (Meng, 2000).

III. Migration Studies

Most empirical studies on labor migration deal with the causes of labor migration. We will examine some studies dealing with migration in general, Asian labor migration and Chinese labor migration.

A. Migration in general

The most common trend in labor migration studies is to look for individualistic factors that cause migration (Portes-Walton, 1981). An individual has two means of changing his or her social condition: 1) seek individual improvement through the improvement of one’s group – by regional or national development; or 2) seek improvement in one’s personal situation through emigration from a less developed to a more highly developed region or country (Rist, 1978).

There are, however, other reasons for migration besides economic consideration, including seeking political asylum, reunification with one's family, and education of children.

The most commonly cited reason for human migration is economic. The assumption is that the individual's decision to migrate is based on rational economic calculation. Todaro (1969), for instance, argues that rural-to-urban migration is an individual response to an expected higher urban income. Since migrating to an urban area does not automatically guarantee a job, a migrant must look not only at prevailing income differentials but rather at the rural-urban expected income differential. A migrant must therefore balance the probabilities and risks of being unemployed or sporadically employed in the city for a certain period of time against the favorable urban wage differential.

Katz and Stark (1986) on the other hand, argue that "rural-urban labor migration is perfectly rational even if urban expected income is lower than rural income" (p. 140). They found that "a small chance of reaping a high reward is sufficient to trigger rural-to-urban labor migration" (p. 141).

De Jong and Fawcett (1981) proposed a value-expectancy theory. According to this model, migration is a purposive behavior. The potential migrant makes the decision on migration by weighing and evaluating the perceived consequences of migration. The process involves comparisons between present residence and the alternative destination. The authors proposed the following basic categories: wealth, status, affiliation, comfort, stimulation, autonomy, and morality. Using these categories, their model leads toward a methodology for assessing the subjective cost-benefit calculus in migration decision-making.

Size-of-place and urban proximity are other issues that factor into the decision to migrate. It has been generally held that Americans prefer to live in comparatively small cities, town and rural areas than in large cities. De Jong (1977) made a one-year panel survey of Pennsylvania households. He found that smaller-size places and proximity to a city were not correlated with

where people actually moved when the size and proximity of the previous residence were considered. The author concludes that most people want to have the best of both the urban and rural environments. This is achieved by living out, but not way out of a large city.

Family ties have been found to be relevant to migration decision-making. Mincer (1978) found that family ties tend to deter migration, to reduce the employment and earning of migrating wives and to increase the employment and earnings of their husbands. Two-earner families are more likely to be deterred from migrating than single-earner families. Earners in single-earner families are almost always men. It is families with working wives whose migration is most likely to be inhibited.

Remittances of migrant laborers are viewed as essential in restoring a balance of payments, stimulating savings and investment at the place of origin (Wood, 1982). In this sense, remittance supports the equilibrium theory. According to Stahi (1986), remittances are very important for the economies of labor-sending countries. Remittances spent on domestic goods and services in Asia, for instance, provided an important stimulus to indigenous industries and to the economies of the labor-supplying countries. Appleyard (1989) acknowledges remittances' positive impact on the balance of payments of recipient countries. He cautions, however, that such gains should be qualified by costs such as: the increased demand for imported goods; the inability of central banks, which generally capture foreign exchange, to determine patterns of expenditures; and the dependence on remittances which compromise security in that continued flows depend on political and economic development in the host country. Keely and Tran (1989) argue that the negative view on remittances (increased dependency, political instability, etc.) has not materialized in their studies of labor supply countries to Europe and the Middle East. They caution readers of overstating the positive effects of remittances due to lack of data.

B. Asian labor migration studies

In the late 1970s and early 1980s Asian labor migration flows were concentrated toward Middle-East nations like Saudi Arabia, Qatar, Yemen, Lebanon, Oman, and Libya. The economic boom in that region spurred large migrant labor flows. The escalation of oil prices in 1973-1974 created enormous capital that enabled these nations to embark upon massive investments in physical and infrastructural development programs. This economic boom created serious labor shortages which required foreign labor and expertise (Ball, 1990). Low-skill workforces, aversion to manual labor by local workers, and low participation of women in the labor force aggravated labor shortages (Arnold & Shah, 1984). Initially, neighboring Islamic nations such as Egypt, Yemen and Jordan met these labor needs, but with more capital available, development plans changed from basic infrastructure development to economic and productive activities based on heavy-industries, transportation, communication, banking, and business development (Ball, 1990). By the late 1970s and early 1980s, South and Southeast Asian countries such as Pakistan, India, Thailand, Indonesia, Korea and the Philippines met the labor demand. By 1985, 43 percent of the international workforce came from South Asia (Arnold & Shah, 1984). In contrast with labor migrations to the U.S. and Canada which tend to be permanent, the labor migration to the Gulf States was temporary in nature. Migrant workers go back to their home countries upon completion of the work contracts.

C. Chinese labor migration studies

China's market-oriented economic reform, openness to the outside world, and change in ideology since 1978 has caused a dynamic population movement domestically and internationally. Under the new policy, thousands of university students went abroad to study or to

work, resulting in the brain drain phenomenon. One estimate says that, of the 220,000 Chinese students who have left China since 1979, only 75,000 have returned (Lianhe Zaobao, 1995).

Today about 27 million Chinese and their descendants are scattered all over the world in more than 130 countries and areas (Poston, & Yu, 1992). The history of Chinese emigration may be divided into four main periods (Liu, 1995). The first is the ancient period, covering the past two to three thousand years to the Mid-Qing dynasty in the eighteenth century, during which Chinese mainly migrated to other Asian countries, particularly the Southeast Asian countries. The second period covers the late Qing imperial China to the Republican period, when Chinese migrated to every part of the world. The California gold rush during the late 1840s brought the first wave of Chinese to North America.

The third period is the first three decades of the People's Republic of China (1949-1979) when Chinese emigration from the mainland was severely restricted. The fourth one is the open door policy period since 1979. During this period, legal and illegal emigration increased.

The main countries and areas now hosting the 27 million overseas Chinese are listed in Table 2.1. Almost two-thirds of the Chinese emigrants are in Indonesia, Thailand, Malaysia, and Singapore. The U.S. is the major country outside Asia with overseas Chinese. This could be attributed to the U.S. Immigration Act of 1965 that abolished racial and national criteria for immigration in favor of economic criteria. In fact, after thirty years of severe restriction, China's open door policy rekindled people's desire to go abroad. Attracted by the high living standards, developed countries have become the major target of legal and illegal Chinese emigrants.

1. Legal Migration from China

Despite the largest population in the world, legal emigration of Chinese from the mainland has been kept small in the past few decades. During the first thirty years of the communist regime, emigration was severely restricted. Even though the control has been

loosened gradually since 1979, China is still the most difficult country in the world for people to get a passport.

Legal emigration depends not only on China, but also on immigration countries. China adopted a new policy recently that required university graduates to serve their country for five years before going abroad. Other people are institutionally free to emigrate.

Many Chinese have a strong desire to emigrate. Every kind of possible method is used to pursue this purpose, both legally and illegally. "Going abroad" as a student is one of the channels for the young Chinese students to emigrate eventually. Because of the loose controls in the U.S., Canada, and Australia, these countries are popular destinations for Chinese migrants (Table 2.2).

2. Illegal Migration from China

Illegal Chinese migrants have been apprehended in the U.S., Australia, Canada, Japan and other places like Hong Kong and Russia in the past few years. In 1993, the *Golden Venture*, with a few hundred illegal Chinese migrants, ran aground off New York City, while Chinese boat people have been located in Australia and Japan (Liu, 1995).

The Chinese economy is booming, with an annual growth rate close to ten percent for more than ten years, but not everyone is benefiting from fast economic development. Most farmers still have very low per capital incomes. There are more than 100 million rural surplus laborers, who are pressured to find jobs away from home. Urban people, seeing relatives and friends abroad making money, dream of emigrating to "get rich quick" (Liu, 1995).

The U.S. is the most favored destination for illegal Chinese emigrants. One report indicates that syndicates smuggling Chinese to the U.S. and Europe have organized a labyrinth of international air, sea and land routes that involved roughly 30 countries. Tens of thousands of migrants, mostly from the coastal regions of South Fujian and East Guangdong in China are transited via Poland, Hungary, and the Czech and Slovak republics into Western Europe and the U.S. According to some estimates, about 100,000 Chinese are smuggled illegally into the U.S.

each year, and another 100,000 to Europe, with the clans of Chinese triads obtaining an estimated \$3 billion per year smuggling Chinese aliens. An “official government business” passport, which is rarely challenged by Immigration and Naturalization Service (INS), costs additional YS\$15,000 (Migration News, 1994).

TABLE 2.1

The Top Ten Countries and Areas Hosting Most of the Overseas Chinese in 1980-82 (Persons)

<i>Country</i>	<i>No.</i>
Indonesia	6,150,000
Hong Kong	4,885,600
Thailand	4,800,000
Malaysia	3,630,542
Singapore	1,856,237
United States	1,600,000
Philippines	1,036,000
Vietnam	700,000
Myanmar	700,000
Canada	289,245

Source: *The Population of Modern China*, edited by Dunley L. Poston, Jr. and David Yaukey, New York and London: Plenum Press, 1992)

TABLE 2.2

Legal Emigration of Mainland Chinese to the United States, Canada and
Australia

<i>Year</i>	<i>United States</i>	<i>Canada</i>	<i>Australia</i>
1985	15,578	1,883	1,439
1986	16,458	1,902	1,663
1987	18,589	2,625	1,041
1988	21,924	2,778	1,014
1989	20,672	4,430	1,570
1990	20,879	7,989	1,005
1991	23,121	13,915	1,128
1992	--	10,420	1,525

Source: Ronald Skeldon, "East Asian Migration and the Changing World Order" in *Population Migration and the Changing World Order*, edited by W. Gould and A. Findlay, 179-181.

CHAPTER 3

IMMIGRATION LAWS IN THE UNITED STATES AND THEIR IMPACT

Immigration law is a complex issue. However, a brief review of the U.S. immigration law is necessary to understand the situation of the immigration of international nurses to the U.S. This chapter will discuss the major U.S. immigration laws and their impact on nurse immigration.

I. Immigration Laws

Immigration is possible only if receiving countries are willing to accept arriving aliens. Receiving countries establish laws which determine who are acceptable and who are to be barred from entering and setting in their territories. The immigration laws of the U.S., for instance, are designed “to restrict numerically the volume of immigration into the United States ... in such a way as to preserve, as far as possible, the balance among the various ethnic in the American population” (Auerbach, 1961, p. 75).

Immigration is a technical term. Not all aliens arriving in the U.S. are considered immigrants. Aliens are classified either as immigrants or nonimmigrants depending on the status of their residency in this country (Auerbach, 1961). Immigrants are those “nonresident aliens admitted to the United States for permanent residence.” Nonimmigrants, on the other hand, are “nonresident aliens admitted for a temporary period” (United State Historical Statistics, p98, cited by Muncada, p. 44). Auerbach (1961) outlines the classes considered nonimmigrants by the U.S. immigration laws:

- 1) Foreign government officials
- 2) International organization aliens

- 3) NATO aliens
- 4) Temporary visitors for business or pleasure
- 5) Students
- 6) Exchange visitors
- 7) Treaty traders and investors
- 8) Representatives of the foreign press, radio, film or other information media
- 9) Temporary workers and industrial trainees
- 10) aliens in transit
- 11) Crewmen (Auerbach, 1961, p65)

Until 1968, immigrants were further classified as quota or nonquota immigrants. Quota immigrants were those aliens and their dependents subject to established numerical limitations of the Eastern hemisphere. Quota immigrants may not be issued immigrant visas “unless quota numbers are available for issuance to them in the fiscal year in which they apply for visas or, if the quota numbers not then available, until their turns are reached on the quota waiting list” (Auerbach, 1961, p. 61).

Nonquota immigrants, on the other hand, include “native of the Western Hemisphere and their spouses and children, immediate relatives of the U.S. citizen, and certain groups of special immigrants” (United States Historical Statistics, p. 101, cited by Muncada, p. 44). Nonquota immigrants are not subject to any numerical limitations. Auerbach (1961) outlines the classes of immigrants to whom the Immigration and Nationality Act accords nonquota status:

- 1) Spouses and children of American citizens
- 2) Returning resident aliens
- 3) Natives of certain independent countries of the Western Hemisphere, their spouses and children
- 4) Women expatriates
- 5) Military expatriates
- 6) Child expatriates
- 7) Ministers of religion, and
- 8) Certain United States government employees and former employees (Auerbach, 1961, p64)

Three immigration laws exerted great influence on those admitted into the U.S. as immigrants between 1950 and 1989: 1) *National Origins Act of 1924*, 2) *the Immigration and Nationality Act of 1955*, and 3) *the Act of October 3, 1965*.

A. National Origins Act (1924)

The National Origins Act was passed on May 26, 1924 (Auerbach, 1961). The underlying fundamental assumption of the National Origins Act is that “the place of birth of perspective immigrant is a reliable indication of their possible contribution to the United States and the likelihood of becoming good citizens” (Report of the President’s Commission on Immigration and Naturalization, 1953, p. 91, cited by Muncada, p. 46). Other assumptions of the act are: 1) that there are inferior and superior races; 2) that immigration is harmful ... to the economic life of America and 3) that ‘new’ immigrants have inferior personal qualities (Report of the President’s Commission on Immigration and Naturalization, 1953, cited by Muncada).

Under this regulation, quotas were established according to the national origins of the aliens. The annual quota equals “one-sixth of one percent of the number of white inhabitants in the continental United States in 1920, less Western Hemisphere immigrants and their descendants.” (United States Historical Statistics, p. 100, cited by Muncada, p. 46). It was determined that the annual quota per nationality would be the ratio to 150,000 “as the inhabitants of each nationality living in the continental United States in 1920 to the total inhabitants...” (Auertach, 1961, p. 76).

In 1953, the *President’s Commission on Immigration and Naturalization* stated that “the national origins system is based on false assumption, unsubstantiated by physical science, history, sociology, economics or anthropology.” (Report of the President’s Commission on Immigration and Naturalization, 1953, p. 95, cited by Muncada, p. 46). Scientific evidence indicates no evidence of any inborn difference of personal character, intelligence, or cultural and social traits among races. With regards to economic harm that immigration may bring, the Commission found that “a reasonably limited amount of immigration has no adverse effect ...; on the other hand, ... considerable economic gains and advantages” could be derived from such immigration (Report,

p. 95, cited by Muncada, p. 46). With regards to immigrants having inferior personal qualities, the Commission found “no reliable evidence that new immigrants were inferior to old immigrants in terms of personal qualities” (Report, p96, cited by Muncada, p. 47). The Commission recommended that the system itself should be eliminated since the basis of the national origins system is gone.

B. Immigration and Nationality Act (1955)

The *Immigration and Nationality Act* replaced the *National Origins Act* on December 24, 1955. This Act, also known as the Walter-McCarran Act after its sponsors in the Senate and House of Representatives, however, involved “no radical departure from earlier Acts” (Weinberg, 1967, p. 3). New to the *Immigration and Nationality Act* were the following features that:

- 1) made all races eligible to naturalization, thereby eliminating race as a bar to immigration;
- 2) eliminated discrimination between sexes with respect to immigration
- 3) introduced a system of selective immigration by giving a quota preference to skilled aliens whose services were urgently needed in the United States;
- 4) placed a limit on the use governing country’s quota by natives of colonies and dependent areas;
- 5) provided an escape clause permitting the immigration of certain former voluntary members of proscribed organizations;
- 6) broadened the grounds for exclusion and deportation of aliens;
- 7) curtailed procedures for the regularization of status aliens in the United States to that of permanent resident aliens and,
- 8) provided greater procedural safeguards to aliens subject to deportation (Auertach, & Bennett, 1963, p. 133).

C. Act of October 3, 1965

The most significant revision of the immigration law was initiated under President Kennedy’s program of immigration reform (Weissbrodt, 1984). The law was enacted under President Johnson in 1965 (Weinberg, 1984). The *Act of October 3, 1965* abolished the

distinction between Eastern and Western hemisphere, and between quota and nonquota immigrants. From that time on, the term “immigrants” means those aliens both subject to and exempt from the numerical limitations of both Eastern and Western hemispheres (United States Historical Statistics, p. 100, cited by Muncada, p. 48). The 1965 law established an “annual limitation of 170,000 immigrants from the Eastern Hemisphere, with no more than 20,000 immigrants from any one country” (United States Historical Statistics, p. 100, cited by Muncada, p. 48). When the law took full effect in July 1968, Western hemisphere immigration to the U.S., previously unrestricted, was slapped with a numerical limitation of 120,000 per year. The abolition of the National Origins system gave equal chance to persons from every country within each hemisphere to immigrate to the U.S. (Weissbrodt, 1984). The law was also designed to facilitate family unification, to grant admission of workers needed by the U.S. economy, and to allow entry of a limited number of refugees (Pido, 1986).

The *Act of 1965* also stipulated new preference categories for countries outside the Western Hemisphere (see Table 3.1). Aside from the 20,000 numerical limits for all countries, each of these preference categories has quotas. The Immigration Act stipulates that the total of immigrants admitted under each preference category should be within the 170,000 annual ceiling. In the actual implementation of the law, unused slots under one preference can be used by the next lower preference category.

D. Act of 1989

The *Immigration Act of 1989* “makes adjustment from temporary to permanent resident status for certain nonimmigrants who were employed in the United States as registered nurses for at least three years and meet established certification standards” (Commissioner’s Fact Book, 1990, cited by Muncada, p. 50). This act was a direct response to the dire need for nurses in

American hospitals. Within this act thousands of nurses with temporary working visas would have to leave the country thereby effectively paralyzing nursing care in American hospitals. While this law benefitted those foreign nurses already in the U.S., it also tightened the hiring of new foreign nurses. Before being approved to hire foreign nurses, hospitals have to prove that: 1) there are no local available for the particular job opening; 2) they have not fired any nurse in the same year. These new stipulations were designed to protect the jobs of local nurses from being lost to foreign nurses.

II. Immigration law for international nurses

Under the current law, international nurses are able to enter the U.S. with two visas: nonimmigrant visa (F, J, H, etc) and immigrant visa (green card or permanent resident status). “F visas are for self-supported nursing students. J visas are for nurses in exchange programs and sponsored education/training. H visas are for nurses coming to this country to perform needed services. The three types of nonimmigrant visas have different regulations and procedures with regard to the length of stay, legality of employment, and immigration” (Xu, Xu, & Zhang, 1999, p. 327).

Normally in order to protect the domestic labor market the Department of Labor is required to offer a labor certification to an alien who is hired in the U.S. and demonstrate to the Department of State and Immigration and Naturalization Service (INS) that: “(a) no U.S. citizens and permanent residents are available or qualified for a given job, and (b) the employment of an alien will not adversely affect the wages of the concerned profession” (Xu, Xu, & Zhang, 1999, p. 327). Meanwhile, for the sake of the U.S. interest, the immigration law classified certain occupations and professions which don’t need labor certification as the shortage fields in the U.S., including nursing (Xu, Xu, & Zhang, 1999).

Due to the severe nurse shortage in the mid-1980s, Congress passed the Immigration Nursing Relief Act (INRA) of 1989. This act created H-1A visa for international nurses and permitted U.S. employers to recruit international nurses to provide nursing service in the U.S. The purpose of this act was to alleviate the nurse shortage in the U.S. while protecting “the domestic nursing workforce through extensive documentation and certification to the Department of Labor” (Xu, Xu, & Zhang, 1999, p. 328).

Table 3.1
Preference Categories

Preference	Description
First	Unmarried sons and daughters, over 21 years of age, of United States Citizens
Second	Spouses and unmarried sons and daughters of aliens lawfully admitted to the United States for permanent residence
Third	Members of the professions or persons of exceptional ability in the sciences or arts
Fourth	Married sons or daughters of the United States citizens
Fifth	Brothers and sisters of the United States citizens
Sixth	Skilled or unskilled workers in short supply in the United States
Seventh	Refugees

Source: *New Procedures for Admission of Alien Workers Under the 1965 Amendment to the U.S. Immigration and Nationality Act*, official release dated November 26, 1965, by the Bureau of Employment security, U.S. Department of Labor (cited by Muncada, p63).

CHAPTER 4

NURSING IN THE UNITED STATES

This chapter examines the nursing shortages in the U.S., then discusses the supply of nurses as represented by trends in nursing school enrollment. Reasons for the nursing shortage and solutions to alleviate the shortage will be presented.

I. Nurse Shortage

A. Overview of Nurse Shortage in the United States

The literature is full of discussion regarding the critical nursing shortage and its negative effects on the quality and costs of healthcare services. Changes in the health care industry, greater career and educational opportunities for women, an aging workforce, and stressful working conditions have resulted in today's nursing shortage (Kimball & O'Neil, 2002). In a recent article, Buerhaus et al. (2003) conclude that the shortage of nurses in the U.S. is expected to continue without any long-term solution in sight.

Estimates indicate that the national nursing shortage in 2000 approached six percent with demand for nurses exceeding the supply by 110,000 (U.S. Department of Health and Human Services, 2002a). "Between the years 2000 and 2020, the demand for nurses will increase by 40 percent, but supply during this same period is expected to increase by only 6 percent" (U.S. Department of Health and Human Services, 2002a). The net effect nationally is an anticipated shortage approaching 29 percent or 808,000 nurses by the year 2020 (U.S. Department of Health and Human Services, 2002a).

“The shortage issue is compounded by the fact that only 9 percent of the nursing workforce is under 30, while 51 percent of the nursing workforce is over the age of 45” (U.S. Department of Health and Human Services, 2002a). Retirement issues will only exacerbate the issue.

As the U.S. population ages, demands for RNs will greatly increase. In the years ahead, the fastest growing segment of the population will be those over 65 years old. (Moody, 2002) (Table 4.1). This will exacerbate the impact of the expected shortage of nurses (Florida Hospital Association, 2005) (Figure 4.1). The nursing shortage is a problem that will cause the U.S. concern for many years.

B. Hospital Nurse Shortages

During the 1980s and 1990s, for-profit hospitals began entering the healthcare market and competing with not-for-profit hospitals. This changing marketplace along with the rise of managed care and a growing emphasis on controlling costs influenced the work environment in many hospitals (Salamon, 1995; Kuttner, 1997).

With forty percent of all RNs currently employed outside of the hospital sector and indications that there will be a further exodus of nurses from hospitals, there is concern that there will be continued strain on the hospital sector where nurses are in greatest demand and vacancy rates already stand at 13 percent nationally (American Hospital Association, 2001; U.S. Department of Health and Human Services, 2002b). As nurses leave the hospitals in favor of working in environments perceived as less stressful, such as the home health sector and the doctor's office, there is the additional disturbing fact that many are choosing to leave the profession altogether. Nationally, 81.7 percent of those licensed to be RNs currently work in the field of nursing (U.S. Department of Health and Human Services, 2002b). Of those employed in

the field, twenty percent are only working part time (U.S. Department of Health and Human Services, 2002b).

For example, the hospital nursing vacancy rate in Florida is currently estimated at 8.2 percent (Florida Hospital Association, 2005). Although this is an improvement from the 12.5 percent vacancy rate reported in 2002 in Florida, this decline is due, in large part, to proactive retention strategies initiated by the hospital sector (Florida Hospital Association, 2003, 2005). Nonetheless, in 2004 there was a shortage of 5,342 nurses in the state, an estimate expected to increase to 61,000 by the year 2020 (Florida Hospital Association, 2005).

Spetz and Given suggest that this critical long-term shortage can only be avoided through significant economic incentives, i.e., wage increases on an annualized basis of 3.2 to 3.8 percent (Spetz & Given, 2003). Their models indicate that there are significant lag times between increased salaries and growth in the output of nurses from nursing schools, suggesting that even if such measures are taken, their impact will not be felt immediately. Implicit in the discussion concerning required salary increases and output from the education system is the concept of return on the investment made in a nursing education, which is related to the upfront costs of obtaining that nursing education in the first place and to salaries upon graduation.

C. Quality and Nurse Shortages

The impact of nursing shortage on the quality of healthcare services is very serious. In a 2003 survey of hospitals conducted by the Florida Hospital Association, 44 percent of those surveyed indicated that the nursing shortage was directly affecting overcrowding in the emergency room. This is due to a domino effect, wherein staffed beds are not available in the main part of the hospital (23.8 percent of the hospitals indicated a decreased number of nurse-staffed hospital beds), thereby causing a backup in the emergency room (Florida Hospital

Association, 2003). Over 25 percent of the hospitals surveyed indicated “decreased patient satisfaction resulting directly from the nursing shortage, and nearly 20 percent self-reported an increased rate of reported incidents. Additional consequences included increased wait times for surgical procedures, the closing of nursing units, and the cancellation of elective surgical procedures” (Florida Hospital Association, 2003). In a study conducted by researchers at the Harvard School of Public Health and, Vanderbilt University’s School of Nursing, hospital nurse staffing was found to have “a direct relationship with patient outcomes, with reduced staffing resulting in a greater incidence of urinary tract infections and bleeding” (U.S. Department of Health and Human Services, 2001).

II. Nurse Production – Trends in Nursing School Enrollment

Perhaps what is most disturbing is the downward trend in nursing school enrollment, exactly at the time when the predictions for nursing shortages are increasing for the country in general (Steven et al, 2006). For instance, in 2000-2001 7,961 students enrolled in nursing programs in Florida; in 2002-2003, that number fell to 4,679, a decrease of nearly one-third (Florida Hospital Association, 2003; Florida Hospital Association, 2005). Recently, enrollments have started to increase, but these levels are still not enough to meet demand.

This situation is compounded by a major shortage of staff nursing school faculty. For example, of the 795 nursing instructors in Florida in 2000, “143 planned to retire by 2003. Therefore, it is not surprising that several schools in Florida had four times as many applicants as vacancies, a factor partially determined by the faculty available to teach” (Florida Hospital Association, 2001).

Much of the responsibility for dealing with the nursing shortage has been placed on the shoulders of the public sector. With limitations on federal and state budgets, and demands placed

on these budgets, resources devoted to and outcomes resulting from the public sector's efforts have not been encouraging. The question then arises whether those in the private sector have the potential to have the necessary influence on this problem from a strategic perspective.

III. Reasons for Shortages

A. Low Social Status.

The low social status of nurses contributes to the profession's failure to attract new recruits and to retain old ones. The nursing profession has always been dominated by women, however, male physicians and administrators have had a significant impact on the profession. On the one hand, as professionals, nurses expect to do some decision-making on the job, especially when they take over much of the work done by doctors. On the other hand, the reality is that nurses are required to comply with physicians' and administrators' decisions whether these decisions are right or not (Aikin, 1982). When hospitals become a less satisfying place for professional nurses to work, lots of nurses leave hospitals and change to other occupations.

B. Low Salaries

Nurses lament the low remuneration they get for their job. When people choose careers, one primary consideration is their potential lifetime earnings. Though nurses' starting salaries are now comparable with some professions (such as teaching), their salaries level out in five to ten years after entry (McKibbin, 1990). This is so called "salary ceiling".

A nurse's maximum salary is a mere 69 percent more than the starting salary compared to 226 percent for attorneys, 209 percent for accountants, 184 percent for engineers, and 103

percent for programmers (McKibbin, 1990). Nurse's limited salary growth has been described as one of the single most important factors for contributing to the current national shortage of nurses (Aikin, 1982). Hospitals benefit from nurses' low salaries which enable hospitals to substitute nurses for nonnurses.

C. Limited Funds.

Because most hospitals are non-profit, there are not enough funds available for them to employ more nurses to meet the increased demand. This short-handed situation leads to extra work to nurses on the job and a heavy workload causes more dissatisfaction and frustrations among nurses (Mundaca, 1995).

On the other hand, another reason for the nurse shortages is the cutback in Federal educational assistance because of a wrong view that the current supply of nurses is adequate (Fagin, 1982). The Reagan administration did not believe that there were real nurse shortages. Nurse shortages are caused by an "inactive pool" of nurses. However, such a view does not take into consideration studies that show that 34.5 percent of inactive nurses have children under 17; more than one third of the inactive group were nurses over 50 years old, and more than 80 percent of this group have no credentials higher than the diploma (Fagin, 1982). The Bush administration had allocated zero money for nursing education in the FY 1991 budget. Even now realizing this problem, Congress has no extra funds to help nursing due to the country's multi-billion deficit (Mundaca, 1995).

IV. Solutions to Shortages

A. New Approaches to Recruitment

To attract nurses, hospital executives are now evaluating their competitive position in the job market, including their hospitals' strength and weakness, in order to attract nurses. For this reason, hospitals and nurse executives are trying new approaches to recruitment such as the marketing model (Barigar et al., 1990). Guidance counselor connections even at high schools have also been suggested to screen candidates (King & Sherman, 1990). In order to maintain close supervision and contact with the new recruit, mentorship has been recommended (Kinsey, 1990). Peer reviews have also been suggested for improving the screening process of nurse applicants and for enhancing nursing service (Ott et al., 1990).

Hospitals spend large sums of money on recruitment of nurses. Advertisements in newspaper classified sections—both in this country and abroad have been stepped-up. The average annual recruitment budget of hospitals is estimated to be around \$103,000. Nurse recruitment takes up most of this budget. Nurse recruitment at the national level costs in the range of \$1,300 to \$6,000 per recruit. To attract nurses, hospitals sometimes offer additional incentives in terms of bonuses and bounties. For signing up, for instance, a nurse might receive a \$2,000 bonus. The nurse receives another \$1,000 for staying six months. There is also a \$500 “finder’s fee” to their own employees who successfully recruit a new nurse (The New York Times, 1987).

B. Hire New Nurses from Foreign Countries

A quick solution to the nursing shortage is to recruit foreign nurses. U.S. hospitals have usually recruited from countries like Canada, England, Ireland, Scotland, the Philippines, Australia, and New Zealand (Shockley, 1989).

There are three methods for recruiting foreign nurses. The first method is done by a U.S. organization (for instance, the hospitals) totally on its own. The organization does the advertising campaign, travels to the country of choice, interviews and selects qualified nurses. In the second method, the organization hires a recruitment firm in the country of choice which does all the advertising, interviews and selection. A set fee is paid for every nurse recruited. The third method is a combination of the first two. A U.S.-based organization's recruiter travels to the target country and participates in nursing job fairs organized and advertised by a local recruitment firm. When the candidates are selected and interviewed, the organization's recruiters do the follow-up (Shockley, 1989).

Shockley (1989) estimates the total cost of recruiting a foreign nurse from England, for example, would be about \$5,500 – still less than the highest range for recruiting a nurse at the national level. The package includes \$2,500 recruitment fee to the firm, securing an H-1 visa, and relocation fee (Shockley, 1989).

If a hospital hires supplemental staff on 13-week contracts to fill core staff positions, it would cost \$17,680 in one 13-week contract. On the other hand, it would only cost the hospital \$11,180 if it were paying its own staff. (see Exhibit 1 below). With a minimum one-year contract, hiring foreign nurses becomes a very attractive alternative since recruitment cost is offset in one “13-week period” (Shockley, 1989).

EXHIBIT 1

A.

13 week contract
 x 40 work hours/week

520
 x 34 hourly cost for supplement staff

\$17,680 13-week cost

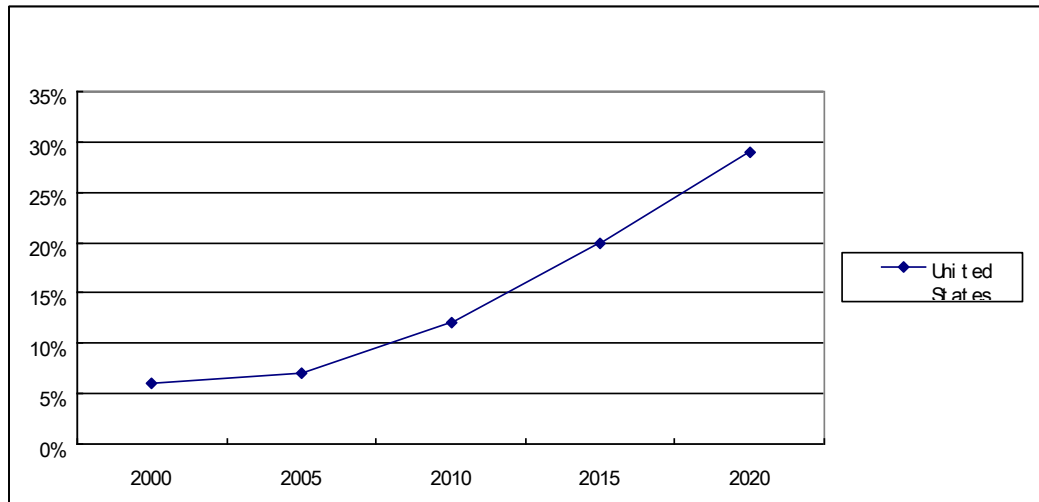
B.

\$15.00 your own staff nurse salary/hour
 \$2.75 11-7 shift differential
 \$3.75 25% allowance for 1st year benefits

\$21.50 cost/hour for your own staff
 x 520 hour/13 weeks

\$11,180,00

Figure 4.1
Estimated Per cent Shortage of Registered Nurses 2000-2020



Source: U.S. Department of Health and Human Services, 2000.

Table 4.1
Population Growth by 2020 in the U.S.

Population Growth by 2020	U.S.
Total	10%
Over 65	53%

Source: U.S. Department of Health and Human Services, 2000.

CHAPTER 5

METHODOLOGY

This research uses qualitative, descriptive methodology. Qualitative methodology was chosen to use because of the flexibility that it offers in studying lived experiences of nurses working in the U.S. healthcare system. Qualitative research methods have been refined over several decades and are now accepted as sound research methods across many disciplines such as anthropology, sociology, and nursing (Denzin & Lincoln, 1998).

The qualitative paradigm recognizes that there are different ways of knowing and different ways of conveying participants' experiences. For this study it was important to use strategies that would enable participants to convey their stories without feeling threatened in any way and to interact with participants in a nonthreatening environment that created trust and respect. In a qualitative design it is possible to use several strategies for collecting data. In this study, open-ended, semi-structured interviews, which avoided questions requiring participants to respond to forced choices, was chosen. This is a strategy commonly used in the positivistic paradigm (Lofland & Lofland, 1984; Marshall & Rossman, 1989).

I. Designing and Implementing the Research

The qualitative approach enables researchers to develop flexible yet rigorous approaches. This approach requires the researcher to frame and reframe the research questions so that they will be clear and reflect the focus of the research. Part of the flexibility of the design enables the researcher to select a sample of participants who can respond to concerns that are germane to the investigation. The central goal of this thesis is to examine lived experiences of immigrant Chinese

people as they experience their careers as nurses. It is crucial to use a research strategy that enables participants to convey their stories in their own voices. The use of open-ended, semi-structured questions was selected because it offered a way to hear participants' voices, without their having to provide structured responses to specific predetermined questions.

In making the decision to gather qualitative descriptive data through the use of open-ended interviews, it was possible to collect rich data that captured details of participants' lived experiences. The interview method allows the researcher to engage with the participants in natural conversation that involves asking questions, and active listening (Denzin & Lincoln, 1998). Using a semi-structured interview guide with open-ended questions enabled participants to relate stories of their lived experiences without constraints. The decision to select a small sample of participants was deliberate. Qualitative research does not emphasize large samples, such as those that are used in gathering data from large-scale surveys. Using open-ended interviews, with a small number of participants, can produce large amounts of data. The richness of the data allows the researcher to explore themes and patterns without reaching saturation (Lincoln & Guba, 1985). The decision to focus on a group of immigrant Chinese nurses working in the US was based on reflexivity. The concept of reflexivity "implies that the researcher is part of the world that she or he studies and is affected by it" (Morse, 1994, p. 165). The researcher's personal knowledge gained from being a person from China enabled her to share common experiences with the participants. The researcher had insights that facilitated the interview process, and was able to pick up important cues in the interviews. These were used as prompts enabling participants to tell stories that added depth to the richness of the data. It was important to hear their voices with the intonations, and nuances that provided deeper understanding of their lived experiences with the attendant emotions and feeling.

The semi-structured interview guide included open-ended questions that were developed for the purpose of this research. The finalized interview guide consisted of five open-ended

questions that focused on three areas. The first area of questions asked why participants immigrated to the U.S. The next set of questions explored their immigration process. The final set of questions focused on barriers they faced in navigating their careers as RNs in the U.S. The overall intent of the questions was to investigate the subject's perception of their lived experiences in nursing, as they were influenced by race, gender, and class, and how they perceived their ability to achieve their careers in the US.

During the interviews, the questions were used only as a guide. The interview process was flexible and the researcher was able to build on cues from the participants' conversation. The researcher used active listening that enabled her to pick up on cues and use them as prompts to encourage participants to explore areas that emerged in the conversations. This process used interactive strategies and ensured the interviewees felt comfortable and safe in sharing their stories. The researcher was continuously aware of her verbal posture, and was particularly careful not to introduce her own views. When later reviewing the audiotapes, the researcher was able to pick up and pursue cues that reflected concerns of the participants. In addition to the interviews, demographic data were also obtained using questions related to age range, education background, migration history, and work experiences.

II. Selection of Participants

A purposeful sample of 10 nurses in the U.S. participated in the study. They were recruited by network or snowballing sampling. The rationale for choosing this method of sampling took into considerations that the researcher needed to recruit participants who had knowledge and experience of the areas of investigation in the study.

The criteria for inclusion of participants were predetermined. All participants selected were Chinese nurses who immigrated to the US from China. All were non-English speakers, having English as their second language. They all worked as RNs in the U.S. hospitals.

III. Ethical Considerations

In conducting qualitative research, the researcher must take precautions to ensure that participants are receptive and confident, and no harm will come to them (Marshall & Rossman, 1989). This research ventures into territory that is not only sensitive, but political in nature. So it was important to clarify ethical guidelines with particular emphasis on demonstrating elements of confidentiality to participants. Because participants were asked to discuss experiences related to career and work, concerns about possible identification of employers and colleagues were foremost. Methods were designed to maintain strict confidentiality, reduce risk of harm, and ensure a sense of trust and comfort in the participants that no disclosure of confidential information would occur.

In managing the research, the researcher built in contingencies to achieve the utmost confidentiality. Participants were informed about the purpose of the research. Contacts were made by telephone, at which time a brief overview of the research was explained. Subjects were given an opportunity to think about whether they were willing to participate, and then were offered the option to choose the time for the interviews.

IV. Data Collection and Analysis

The study was approved by Penn State University's Institutional Review Board (IRB). After consent was obtained, an in-depth interview was conducted with each nurse by telephone.

Each interview lasted from 30 to 45 minutes. Following each interview, a demographic information sheet was completed.

Field data were collected through open-ended, semi-structured interviews and were analyzed using strategies that enabled the voices of the participants to be heard. Interview questions and prompts focused on areas that identified the lived experiences of this group of Chinese nurses working in the US healthcare environment. Once the interviews were transcribed verbatim, the researcher performed independent data analysis. The first phase of analyzing data involved a thorough reading of the interview as soon as they were completed. Subsequently, all interviews were read as a whole. At the initial and subsequent reading, significant statements were extracted and recurrent themes were selected from the narratives. The next step involved grouping common themes. At this stage, themes were categorized and placed into groups.

V. Demographics of Sample

The final sample of participants included 10 Chinese nurses working in the U.S. All participants are women, with an average age of 36.9 (range = 27-51) years. The mean time of living in the U.S. is 10.8 (range = 6-22) years, and the average time of working as a RN in the U.S. is 7.6 (range = 2-19) years. Regarding basic nursing education, three participants graduated from US associate degree programs, three from bachelor degree programs in China and four from secondary-level nursing programs in China. The highest nursing degrees obtained by the participants are two associates, five bachelors, and three masters degrees. All of the participants work in hospitals. Regarding their current positions, six work as staff nurses, three as clinical leaders, and one as a supervisor. In terms of their jobs before their arrival in the U.S., six worked as nurses, one as a cashier, one as a teacher, one as a salesperson, and one as a physician.

ID# Name & Interview Date	Age Range	Level of Education	Years Nursing in the U.S.	Type of Workplace	Current employment Title
#1 Jane 11/12/2008	26 to30	Master	2	Urban Hospital	Staff Nurse
#2 Jessica 11/14/2008	46 to 50	Master	8	Urban Hospital	Supervisor
#3 Yan 11/15/2008	51 to 55	Bachelor	19	Urban Hospital	Clinical Leader
#4 Ning 11/18/2008	36 to 40	Bachelor	8	Urban Hospital	Staff Nurse
#5 Qin 11/18/2008	41 to 45	Bachelor	10	Urban Hospital	Clinical Leader
#6 Ann 11/18/2008	31 to 35	Bachelor	5	Urban Hospital	Staff Nurse
#7 Lin 11/20/2008	41 to 45	Master	11	Urban Hospital	Clinical Leader
#8 Lucy 11/22/2008	31 to 35	Associate	3	Urban Hospital	Staff Nurse
#9 Sunny 11/22/2008	31 to 35	Associate	4	Urban Hospital	Staff Nurse
#10 Lan 11/24/2008	36 to 40	Bachelor	6	Urban Hospital	Staff Nurse

CHAPTER 6

LIVED EXPERIENCE OF IMMIGRANT CHINESE NURSES IN THE UNITED STATES

This chapter will discuss the data collected during the interview process. The narratives of the nurse/participants lived experiences focus on why they immigrated to the U.S., their experience in the immigration processes, and what barriers they encountered as they navigated their careers as RNs working in the U.S. healthcare system. Their experiences related to their identities as immigrant Chinese women who were attempting to access professional nursing in the U.S.

I. The Reasons for Immigration

As discussed in the literature, the push factors in the donor countries and the pull factors in the receiving countries result in the international migration of nurses.

In the interviews, participants were asked to talk about why they immigrated to the U.S. Through their narratives they expressed concerns over lack of job opportunities, low wages, and working conditions in China.

A. Lack of Job Opportunities

The high unemployment rate among Chinese nurses has motivated them to leave China and migrate to other countries. According to Xu (2003), now China has around 2 million nurses, the second largest in the world. However, it is hard for them, especially graduates of secondary

nursing schools, to get jobs even at the salary level of \$3,000 per year. Yan worked in the same hospital for all of her nursing career that spanned over ten years. She started out as a registered nursing assistant, then went on to complete her education as a registered nurse. Before coming to the U.S., she graduated from a secondary nursing school in China and got a mid-associate degree in nursing. (The following excerpt is taken from the participants' response when I asked them to tell me about what motivated them to immigrate to the U.S.)

When I was 18, I graduated from a secondary nursing school in a mid-city in the southeast of China. Since I was born and grew up in that city I wanted to work for a local urban hospital as a nursing assistant upon graduation. However, I found that it was really hard for students with a mid-associate degree in nursing to enter such an urban hospital. Due to the so-called "staff quota formula" urban hospitals preferred medical and administrative personnel to nurses. As a result I had to work in a small medical center upon my parents' help. However, I was still lucky since I had opportunity working in the city. Because of no job opportunities some of my classmates had to go back to their hometown and worked in rural hospitals. Others couldn't even find any jobs. (Interview #3, 11/15/2008)

B. Low Salary

The socioeconomic status of Chinese nurses is worsening. Surveys indicated that "only 58 percent of Chinese nurses feel relatively satisfied or satisfied with their jobs" (Sun & Yan, 2001, p. 93). "In most regions and cities in China, the average salary for a nurse with 3–10 years working experience is only around \$200 per month. With more than 15 years of experience, the average is about \$300 per month" (Fang, 2007, p. 1421).

In the interviews, the majority of participants voiced concerns about low salary in China and saw this as the primary reason to immigrate to the U.S. Lin had more than 5 years of experience working as a staff nurse in the same hospital since she graduated from a basic nursing diploma program in China. She discussed the average salary for Chinese nurse:

The entry level salary for nurse assistances is 500 to 600 Yuan (\$71 - \$85) per month (around 2000 in rural hospitals), not higher than that of janitors. Even such positions are hard to find. The earning differences can be up to 30 or 50 times if they work in the U.S. as RNs. (Interview #7, 11/20/2008)

Another participant, Qin, also raised concerns related to low salaries for Chinese nurses. Before immigrating to the U.S., she worked in the same hospital in Shanghai for more than four years. She started out as a nursing assistant, then held staff nurse positions in a variety of specialty areas, and was promoted to a nurse manager in the fourth year. She said:

My starting salary as a nursing assistant was around \$100 per month which was much higher than that of other nurses working in small cities or towns. During three years afterwards I got 5 percent to 10 percent salary increases every single year. In the fourth year as a nurse manager my salary was around \$200 per month. However, due to the high cost of living in Shanghai my income was not enough to support the whole family (she has a three-people family – husband and one child). Fortunately my husband earned much higher as a marketing manager. (Interview #5, 11/18/2008)

C. Further Education

“Nursing in China still remains in its infancy in its development” (Xu, 2003, p. 270). A large number of Chinese nurses with bachelors or higher degree feel that their education and knowledge is devalued because their job duties are not different from those of nurses graduating from associate degree and/or secondary nursing schools (Xu, 2003). As a result, most Chinese nurses, especially those with bachelors or higher degree, are interested in pursuing personal and professional development outside China. Usually they realize their dreams – the acquirement of newly advanced knowledge, skills, and practices in nursing – by migrating to other countries (Kingma, 2001). “The more skilled professionals migrate in the explicit expectation of a better and more rewarding professional career — often using overseas postgraduate training as the starting point” (Kingma, 2001, cited by Xu, 2003, p. 272).

A participant, Jane, stated that in the beginning she came to the U.S. in order to get a masters degree in nursing. She obtained a bachelors degree in nursing in a well-known medical college in China, and then entered a masters nursing diploma program in the U.S.

I received my bachelor degree in nursing in China. During my college, one of my father's friends worked in a nursing department in an American university as faculty. She told me that the U.S. has the most advanced medical technology and mature education system, and encouraged me to apply for the masters program in nursing in the U.S. Upon her assistance I got the admission of her department and came to the U.S. after graduation. (Interview #1, 11/12/2008)

D. Lack of Respect

Nursing in China is perceived by the public as a dead-end, no-challenge job that requires little formal education/training. In China nurses are thought of as the physicians' "handmaidens" with no "brain". Consequently, Chinese nurses do not enjoy working in China and, in fact, are ashamed of their profession. In contrast, nursing commands much greater socioeconomic status, prestige, and respect in the U.S. because it is regarded as a profession that requires independent clinical judgment and provides 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. (Xu & Kim, 2008).

Lin stated her observations of significant differences in nursing between China and the U.S.

The reason (why I didn't like to be a nurse in China) is because that they (the public) don't think you are a profession. They think the nurse is just a kind of person to wash people, to put the bedpan on patients. It is a dirty job, and you didn't get enough respect.

Nursing is rewarding because in this country (the U.S.) 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 physicians. You feel like you are somebody. (Interview #7, 11/20/2008)

II. Immigration Process

Migration of Chinese nurses to the U.S. is a post-Mao phenomenon that coincides with the policy of "opening to the outside world" adopted in 1978 under Deng Xiaoping (Xu, 2003).

To relieve nurse shortages the U.S. healthcare providers are very interested in recruiting RNs

from the Chinese market. However, since the U.S. immigration laws created legal constraints like immigration quotas and visa requirements for immigrant nurses, the number of Chinese nurses admitted to work in the U.S. is still small. To legally work in the U.S. as RNs non-English-speaking foreign nurses are required to experience the following process: 1) passing the Test of English as a Foreign Language (TOEFL) and CGFNS certification exam; 2) getting hired by a healthcare agency, like hospital; 3) applying a work visa through the employer's sponsorship. The whole process lasts at least 2 years (Xu, 2003). On the other hand, due to language deficiency and differences in medical education and practice the CGFNS and TOEFL exams also present a big challenge. As a result, compared to nurses from the Philippines and India, the number of immigrant Chinese nurses working in the U.S. is still small.

In interviews, the participants were asked how they immigrated to the U.S. and why they chose to work as RNs. Seven out of ten stated that they immigrated to the U.S. with their husbands or relatives and then obtained nursing education in the U.S. Two came to the U.S. from a third country (one from Singapore, the other from Canada). The last one received a bachelors degree in nursing in China and after graduation entered a nursing master program in the U.S.

Due to multiple barriers such as exams and visa, over the last twenty years it has really been hard for Chinese nurses to legally immigrate and work in the U.S. as RNs. So most of immigrant Chinese nurses came to the U.S. first, either with their spouses or relatives or friends, then they obtained additional nursing education here, and worked as RNs in the U.S.

Ning came to the U.S. with his husband around fifteen years ago. She was a registered nurse prior to coming to the U.S., but once she arrived her identity as an RN was questioned. Nursing credentials obtained prior to coming to the U.S. became unacceptable. As a result she had to go back to school and pursued a nursing education again.

I came to America with my husband around fifteen years ago. My husband worked in a university as a technician. Since his salary was not enough to support the family I decided to look for a job. Prior to coming to America I worked in China as a nurse for one and half year. However my

experience and education in China was not accepted here. I went to community college and did nursing there. Once I got in the program, I found that I had to do the whole program all over because of the differences in nursing education between China and the U.S. and my poor English. Fortunately I went through it, and passed the CGFNS exam. (Interview #4, 11/18/2008)

Some participants expressed concern about meeting the needs of their families and doing shift work. For those who were raising children, their early years in the U.S. were shaped by the demands of family life and the need to advance their careers as registered nurses. These women indicated that shift work provided flexibility of working different hours, so they were able to accommodate family demands, ensure income, and take advantage of opportunities to upgrade their education.

Sunny immigrated to the U.S. as a young woman and married her partner shortly after arrival. She spoke of not participating in nursing as a career choice, but when she got married, she found that nursing provided flexibility and enabled her to have some choices in selecting hours for child care and for work. She realized that a career in nursing would provide some economic stability. The choices she faced relating to family and career are common to young women in her age group.

When I was around 19 I immigrated to the U.S. because my parents opened a Chinese restaurant in America. I never anticipated that I would study nursing in the U.S. However, I was married very young. So I started realistically looking at something that would accommodate to the family and not just for profit ... So I decided to become a registered nursing assistant. (Interview #9, 11/22/2008)

Another participant, Lan, also expressed that employment in nursing allowed her the opportunity to choose flexible work hours that enabled her to earn a salary while care for her young children.

Before coming to the U.S., I was a teacher working in a middle school. My husband applied to the U.S. He was a professional and got us a place to live. I thought of different career options and decided on nursing as a career because it offered many choices and fitted well with my life. Basically I worked for one or two days a week. I was making money and providing child care for my kids when they were very young, so I was very accessible to them while I could pursue some kind of a career. (Interview #10, 11/24/2008)

Two participants were sent to other countries by the Chinese government or a private agency. Around in 1992 the Chinese government began recruiting English-speaking nurses to work in Singapore and Saudi Arabia. After passing the exams Chinese nurses signed the government arranged contracts and work in these countries. They should pay 10-15 percent of their annual salary to the Chinese government as “handling fee”. Usually these contracts lasted 2-3 years, and the migrant Chinese nurses were required to go back to China and work for their original hospitals (Fang, 2007). By this contract Lin migrated to Singapore first, and then applied to the U.S.

In the sixth year when I worked in China, the Chinese government began organizing English-speaking nurses to work in Singapore. Since I got nursing bachelor degree, had five-years working experience, and middle-level English skill, I successfully passed the exam and then signed three-year contract to work in Singapore. Although this contract required me to return to China, due to my excellent performance the hospital for which I worked in Singapore continued hiring me to work there. In the fourth year when I worked in Singapore I applied a nursing training program in Canada, studied there for one year, and then passed NCLEX-RN, applied to work in the U.S. (Interview #7, 11/20/2008)

In recent years, in order to make profits in China lots of private operations has mushroomed to help Chinese nurses migrate and work in Australia and England, especially after these countries lowered immigration requirements to relieve their current nurse shortages. These private companies charged a significant amount of money (\$4,000-15,000, 5-20 times higher than a Chinese nurse’s annual salary) to provide this service to nurses who were interested in migration. As a result, most of Chinese nurses had to borrow money from their families and friends, hoping earning 10-20 times higher income in these industrialized countries (Fang, 2007). Jessica, now working in a hospital as a supervisor, emigrated to the U.S. from Canada.

Before migrating to Canada, I worked in China as a nurse manager for several years. I was tired with my work environment and looking forward to changing it. So I contacted one private company which helped Chinese nurses migrate and work in other countries. I paid them around \$10,000. They applied for a student visa in Canada for me and I entered a nursing training program there. After two-year of study I passed NCLEX and received a RN certificate. Because my high score in exams I obtained the Green Card in one year and got a job offer in the U.S. (Interview #2, 11/14/2008)

III. Barriers to Career

A. Communication as a Daunting Challenge

Communication is critical in healthcare settings, especially for nurses who work with patients assessing, planning, coordinating, and delivering care, and evaluating interventions (Xu, 2007). By definition, “communication is the creation of shared meaning and understanding” (Xu, 2007, p. 249). However, because of a variety of factors, Chinese nurses encounter lots of difficulties that hinder their ability to communicate.

The data obtained suggests 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. No matter how well they thought they were prepared linguistically, they still found themselves not prepared enough to meet the communication needs in a foreign country. 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.” (Xu & Kim, 2008, p. 40).

A number of the Chinese nurses found it stressful to communicate with patients and families of diverse backgrounds, particularly when they could not communicate their ideas or when the patients and families talked about matters beyond healthcare issues.

I remembered that during the first few months when I worked in this hospital (in the U.S.), I was responsible to take care of a young man who is really funny. Several times when he said jokes with me, everyone in the room laughed loudly. Only I stood there, not knowing what happened

since I didn't get what he said. It was extremely embarrassing and humiliating. (Interview #4, 11/18/2008)

One nurse found it psychologically painful when physicians and coworkers failed to understand her after repeated efforts.

It is pretty hurtful because they cannot just get it. (Interview #9, 11/22/2008)

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, you need the right spelling so the pharmacist can give the right medication for patient safety. (Interview #2, 11/14/2008).

Verbal communication over the telephone was reported as the most daunting challenge for Chinese nurses. Several Chinese RNs stated that they were afraid of making medical errors from communication mistakes due to absence of nonverbal cues over the phone:

During the first few days on the job, I ran to the bathroom when the phone rang. (Interview #4, 11/18/2008)

Even now the most daunting experience for me is that at an early morning hour the patients or their families called to ask for help or order medicines since usually I have to work alone and sometime couldn't get their exact ideas by phone. (Interview #10, 11/24/2008)

In addition, language and communication deficiencies made it difficult for the Chinese nurses to mingle with their American peers, to ask for assistance, to advocate for their patients, and to speak up for themselves when necessary. As a result, improving language skill was also the most frequently mentioned advice the Chinese nurses gave to their newly arrived peers or those who wanted to come from China to work in the U.S. Prior to emigrating with her husband, Ann worked in China as a salesperson. She completed her nursing education here and found a job in an urban hospital as a RN. She reflected on her experience related to language deficiencies:

When your language cannot communicate better, you are the easy one to pick on ... 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. (Interview #6, 11/18/2008)

B. Devalued Knowledge

When asked to talk about their journey to becoming a nurse in the U.S., participants' narratives reflected perceptions that their knowledge and skills were devalued. Several of these participants had completed basic nursing education in China. Some indicated that they had received additional training; many had practiced as RNs prior to coming to the U.S. When these women arrived here, their knowledge was construed to be less valuable than those who completed nursing education in the U.S.

Collins (1991) maintains that subordinate groups possess knowledge beyond Eurocentric view points. This knowledge is viewed by the dominant group as subordinate knowledge. Foucault (1980) argued that bodies of knowledge that are viewed as subjugated are important because they convey the history of people's struggles. "Nursing, in its quest to enhance its professional status, developed its knowledge base from a Eurocentric standpoint and became grounded in that medical model. In doing so, nursing knowledge that is derived from interactions with patients and their families and with colleagues is not seen as legitimate, and is lost when medical knowledge is seen as the only source of legitimate knowledge. Although nursing has moved away from total reliance on the medical model, and has made progress in developing a body of nursing knowledge, there is hierarchy in what is seen as acceptable nursing knowledge" (p. 87). For example, when nurses who received their education overseas, some of whom have been practicing nurses, attempt to become licensed in the U.S., their knowledge is not evaluated as comparable to their American counterparts.

Many participants encountered barriers in attempting to gain credentials to practice as nurses. When they arrived in the U.S. they were made to feel that their education and experiences in nursing were foreign and inferior to those acquired in the U.S. Although several participants

had received basic, or even high-level nursing education, they were required to complete various parts of nursing programs and pass qualifying exams to become eligible to practice as RNS.

In order to practice as a RN in the U.S., one needed to pass the exam. I was a foreign-trained nurse ... so it was necessary for me to go back to school and take a three-month course or something like that at a college in the evenings to prepare me to take my RN exam. (Interview #5, 11/18/2008)

C. Differences in Nursing Practice

The Chinese nurses interviewed noted significant differences in nursing between China and the U.S. One of the first differences was the autonomy granted by laws and regulations as well as the accountability in Western nursing. It was surprising for them to learn that nurses in Western countries functioned much more independently.

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. 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 nurses' public image and affecting its development as a profession (Xu, 2008).

I found that our American peers functioned much more independently and were responsible for their own actions. I believed that this has contributed to nurses' professional status and job satisfaction in the U.S. Such critical thinking was a huge challenge to the Chinese nurses, especially during the transition and adaptation period, because nurses in China didn't need to do any independent clinical judgment. (Interview #1, 11/12/2008)

In China 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. (Interview # 7, 11/20/2008)

Activities of daily living, such as washing patients, were another difference. Whereas activities of daily living (ADLs) were primarily performed by families who were at the bedside in

China, these activities were the responsibilities of the nursing staff in the U.S. The Chinese nurses were surprised that family members did not provide or assist with ADLs at all and depended completely on the nursing staff for meeting such needs. In China they were not used to providing ADLs because those basic needs were taken care of by families. Chinese family members regard providing such basic and for their loved one as their responsibilities. Consequently, many Chinese nurses perceived providing ADLs as being deskilled, humiliating, and a waste of their education.

I feel degraded and frustrated having to wash patients ... I did not expect that life as a nurse would go around words like pee, loo, and poo. (Interview #9, 11/22/2008)

For the family (in the U.S.), 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. (Interview #2, 11/14/2008)

Meanwhile, the Chinese nurses were shocked by the amount of paperwork required institutionally and legally.

Nursing is bedside care, not paper work. I am tired and sick of having to fill in a bunch of forms no matter whatever I am doing. (Interview #6, 11/18/2008)

D. Marginalization, Discrimination, and Inequality

All participants are female. 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 (Davison, 1993). On a cultural level, the Chinese 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 found it hard to relate to their peers.

Nobody could pronounce my name right during the first 5 months I worked, and when they called me . . . they shortened it and pronounced it wrong. I finally stopped correcting them. (Interview #2, 11/14/2008)

The Chinese nurses indicated that they had trouble joining a conversation when it came to sports, popular music, or other social situations

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. (Interview #10, 11/24/2008)

In reflecting on working relationships with colleagues, several participants characterized their relationships as somewhat ambivalent. Participants indicated that they often felt that they are never fully accepted as part of work groups with colleagues. Moreover, they felt that they were discriminated against because of their skin color, accent, 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. (Interview #3, 11/15/2008)

They (American nursing staff) hate my accent. That's why they don't want to work with me. Although they don't say that, you just sense it. (Interview #10, 11/24/2008)

Sometimes you ask them (American peers) 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. (Interview #4, 11/18/2008)

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. (Interview #6, 11/18/2008)

There are frequent doubt about Chinese nurses' worth and competence. Such suspicion was particularly hurtful when patients under your care were dubious about the medication you gave to them and checked with our white peers behind our back. (Interview #4, 11/18/2008)

Among the participants, some spoke of perceptions of outright discriminatory behaviors on the part of patients. Perceptions related to patients' questioning their knowledge, failing to acknowledge them as professional nurses and the lack of recognition from patients.

The most racist thing to me is that the patients can ask me "where were you trained? What are you doing in this country?" ... They will ask the cleaners sometimes before they ask you, because they don't like to give that recognition of you as a professional. (Interview #5, 11/18/2008)

"You again? Where are those White nurses?" As a foreign nurse, I have to prove myself. (Interview #2, 11/14/2008)

A few of us talked about this ... no matter how much you do for a patient, you may do everything; it's just not recognized ... we had patient X, we washed this person, showered him, shampooed his hair, walked him ... of course the other White nurses would probably provide similar care, yet when the cards of thanks came, the other nurses' names were there and yours was not. (Interview #8, 11/22/2008)

In addition, the Chinese nurses were frequently passed over for career opportunities and believed that race determines promotion. Participants discussed frustrations related to their efforts, especially in making sacrifices to obtain qualifications, and yet they were denied opportunities for advancement to more prestigious and better paying positions in nursing. When they applied for these positions, their applications were consistently denied. When information about requirements for promotion was sought, responses were vague or nonexistent.

I think I should have had more opportunities. I and another colleague, a White American, started to work on the same day. She was oriented to the desk and then was promoted. I wasn't oriented. After six to eight months afterwards, people began to notice. Some peers began to ask. I told them I really didn't care because of the pressures you were under. They told me that was not the point. So when I confronted the manager, she couldn't give me a good answer. I told her maybe I was being discriminated against. She said it just slipped her mind. (Interview #3, 11/15/2008)

You are stuck: no encouragement for advancement; no encouragement when you apply for positions. There is no encouragement to understand what it is you are lacking, what is missing, and what you need to do to get those positions. Sometimes your application is ignored. You knew people were selected, honestly I didn't know how they were selected. I can make assumptions, but I do know a fact that they were not more academically prepared, or more clinically experienced than I was for positions that I applied for. (Interview #3, 11/15/2008)

E. Cultural Differences

There were significant cultural differences noted by the Chinese nurses that impacted their work and everyday lives. They felt “uprooted” culturally and characterized their situation as “being thrown into a different world,” especially during their initial transition after arrival. Meanwhile, they experienced mounting pressure to “re-root” in the new culture (Alexis, 2004, p. 17). They were challenged to understand the host culture and adjust to new ways of life. During this adaptation process, their own values, beliefs, and cultural norms unavoidably clashed with those of Western societies (Davison, 1993). These cultural differences ranged from different concepts of time to different communication styles, foods, and ways of life and customs and customs.

I felt being torn between two cultures, like “a foot here, a foot there, and a foot nowhere”. (Interview #1, 11/12/2008)

The sense of cultural displacement was made worse because I left my families behind. During the first one year after my arrival, I spent an average of \$500 monthly on telephone fees to relieve my nostalgia. (Interview # 7, 11/20/2008)

The Chinese culture is collectivistic, whereas the US culture is individualistic. In the former, the interest of groups (i.e., family and community) comes before that of the individual. In the latter, individual self-interest is supreme (Xu, 2008).

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. (Interview #2, 11/14/2008)

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. (Interview #4, 11/18/2008)

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 U.S. naturally motivated the nurses to rethink who they were as cultural beings (Xu, 2008).

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. (Interview #10, 11/24/2008)

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. (Interview #1, 11/12/2008)

CHAPTER 7

Discussion and Conclusion

“Providing the opportunity to Chinese nurses to work abroad is a win-win scenario” (Xu, 2003, p. 273). As mentioned above the nurse shortage has become a global issue, especially for those wealthy, industrialized countries, like the U.S. To solve this problem most developed countries began recruiting international nurses from developing countries to meet their outpacing demand. On the other hand, Chinese people are known for their passion for learning, the hard-working ethnic and solid, well-rounded education. Empirical studies have demonstrated that in international market Chinese nurses are “competitive” and “appealing”, and they are “comparable, if not superior, to those of their counterparts” (Xu, 2003, p. 273).

Further, the Chinese government and migrant nurses potentially benefit from nurse mobility and migration. For Chinese government, Chinese nurse migration can help alleviate unemployment problem in nursing to some extent and reduce “the potential of social instability and pressure from unemployment and underemployment” (Xu, 2003, p. 273). Meanwhile, the remittance from migrant Chinese nurse will become an important source of foreign exchange for the donor country. For migrant Chinese nurses, they will benefit financially. The acquirement of work experience on the job and newly knowledge and skills in nursing in further education and trainings will make Chinese nurses much more competitive and appealing in international market.

I. Implication of the Research

The data gathered from this research clearly identifies the reasons for Chinese nurse immigration. The data also provide insight into the experiences of Chinese nurses with the immigration process and the existence of barriers that impeded the careers of participants as RNs in the U.S. healthcare system. The findings of this research have implications for all minority and immigrant nurses in the U.S.

To a large extent, data from this research led to findings similar to those of previous research. Hagey, Choudhry, Gurugue, Turritin, Collins, and Lee (2001) reported a Canadian study that documented the experiences of immigrant women with workplace racism, and recommended strategies to address barriers related to this problem. Culley and Dyson (2001) reported on British studies which found that immigrants and minorities in the U.K. experienced disadvantages in their nursing careers. Another British study involving 88 participants examined the experiences of minority staff nurses. Findings of that study indicated that immigrant nurses who had achieved leadership positions were also subject to discrimination, which took various forms in the early and later phases of their careers (Culley & Dyson, 2001).

Data from this study indicated that Chinese nurses encountered barriers in the early part of their careers. However, the majority were able to attain education beyond the basic nursing diploma. These nurses worked in various nursing specialties, and a few acquired positions as managers. From the data it was apparent that existing policies and practices in nursing created barriers for participants in their careers as RNs. Most participants achieved some career goals and made positive contributions to nursing, but not without encountering numerous obstacles during their experiences. There has been a significant increase in the number of Chinese people who are choosing nursing as a career in the U.S. Among these groups, people continue to experience

barriers to navigate their careers. How can these barriers be addressed? While not easily solved, these problems can be addressed if all sectors of nursing are committed to change.

II. Implication for Policy Making

This study reported widespread discriminatory practices and behaviors in one form or another. Often, 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” (Xu, 2007, p. 260). 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.

The goal of antiracism is to unravel multiple and interlocking systems of oppression, and bring about social justice and equity through power sharing (Dei, 1996a). If this goal is to become a reality in nursing, changes should take place at all levels, including ideological and attitudinal standpoints that influence interactions in nursing. The responsibility to bring about change encompasses all facets of nursing, including regulatory and professional organizations, education, employment agencies, unions, and other participants in the healthcare system. In their work on equity in education, McCarthy and Crichlow (1993) call for relational and non-essentialist approaches. Their proposals go beyond treating people as “homogeneous entities,” (p. 62) to taking into account differences within and between minority groups, as well as among dominant group.

Nursing has lamented its lack of authority and power, a situation that is rooted in gender oppression. As the largest group of healthcare providers in the U.S., nurses have the potential to make a significant impact in changing established practices. If nurses used the collective strength

of their profession, they could greatly reduce the sexism and racism that still exists in the American healthcare system.

III. Implication for Nursing Education

“Education reproduces the profession with its attitudes, norms and values, therefore, a change in established models for developing and delivering nursing curricula is a critical place to begin” (Mundaca, 1995, p. 198). Nursing education claims a mandate to educate practitioners who are qualified to meet the complex needs of a changing society. Rapid changes in the society are creating major challenges for nursing educators to prepare practitioners with relevant skills and knowledge for the future (Collins, 2004). Dealing with different cultures should be a part of that education.

Sleeter (1993) proposed that curriculum content aimed at increasing knowledge of antiracism theory should be a requirement for practice in all areas of nursing. Given the demographics of American population, with its rapidly changing cultural and racial mix, it is important that education include antiracism strategies to address the histories and realities of students, faculty, the community, and the healthcare system. Sleeter (1993) argued that people from both majority and minority groups need to learn about racism: “education is a good place to confront racism” (p. 168). Strategies should include teaching about differences, focusing on positive aspects of differences, as well as addressing how oppressions are created through differences and how they can be eradicated. A central part of teaching approaches should be aimed at responding to and dealing with resistance. A move toward integrating antiracism education principles would empower members of the profession in confronting histories and identities that have been negated or erased, thus enabling all those involved in education to develop strategies to include all nurses’ (both majority and minority groups) experiences.

IV. Implication for Practice

Several issues identified in this study have implications for practice at the institutional level. First, apart from the general facility orientation, there should be a transitional program for IRNs that specifically addresses their needs in regard to nursing practice, including elaborations on legal issues, 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 which enhance 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 Chinese nurses, such training needs to be included in prearrival recruitment programs. Meanwhile, training aimed at increasing knowledge of cultural differences should also be a requirement for U.S. nurses. The content should include a focus on cultural sensitivity and facilitating mutual understanding.

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. As discussed above communication is the root cause for most medical errors and events. Improving communication effectiveness is critical to ensuring patient safety and quality of care. It should be kept in mind, however, that it is impossible to overcome the communication challenge overnight. "Nor can communication effectiveness be enhanced by merely improving language skills because language requisition and

communication also contain a socio-cultural dimension (knowledge of idioms and figurative language; knowledge of culture, custom, and institutions; and knowledge of cultural references) and personal dimension (attitude or personality, level of effort, etc)” (Xu & Kim, 2008, p. 46). 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. Language skills and cultural knowledge take time to accumulate and persistent efforts need to be made for notable improvement to occur. 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 challenging and could be painful 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 socio-cultural differences to make informed, sound adjustment decisions.

V. Limitations of Research

This research used qualitative methodology; it examined the experiences of a group of ten Chinese nurses who had emigrated to the U.S. and worked as nurses. This makes the sample a limited one, since it was neither random nor stratified. The voices of these ten participants represent the uniqueness of their experiences as they navigated their careers as RNs; their accounts do not necessarily represent the experiences of other women of color. Immigrant and minority women in nursing are drawn from numerous groups, and they reflect a wide range of people who claim various national, historical, ethnic, and racial affiliations that reflect the diverse demographics of the U.S. The data found that the majority of participants had completed

education beyond entry-level nursing qualifications. For that reason the sample may have disproportionately represented people who had a commitment to education.

The narratives of participants highlighted barriers that impeded their careers as RNs. In retrospect, it may have been useful to include questions in the interviews that solicited their perceptions concerning strategies for removing barriers to advance their careers.

VI. 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 (Xu, 2003). 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 enter the global nursing market, including the U.S. Although Chinese nurses have the language deficit compared with international nurses from English-speaking countries, this study indicates that they do possess unique strengths that are appealing to and valued by Western countries. A transitional program will facilitate their adaptation to the new work environment and ultimately their integration into the U.S. nurse workforce. Such a program will benefit not only these international nurses but also the U.S. employers and, most importantly, the American public.

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Appendix A

IRB Approval

The Office for Research Protections (ORP) has reviewed the above-referenced study and determined it to be exempt from IRB review. You may begin your research.

This study qualifies under the following category (ies):

Category 2: Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observations of public behavior unless: (i) information obtained is recorded in such a manner that human participants can be identified, directly or through identifiers linked to the participants; and (ii) any disclosure of the human participants' responses outside the research could reasonably place the participants at risk of criminal or civil liability or be damaging to the participants' financial standing, employability, or reputation. [45 CFR 46.101(b)(2)]

Appendix B

Interview Outline

1. Demographic information, including gender, age, education, the time working in the US as nurses, and etc.
2. Why did you immigrate to the U.S.?
-- work environment, salary, further education
3. Tell me your journey to immigrating to the U.S.
4. What factors presented barriers that hindered you in your career?
-- communication difficulty, cultural differences, differences in nursing practice or education
5. Did you pursue any further education or trainings to advance your career in the US?