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A Study of the Critical Factors That Influence the Attitudes, Beliefs, and Perceptions of Foreign-Educated Physicians (FEPs) Who Have Entered Nursing as a Second Career

Nora Hernandez-Pupo

A STUDY OF THE CRITICAL FACTORS THAT INFLUENCE THE ATTITUDES, BELIEFS, AND PERCEPTIONS OF FOREIGN-EDUCATED PHYSICIANS (FEPs) WHO HAVE ENTERED NURSING AS A SECOND CAREER

DISSERTATION

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Nora Hernandez-Pupo

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A STUDY OF THE CRITICAL FACTORS THAT INFLUENCE THE ATTITUDES, BELIEFS, AND PERCEPTIONS OF FOREIGN-EDUCATED PHYSICIANS (FEPs) AS THEY PRACTICE IN A NURSING ROLE

DISSERTATION

by

Nora Hernandez-Pupo

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APPROVED BY:

_____
Jessie M. Colin PhD, RN, FRE, FAAN
Chairperson, Dissertation Committee
Program Director, College of Nursing and Health Sciences

_____
Ferrona A. Beason PhD, ARNP
Member, Dissertation Committee

_____
Robin Walter, PhD, RN, CNE
Member, Dissertation Committee

_____
John McFadden, PhD, CRNA
Dean, College of Nursing and Health Sciences

Abstract

Background: Foreign-educated physicians (FEP) are increasingly transitioning to licensed registered nurses in the United States. There is a dearth of research about how effectively this group assimilates the professional nursing role. There is a gap in the current body of knowledge on how foreign-educated physicians are socialized and assimilate into the nursing role. How they see themselves as practicing nurses, and how they came to realize that professional identity is unknown. This information could assist FEPs to effectively transition into the nursing role. Nursing's social contract requires the profession to provide safe, holistic, nursing care to promote the health and well-being of the public. Foreign-educated physicians have difficulty performing basic nursing tasks, and many report completing their degree without attending nursing classes. This may compromise their ability to provide optimal nursing care, at best, and may pose a risk to patient safety at worst. Nurses, alone, have the professional and ethical responsibility to maintain the foundational tenets, expectations, and practices of their own discipline.

Purpose: The purpose of this classical grounded theory study was to discover a substantive theory explaining the process of foreign-educated physicians (FEPs) experience as they transition from their original role as physicians in their country of origin, to their new role as registered nurses in the United States. The theory was grounded in data gathered regarding the critical factors influencing the attitudes, beliefs, and perceptions of FEPs who have entered nursing as a second career.

Methods: The researcher utilized the classical or Glaserian grounded theory design to answer the research questions: (a) What are the critical factors that influence the attitudes, beliefs, and perceptions of foreign-educated physician as they practice in the professional

nursing role in the United States? and (b) How do FEPs view their role in nursing as compared to their physician role?

Results: The basic social process identified in this study was the: ***Acculturating Pathway to Practice,*** which conceptualizes the most active and finite process that offers an in-depth description of the dynamic process of FEPs and their integration, socialization, and transition into nursing as a second career. The three categories that explained this process are ***practicing, transitioning,*** and ***reconciling*****.**

Conclusions: The theoretical framework that emerged from this study is useful to inform nursing education, health policy, academic, and healthcare institutions. Understanding the factors that are influencing this group of nursing professionals is an essential component to retention, patient care, and improvements in academic and healthcare institutions. This study provides insights and increases the body of knowledge within the profession.

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As well to those who volunteered to be part of this study and share their knowledge for the advancement of the nursing profession. I will always be indebted to each nursing professional who participated in this research.

DEDICATION

I would like to dedicate this dissertation to my father Ramiro Eulalio Hernandez Bombino and my husband Alain Pupo. A commitment of such as pursuing one's PhD is genuinely a family effort and not possible without the continued support and encouragement of one's inner circle of loved ones. My father instilled in me, before his death, the love of books, knowledge, and learning. It has been a fulfilling and life changing experience to complete this journey and honor his memory with it.

My husband has been the ultimate gift during my PhD program, and he has taught me what matters most in life. I am so grateful and humbled that he has supported my dream and desire to complete my studies without hesitations. His gentle presence and encouragement during every step of my program allowed me to continue and most importantly finish. I am so thankful to have him in my life as my husband, my love, my best friend.

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CHAPTER ONE

The nursing shortage is expected to reach record numbers. The Bureau of Labor Statistics' Employment Projections 2012-2022 published in December 2013 has projected nursing to be one of the professions with the most job growth through 2022, with estimated total job vacancies for nurses due to growth and replacements to 1.05 million by 2022 ("Nursing shortage," 2016). The registered nurse profession is anticipated to expand from 2.71 million in 2012 to 3.24 million in 2022, which translates to an increase of 526,800 or 19%. Many educational institutions have considered nontraditional sets of individuals who may be representative of an available source of health care professionals with clinical expertise. One such group is the foreign-educated physicians (FEPs) who have a desire to transition and practice as registered nurses (RNs) and advanced registered nurse practitioners (ARNPs). These individuals are practicing as nurse professionals; however, little is known about how well they have integrated the two disciplines and recognize their new role and the values of said role. This research will discover the transition and socialization process of FEPs as they progress from physician to nurse in their second career.

PROBLEM AND DOMAIN OF THE STUDY

Background of the Study

Socialization is a term used by sociologists, social psychologists, anthropologists, political scientists, and educationalists to denote the constant process of reviewing and discussing norms, customs, and ideologies and providing individuals with the skills and habits essential for contributing to their own society. Therefore, socialization is referred to as the manner by which societal, cultural, and traditional continuousness are achieved

(Clausen, 1968). Socialization refers to a progression, which may lead to wanted consequences—at times categorized as moral—as it denotes the society where it occurs. Several scientists state that socialization represents the complete process of learning through the life course and is a central influence on the behaviors, beliefs, and actions of adults and children alike ("Socialization", 2015).

The process of socialization starts at birth, when a newborn is presented with the expectations of suitable behavior, to ideas such as gender and the symbolic communication through language. Although not all socialization is determined, the process is never finished (Inkeles, 1968). Within the socialization process, the social group forms a commonality amongst its participants who share a set of mutual value guidelines. There are different theoretical perspectives that help explain the socialization process.

Historical Evolution of the Socialization Process

Sociological Theoretical Perspective

Socialization is the process by which persons acquire social rules and turn into contributors of groups (Blais & Hayes, 2015). It involves learning to conduct oneself in a manner that is consistent with the actions of other persons residing in the similar role. A sociological approach to self and identity starts with the supposition that there is a mutual connection amongst the self and society. Individuals begin to learn how to reason, perform, and act via delegates of socialization: those groups that effect self-concept, approaches, comportments, or other focuses toward life (Blumer, 1986). Socialization can be organizational where the employee learns the knowledge and skills necessary to assume his or her organization role, or it can be group socialization where an individual's

peer groups, rather than parental figures, influences his or her personality and behavior in adulthood. Racial socialization has been defined as the development process by which children acquire the behaviors, perceptions, values, and attitudes of an ethnic group and come to see themselves and others as members of that particular group (Rotherman & Phinney, 1987). In the social sciences, institutions are the organizations and instruments of social order and collaboration leading to the behavior of a set of individuals within a given human group. Socialization and all its components and attributes affect how persons see themselves within the organization and group. It is dependent on the enculturation and assimilation of language, personality, racial identity, learning, social behaviors, trust, and mistrust. As socialization has evolved, scientists have developed theories that note all the components of that process and the impact they have on the individual. Understanding these processes assists the scientist in facilitating a smooth transition for these individuals.

Since the 1980s, sociological and psychological theories have been connected with the term socialization. One such example is the theory of Kalaus Hurrelmann (1988), which is explicated in his book *Social Structure and Personality Development*. Dynamic processing of interior and exterior realities results in human and intellectual ability and behavior that establishes a person's inner reality and conditions of societal and environmental reality (Hurrelmann, 1988). A person's identity is established, as all these realities are incorporated within the developmental tasks and acquisition of the socialization process.

Another theory that has influenced the historical development of socialization was that of Lawrence Kohlberg (1981) in his theory of moral development. This theory

described how individuals reason situations as right and wrong. It consisted of three stages: (a) pre-conventional (pain/pleasure); (b) conventional (good child/bad child, teenagers as they mature and relate to right and wrong according to the desires of their parents when they begin to conform to cultural norms resulting in a decrease of selfishness); and (c) moral development (individual advance beyond the society's norms when they consider abstract higher level ethical principles) (Duska, 1974). In addition to Kohlberg (1981) and his theory of moral development, other theorists of development include Piaget's theory of cognitive development (comprehensive theory about the nature and development of human intelligence), Erik Erikson, who proposed the stages of psychosocial development, and James Marcia, known for the theory of identity achievement.

Based on comparative research in different societies, focusing on the role of language in child development, linguistic anthropologists Elinor Ochs and Bambi Schieffelin developed the theory of language socialization (Ochs, 1988; Blackwell, 2014). They discovered that the process of socialization does not happen separately from the process of language achievement but that children obtain language and culture collectively in what amounts to a combined process. Participants of all cultures socialize children both to and through the use of language; while attaining skill in a language, the beginner is by the same token socialized into the groups and norms of the culture, while the culture, in turn, offers the norms of the use of language (Blackwell, 2014). This is most critical as the foreign-educated physicians (FEPs) are gaining a new language, new culture in many instances including a new role identity, which must be integrated and socialized.

Behaviorists' Perspectives

George Herbert Mead (1863-1931) was an American philosopher, sociologist, and psychologist, primarily affiliated with the University of Chicago who argued that the significance of behavioral psychology was restricted because it regarded humans as only instinctual and reflexive beings ("Mead," 1968). Mead went on to note that by ignoring the social dimension of human interaction, behaviorists had eliminated a critical factor in understanding the cognitive process. This is an important concept and theory of social behaviorism that explained social experience and a very important concept for socialization of individuals ("Mead," 1968). Other major behaviorists include John Watson, known as the father of behaviorism; Ivan Pavlov, best known for classical conditioning; B. F. Skinner, known for operant conditioning; and Edward Thorndike, known for the law of effect.

Professional socialization. Professional socialization is described as the progression by which persons obtain the specific knowledge, skills, attitudes, values, norms, and interest required to accomplish their professional roles acceptably (MacIntyre, Murray, Teel, & Karshmer, 2009). In the 1980s, Richard Moreland and John Levine created a model group of professional socialization based upon the assumption that individuals and groups change their evaluations and commitments to each other over time (Moreland & Levine, 1982). Moreland and Levine ventured that there was an expected order of stages that occurred for an individual to transition through a group. The five stages of socialization that mark this transition as defined by Moreland and Levine (1982) are investigation, socialization, maintenance, resocialization, and remembrance. As the transition progresses, the individual and group assess each other, which results in an

increase, or decrease in commitment to socialization. This socialization pushes the individual from prospective, new, full, marginal, and ex-member (Moreland & Levine, 1982).

The goal of professional socialization is to internalize a professional identity that includes the norms, values, attitudes, and behaviors of the profession (Blais & Hayes, 2015, p. 22). Professional socialization transmits values, norms, and ways of viewing a situation that are unique to the profession and provide a common ground that shapes the ways in which work is conducted. This common ground enables the members to effectively communicate; therefore, the socialization process yields the formation of "an individual's professional identity, the self-view as a member of a profession with the requisite knowledge, skills, responsibilities, and obligations" (Blais & Hayes, 2015, p. 17).

The definitive objective of professional socialization is to advance a professional identity, whereby each of these qualities turn into a portion of a nurse's personal and professional self-image and behavior (Haynes, Butcher, & Boese, 2004). Professional socialization is the outcome of contact with various socialization agents who are the persons beginning the socialization process (Blais, Hayes, Kosier, & Erb, 2006). Because of professional socialization, students' predetermined values are substituted with the values of the nursing profession. The transformation in an individual's values will consequently end in a modification in comportment and attitudes. Finally, a person's self-concept is altered with the product of that growth being a professional identity (Blais et al., 2006; Creasia & Parker, 2007).

Another aspect of professional socialization is role socialization, which is influenced by the manner in which the role is conceptualized. A consequence of role socialization is when an individual has acquired the skills, values, and norms for a specific occupation and has assumed that specific role (Leddy, 1998). Blais and Hayes (2015) have indicated that nurses educated at various levels may not have common values, language, or a common understanding of the multiple roles of the professional nurse, which include being an interprofessional team member, educator, mentor, and research scientist. Consequently, nurses may have diverse viewpoints relative to what constitutes professional role socialization.

Based on the literature, professional socialization can be described as a process and an outcome (Blais et al., 2006). Professional socialization is established upon the role theory, which has its foundation in the sociology field (Blais et al., 2006). Role theory stresses the training of students to face specific occupation expectations or roles instead of facing life in society (Leddy, 1998). A role is the expectations coming with a position in society (Blais et al., 2006). Two processes help individuals learning their roles: first is the process of interrelating with groups and significant others and second is to learn from role-playing and role negotiation, modeling, identification, training, trial and error, and reflection (Creasia & Parker, 2007). Professional socialization is a lifelong process beginning at its inception when the student starts in the nursing curriculum and his/her relationship with faculty and extending into the work setting (Creasia & Parker, 2007).

Roles and Transitions

Socialization has a perspective that transcends into the process of role transition and development; that important theoretical perspective of socialization is symbolic interactionism. Symbolic interactionism states people build their roles as they interrelate; they do not just acquire the roles that society has set out for them—they create the reality of these circumstances ("Symbolic Interactionalism," 2003). Through this process, the self emerges. Socialization has three important concepts: anticipatory socialization, re-socialization, and reverse socialization (Mondal, 2015). Anticipatory socialization is where non-group members adopt the values and standards of groups that they aspire to join. Re-socialization refers to changing someone's personality by carefully controlling his/her environment and reverse socialization refers to the process whereby persons typically being socialized are at the same interval socializing his or her socializers (Mondal, 2015). These perspectives are interrelated and affect the role progression, identity, and socialization of person. Another relationship between socialization and transitions is the part roles play in influencing a person's behavior and perspectives. "From a structural perspective, roles are the culturally defined norm—rights, duties, expectations, and standards for behavior—associated with a given social position" ("Role Theory," 2003, p. 1).

As individuals progress from one position to another, they experience transition. The definition of the major concept of transition defines transition as a periodic process through which change is facilitated into the environment or life of an individual. The definition also states that there have to be some commonalities in the periodic processes that are characteristic of a transition, such as the production of a permanent change on the

environment or the individual (Schumacher & Meleis, 1994). Transitions are complex and multidimensional. Transitions have patterns of multiplicity and complexity. Flow and movement over time characterize all transitions. Transition cause changes in identities, roles, relationships, abilities, and patterns of behavior (Meleis, 2007).

Transitions involve a person's reaction through a passage of time. A transition transpires during time and involves change and adaptation. Adaptation comes as a result of change; however, it does not necessarily signify adaptation. When there is adaptation and change, it may be, for instance, developmental, individual, social, situational, group or environmental, but not all change involves transition (Meleis, Sawyer, Im, & Schumacker, 2000). Transition is the manner people react to change over time. People experience transition when they need to acclimate to new situations or circumstances to integrate the change event into their lives (Schumacher & Meleis, 1994). Transition is a concept that is important to nursing. According to Schumacher and Meleis (1994), there are different kinds of transitions. Developmental transitions were those associated to the reaction of persons when they experienced the changes that occur during the life cycle, such as becoming a parent. Situational transitions were associated with various educational and professional roles, for example, a transition of a student nurse to that of a graduate nurse. Organization transitions characterize those that happen in the setting and are triggered by changes in the social, political, or economic context, like a change in leadership within an organization (Schumacher & Meleis, 1994). Organizational and cultural consequences are when an employee learns skills and knowledge to assume a role within the organization (Blais & Hayes, 2015).

A positive or a healthy transition is one where feelings of anguish are substituted with a sense of security and mastery of a change event (Schumacher & Meleis, 1994). As stated by Schumacher and Meleis (1994), positive/healthy transitions lead to a sense of security and mastery of a change event and for this to occur the person must have been socialized into that new role or situation. Meleis (1994) states that an unhealthy or incomplete transition may be due to conditions or circumstances that influence the way a person moves though a transition, and hinder progress toward achieving a healthy transition. Meleis (2010) goes further to explain that there are indicators of healthy transitions such as "subjective well-being, role mastery, and well-being relationships" (p. 5). Anticipatory preparation or lack of preparation could facilitate or inhibit people's transition experiences. Transition conditions include personal, community, or societal factors that may facilitate or constrain the processes and outcomes of healthy transitions. Personal conditions include meanings, cultural beliefs and attitudes, socioeconomic status, preparation, and knowledge. Meleis et al. (2000) considered that the meanings attributed to events precipitating a transition and the transition process itself may facilitate or hinder healthy transitions. Cultural beliefs and attitudes such as stigma attached to a transition experience would influence the transition experience.

Health Care Disciplines and Socialization

A dearth of studies exists depicting other disciplines and socialization. Pitkala and Mantyranta's (2003) qualitative study investigated medical students' professional socialization to the physician role. The researchers examined 22 first-year medical students; the overwhelming theme identified to their transition, and socialization was stress as the result of the tremendous demands of medical school. From the analysis of

the writings, diaries, and interviews, the fear of being credible and competent emerged from the participants. In the study, the transformation to physician appeared to originate mostly from an engaged internal, mindful, reflective process (Pitkala & Mantyranta, 2003, p. 158). A theme that emerged from the participants' writings was one of "the image as a future physician being largely built on and constantly reflected in patient contacts" (Pitkala & Mantyranta, 2003, p. 158). The students were active agents in their developmental process. As stated earlier, socialization has a perspective that transcends into the process of role transition and development; that important perspective of socialization is symbolic interactionism. The authors concluded that portfolios and writing journals as learning tools might help in identifying key occurrences and aid in helping professional development.

Kedrowicz, Fish, and Hammond (2015) examined the relationship between anticipatory socialization experiences and first-year veterinary students' career interests. Socialization is a development of "professional identity development whereby an individual learns the norms, values, behaviors, expectations, and skills appropriate to a specific role, position, or occupation" (Kedrowicz et al., 2015, p. 18). This project explored the role of vocational anticipatory socialization, in addition to exposure of role models, individual characteristics and interests, occupational prospects and revenue possibilities as factors influencing student's career choices. They utilized the Veterinary Careers Survey, and as per the authors, there were several remarkable, statistically noteworthy relationships between vocational anticipatory socialization experiences and the participants self-reported career interests. Socialization processes and interactions helped novices refine their expectations. Data from this study, as per the authors,

demonstrated that the *Careers Course* did aid the novice students in improving their outlook as it related to the varied career opportunities available to them (Kedrowicz et al., 2015). As students progressed through the curriculum, they concentrated their focus on gaining specific information in their course matter of interest. These findings, as suggested by the authors, presented the opportunity for faculty instructors to present a clear and realistic occupational picture.

A key implication from this research is that to ensure a positive socialization process, early socialization occurrences, add to students' evolving professional identity through relationships with role models and acquaintance to various career options in veterinary medicine (Kedrowicz et al., 2015). As noted earlier, professional socialization is designed to prepare students to enter into a career and this study demonstrated the value of faculty interactions to assist students in sharpening expectations and in offering a correct occupational picture in an active professional realm.

Second career individuals are becoming a large percentage of the nursing profession today, and it has been established they bring their own set of values, experiences, and expertise to the profession; however, it is important to answer how these individuals are affecting the profession by how they see themselves in the profession and practice within it.

Statement of the Problem

All students who enter the nursing profession should expect nursing education that prepares them to successfully socialize into the profession. Socialization into a professional role is affected by how the individual understands and assimilates the norms, values, and traditions of that discipline. Second career students, such as FEPs, may

experience unique challenges in adapting to their new role as a nurse. Little is known about the social process of FEPs transitioning to the professional nursing role. In the absence of understating the key factors influencing this transition process, nurse educators are less likely to successfully educate FEPs to the professional nursing role. This not only leaves the FEP-RN at risk of practicing outside the scope of professional nursing practice but may also jeopardize the quality of nursing to clients.

Purpose of the Study

The purpose of this classical grounded theory study is to discover a substantive theory explaining the process of foreign-educated physicians (FEPs) experience as they transition from their original role as physicians in their country of origin, to their new role as registered nurses in the United States. The theory was grounded in data gathered regarding the critical factors influencing the attitudes, beliefs, and perceptions of FEPs who have entered nursing as a second career.

Research Questions

- What are the critical factors that influence the attitudes, beliefs, and perceptions of foreign-educated physician as they practice in the professional nursing role in the United States?
- How do FEPs differentiate their role in nursing as compared to their physician role?

Philosophical/Theoretical Perspectives

Positivism and Post Positivism

Quantitative research is rooted in the positivist and post-positivist paradigm and uses deductive reasoning in order to generate a hypothesis that needs to be tested using a

scientific method (Polit & Beck, 2006). In experimental research, the investigator actively intervenes and introduces a treatment; on the other hand, nonexperimental research, the researchers or investigators make explanations of present characteristics and behaviors without intervening (Polit & Beck, 2006). Quantitative investigators collect empirical evidence that is positioned in objective reality and gathered directly or indirectly through the senses instead of personal beliefs or hunches. Positivism originates from the 19th century thinking, steered by such philosophers as Comte, Newton, and Locke (Polit & Beck, 2006). The positivist approach assumes that nature is orderly and that observable facts and events (i.e., phenomena) are not random, but rather have antecedent causes. Within this positivist paradigm, much of the scientific inquiry is focused on comprehending the primary causes of the natural phenomena (Polit & Beck, 2006). Positivism demands orderly and methodical procedures with strict controls over the research situation to test researchers' hypothesis about the nature of the phenomena being studied and the relationships among them (Polit & Beck, 2006).

The key approach of positivism is the implementation of the scientific method through experimentation, which includes direct manipulation and observation. Since the middle part of the 20th century our views of science have evolved and changed. Probably the most important has been the shift away from positivism into what is now termed: post-positivism. The post-positivist paradigm underpins grounded theory and has evolved from a broader worldview to a more focus worldview as delineated by Strauss. Post-positivism recognizes that the way scientists think and work and the way we think in our everyday life are not distinctly different. Scientific reasoning and common sense are

essentially the same process. The post-positivists share with the positivists the assumption that there is only one reality (one truth), but it can only be partiality known.

The goal of post-positivist is to have a greater understanding of that truth/one reality. Classical grounded theory is underpinned by the post-positivist worldview, meaning the post-positivist worldview assumes an objectivist epistemology and critical realist ontology (Annelis, 1997). Due to its critical realist ontology, post-positivist research scientists agree that knowledge is imperfect because it is shaped by contextual influences but believe that objective analysis will bring the researcher closer to the truth (McEvoy & Richards, 2003). Post-positivists do not rely on strict cause and effect and, instead, identify that all cause and effect is a possibility that may or may not happen (Creswell, 2013, p. 24). In the post-positivist paradigm, there is an acceptance of reality and a desire to comprehend it; however, post-positivists are aware of the unfeasibility of total objectivity, and every effort is made to remain as neutral and objective as possible (Polit & Beck, 2006). Classical grounded theory comes from this post-positivist perspective, which understands that one reality is only known partially. This challenge to positivism opened the away for interpretivism to evolve. In the interpretivist worldview, the ontological assumption is that reality is multiple and relative. Strauss' engagement in grounded theory brought constructivism and constructionism into the philosophical underpinnings. However, when Glaser and Strauss separated, Glaser continued with his positivist view, and Strauss remained with his post-positivist view.

Interpretive Worldview

The interpretivist approach "looks for culturally derived and historically situated interpretations of the social life-world" (Crotty, 1998, p. 67). Interpretivism is linked to

the thoughts of Max Weber (1864-1920), who suggests that in the human sciences we are concerned with Verstehen (understanding) (Crotty, 1998, p. 67). This was taken to mean that Weber is contrasting the interpretative approach (Verstehen, understanding) needed in the human and social sciences with the explicative approach (Erklaren, explaining), focused on causality, which is found in the natural sciences. Interpretivist research is "guided by the researcher's set of beliefs and feelings about the world and how it should be understood and studied" (Denzin & Lincoln, 2005, p. 22). In the interpretive paradigm, knowledge is proportional to specific situations— "historical, temporal, cultural, subjective"— and occurs in several "forms" as representations of reality. Interpretivists accept multiple meanings and ways of knowing (Munhall, 2012; Crotty, 1998). The interpretive paradigm emphasizes mainly recognizing and describing the meaning of human experiences and actions (Fossey, Harvey, McDermott, & Davidson, 2002).

Interpretivism consists of the researchers interpreting the aspects of the study; thus, interpretivism incorporates human interest into the study. The interpretive researcher presumes that access to the reality, which may be given or socially constructed, is only through the social constructs of language, consciousness, and shared meanings that the researcher presents the findings. Interpretivism is connected to the philosophical position of idealism and is used to group various approaches, including social constructivism, phenomenology, and hermeneutics (Munhall, 2012). In the interpretivist approach, the researcher may be viewed as a social illustrator appreciating the differences between the participants' realities and perceptions. Additionally, interpretivism studies tend to center on meaning and may utilize several methods in order

to reveal different aspects of the phenomenon of interest (Crotty, 1998; Munhall, 2012). The interpretivist approach is grounded on the naturalistic method of data collection such as interviews and observations. The meanings of the data or findings usually emerge near the end of the research process. There are two theoretical views, which support interpretivism: constructivism and constructionism.

Constructivism

Constructivist research often addresses the processes of interaction among individuals. The researcher's intent, then, is to make sense or (interpret) the meanings others have about the world (Creswell, 2013, p. 25). Constructivism is the acknowledgment that actuality is a creation of individual's intellect interrelating with involvement in the real world (Crotty, 1998, p. 79). Constructivism accepts the belief of multiple social realities, acknowledges the shared formation of knowledge by the observer and the observed, and aspires to explanatory understandings of the subject's meanings (Charmaz, 2000a, p. 510). Constructivism describes the person relating with things and persons in the world and creating meaning of them (Munhall, 2012, pp. 249-251). Constructivism agrees to reality as an idea of the human mind; consequently, it is perceived to be subjective. Furthermore, this philosophical approach is strongly linked with pragmatism and relativism (Crotty, 1998). The chief difference between constructivism philosophy and positivism is that while positivism contends that knowledge is created in a scientific method, constructivism sustains that scientists create knowledge, and it disputes the notion that there is a solitary methodology to produce knowledge (Crotty, 1998; Munhall, 2012).

Constructionism

Constructionism claims that human beings construct meanings as they engage with the world. Constructionism discards the idea of objective truth waiting for the individual to uncover it (Crotty, 1998, p. 8). According to Crotty (1998), constructionism:

> is the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essential social context. (p. 42)

From the constructionist viewpoint, therefore, meaning (or truth) cannot be described simply as objective or simply as subjective (Crotty, 1998, p. 43). When explaining constructionism, an individual must be aware that society has an impact on the individual objectively and subjectively. Objectively from an empirical or observable phenomenon existing independently of an individual's conceptions and subjectively from the meaning that it is given. In constructionism, it is appreciated that the outside world and society influence the reality and perceptions of individuals. In this perception of knowledge, it is evident that various people may construct meaning in multiple ways, even in association to the identical phenomenon (Crotty, 1998).

Qualitative Research

Qualitative research has an extensive and energetic portfolio in the humanities, health sciences, and of course in the social sciences. During its evolution in history, qualitative research has meant different things. Several disciplines have affected the advance of qualitative research (Given, 2008). The disciplines of social sciences, health sciences, and humanities, anthropology, ethnomethodology, phenomenology, feminism,

and postmodernism to name a few, have with its own theoretical leanings, conception of reality, and methodological preferences contributed significantly to the continued development of qualitative research (Crotty, 1998; Munhall, 2012).

Qualitative research is a positioned action that places the researcher in the world or the phenomenon. It involves a set of interpretive, measurable applications that causes the phenomenon to be seen. This method sorts the phenomena of interest into a series of exemplifications, containing interviews, conversations, field notes, recordings, and reflexive memos. At this level, qualitative research consists of an interpretive, naturalistic method. In other words, qualitative researchers investigate incidents in their natural settings, to interpret, or to make sense of the phenomena in terms of the meaning and significance people bring to them (Denzin & Lincoln, 2005, p. 3). A shared link throughout almost all methods of qualitative research is an inductive and flexible structure. Though there are undoubtedly some qualitative data collection and analysis procedures that are more structured and deductively situated than others, such as content analysis, the majority of research initiatives in the qualitative method take a repetitive approach (Crotty, 1998).

Scientific Assumptions

Five scientific assumptions guide scientific inquiry; they include ontology, epistemology, axiology, rhetorical, and methodology (Creswell, 2013). The ontological assumptions relate to the nature of reality and its characteristics. The ontological assumption addresses the question, “What is reality?” In qualitative research, the notion of one reality that can be fragmented and studied apart from the individual is replaced by the assumption of multiple, non-reducible realities created by each individual. This

ontological assumption is referred to as relativism. In classical grounded theory, Glaser's post-positivist approach challenges this assumption. The post-positivist tends to disagree with the idea of multiple realities and instead assumes one objective reality that can only be known partially. The FEPs' social reality is dynamic as they shift from one reality to the next; it is this researcher's assumption that the FEPs have two realities. Due to this, the researcher will accept the notion of multiple realities and account for these multiple realities by investigating several styles of evidence from diverse individuals' viewpoints and encounters (Creswell, 2013, p. 20). The researcher will report the perspectives and realities of the FEPs as they emerge from the data collected and have their voice convey the meanings of their reality.

The epistemological assumption addresses two questions: "How do we know what we know?" and "What is the relationship of the researcher to the researched?" In qualitative research, the knower is the participant, as opposed to the researcher. Therefore, in order to know, the researcher must become engaged with the knower. This is another area where Glaser's post-positivist perspective influences his approach of grounded theory. Whereas, post-positivists agree with the subjective influence of how we know what we know; they argue that the researcher must maintain a certain level of objectivity in the collection and analysis of data provided by the participant. The motivation of post-positivists to keep a modified-objectivity epistemologically is for the reason that they have critical realist ontologically (one reality that is partially known). If there is only one truth, and it occurs separately of the individual, then the individual must maintain some level of objectivity-distance in order to be able to discover that one truth

(Glaser, 2001). With classical grounded theory, the observer is separate from the study, remains objective, and aims to uncover the subjective reality of the participant.

The axiological assumption addresses how researcher bias is addressed in research. The post-positivist axiological assumption reflects a modified objectivist perspective (Lincoln & Guba, 1985). The researcher discloses his or her values in the study and proactively reports biases "as well as the value-laden nature of information gathered from the field" (Creswell, 2013, p. 20). The researcher reflected upon assumptions about the world that have been made in the course of the research. The researcher disclosed influences that may bias the study and entered the field without any preconceived or a priori idea of the subject area. Memoing concerning the researcher's opinions, interests, involvements, and characteristics, which may affect the research, are noted. In addition, in classical grounded theory, all researcher opinions and/or ideas about the emerging conceptual categories must be confirmed by the data before they can influence the research findings.

The rhetorical assumption addresses the language of research. The language of the researcher utilizing the grounded theory method turns into language that is personal, scholarly, and based on definitions that evolve during the study rather than being defined by the researcher. As language is theorized as being dynamic—it has the likelihood to build particular versions of the participants' reality as to their role within the nursing profession. The researcher paid close attention to the manner of which language is reported in the study as this may influence the research findings. In addition, words such as "discover," "understanding," and "meaning" are important rhetorical markers in the writing of the study.

The methodological assumption addresses the process of research. Grounded theory is classified as an inductive method, and theoretical sampling is a deductive activity grounded in inducted categories (Glaser, 1998). Glaser (1998) sustained that "[d]eductions for theoretical sampling fosters better sources of data, therefore better-grounded deductions" (p. 43). The variations between a deductive and an inductive method relates to where in the process the researcher examines the data; if the researcher examines the data first and then formulates a hypothesis (inductive), or if the researcher formulates a hypothesis first by conjecture and then looks for research data to confirm the deduction (deductive) (Glaser, 1998). This classical grounded theory utilized induction and deduction activities: specifically, the recording and the transcribing of interviews and the utilization of a qualitative data coding and analysis tool. As the research was being undertaken, the researcher described the context of the study and continued to revise questions and findings as new data emerged and abduction was used as a sensible and scientific form of inference. The methodological assumption has the characteristics in the process of research of being inductive, emerging, and shaped by the researcher's experience in collecting and analyzing the data (Creswell, 2013, p. 22). Qualitative methodology can be idyllic for guiding research in a social discipline such as nursing, which is greatly based on human interaction. This study utilized classical grounded theory to discover a substantive framework or theory explaining the attitudes, beliefs, and perceptions of FEPs in relation to their role as practicing nurses.

The theoretical underpinnings for the method of grounded theory are pragmatism and symbolic interactionism, which was derived from a social psychological theoretical framework.

Pragmatism

Pragmatism was a fragment of an overall rebellion against the exceedingly academic, slightly demanding, and closed organizations of idealism in 19th-century philosophy ("Pragmatism," 2016). Pragmatism was prevailing in the United States in the first quarter of the 20th century, and it was founded on the belief that the effectiveness, workability, and realism of concepts, guidelines, and suggestions are the criteria of merit ("Pragmatism," 2016). Charles Sanders Peirce is considered one of the classical pragmatists and he was more part of a broad theory of thought and of signs ("Pragmatism," 2016). As per Peirce, to declare that a principle is true is to believe that, if a particular procedure is the topic of endless systematic investigation by the community of researchers, agreement to the belief would rise and disagreement decreases “in the infinite long run” ("Pragmatism," 2016, para. 18). Subsequently, the thought is purposive and meaning transmits a position to the future. James’ pragmatism utilized a psychological and moral method principally unpredicted by Peirce. A simple dissimilarity amongst Peirce and James is apparent in their individual beginnings of the course to be engaged by pragmatic analysis ("Pragmatism," 2016). While Peirce inspected meaning in overall, provisional plan, and participant, James concentrated on the distinctive contributions that notions and principles make to exact forms of human understanding on the living level of real-world desires and purposes ("Pragmatism," 2016).

Pragmatism speaks to theoretical viewpoints that accentuate the real world, giving dominance to practicality over theoretical knowledge; as such, the objective is transformative (Seigfried, 1998). According to the pragmatist perspective, truth has to be

advanced inductively with continuous empirical verification instead of through deductive reasoning from priori theory (Munhall, 2012, p. 228). The truth is revised, changed as new discoveries come to the forefront and truth is relational to time and place. The goals of inquiry under pragmatism are adjudicated in relations of their effectiveness for creation change and thus values are an intrinsic part of pragmatism (Munhall, 2012, p. 229). Both meaning and social context influence the ways that human agency is enacted. Pragmatism champions looking for revised understandings for the reason of making beneficial modification through inductive investigation of varied situated human experiences with instinctive confirmation and use of appropriate current knowledge. Therefore, grounded theory's goal is to identify and explain what is happening in a social setting (Crotty, 1998).

Symbolic Interactionism

Symbolic interactionism is an observed social science viewpoint on the investigation of human group life and human conduct (Blumer, 1969). Even though the work of the Chicago School in the 1920s and 1930s emphasized the fundamental role of qualitative research in social research, an assortment of additional disciplines also accounted for the rise and continuous growth of qualitative approaches (Given, 2008). The Chicago School is predominantly connected with qualitative methodologies, specifically those utilizing a naturalistic observational method to the study of human group life and human conduct, such as symbolic interactionism (Blumer, 1969). Mead's work (1863-1931) added to the comprehension of social behavior and self. John Dewey, George Herbert Mead, and Herbert Blumer stressed revolution, action, and interaction in public settings and the building of meaning through our deliberations on both the

phenomena and our own roles (Grbich, 2013, p. 80). The emphasis in grounded theory then turns out to be life as it is happening — "the empirical, social world 'out there'" (Grbich, 2013, p. 80). The philosophical idea of symbolic interactionism places the symbol as the center of social interaction. The symbols create a social object used to characterize the individuals, groups, and society agrees it shall represent. The symbol expresses held meanings. It is a funnel to what is seen, noticed, interpreted, defined, and how individuals act. Symbolic interactionism maintains that humans are dynamic contributors in their world and by nature are predisposed by the environment around them. Individual's reason, express, are swayed by past experiences, and make choices based on perceptions of the current situation. This progression is in a constant state of development and accounts for the distinctive, dynamic, and impulsiveness of human nature and interaction (Laurent, 2015, p. 43).

The philosophical foundation of symbolic interaction, a term conceived by Herbert Blumer (1969), founded on the work of George Herbert Mead in the 1930s (Olshansky, 2015, p. 2). According to Blumer (1969) who coined the term symbolic interactionism, reality is socially constructed. He also identified three assumptions of symbolic interactionism: (a) individuals act towards people and things on the foundation of the values or meanings they have for them, (b) meanings or values come from dealings with others, and (c) people's meanings or values are altered by an explanatory method used to create sense of and deal with their social worlds (Munhall, 2012, p. 228).

Grounded Theory

Sociologists Anselm Strauss and Barney Glaser established grounded theory in 1967 (Glaser & Strauss, 1967). Grounded theory is a qualitative research methodology

that pursues to inductively refine concerns that are significant to a particular group of people, producing meaning through analysis and creation of a theory (Glaser & Strauss, 1967). Of the qualitative methodologies to an investigation, grounded theory is perhaps the most systematic in its approach (Munhall, 2012, p. 230). It is closely linked to sociology (the study of people in society and social groups) philosophically and practically. Grounded theory begins from a familiar position as a general method of comparative analysis for the creation of theory from experimental data in opposition to other methods where data were collected and analyzed to verify speculative theory (Glaser & Strauss, 1967). Glaser's contribution of theoretical integration and formulation via the central role of core categories and Straus's ability for sociological conceptualization both contribute to the fundamental development of grounded theory methodology.

In Strauss' work (as cited by Munhall, 2012, p. 227) the underlying assumptions of grounded theory are: (a) "change is a feature of social life that needs to be accounted for through attention to social interaction and social process" and (b) "interaction, process, and social change are best understood by grasping the actor's viewpoint." Glaser stated in his 1992 writings, that an assumption of grounded theory methodology is "that people actively shape the worlds they live in through the process of symbolic interaction and that life is characterized by variability, complexity, change and process" (as cited by Munhall, 2012, p. 227).

Grounded theory is frequently quoted as a positivist/post-positivist method (King & Horrocks, 2010). The creators of grounded theory contended that much of the current research of the time of its inception was centered around the confirmation of the current

existing theories instead of the development of theories through logical deduction from research data collected (Glaser, 1978). The current status quo of the time was to verify existing theories, not generate new ones. The prevailing research culture stressed and venerated good scientific, quantitative confirmation studies and diminished the importance of qualitative studies whose purpose was to generate a theory. Therefore, most theory was generated through logical deduction from past studies and knowledge and not from the data itself. The development of grounded theory changed this (Glaser & Strauss, 1967; Holton & Walsh, 2017).

Grounded theory describes social development in a social framework, the grounded theory research approach is most beneficial when the aim is a framework or theory that identifies and explains human behavior in context. Grounded theory methodology advances the understanding of people's behavior in terms of fundamental meaning and change in variable conditions over time (Olshansky, 2015).

Grounded theory method has evolved to include several different approaches. The three most common are: Glaser's classical approach; Strauss' and Corbin's perspective analytical approach, and Charmaz's constructivist/interpretivist approach. Glaser's classic mode is characterized as critical realist and modified objectivist (Annelis, 1997), Strauss' and Corbin's (1998) relativist and subjectivist position, and Charmaz (2000) proposes that both agree to a realist ontology and positivist epistemology, although with some differences.

Classical (Glaserian) grounded theory methodology can be described as a constant methodical process of gathering, coding, analyzing and theoretically classifying data using the elements that develop from the data itself, instead of pushing predetermined

concepts onto the coding and subsequent analysis (Higginbottom & Lauridsen, 2014, p. 8). According to Glaser (1978), grounded theory is an inductive qualitative methodology that permits the investigator to isolate the key concern of a group of individuals and the behaviors these persons employ to answer their key concern. The researcher then articulates this assessment in a theory identified by a judiciously chosen phrase that depicts the subjects' experience. Classical or Glaserian grounded theory implements an interpretive approach and is guided by a critical realist ontology and a post-positivist paradigm (Glaser, 2001).

In classical grounded theory, the constant comparative analysis is a foundational pillar of its methodology. The constant comparative technique became the influential analytical procedure of grounded theory to generate and discover theory. Instead of identifying a concept and then looking for indicators to exemplify it, Glaser (1978) inverted the relationship and contended that indicators indicate concepts. A good grounded theory would then emerge that fits, works, has relevance, and can be modified easily with the discovery of new data (Glaser, 1978). A grounded theory clarifies, not merely labels, what is occurring is a social setting by conceptualizing the abstract idea from the observed indicators (i.e., incidents in the data under analysis). This lack of the encumbrance of illustrative detail is what differentiates classical grounded theory methodology from qualitative data analysis. This abstraction to a conceptual level academically clarifies rather than labels behavior that happens theoretically and commonly in numerous varied groups with a common concern (Glaser, 2003).

Classical grounded theory uses data of all types and the methodology is epistemologically and ontologically flexible; in other words, it adjusts to a variety of

epistemological and ontological viewpoints without having to adopt any one perspective. What is important in classical grounded theory is the discovery of the abstract concepts that are within the data (Glaser, 2001). The skill of the researcher lies within his or her ability to conceptualize ideas by separating the details of the data, elevating the concepts above the data, and incorporating them into a theory that explains the hidden social basic pattern of behavior in the fundamental area (Glaser, 2001; Glaser, 2003).

When describing Strauss and Corbin's grounded theory methodology, the main difference to Glaser relates to their approach on how the data is analyzed (Strauss & Corbin, 1998). Strauss and Corbin (1998) stressed two main points: (a) the primary role in any qualitative research is the participants' own comprehension of their social environment and (b) the significance of flexibility, the necessity for investigators to be imaginative and adapt the methodology to their own research settings and interests. Rigor and objectivity are essential in the research process, but the researcher must not become robotic in their adherence to a pre-set methodological formula. When comparing data analysis in grounded theory, it is important to note that the core conflict between Glaser and Strauss is whether verification should be an outcome of grounded theory analysis or not (Charmaz, 2000b). Strauss (1987) specified that induction, deduction, and verification are unequivocally vital whereas Glaser (1998) sustained grounded theory is classified as an inductive and deductive method, where abduction is used as a sensible and scientific form of inference and theoretical sampling is a deductive activity grounded in inducted categories (Glaser, 1998). According to Annelis (1997), Strauss and Corbin's version of grounded theory has shifted to the constructivist paradigm as they have

accepted the fact that researchers out of the stories that are constructed by the research participants' construct concepts and theories.

Constructivist grounded theory is rooted in pragmatism and relativist epistemology and believes that neither data nor theories are discovered (Charmaz, 2006). According to Charmaz, the data organize the underpinning of the theory, while data analysis creates the ideas researchers create (2006). Exploration of the data is contextually positioned in time, place, culture, and situation. The fact data is constructed through an ongoing interaction between researcher and the participants makes it different from other versions of grounded theory (Charmaz, 2000a). In constructivist grounded theory, interviews offer the position for dynamic exchanges between researcher and participants, which end in results that are jointly discussed and circumstantial (Charmaz, 2000b; Charmaz, 2006).

Relationship of Classical Grounded Theory to This Study

Glaserian or classical grounded theory was chosen because of its openness that allowed the data to speak. The researcher also has an inclination towards post-positivist ontological and epistemological worldview that fits better with Glaser's classical grounded theory methodology. The goal of grounded theory is to discover a theory that explains and clarifies a pattern of behavior that is pertinent and challenging for those involved (Glaser, 1978; Glaser, 1998). The process of discovering and allowing the theory to emerge from the data is very appealing to this researcher. Basic social processes are universal since they are central, developed processes in the structure of social behaviors, which happen over time and go on regardless of the provisional difference of place. The basic social process or problem of FEPs acting more like

physicians than nurses is very concerning to the researcher, as this impacts the core values and expectations of the nursing profession. Misunderstandings such as all grounded theories are basic social processes or actions lead to forcing a theory to fit the misunderstanding (Creswell, 2013; Langley, 1999). Grounded theory methodology allowed the researcher to understand what is occurring, and classical grounded theory forced the researcher to maintain her own biases out of the study.

The aim of this study was to explain the attitudes, beliefs, and perceptions of foreign-educated physicians practicing in the United States as a nursing professional. Currently, there is very little known about the attitudes, beliefs, perceptions, and behaviors of foreign-educated physicians practicing in a nursing role within the United States. As little is known about this particular interest and there are no theoretical perspectives that explain the human behavior in context, grounded theory was useful. This is especially true, as grounded theory is particularly helpful when investigating social issues or situations in which people must adapt (Benoliel, 1996).

Glaser (1978) sustained that fundamental social processes happen over time and are essential patterns in the association of social behavior. For a grounded theory inquiry, the fundamental social process can be linked to a psychological process, an operational process or both; they can be discovered or be an emergent fit; and they can be fully functioning during every step of the research process (106). The researcher interviewed, listened, and observed the participants to discover their pattern of meaning to explain the socialization process of FEPs in the nursing role.

Significance of the Study

A problem exists when individuals are not socialized into a profession and their values are not commensurable with that of the profession. Limited studies revealed issues regarding the socialization of the participants into nursing. Pascual, Marcaida, and Salvador (2005) revealed that the faculty referred to the nursing students as "doctors" both in the clinical and classroom areas. As individuals transition to a second career, many changes occur and require adaptation within that new profession. This grounded theory study will assist other disciplines to better understand their own professions as second-career individuals are increasing in numbers within society. It is the hope that this study may add to the body of the literature in scientific research by highlighting the importance of socialization of individuals to their new professions.

Significance of the Study to Nursing

The Florida Center for Nursing (2013) has predicted that by 2025 there will be a shortage of 50,000 full-time registered nurse positions. The number of FEPs living in the United States and in Florida who are "underemployed or unemployed" is a nontraditional set of individuals who are representative of an available source of health care professionals, with clinical expertise and capability (Grossman & Jorda, 2008, p. 545). The shifting of an individual's profession is a normal incidence in today's global economy and market. In order to adapt to midlife career change, individuals must make changes in their "cognitive, emotional, and behavioral realms" (Barclay, Stoltz, & Chung, 2011, p. 388). According to Provision 4 of the 2016 Code of Ethics for Nurses, "nurses are accountable and responsible for adhering to the standards relevant to their particular role and domain of nursing practice" (Fowler, 2015, p. 59). This is to include the

representation of qualified actions at a level "commensurate with one's education and in compliance with applicable laws" (Fowler, 2015, p. 59). Examining the relationship between these FEPs successful socialization/transition to nursing, their role identity, and perception would reveal the unique challenges that FEPs face as they embark on their new role within the nursing profession. There is not sufficient research on this question.

These physician-to-nurse students also had a great level of difficulty performing basic nursing tasks, as many reported completing their degree without even attending nursing classes (Pascual et al., 2005). These health care providers may not be fulfilling their obligations to promote health and provide optimal care; they may also be jeopardizing and increasing the risk to patient safety and mortality. The role development of all nurses is an important component of their success as nurses, and it is the hope of this researcher that this investigation may yield strategies to assist the second career FEPs, as health care is becoming more global and their numbers within the profession is increasing. All nursing professionals influence the profession, and it is important that the contributions of these second career nurses be explored.

Implications for Nursing Education

Another area noted by the limited studies was the "un-training" that had to be achieved by the former physicians as they began their new nurse role. This investigation may shed some light on how to achieve this successfully and effectively by producing best practices or strategies for curriculum development and/or instruction. This investigation may enlighten the nursing profession on ways to assist them in their socialization and transition to the nursing role, as health care becomes more global and

FEPs practicing as nursing professionals continue to become an ever-growing number within the profession.

Implications for Nursing Practice

The information from this grounded theory study would add to the scarcity of knowledge that exists on FEPs and their socialization process. This study would help filli the gaps of how not only FEPs but also second career nurses from other professions are personifying their roles within nursing. How nurses relate to their patients, and most importantly how they see themselves within the nursing role may affect their clinical practice and patient safety. Understanding the impact of these second career nurses' behavior and performance may shed some insight as to how the nursing profession is responding to these new nurses and how the profession may assist them within the profession. This study may yield strategies that may be implemented into nursing curriculum to assist the second career FEP's socialization into nursing practice. These strategies may assist the FEP in maintaining their practice within the nursing scope of practice.

Implications for Nursing Research

The critical factors that influence how FEPs practicing within the nursing profession is missing from the current nursing knowledge. How these second career nurses are practicing within the profession is unknown, and their contributions to patient outcomes and safety whether positive or negative are also unknown. This study may be the first step in filling the knowledge gap. Understanding the process and the factors affecting the FEPs' nursing practice could stimulate investigation of best-practice strategies to support their socialization and practice within the nursing profession.

Implications for Health/Public Policy

As health care is becoming more global and the number of FEPs as second career nurses are increasing, many educational institutions are competing for government and private funds for their academic programs. As these educational programs are awarded state, federal, and private dollars for the education of FEPs in the nursing profession, the understanding and contributions to the nursing profession of these FEPs has not been investigated. This study may yield strategies that result in policies and health education reform with added monies to facilitate their transition to the new nursing role. This study's findings in turn may translate to added funds and assistance to the FEPs as they navigate through the immigration and legislative regulations in the United States.

Scope and Limitations of the Study

The scope of this study was limited to FEPs practicing within a nursing role in the United States. The participants were all actively working registered nurses in a healthcare setting for 6 months or longer. A limitation may be that the participants may refuse to answer certain questions and may not be completely truthful when they do answer. The fact that classical grounded theory may not have been the best-grounded theory approach to investigate the phenomenon of interest may also be a limitation. The study being conducted by a novice researcher may be a limitation. The researcher not having control of who volunteers to participate in the study may be a limitation to the study. Another limitation of the study may be not utilizing grounded theory methodology to its fullest potential.

Chapter Summary

This chapter provided a background regarding socialization and transitions. The problem statement and purpose of this phenomenon of interest were explained, in addition to the possible benefits of answering this issue through a classical (Glaserian) grounded theory approach. The philosophical underpinnings, scope, and limitations were discussed.

CHAPTER TWO

REVIEW OF THE LITERATURE

The purpose of this classical grounded theory study was to discover a substantive theory explaining the process of foreign-educated physicians (FEPs) experience as they transition from their original role as physicians in their country of origin, to their new role as registered nurses in the United States. The theory was grounded in data gathered regarding the critical factors influencing the attitudes, beliefs, and perceptions of FEPs who have entered nursing as a second career.

According to Glaser (1967), in order not to preconceive the concepts to be studied, reading on the phenomenon of interest should be general; a more in-depth literature review should be completed after the study's core categories are identified. As identified by Glaser, the researcher does not know what direction the research will take; it is not possible to know what data and information will be needed to continue the research investigation. However, this does not mean that the researcher must start with a tabula rasa, as is often assumed an open mind not an empty head. A literature review is used to inform the analysis rather than to direct it and places the study in context.

Review of the Literature

Utilizing CINAHL, Health Consumer and Nursing, GreenFile, ERIC, Medline, PsycArticles, and Ebsco database, a peer-reviewed literature search was initially conducted from 2010 to 2016, with the following keywords: second-career nurses, nursing census data, and RN shortage. The results were minimal, and the parameters were expanded from 2005 to 2016 with the same keywords. This time, the search yielded the following results: nursing census data (yielded 80 sources), and RN shortage (yielded

571 sources). This search produced several articles of which 12 articles were selected for a closer examination. There were some articles that were discovered when these keywords were used, and the parameter dates were 1985 to 2016 which yielded 75 articles/textbooks/dissertations. After careful screening, eight articles were considered for discussion; two of these were considered seminal and important for this review and were included. The following content areas will be synthesized: historical context, changing careers, and second-career nurses.

Historical Context

The Bureau of Labor Statistics' Employment Projections 2012-2022 published in December 2013, that the registered nurse (RN) role will have the highest job expansion through 2022. The RN workforce is projected to increase from 2.71 million in 2012 to 3.24 million in 2022, a growth of 526,800 or 19%. The Bureau also anticipates the need for 525,000 replacements nurses in the workforce bringing the complete number of job opportunities for nurses due to growth and replacements to 1.05 million by 2022 ("Occupational handbook," 2015).

As a response to the ever-growing shortage of registered nurses, many school officials and administrators have looked for innovative approaches to recruitment and have begun to look at nontraditional groups ("Nurse workforce", 2001). In Florida, one such approach of targeting the "underrepresented and nontraditional groups" was instituted by a university in development of a program to transition foreign-educated physicians to nursing. Even though these non-traditional groups were discussed in the literature, only a few studies made specific references regarding FEP transitioning to the registered nurse role (Grossman & Jorda, 2008).

Changing Careers

Simpson (1967) reported in the journal *Sociological Inquiry* on a quantitative, descriptive study of how socialization of an adult into occupational roles also involves a sequential process. This article may be considered a seminal work that laid the foundation for further studies. The intent of the author was to develop a general hypothesis about professionalization process into a professional role, not to test its generality. The data were obtained from a four-year collegiate school of nursing which was connected to a teaching hospital. The participants consisted of 57 freshmen, 21 sophomores, and 17 juniors. The data was derived from "observing the students in the hospital, from interviews, school records, and questionnaires, and from five and one-half months' observation as a resident in the student nurses' dormitory" (Simpson, 1967, p. 48).

Simpson (1967) identified three phases of socialization in this study. The first phase: transition to task orientation. The first task of socialization into a profession is consequently to convert the person's lay notions about the occupation into the practical positioning of the insider. In this phase, the student is concerned with obtaining skills; the student's self-identification then becomes more consistent with the recently learned social content of the role (Simpson, 1967). During this phase, the participants reported an increased awareness that "a nurse is distinguished by the skill level of the tasks she performs rather than by how close a relationship she has with her patients" (Simpson, 1967, p. 49). The second phase consisted of attachment to significant others in the work environment. During this phase, on-the-job training relationships with senior colleagues become significant to the professional trainee. The author reported students began to

share other hospital personnel's alignment to the work condition, specifically, a concern with procedural tasks and increasing role connections with co-workers in the hospital (Simpson, 1967). The students' attention moved to pursuing approval as a professional colleague.

The final and third phase was internalization of professional values. Once the professional novice had become oriented to significant others in the job setting, the student "begins to evaluate significant others on the basis of symbols from the professional culture, personal, extra-professional criteria becoming less meaningful" (Simpson, 1967, p. 52). During this phase, the profession becomes the prevailing reference group, and the thoughts of outsiders become insignificant. Full internalization of professional values happens to the degree that the profession recognizes the individual in its private circle so that they are free from burdens by outsiders.

This study noted one very important concept: the difference between socialization in early childhood and socialization into an adult role. The author noted that the adult is not "a tabula rasa;" an adult comes with several values and previous learned roles which give him or her a perspective in which to appraise the world (Simpson, 1967, p. 48). As stated, this study may be considered one that presented seminal work clearly and proposed a general hypothesis of sequential patterns of socialization into professions, from acquisition of technical knowledge, peer relationships, and accepting and internalization of the professions values. This is important as the critical factors that influence the attitudes, beliefs, and perceptions of these FEPs as they practice within the nursing role was examined. It is understood that one objective of a professional school is

to produce professionals who have adopted the occupational group's behaviors and values as this will affect their practice within the profession.

Brown (1995) outlined a holistic values-based approach to facilitate transitions and how values provide standards of behavior. This article presented seminal work. The purpose of this article was to outline several qualitative and quantitative approaches and their disadvantages and advantages in measuring and facilitating transitions. Brown (1995) cited qualitative approaches, such as projective techniques, having some advantages, such as connecting clients more dynamically in the procedure of recognizing their values and permitting for more counselor-client collaboration. On the other hand, the author identified quantitative approaches such as the Values Scale by Rokeach (1973) as being a more effective means of collecting information about values as they offer a construct validity. The author stated that some instruments incorporate both qualitative and quantitative approaches in identifying values, such as the Life Values Inventory by Grace and Brown (1992). However, he cautioned that the qualitative dimensions of the scale are yet untested (Brown, 1995).

Values have cognitive and affective elements and the value of decisions will be reliant on the clarity of the individual's values and the degree to which data about choices is available (Brown, 1995). As per the author, clarity has two dimensions: the level of crystallization of specific values and the degree to which values have been ranked (1995). The author further explained that a crystallized value is one that has a description that has meaning to the individual and can be used to understand present behavior and the consequence of that behavior. Affective dimensions can be positive and/or negative (Brown, 1995, p. 5). A positive effective dimension can occur when a person acts in

accordance with his or her values and achieves the desired outcome; whereas a negative effective dimension may be the opposite and their self-evaluations are diminished. As cited in Brown (1995), Feather (1992) stated that actions that are in conflict with values or that fail to achieve desired outcomes may impair decision making. In career change and transitions, values are used by persons to relate themselves with others as well as to create goals. Unplanned transitions, (such as one of the foreign educated physician) often comes as a shock and negative feelings. These negative feelings may be as a result of "interrole" conflict, and it is important to address as it may affect decision making (Brown, 1995, p. 10).

In the findings, Brown (1995) noted for a profession to be fulfilling, it must permit persons to participate in undertakings that they accept as worthwhile, which in turn allows them to associate themselves positively with others. Brown (1995) stated that individuals who are unable to participate in work that they believe to be significant disrupt their standards of behavior and are likely to be discontented in their jobs. More importantly, he noted that if the individual's values are different that those of their supervisor they will have a contradictory view of the comparative importance of several features of the job. This concept is important as the critical factors that influence the attitudes, beliefs, and perceptions of FEPs as they practice in a professional nursing role in the United States regarding their scope of practice was examined. The author concluded and recommended that a value-based method to supporting occupational transitions must begin by pinpointing, expounding, and ranking values. The need for a career counselor to facilitate the transition and identify intra-role conflicts is essential in facilitating occupational transitions.

Burke (2006) from the University of California, Riverside, examined the two mechanisms by which persons' identities' change over time. Burke's quasi-experimental study obtained data from a longitudinal study of first-married couples utilized data from the Marital Roles Project, where spousal and gender identities of newly married couples over the first years of marriage involved in everyday activities were examined. The research question for this study was: How identities change? The sample was drawn from marriage registration records from 1991-1992 in two midsized communities in Washington State. In this study, 286 couples completed the data collection process for the first year. Attrition was 15% from year 1 to year 2, and 4% from year 2 to year 3. Burke (2006) utilized identity control theory (ICT) which states that "an identity is viewed as a set of self-relevant meanings held as standards for the identity in questions" (Burke, 2006, p. 81). Burke (2006) hypothesized that since ICT has hierarchical views of identities as control systems it would be able to answer the theoretical mechanisms involved in the change of identities over time. A second mechanism of change in identities is theorized by the author is as a "result from persons holding multiple identities that share meanings" (Burke, 2006, p. 81). Identities that share scopes of meanings affect each other's standard to preserve the mutual meaning at a joint level.

The spousal role identity was determined by asking the respondents to rate each of eight spousal activities by how much they felt that they should engage in that activity. The importance is in what it means to engage in those activities, not the role activities themselves. This in turn, per the author, would capture the important underlying dimensions of the spousal identity meaning (Burke, 2006, p. 87). The items ranged from "not doing that activity in the household" (coded 0) to "doing all of that activity in the

household" (coded 4) (Burke, 2006, p. 87). The items had an omega reliability of .90 with four items being reverse coded. High scores on the underlying dimension of meaning represented a more traditional (feminine) definition of spousal identity. Gender identity in this study was measured using the Burke and Tully (1977) method on items taken from the Spence and Helmreich (1978) Personal Attributes Questionnaire (PAQ) (Burke, 2006, p. 88). The author selected 15 items that distinguished meaningfully between male and female meanings across the three points, using a discriminant function; applying this function a high score indicated a more feminine meaning (Burke, 2006, p. 88). The omega reliability was .83 for this scale.

The three concepts— "the meanings of spousal identity standard, the meanings of the spousal role performance, and the meanings of the gender identity standard"— as they correlate to each other over time was used for the structural equation model (Burke, 2006, p. 88-89). The authors reported a chi-square test for goodness of fit at 34.7 (p = .07) and revealed a good fit of the data to the model, to include the assumption of equal effects over time. The study revealed that "identity change involves changes in the meanings of the self: changes in what it means to be who one is a member of a group, who one is in a role, or who one is as a person" (Burke, 2006, p. 92). These meanings are maintained in the identity standard, the portion of the identity that functions as a signal for judging self-in-situation meanings. The author suggested two mechanisms whereby identities change over time: (a) slow change that happens as the meanings in the identity standard change to be more like the self-relevant meanings that are comprehended in the situation and (b) an adaptive response, in which two identities that share some common

dimensions of meaning in their standards develop more like each other in their surroundings on that dimension when they are produced together (Burke, 2006, p. 92-93).

This study's significant findings revealed that the identity that changes more is dependent on other factors; to include which one the individual is more committed to. Whereas an identity cannot change the circumstance, it adjusts slowly, acquiring control where it can, and acclimatizing where it must. This point is coherent with the traditional symbolic interaction appreciation of self as a process.

Barclay et al. (2011) presented an integration of a well investigated behavior change theory, the transtheoretical model of change (TTM), with Super's 1990 life-span life-space approach to career development (LSLS) to aid career counselors theorizing the change process for the use of suitable interventions. The authors utilized a descriptive measurement of program outcomes to describe the integration of the TTM and LSLS approach in voluntary midlife career changes. The authors concluded after examination of the theory and processes that in order to adapt to midlife career change individuals must make changes in their "cognitive, emotional, and behavioral realms," and this could be explained by the TTM and the LSLS (Barclay et al., 2011, p. 338). The TTM was originally developed to assist clients with smoking cessation, and it represents stages through which individuals move through to alter health-related behaviors. The exact stages are pre-contemplation, contemplation, preparation, action, maintenance, and termination. These tools may be used as a guide with counselors during many points during the career change and to support individuals as they explore career changes. According to the authors, TTM permits career counselors to manage clients from a meso-

theory, using accepted change processes and levels as the emphasis of interventions (Barclay et al., 2011).

The Super's LSLS approach (as cited in Barclay et al., 2011, p. 390) adopts the development of major career and life role stages of development. These stages include "growth, exploration, establishment, maintenance, and disengagement and occur over the life span maxicyle" (p. 390). The authors developed an integrated model by matching of the TTM stages of change with a specific stage of the LSLS approach in accordance with the TTM literature.

Incorporating the TTM with the LSLS approach supports to recognize the processes of change that may be pursued by career counselors to aid clients understand their career change objectives (Barclay et al., 2011). The author's findings noted that life experiences only are not sufficient to prepare the mid-lifer for a career change as 50% to 80% of midlife career changers return to school where they obtain new skills and proficiencies for their new career. The findings of this study concluded that the TTM can be integrated with the LSLS approach for use in mid-life career change counseling with positive effects. TTM is considered a bridge theory between counseling theories and technique (Barclay et al., 2011). This article depicted the stages individuals go through as they progress through a career change and the benefit that could be had for a smooth transition by the individual if the tools are utilized to aid in the process.

These four articles examined second career changes and the structural symbolic interaction assessment that identities transpire within the structural framework of society and how they are predisposed by their situation within that framework (Burke, 2006, p. 93). These studies recognized that second career individuals and persons making a career

change go through changes in their perceptive, emotional, and social realms. Burke (2006) and Barclay et al. (2011) both agreed that career counselors could use theoretical approaches to facilitate and assist those embarking on a second career.

Simpson (1967) also identified phases of socialization into professionals that are dependent on the emotional, social, and cognitive realms of those progressing through the transition. As did Brown (1995) when he identified that in career change and transitions, values are used by persons to relate themselves with others as well as to create goals. An important concept to remember as the phenomenon of interest is examined.

These articles examined approaches that determined that counseling-based career assistance methodology should incorporate more than assessment instruments and an individual to setting fit process. What is needed must be comprised of an emotional, cognitive, and behavioral element along with traditional career instruction to facilitate a smooth transition. This classical grounded theory examined the second career phenomenon, specifically the FEPs in their role as nurses, adding to the enlightenment of the nursing profession, nursing research, and education on how these second career nurses transitioned to their new role and what they require for a smooth transition.

Second-Career Nurses

Seidi and Sauter (1990) conducted a quantitative study comparing traditional undergraduate generic students with a group of non-traditional students with the hopes to "dispel myths" and to develop guidelines and educational approaches (p. 13). This study was considered to present seminal work relevant to the phenomenon of interest. The purpose of this study was to:

- Develop a profile of the non-traditional adult student in the baccalaureate program of nursing education;
- Compare traditional and non-traditional students with respect to demographic characteristics, educational goals, sources of financial and psychological support, study habits, and preferred schedules and methods of instruction;
- Compare the traditional and non-traditional groups with respect to their learning styles. Learning style parameters examined in this study were receptive versus discovery modes of learning new information; and
- Compare the scores of traditional and non-traditional groups on a test of judgement ability in the nursing profession. The purpose of this comparison was of assess the effects of life experiences on the practical problem-solving skills. (Seidi & Sauter, 1990, p. 15)

Both sets of students were compared on "demographic variables, educational goals, sources of psychological and financial support, study habits, learning style, and clinical judgement skills" (Seidi & Sauter, 1990, p. 13). The sample size consisted of 129 persons: 78 traditional and 51 non-traditional students.

Three instruments were used: the first one was a 22-item survey questionnaire that focused on demographic information, goals, educational background, ideal methods of being taught, study habits, and forms of support (Seidi & Sauter, 1990, p. 15). The second instrument utilized by the researchers was the Preferred Learning Style Index

(Stone, 1974), which contained 13 statements describing various types of learning activities. The final instrument was a 28-item test developed by the authors called the Scale of Judgmental Ability in Nursing. This instrument examined four areas of professional judgment: "legal/ethical, problem solving/decision making, communication, and leadership/team functioning" (Seidi & Sauter, 1990, p. 15).

The students were enrolled in two consecutive sessions as they began their course work in the School of Nursing and were contacted to voluntarily complete the instruments. Of the 129 students enrolled, 31 returned the questionnaires: 15 traditional and 16 non-traditional. The data obtained from the demographic questionnaire was readily available for all 129 students (traditional and non-traditional) and the data were analyzed to compare group differences, chi-square analyses on categorical variables, Mann-Whitney U tests were performed on the continuous variables. The Learning Style Index and the Scale of Judgment Ability in Nursing were assessed by means of *t*-tests, Kendall's tau correlations were computed for selected variables for the 31 students who voluntarily submitted the questionnaires (Seidi & Sauter, 1990, p. 15).

When the survey questionnaire was examined for the demographic variables of the 31 students who submitted the surveys, the authors reported marital status as a "strikingly" difference between the groups (Seidi & Sauter, 1990, p. 16). All the traditional students were single and had no children, while a third of the non-traditional students were married (3.2% divorced) and 43% on the non-traditional students had children (Seidi & Sauter, 1990, p. 16). Traditional students used parents as financial support and nursing classmates, friends, parents for physiological support ($x^2 = 6.39$, 3 *df*, $p < .10$). On the other hand, non-traditional students' source of support was spouses or

significant others and they financially depended on themselves or loans (x^2 =9.76, *df* =.5, *p* <.10(.082)). Noteworthy variations were found between the two groups in relation to their educational plans. Non-traditional students had significantly higher degree ambitions (Mann-Whitney U = 86.5, *p* < .10 (.068)), 69% were aspiring to pursue a master's or doctoral level degrees (Seidi & Sauter, 1990, p. 16). The future career goals of both groups were not significantly different: both groups of students in this study specified a main pursuit of primary health with no interest in research, consultation, or administration (Seidi & Sauter, 1990, p. 16).

In the Learning Style Index, non-traditional students were strongly characterized as discovery learners versus receptive learners as in the traditional group (*t* = 2.88, *df* = 27, *p* < .01 (.004)). On the Judgmental Ability in Nursing Scale, non-traditional students with their acquired skills and experiences suggested that they possess a higher judgmental ability in professional contexts as they scored significantly higher (*t* = 1.73, *df* = 24, *p* < .05 (.084)).

The findings of this study demonstrated that there are positive relationships between a tendency toward discovery learning and experiences in higher education, semester grade-point average (GPA), and age. In addition, the ability of the students to make professional judgments as indicated by their scores on the Scale of Judgment Ability in Nursing was significantly related to their learning styles and correlated to the ability to make higher level professional judgments (Seidi & Sauter, 1990, p. 17). The findings of this study suggest that the interactive relationships that the counselors have with faculty and staff can be utilized for the advantage of the non-traditional student. Additionally, the findings suggested that counselor's skills are progressively needed as

they interact to the adult student who is managing the various roles of parent, spouse, and/or worker. Counselors should be cognizant of the academic and community resources available to the students and importance of the impact of family support on their success (Seidi & Sauter, 1990). This seminal study is important, as it indicates that even back in the 1990s when non-traditional students were first entering the nursing profession in larger numbers, it was noted that the programs needed to adjust for the particular challenges and demands this group would bring to the schools of nursing.

Utley-Smith, Philips, and Turner (2007) utilized the returning-to-school syndrome model in assisting second-degree students navigate through an accelerated Bachelor of Nursing Science (BSN) program. The theoretical underpinning for the model is the "reality shock" construct utilized by Kramer (1974) to explain the struggle new nursing graduates undergo when transitioning from nursing school to the work setting (Utley-Smith et al., 2007, p. 423). The purpose of using this model was to identify transition points and offer student support through specific stages and how these steps could better prepare and assist the students in meeting the challenges of their course work. As well as assisting the faculty in becoming more proficient at providing resources and executing supportive approaches at the suitable times (Utley-Smith et al., 2007, p. 423). The participants for this study came from students enrolled in the universities 16 month accelerated BSN program. The returning-to-school syndrome model identified three stages in the educational process: honeymoon, conflict, and reintegration. In this study, the authors discussed the model, described their nursing programs, the application of the model, and its benefits. Data were collected during the 16-month program and correlated to the phases of the model.

The authors explained a key step in putting the returning-to school syndrome model into practice was assessing critical transition points in the curriculum (Utley-Smith et al., 2007, p. 425). During the 16-month program, the authors were able to find the points that correlated with the stages of the model. Findings of the study consisted of implications for educators during each phase of the returning-to-school model. During the first semester, educators are to introduce the model to the students, emphasizing the expected role change and strain, in addition to the normalcy of experiencing the stages. Here the students enter the first phase: the honeymoon period (Utley-Smith, Philips, & Turner, 2007).

The conflict period (stage two) usually happened during the second semester, when the students were taking their first intense clinical course ("with its long hours, high expectations, and steadily increasing responsibilities") (Utley-Smith et al., 2007, p. 425). During this second stage, the findings included that faculty support and advisement, coupled with faculty making appropriate referrals made to support agencies for a smoother socialization outcome. As stated by Utley-Smith et al. (2007), students tended to shift toward the beginning of the reintegration stage (the final stage) at the end of the second semester. This could lead the students to positive resolution or maladaptation. This phase, as noted by the authors, could progress into the third semester; however, most students reached positive resolution by the fourth semester. During the stage, the findings noted the importance of the faculty in assisting the students on focusing on the larger goals and the benefits of reintegration (Utley-Smith et al., 2007).

Utley-Smith et al. (2007) noted that the students were encouraged to request assistance from the faculty advisors and to remain aware in which stage of the model they

are in. Students were encouraged not to be drawn in by their peers into maladaptive responses, while at the same time encouraging their maladaptive peers to seek help. An integral part explained by the authors was the faculty's role in contributing support and resources proactively as the students are aware of what is occurring to them (Utley-Smith et al., 2007, p. 426). The authors recommended, as the findings suggested, that teaching students to use the model to recognize their own transitions and providing students support through the transitions can point to better student socialization and enhanced student and program outcomes (Utley-Smith et al., 2007, p. 426).

Kohn and Truglio-Londrigan (2007) conducted a hermeneutic phenomenological qualitative study utilizing van Manen's approach to explore the lived experience of being a second career student. As per the authors, the research was focused on the importance of these types of programs being a solution to the nursing shortage (Kohn & Truglio-Londrigan, 2007). The purposive sampling consisted of participants recruited from a cohort group of second-career BSN students at a major university in New York. The participants who were eligible were full-time students enrolled in the 1 calendar year program. Nine participants were initially recruited, three dropped out almost immediately citing factors of stress, and an additional participant dropped out during the second semester. This resulted in a total of five participants in the study.

The initial interviews lasted 45 minutes to 1 hour. Participants were interviewed four additional times throughout their three-semester course of study. The interviews consisted of open-ended questions to solicit information of how their experience was of being a second career student, of returning to school, of taking nursing courses, and of returning to school to become a nurse (Kohn & Truglio-Londrigan, 2007). Data findings

consisted of several themes. The themes were: "*Questioning one's place in the world; Seeing one's place in the world in another way; Preparing for the plunge; Trying transitions; A bundle of emotions; Faculty control, student imbalance; and Almost there and scared"* (Kohn & Truglio-Londrigan, 2007, p. 394).

In the findings under the theme of "*Questioning one's place in the world,"* many participants remarked that they had questions concerning their place in life and the jobs they held in their past careers. These individuals had been exposed to sentinel or traumatic event that brought their purpose in life into perspective, and they gained a desire to be of help to others. Under the theme of "s*eeing one's place in the world in another way,"* the participants observed nurses taking care of people and they liked what they saw. Some participants stated they saw nursing as a practical profession, whereas others saw nursing as a caring profession where they made a difference. Under "*preparing for the plunge,"* the participants reported that preparing for the change centered on prioritizing, decreasing work hours to ease the transition to the full-time nursing program, and preparing their families. Participants found the transition "difficult at best" and "intense" (Kohn & Truglio-Londrigan, 2007, p. 395).

Under the theme of *"trying transitions,"* it was evident among the second career nursing students, that most had to seriously consider leaving well-established leadership positions and the impact that would have. From the findings, the authors denoted that to begin anew required a deep commitment and conscious recognition of changing professions, beliefs, values, and past practices (Kohn & Truglio-Londrigan, 2007). Under the theme of *"a bundle of emotions,"* the participants reported high levels of stress, anxiety, feelings of being lost and overwhelmed. The authors reported in their

findings that the students seemed to cope with this stress by trying to maintain controlled order at all times. They achieved this by arranging their entire semester weeks prior to its beginning, arranging for childcare and work schedules. Many participants described a lack of fundamental support under the theme of: *"faculty control, student imbalance."* According to the authors the findings under this theme centered on the participant's perception of faculty not communicating changes in a timely manner and not being allowed to be involved in the program change processes. Study participants indicated that when there was break in communication or unplanned changes occurred feelings of anger and frustration surfaced (Kohn & Truglio-Londrigan, 2007).

The final theme of *"almost there and scared"* spoke of the relief the participants had about the worst being over, but with an overwhelming sense of concern for the "nexts" that where yet to come; "I have to find a job; I [have] got to move; I go to pass the NCLEX" (Kohn & Truglio-Londrigan, 2007, p. 397). As per the study's findings, the students spoke anxiously about this transition from student to professional nurse and of their feelings of being unprepared.

The authors noted several implications and recommendations based on the findings of this study. Firstly, the authors suggested an examination of the curriculum to ensure it flowed in an organized manner and included student representation in the development and change of the curriculum. In addition, as it was noted by this study, the second-career students would appreciate a blueprint of the entire curriculum, as it would assist the students in their need to controlled order. Another important recommendation that was noted in the previous literature review section was the importance of faculty assignments. The authors noted and stressed the importance of faculty to be sensitive and

supportive to the students in these cohorts. Faculty mentoring and support sessions were also a recommendation in hopes of providing a venue for the students to voice their feelings and have social support during their program. These recommendations and findings were echoed by the previous studies reviewed.

Dela Cruz, Faar, Klakovich, and Esslinger (2013) conducted a quantitative, descriptive study to measure the program outcomes of the Second Careers and Nursing (SCAN) program in socializing second-career students into professional nursing. The pre-licensure phase of the program is directed by Schlossberg's transition theory of moving in, moving through, and moving out. Moving in consist of setting expectations, "from the admission interview to the two-day intense orientation" (Dela Cruz et al., 2013, p. 12). Moving through involves teaching and drilling nursing's cultural content and values through the program's official and informal curriculum. Moving out reinforces students' emotional state of pride and their pledge to becoming professional nurses through an intense internship (Dela Cruz et al., 2013, p. 12). The data were collected on 68 out of 74 pre-licensure students in Cohort 1 to 4 (Utley-Smith et al., 2007, p. 15).

The SCAN program utilized three psychometrically validated scales to assess students' competence before and after the pre-licensure program. The Interpersonal Communication Scale, the Pre-Professional Clinical Competence Scale, the Cultural Self-Efficacy Cultural Scale, and the Dempster Professional Behavior Scale were used in this retrospective approach study. The SCAN program collected pre-and-post competency ratings simultaneously at the end of the pre-licensure phase. Interpersonal Communication Scale consisted of 23 items produced three subscales with descriptive factor analysis: therapeutic use of self, validation, and advocacy with respective

Cronbach alphas of .93, .84, and .93. The pre-post Cronbach's alphas for this student section ranged from .84 to .94. The Pre-Professional Clinical Competence Scale was a 54-item scale, measuring students' clinical performance competencies. Initial psychometric testing produced six factors: professionalism, ethical behaviors, coordination and evaluation, planning, psychomotor skills, and nursing assessment; Cronbach's alphas ranged from .87 to .95. The pre-post Cronbach's alphas in this student sample ranged from .95 to .99 (Dela Cruz et al., 2013, p. 15).

The Cultural Self-Efficacy Cultural Scale is a 26-item scale with three subscales: "confidence in knowledge of cultural concepts, confidence in knowledge of cultural patterns for African American, Hispanic, Asian, and American Indian cultures, and confidence in specific cultural nursing skills" (Dela Cruz et al., 2013, p. 15). According to the authors, studies have reported the measure's construct validity and its internal consistency for this instrument ranging from .86 to .98. The pre-post Cronbach's alphas in this student group ranged from .95 to .99. The Dempster Professional Behaviors Scale is a 30-item scale consists of four subscales: "readiness, empowerment, actualization, and valuation" (Dela Cruz et al., 2013, p. 15). Factorial validity demonstrated these four subscales and the total Cronbach's alpha as .95 and the post program Cronbach's alphas in this student group ranged from .91 to .94 (Dela Cruz et al., 2013, p. 15).

The authors reported multivariate repetitive measures of analysis of variance exposed that students in Cohorts 1-4 demonstrated little dissimilarities in their clinical, interpersonal, and cultural competencies from the end of the first semester to the end of the fifth semester, $F (3.60) + 80.233$, $p < .01$, scores where significantly increasing from pretest to posttest (Dela Cruz et al., 2013, p. 16). There was a possible score of 150,

mean scores for professional autonomy perceptions demonstrated a moderate to high level of autonomy, range 117 (*SD* = 13.6) to 130 (*SD* = 11.2) (Dela Cruz et al., 2013, p. 16). This study utilized focus groups with students in cohort groups 1-4 where they "unanimously" communicated their approval for the clinical experience obtained in the course of the internship (Dela Cruz et al., 2013, p. 16). The authors also reported that all students from Cohort 1-4 who passed the NCLEX found jobs, most at the hospital where they completed their internship.

Dela Cruz et al. (2013) reported just as Utley-Smith et al. (2007) that second-career students face a unique set of challenges and the effective transition into nursing necessitates an assortment of cooperative and contextualized teaching/learning approaches through the informal and formal curriculum. Both of these studies highlighted the importance of faculty keeping informed on the method selected for the program and their connection to the students in the program. Evaluation and straightforward feedback motivated the faculty and students alike to carry out helpful transition approaches and activities to ensure successful student and program outcomes (Dela Cruz et al., 2013; Utley-Smith et al., 2007).

All of these studies echoed similar findings. The need to incorporate teaching strategies that promote student interaction between faculty and students as a way to emphasize the processes learned and faculty should strive to identify their own strengths in teaching adult learners with their own set of challenges (Dela Cruz et al., 2013; Kohn & Truglio-Londrigan, 2007; Seidi & Sauter, 1990; Utley-Smith et al., 2007). Kohn and Truglio-Londrigan, (2007) just as Dela Cruz et al. (2013) and Utley-Smith et al., (2007) concluded that developing support for students within the second-career BSN program

and mentoring by faculty and collegial mentoring among the students is critical for their success. These studies repeat the need to investigate the phenomenon of interest in order to discover the challenges faced by FEPs as they practice within their new nursing role.

As noted in other studies cited in this literature review of second career nurses, the challenges and struggles have not changed much from Seidi and Sauter's (1990) study. All of these studies reported the profile of second career students includes characteristics of confidence, self-awareness, maturity, and stronger history of academic performance (Seidi & Sauter, 1990). The findings of these studies all suggest that nursing programs for second career students have to structure learning opportunities that facilitate the matching of prior strengths and appropriate values with the new nursing concepts (Dela Cruz et al., 2013; Kohn & Truglio-Londrigan, 2007; Seidi & Sauter, 1990; Utley-Smith et al., 2007). These studies, however, have not addressed the attitudes, beliefs, and perceptions of the second career professional. This was essential in understanding how these professionals had socialized and transitioned into their new profession.

Experiential Context

The notion for undertaking this study grew out of my personal and professional experience with medical doctors that have immigrated to the United States and have either become nurses or have completed the requirements to practice medicine again in their adoptive country. I have been exposed to some FEPs as they work at the bedside, and while many seem fulfilled in their new roles, there has always been curiosity to know what factors influenced their clinical practice as nurses. How do they see themselves in relation to their patients? What influenced them to become nurses in the first place?

One particular incident that sparked my curiosity as to the phenomenon of interest was the not-so-simple removal of a central venous catheter (CVP). The particular hospital unit was a telemetry step-down unit, which cared for cardiac and post-cardiac catheterization patients. As I was rounding with my student and reviewing the charts of the assigned patients, I noticed an order which read "HP to remove CVP line." The meant for the house physician (HP) to remove the CVP catheter. I had worked on this unit previously as an agency nurse and knew that within the scope of practice of this particular floor, nurses were *not* allowed to remove these catheters. I started to guide my student to that room, so I could explain the functionality and the workings of the CVP line before the HP came to remove it. As we entered the room, we observed the registered nurse assigned to the room actually removing the CVP line.

By the time, I realized what was actually happening the catheter had been removed. I asked the nurse if he was going to culture the tip as I knew that was standard procedures for these types of patients. He said "no." I offered a sterile cup and told him to just cut the tip "just in case." My student looked a bit puzzled, and I sent him to get a patient label for the specimen. I introduced myself to the nurse and he stated his name. I pretended ignorance and asked if he was the HP as the order read for the HP to remove the CVP line? He said no he was the nurse for the patient. I said "Oh, wow things have changed since I worked here last—I remember when the floor nurses were not allowed to remove the CVP lines." The nurse calmly stated: "Oh that is because I was a physician in my country and they let me do other [more] things here." I was alarmed and my curiosity grew at that moment. I asked him: "but you are a RN [registered nurse] here, right?" He

said “yes,” and I noticed he started to look at me a bit more intensely. I quickly changed the subject and wandered off to find my student.

Classical grounded theory stresses the importance of the researcher remaining open and willing to keenly listen to the declarations of the participants without imposing his/her predetermined ideas on the data (Glaser, 1998). It is crucial the researcher maintains an objective stance, as no researcher enters a research setting without biases. The preexistent knowledge and suppositions were recognized and controlled. The researcher acknowledged that completing a literature review may have brought her some biases that she was not expecting and worked diligently in recognizing when they come to the surface and not allow them to affect the study.

Reflexivity is an active process of constant critical self-reflection used to recognize researcher bias and positionality, to make beliefs explicit, and to embrace the partiality of knowledge creation during every stage of the research process (Finlay, 2002). The researcher employed self-reflexivity, which created a heightened awareness of the self-process of knowledge creation and a clarification of how one’s beliefs have been socially constructed. The researcher utilized a journal to note reactions during the research process. The researcher understood that she carried with the self her background, life experiences, and memories and just like the second career nurse they cannot be separated. As stated by Guillemen and Gillam (2004), the reflexive process will enhance rigor and assists the researcher to identify any ethical pressures that rise from social exchanges in the research venue. The researcher used journal to make note of the researcher’s responses and emotional state to the interview and memos to record any challenges to the theories. The completion of a limited literature review may have biased

the researcher in exposing her to what could be perceived as negative/positive FEP behavior. The researcher will make a conscious effort to not allow those potential and actual biases to interfere or enter into the study.

As required by classical grounded theory, the researcher made a mindful effort to put away predetermined ideas, reasonable explanations, and concepts collected from the present literature to allow for new concepts, processes, and unconfirmed hypothesis to emerge from the data that was collected. Glaser (1998) did not believe bracketing was necessary as grounded theory refrains from the forcing of the data and instead calls for constant comparison and conceptualization of the data. Nonetheless, the researcher utilized reflexive journaling and put aside preset ideas or biases. Glaser (2001) believed "all is data" and the data has a voice of its own (p. 145).

Chapter Summary

This chapter presented a synthesized literature review covering the following areas: historical context, identity creation from a new career, transitioning to nursing, medical doctors entering nursing, service professionals as second-career nurses, and non-traditional students in nursing. Experiential context was also disclosed. The literature was synthesized noting the lack of studies currently present, while highlighting the gap and benefit of this study.

CHAPTER THREE

METHODS

The purpose of this classical grounded theory study is to discover a substantive theory explaining the process of foreign-educated physicians (FEPs) experience as they transition from their original role as physicians in their country of origin, to their new role as registered nurses in the United States. The theory will be grounded in data gathered regarding the critical factors influencing the attitudes, beliefs, and perceptions of FEPs who have entered nursing as a second career.

Research Design

The grounded theory method is beneficial when the researcher seeks to develop a theory that describes human actions in a social environment (Strauss & Corbin, 1998). This method uses data that is systematically collected from the participants to lead to the understanding of the phenomenon in question, and then the data will be analyzed utilizing a scientific method (Strauss & Corbin, 1998). It is in making these comparisons that the researcher identified a process and linked concepts to discover a substantive theory. The researcher utilized the classical or Glaserian grounded theory design to answer the research questions: (a) What are the critical factors that influence the attitudes, beliefs, and perceptions of foreign-educated physician as they practice in the professional nursing role in the United States? and (b) How do FEPs view their role in nursing as compared to their physician role?

The grounded theory method is a series of actions used to allow the emergence of a theory that explains, at a broad conceptual level, a social process (Munhall, 2012). It presents a step-by-step, systematic method for the beginning researcher. Grounded

theory allowed the researcher to stay close to the data at all times during the analysis process. The grounded theory design was utilized to discover a process about a basic issue and analyze the data for increasing levels of abstraction by employing a constant comparative method and asking questions about their data (Glaser, 1998). During analysis of the data for categories, a core category processed out into a theory (Glaser, 1998; Grbich, 2013). In grounded theory, the researcher investigated this process to develop a theory. Throughout the grounded theory procedure, the researcher utilized memos and reflexive journaling, but will not formulate the hypotheses in advance since preconceived hypotheses result in a theory that is ungrounded from the data (Crotty, 1998).

Glaserian/Classical Grounded Theory Approach

Grounded theory is the methodical creation of theory from data that has itself been scientifically obtained (Glaser, 1978, p. 2). The product of a grounded theory study is not the stating of facts; however, it is the creation of "probability statements" about the connections between ideas or concepts, a set of theoretical hypotheses obtained from empirical data (Glaser, 1998, p. 22). Classical grounded theory is the act of theoretical perception, rather than the precise, detailed reporting of findings in a study. In classical grounded theory, what is important are the concepts (ideas), the connections between those ideas, and the influence they have in giving the individual a theoretical explanation as to the behavior within the social setting being studied. A good-grounded theory is a theory that fits, works, has application, and is easily adjustable on the origins of new data (Glaser, 1998).

A foundational pillar of grounded theory methodology was the development of constant comparative analysis (Glaser, 1992; Glaser, 1998). The continuous comparative method became the significant investigative procedure of grounded theory. Glaser (1978) proposed "indicators indicate concepts" (p. 75). The Glaserian or Classical method urges the investigator to place aside predetermined professional thinking and stay open to what arises as the central point in the topic under study (Holton & Walsh, 2017, p. 8).

Glaser (1978) divided the data coding process into two sections: substantive coding and theoretical coding. Substantive coding includes open and selective coding and theoretical coding in the last phase of Glaser's process, which is centered on one core, fundamental phenomenon that has developed from the data (Glaser, 1978). It is this coding process, which exposes the central themes/ideas, the casual conditions connected to the central theme/idea, the approaches used during interaction, and the consequences of approaches. Comparisons are used to reveal differences and patterns in categories, to connect concepts in the developing theory, and to prompt research reflexivity. Glaser (1978) emphasized the basic social processes was a significant theoretical code that condensed the patterned, systematical actions of social life that individuals went through, and which can be conceptually acquired and additionally understood. As soon as the core category is recognized, the sampling will become theoretical (Glaser, 1978).

Sample and Setting

In this grounded theory study, purposive, snowball, and theoretical sampling methods were used (Strauss & Corbin, 1998). These sampling methods are defined in their appropriate phases. In qualitative research, the goal is not to generalize the

information, but rather to explain the specific information. In grounded theory, studies Creswell (2013) suggest the participants number 20 to 30. This number allowed for a well-saturated, rich theory to be discovered (Creswell, 2013, p. 157). The numbers stated will be only an estimate, as sampling continued until saturation is achieved. Saturation was achieved when no new information is gathered to expand established conceptual categories (Creswell, 2013).

Phase I consisted of a maximum of 30 participants who were recruited utilizing purposive, snowball sampling strategies from the researcher's network of professional colleagues and professional organizations Phase I served as the individual participant interviews.

Phase II was the focus group phase, which was used for theoretical sampling and consisted of a maximum of seven participants. The researcher recruited utilizing purposive, snowball sampling from her network of professional colleagues those who have self-identified as FEPs practicing as ARNP-DNPs or PhD (ARNP or RN).

Access and Recruitment of the Sample

Upon Barry University's Institutional Review Board (IRB) approval, recruitment of the qualified participants began. The researcher is a professional nurse who has worked in numerous hospitals and has a broad professional network throughout several healthcare systems. Access to potential participants was sought through this professional network utilizing purposive and snowball sampling. Another venue of access included the utilization of professional associations and organization websites, including but not limited to National League of Nursing (NLN), Hispanic Nurses Association (NAHN), Florida Nurses Association (FNA) and flyers where posted on her LinkedIn personal

page. Permission was requested to post the recruitment flyers on each website as per their rules and regulations upon IRB approval. The letter of access (Appendix C) and recruitment flyers (Appendix D) where sent via e-mail as designated by the utilized organization. In addition, the researcher utilized her professional network of nursing colleagues to distribute the flyers.

This researcher used purposive and theoretical samples in this study. The recruitment of the participants proceeded in two phases and consisted of two groups. The total number of participants in both phases consisted of 22 participants.

Phase I consisted of 17 participants recruited utilizing purposive and snowball sampling strategies. Purposive sampling is a sampling technique in which the researcher depends on his or her own judgment when selecting members of population to participate in the study. Purposive sampling is a non-probability sampling method (Fain, 2004).

Glaser (1978) stated that purposive sampling denotes the deliberate choice in sampling a specific place affording a preconceived but reasonable initial set of elements (such as time, space, identity, or power), which are implemented in advance for a study. Snowball sampling is identifying cases of interest from sampling individuals who know persons that usually have like characteristics who, in turn know individuals, also with like characteristics. Snowball sampling (also referred to as network or chain referral) is a method for identifying and sampling the cases within a network (Given, 2008). As the participants communicated with the researcher their desire to volunteer for the study they were evaluated as per the inclusion criteria. The researcher had this initial discussion either through email, face-to-face, or phone as the participants choose. The reason of this sample was to indicate the substantive area of the study. All 17 participants met the

inclusion criteria and where invited to a face-to-face interview by the researcher at a mutually agreed upon time and setting by the researcher and participant. The participants all self-identified as FEPs who had been employed as an RN for at least 6 months. Once the researcher obtained the signed consent, the participants were offered a $20 Walmart gift card, which was theirs to keep even if they choose not to answer questions and/or choose not to finish the interview.

Phase II was the focus group and began once phase I was completed. The focus group was used for theoretical sampling and consisted of five participants. Theoretical sampling was used to completely saturate and confirm the core category generated by phase I interviews. The researcher recruited utilizing purposive, snowball sampling from her network of professional colleagues those who had self-identified as FEPs practicing as ARNP-DNPs or PhD (ARNP or RN). Once the researcher obtained the signed consent, the participants were offered a $20 Walmart gift card, which was theirs to keep even if they choose not to answer questions and/or choose not to finish the focus group interview.

Inclusion Criteria

Phase I. The phase I group consisted of the participants for the individual interviews. The inclusion criteria for the participants in phase I included the following:

1. Self-identifies as a foreign-educated physician (FEP)
2. Licensed as an RN or ARNP in the United States
3. Employed for more than a six-month period in a nursing role
4. Fluent in English
5. Willing to share his/her attitudes, beliefs, and perceptions about his or her new

role as a RN or ARNP

6. Willing to participate in an audiotaped interview, which will be transcribed
7. Has access to a computer, email, and a phone
8. Willing to review and return the transcriptions of their individual interview

Phase II. The phase II group consisted of the participants for the focus group, which was used for theoretical sampling. The inclusion criteria for the participants in phase II included the following:

1.Self-identifies as a FEP –DNP/PhD (RN or ARNP)

2.Employed for a minimum of 5 years in a professional nursing role.

3.Willing to review and reflect on the usefulness and fit of the emerging theory.

4.Fluent in English.

5.Willing to participate in an audiotaped focus group interview, which will be transcribed

6. Has access to a computer, email, and a phone in order to contact the researcher of his or her willingness to participate in the study

Exclusion Criteria

Phase I. Phase I exclusion criteria included (a) a FEP who had not obtained a Registered Nurse (RN) license or Advanced Registered Nurse Practitioner (ARNP) license, (b) a RN who was not fluent in the English language, (c) active FEP-RNs who had not been employed for at least six months in a professional nursing role, and (d) a FEP (RN or ARNP) who was a DNP or PHD.

Phase II. Phase II exclusion criteria included (a) FEP-DNP (RN or ARNP) or PhD (RN or ARNP) who had not been actively employed in any of the following roles for a minimum of 5 years and (b) a FEP-DNP (RN or ARNP) or PhD (RN or ARNP) who was not fluent in the English language.

Ethical Considerations/Potential of Human Subjects

Institutional Review Board (IRB) approval from Barry University was secured prior to commencement of the study. Each phase had its own specific informed consent. Phase I had the individual informed consent. The informed consent was explained and discussed with the individual participant. The participant was allowed time for questions. Before the beginning of the interview, the participant was offered their token of appreciation in the form of a $20 Walmart gift card and was informed about the confidentiality process for the data collection and storage. Once the participant agreed to proceed and participate in the study, the consent was signed before the interview began. Once the interviewer signed the consent the interview began. A transcription service was used to transcribe the Phase I and Phase II interviews. A third-party confidentiality agreement is located in Appendix H. The participant was asked to choose a pseudonym to protect his or her confidentiality and avoid a connection.

Phase II consisted of the focus group. The focus group's informed consent was explained and discussed with the participants. The participants were allowed time for questions. The focus group participants were informed that due to the nature of group process confidentiality cannot be guaranteed, although every possible effort will be made to ensure confidentiality to the extent permitted by law. In addition, each focus group participant where asked to maintain confidentiality and not share who was present and

what was discussed in the focus group. Once the participants all agree to proceed and participate in the study, each signed their consent before the interview began. Once the interviewer had the signed consent the interview began. Before the beginning of the interview, the participants received their token of appreciation in the form of a $20 Walmart gift card and were informed about the confidentiality process for the data collection and storage. The participants were each asked to choose a pseudonym to protect his/her confidentiality and avoid a connection. Furthermore, each participant was instructed to indicate their pseudonym as they speak.

Once the audiotapes of the interviews (both individual and focused group) were transcribed by the transcriptionist and member checking was verified, the audiotapes were destroyed. Confidentiality of the written transcripts, memos, and notes are maintained by keeping all files in a locked file cabinet in the researcher's home office. The signed consents are kept in a separate locked file cabinet to maintain confidentiality. All transcribed data will be kept initially for 5 years and then indefinitely.

This study presented no risk to the participants. The participants in the study received no direct benefit from this study.

Procedures for Data Collection

Once IRB approval was granted, data collection began. Flyers were distributed to the professional network of the researcher by email or in person. Individuals who choose to participate in the study contacted the researcher at the contact information provided in the recruitment flyer. As the participants communicated with the researcher their desire to volunteer for the study, they were evaluated based on the inclusion criteria. The researcher had this initial discussion either through email, face-to-face, or phone as the

participants choose. Participants meeting the inclusion criteria where interviewed face-to-face by the researcher at a mutually agreed upon time and setting by the researcher and participant. Face-to-face meetings where conducted in a safe location.

The study's protocol, purpose of the study, recordings, and informed consents were discussed and explained to the participants. Time was allowed for questions and clarifications. Once the participant agreed, before the interview began, informed consent was obtained (see Appendix B). Once the researcher obtained the signed consent, the interview began. The participants were offered their $20 Walmart gift card, which was theirs to keep even if they chose not to answer questions or chose not to finish the interview. The participant had the option to stop the interview at any time without penalty or consequence. The $20 Walmart gift card was theirs to keep regardless. All signed consents were scanned and stored by the researcher in a password-protected computer. Hard copies of the informed consent were kept for a minimum of 5 years and then indefinitely, separate from other data in a locked file cabinet in the researcher's home office.

Next, the participants were asked to choose a pseudonym or have one assigned by the researcher. The demographic questionnaire was completed (this took approximately 10 minutes to complete), labeled with the selected pseudonym, and subsequently scanned into the password-protected personal computer of the researcher (see Appendix E).

Semi-structured individual interviews were conducted using a password-protected digital recording device. Digital recordings were transcribed by the transcriptionist. All recorded audio interviews were transcribed word by word and then transferred and maintained on the password-protected personal computer of the researcher. All data,

demographics, recordings, and transcriptions were labeled with the self-identified pseudonym. The transcripts and findings are stored in the researcher's password-protected personal computer.

This study had two phases of data collection processes. Phase I involved semi-structured individual face-to-face interviews (60 minutes) and Phase II involved a face-to-face focus group interview (90 minutes).

Phase I Individual Interviews

Semi-structured interviews were conducted using open-ended questions to initiate the interview (see Appendix F). This approach allowed the participant the freedom to express their thoughts and perceptions freely. It was necessary to utilize probing questions to obtain data from the participants to describe the meaning of the attitudes, beliefs, and perceptions about being a FEP who has entered nursing as a second career. The individual interview process took no more than 70 minutes (60 minutes for the face-to-face interview and 10 minutes for the demographic questionnaire). The participant was assured the researcher will maintain confidentiality at all times. During the entire interview process, an audio recorder and a backup recorder was visibly located. The participants were told they may request it to be stopped at any time.

Upon conclusion of the individual interview, the participant was thanked for their participation again in the study. The participant was informed that once the data was transcribed by the transcriptionist, he or she would receive the transcription by email, fax, or postal mail for their review and clarification (member check); the interview was transcribed within 3 weeks. The review of the transcribed individual interview by the participant took approximately 30 minutes. Next, the researcher contacted the participant

for a follow-up meeting that lasted no more than 30 minutes. This interview took place face-to-face or via telephone as the participant preferred. Total time commitment for individual interview was 100 minutes (10 minutes for demographic questionnaire, 60 minutes for individual interview, and 30 minutes for member checking). Credibility of the findings is a significant step, which allowed the participant to consider the transcribed statements for accuracy.

Phase II Focus Group

Gaining access to focus group participants required the researcher contacting her professional network of colleagues and posting the recruitment flyer on professional organizations and networks sites. This was completed to identify at least seven qualified, expert participants. A total of five qualified expert participants volunteered for the focus group.

Completed informed consents by each focus group participant were obtained. Participants were provided a manuscript of the emerging categories and developing theory for their review during a 2-week period prior to the focus group interview, which took approximately 1 hour to review. A meeting was set at a time and place that was mutually agreeable to all participants and researcher. A semi-structured focus group interview was conducted using open-ended questions specific for the focus group (see Appendix F). Probing questions were used to elicit the data from the participants to explain the meaning and essence of the beliefs, attitudes, and perceptions about second-career FEPs practicing in a nursing role, in an effort to generate an explanation that could lead to an emerging theory. The demographic questionnaire was completed (approximately 10 minutes to complete), labeled with the selected pseudonym, and

subsequently scanned into the password-protected personal computer of the researcher (see Appendix E). The focus group interview lasted no more than 90 minutes. The audio recorder was always clearly located for all participants to see. The focus group was informed as this is a group interview, that the researcher cannot guarantee confidentiality due to the group setting. However, the researcher maintained confidentiality to the degree provided by law and will ask each member to maintain confidentiality. The participants were asked to self-identify with the pseudonym.

Upon conclusion of the focus group interview, the participants were thanked for their participation again in the study. The transcriptionist transcribed the focus group interview. After transcription, the researcher verified accuracy of transcription by listening to the audiotape and reading the transcript. Total time commitment for the focus group interview was as follows 160 minutes or approximately 2.6 hours (10 minutes for demographic questionnaire, 90 minutes for focus group interview, and 1 hour (over the course of 2 weeks) for reviewing the manuscript of the emerging categories and developing theory prior to the focus group.

Interview Questions

Two researcher-developed interview questions (see Appendix F), one for each phase, were utilized. Interviews are an excellent manner in which to collect rich, descriptive data on the topic of interest from the participants' perspectives. The researcher, who in this case is the interviewer, help guide the discussion by presenting one main question with follow-up probing or guiding questions for elaboration purposes. It was important for the researcher to maintain an objective stance while utilizing questions to reveal process, concepts, variations, and interrelationships among concepts.

A semi-structured face-to-face interview process was used. The researcher encouraged the participants to share experiences as FEPs who transitioned to a second career as registered nurses, by using strategic periods of silence, asking for examples, motivational gestures and words, and nonverbal attending skills.

Demographic Data

Two researcher-developed demographic questionnaires (see Appendix E), one for each phase, asked for basic identifying information from the participants. It consisted of information on participant's age, ethnicity, country of origin, country where foreign-educated physician education was completed, what specialty in medicine, years of practice, year obtained RN licensure, years practicing as a nurse, what unit/setting practicing as a nurse, and role at his/her job site. The data from this questionnaire was used to describe the study population. This reporting was completed through the utilization of pseudonyms and in a collective, aggregate form. The collected forms were held securely with the data gathered in the researcher's home office in a locked file cabinet.

Data Analysis

Data analysis began as suggested by the developers of the method, as soon as data collection began. After each interview, the researcher began data analysis through code notes, memos, and field notes. Memos are an important component of data analysis as they enhance the data with systematic ideas, record any pre-existing assumptions, and record the analysis process. The researcher read and re-read each sentence of the transcribed interview, to determine its meaning. A concept that describes it was selected and placed in the table's margin. The concepts and words highlighted were then grouped

into categories. Incoming data was constantly compared with existing data to determine similarities, differences, and gaps in the data.

Glaser (1978) divided the data coding process into two sections: substantive coding and theoretical coding. Substantive coding includes open and selective coding and theoretical coding in the last phase of Glaser's process, which is centered on one core, a fundamental phenomenon that has developed from the data (Glaser, 1978). It is this coding process that exposes the central themes/ideas, the casual conditions connected to the central theme/idea, the approaches used during the interaction, and the consequences of approaches. Theory development is a demanding undertaking; therefore, selecting a tradition that has a systematic approach is advantageous to the novice researcher. The researcher accomplished continuous comparative analysis to make comparisons between the data available, the structure of the evolving theory, and the need for further data to develop more the theory (Strauss & Corbin, 1998). It is in making the comparisons that the researcher recognized a process and links ideas to the development of a grounded theory.

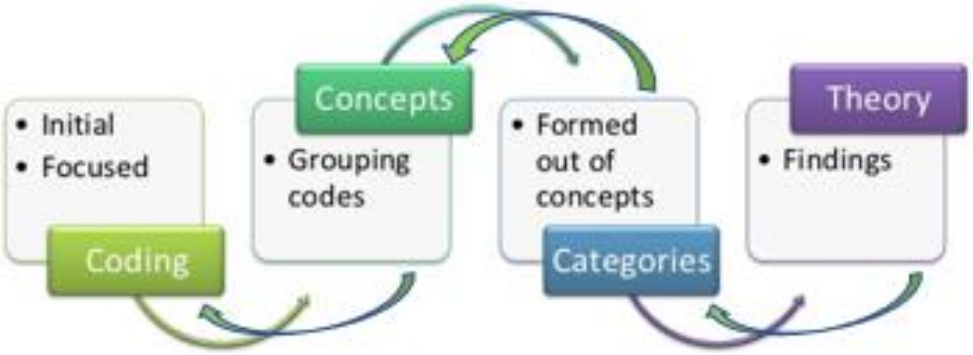

Figure 1. Hernandez-Pupo (2017) representation of classic grounded theory analysis adapted from Glaser (1992).

This methodology is founded on the idea that a social group, or groups, have common social interpretations, and these are not regularly well described. Constant comparisons are used to reveal differences and patterns in categories, to connect concepts in the developing theory, and to prompt research reflexivity. As soon as the core category is recognized, the sampling will become theoretical (Glaser, 1978). Theoretical sensitivity, which is the ability to perceive variables and relationships, comes from the researcher's immersion in the data. The emerging theory is evaluated for fit, work, relevance, and modifiability and is grounded in the data. The data reveals the theory as the basic social process is identified.

The grounded theory method is beneficial when the researcher seeks to develop a theory that describes human actions in a social environment (Strauss & Corbin, 1998). Symbolic interactions are used to explore the truth about one's behavior, making this framework a good fit for grounded theory. This method uses data that is systematically collected from the participants to lead to the understanding of the phenomenon in question, and then the data will be analyzed utilizing a scientific method (Strauss & Corbin, 1998). Since the focus is human behavior, and the meanings these behaviors represented in social contexts are the focus of the researcher's inquiries, individuals who meet the inclusion criteria where pursued as participants.

The open coding process involves the identification of exact words or phrases used by the participants to establish initial concepts and their properties (Strauss & Corbin, 1990). Literature review and member checking were appropriate at this time. Theoretical sampling was used to test propositions in the emerging theory.

Memoing was also used as a method to document advancement during the study. It is also very useful in recording the researcher's insights, thoughts, perspectives, concerns, and questions as they emerge. These journal notes helped to organize and collapse the initial labels or codes into broader, more abstract categories. The researcher also implemented the technique of constant comparative analysis until saturation of the recognized categories took place.

Open coding. All coding in grounded theory is to assist in the conceptualization of concepts. (Holton & Walsh, 2017). Open coding is the line-by-line, word-by-word examination of the data to isolate concepts and categories, which can then be broken down further (Grbich, 2013, p. 83). Open coding is to identify "incidents" in the data that seem to designate one or more concepts or ideas and labeling these using one or two relevant words per code (if possible using verbs to capture the action) (Glaser, 1998; Holton & Walsh, 2017, p. 80). Descriptive labeling of incidents lead the researcher from descriptive to the conceptual level of codes. Continuous comparison of incidences, noting connections and variances among them and looking for patterns developing in the coded data, aided in decreasing the possibility for only noting one incident code. It is important to note that Glaser (1978) did not speak of the line-by-line coding of interview transcripts but instead to the coding of field notes. Glaser (1978) believes that field notes aid the investigator to start the conceptualization process while maintaining the researcher focused on what is truly occurring in the substantive area, what is the main concern. Glaser (1978) recommended that the researcher carrying out the open coding of incident to incident in the data to do so with the list of previously presented questions to prevent the forcing of favorite themes. As the concepts started to take form, the

researcher continued to perform constant comparisons to aid in clarifying the rationality in emergent concepts and their properties as well as decreasing the emerging theory through a reduced set of higher-level interconnected concepts (Glaser, 1998; Holton & Walsh, 2017).

Table 1

Examples of Substantive Coding from 12 Interview and Formation of Categories and Theoretical Memos

Open Codes	Selective Codes (Categorization)	Theoretical Memos
Constantly wanting to practice within healthcare arena Looking for ways to get into 'medicine' again Wanted to use knowledge attained in medical training Wanted to help people "It's what I always wanted to do—be in healthcare" "Never saw myself as anything else but being in 'health'" Misconceptions of nursing profession	Need to practice	Need to be in healthcare Only thing they knew Wanted to use knowledge attained in medical school
No one shared opportunities of choosing nursing Needed information Wasted a lot of time	Road map: ease of transition	Ease of transition Opportunities where greater Financial prospects for supporting family was a guarantee

Took tests [failed/passed] but no guarantee of residency/progression		
Had financial responsibilities		
Had “kids to feed”		
“Had to work to provide for family”	Road map: ease of transition	
Once information of programs [in nursing] became apparent the transition was easier to nursing than medicine		
More opportunity within the nursing profession than other possibilities as foreign educated physician (FEP)		
Recognized the difference between RN and MD	Found their place	Considered themselves: a hybrid clinician: socialized into profession
Time spent with patients, treatments, and involvements with patients ‘entire care’		Wanted to care holistically for entire patient with ‘enough’ time
Holistic approach		
Able to spend time spent with patients		Utilized their medical knowledge and background
Enjoyed ‘helping’ patients the entire patient		
Saw the whole picture of care needed for patient: environment, family, social concerns		Felt their past medical experience helped them in their current role in nursing to be more confident
Did not just diagnose and treat		
Had to look at the whole picture of the patient		
Culture was important in their care of patients		

Found their place: wanted to practice holistically

Selective coding. In selective coding, the researcher restricted coding to only those variables or concepts that connected to the core category in appropriately significant ways to yield a practical theory (Glaser, 1998; Holton & Walsh, 2017). During the initial open coding, the researcher coded numerous incidents with several of these being coded for more than one concept. Once a potential core category was designated, the coding technique moved from open to selective. During this level of coding, if a concept does not have significance in connection to the core category, it was discarded from succeeding analysis and theoretical expansion. In selective coding, the relationship between a nominated central core category emerges as the researcher began the process of "integrating and refining" categories, thereby achieving increased levels of abstraction in the form of core process concepts (Olshansky, 2015, p. 42).

Theoretical coding. Theoretical coding denotes to the shaping of the relationships between and amongst the core category and related concepts as a totally incorporated theory (Glaser, 1978; Holton & Walsh, 2017). It is the final phase in the coding procedure and is mostly accountable for the general modeling of the theory. As the researcher memos, the ideas surrounding the central issue, a core category arose that appeared to explicate the maximum difference in the social behavior around the central issue and how the issue is handled or managed (Glaser, 1978). This core category connected to several other concepts, offering a focus for theoretical incorporation through clarification of the relationships between and among the emergent core and related concepts. Theoretical integration is the "prime function" of the core category,

guaranteeing that the subsequent theory is equally theoretically dense and theoretically saturated because of the increasing development of conceptual correlation that shape the theory (Glaser, 1978, p. 93). The researcher made certain that she had a clear understanding of the difference between the main concern and the core category in the discovery of the theory. The core category explained how the concern was managed, handled, or fixed (Glaser, 1998).

Research Rigor

As grounded theory has its roots in pragmatism and symbolic interactionism and it does not accommodate postmodern concepts of validity, this study utilized the types of rigor and criteria for trustworthiness as described by Lincoln and Guba (1985). Lincoln and Guba (2000) defined two types of rigors: interpretive and methodological. Methodological rigor denotes how the researcher followed the process of the selected qualitative method. Some of these requirements are as follows: purposive sampling, the researcher as an instrument of the study, a naturalistic setting, an evolving design, and an iterative method of data collection and analysis. To meet this type of rigor, the interviews were conducted face-to-face and the participants were selected using a purposive sampling method. In addition, the researcher became an instrument of the process utilizing constant comparative analysis and an evolving design to develop the theory. The researcher paid close attention to the analysis and transcription of the data, code notes, and memos to ground the findings that emerged from the participants themselves. The rigor of the research was also established by the degree of which the research was simulated without errors, and the outcomes and deductions traceable to their sources.

Trustworthiness. According to Lincoln and Guba (1985), trustworthiness is a way to assess qualitative research. Trustworthiness denotes to the assurance that a reader of a research article could take in applying the results. It is the conclusion of these readers of research that defines the trustworthiness of a study. As per Lincoln and Guba (2000), researchers may improve the trustworthiness of a qualitative study by keeping in mind the following four criteria— credibility, transferability, dependability, and confirmability.

Credibility. As stated by Lincoln and Guba (2000), credibility is when in qualitative research the study's findings are consistent and in line with the perspectives of the participants. The researcher utilized several techniques to establish credibility of the study. For instance, the interviews were transcribed word-for-word and were given to the participants for member checking. The participants were encouraged to clarify and verify the information provided; this aided the researcher in obtaining richer and more complete data that would more accurately represent what was said and meant by the participants. The utilization by the researcher of member-check further augmented the credibility of the findings. The focus group was utilized as part of the theoretical sampling to maximize the richness of the data collected and fully saturate the core categories that emerged from the data. The focus group also offered triangulation of the data to increase the credibility and validity of the results. Added representatives of the data often contribute more insight and confirm the same data providing verification and validity.

Dependability. Lincoln and Guba (2000) referred to dependability as the process by which the researcher defines the shifting situations and circumstances that were central to the qualitative research. This was accomplished by maintaining an audit trail

of the data. The research and coding process was rational, observable, and documented, as this enhances dependability (Schwandt, 2001). All interviews were audiotaped, and interview memos were kept during the entire study: this increased dependability. Theoretical memos were written by the researcher to maintain a record of the researcher's though process regarding the future emerging theory. Data is stored in the researcher's password-protected computer after verbatim transcription. Triangulation through theoretical sampling and the utilizing of a focus group added an extra strategy to increase dependability.

Confirmability. Confirmability is equivalent to the quantitative idea of objectivity (Lincoln & Guba, 1985). Confirmability refers to neutrality or the amount to which theoretical orientations, biases, worldviews, expectations, and morals affect data interpretation and research findings. The researcher utilized journaling and memos to enhance confirmability. To add to confirmability, the researcher took notes as stated by Lincoln and Guba (1985). The researcher's preconceptions and biases, when they become apparent, must be congruent and supported by the findings before they become part of the study's discoveries. The prolonged involvement by the researcher with the data, triangulation of the data and keen observations lead to the emergence of any variations, which added to the study's confirmability.

Transferability. According to Lincoln and Guba (2000), transferability refers to the possibility that the study's discoveries may be applied to another comparable circumstance. Qualitative studies that are transferrable may be replicated and reproduced in similar situations and context with same outcomes without any errors. According to Glaser (1978), a grounded theory must meet the four elements of: fit, work, relevance,

and modifiability. The theory is judged to fit the reality that it is being studied, it works by providing a level of understanding to the participants, it shows relevance by dealing with the constructs and core processes that have emerged from the situation, and it is shows modifiability by being open to continuous change as new information or discoveries become available. The presence of these four elements make a theory transferable.

Chapter Summary

This chapter described how this qualitative study using the grounded theory design will be conducted. Importance was placed on the Glaserian (classical) method, which will be utilized in conducting this study. The approach was described systematically including sampling procedures, data collection, and analysis. The research rigor and dependability of the study to deliver solid research findings were explained.

CHAPTER FOUR

FINDINGS OF THE INQUIRY

The purpose of this qualitative classical grounded theory study was to explore the critical factors that influence the attitudes, beliefs, and perceptions of foreign-educated physicians (FEPs) who have entered nursing as a second career. In this chapter, the researcher will present the results of the data collected from a total of 22 FEPs who entered nursing as a second career. The demographics data, which describes those individuals, will be provided. This study produced a theoretical framework that describes the factors influencing FEPs in the nursing profession as a second career. This framework will expand the understanding and knowledge of FEPs within the nursing profession, hospital administrators, researchers, policy makers, and academic institutions.

This study was conducted following Glaser's classical grounded theory method. Glaser has many times commented that grounded theory was discovered, not invented (Glaser, 1992, p. 7). Glaser's classical grounded theory methodology of inherently identify and integrate ideas, to recognize and conceptualize patterns and structures in data closely aligns with this researcher's epistemology. In classical grounded theory, the constant comparative analysis, coding, memoing, and integrating allow for a substantive theory to emerge from the data. Hence, this research was accomplished following as closely as possible to the tenets of the Glaserian or classical grounded theory approach.

Once IRB approval was obtained from Barry University, data collection began, access letters (Appendix C) and flyers (Appendix D) were emailed to professional organizations and the researcher's professional network within the South Florida area. They were asked to post and distribute the flyers within their professional network to gain

access to qualified participants. Flyers were personally distributed within local nursing schools and at conferences. Those participants who met the inclusion criteria were invited to participate in a face-to-face interview. A total of 22 participants who self-identified as FEP and met the inclusion criteria participated in this study. Data was collected in two phases. Phase I consisted of 17 individual interviews, and Phase II consisted of a focus group interview with five participants.

Phase I of this study consisted of individual interviews from 17 self-identified FEPs who met the inclusion criteria. All 17 interviews were semi-structured face-to-face interviews that were audiotaped and transcribed verbatim. Memos, field notes, and journaling by the researcher were completed throughout the entire research process. After each interview was received from the transcriptionist, the transcripts were either emailed or faxed as the participant preferred for member checking within 1 to 3 weeks. Analysis of the data was conducted utilizing open coding, selective coding, and theoretical coding. During this study, the data collection and analysis was conducted in an ongoing, simultaneous manner.

The coding and analysis process followed the Glaserian method and consisted of constant comparative analysis in which the emerging codes were constantly compared to incidents, incidents to codes, incidents to incidents, codes to codes, and incidents to the emerging categories. During phase I, in the open coding process, the interviews were analyzed line-by-line, paragraph-by-paragraph and conceptualized. The researcher made note of emerging words and phrases that were also constantly compared and analyzed. It is in this constant comparison of incidents to incidents that the data was conceptualized, and the emerging data used to generate codes. As more interviews were completed and

more raw data was collected, each data set was coded and constantly compared to prior concepts, codes, and incidents for differences and/or similarities. To ensure theoretical sensitivity and the conceptualization and formulation of the theory as it emerged from the data, the researcher entered the research process with as few preconceived ideas as possible. The researcher asked within which of the categories or properties of categories does this new data fit? What is the data saying?

The researcher saw similar concepts emerging as the constant comparison progressed, thus selective coding was initiated. During this phase of the coding process comparative analysis of incident to incident and incident to the emerging concepts. As the similar pattern, concepts emerged, they were grouped together, and a conceptual category name was given. The categories then spoke for the data and described what was happening within each data set.

Initially, five categories emerged from the data. As the categories emerged, the interview questions were reorganized based on what was emerging from the data. As the interviews continued and more data was collected, coded, and constantly analyzed the major categories began to emerge. Theoretical sorting was utilized to merge and link concepts to each other. During this process, conceptualization led to more abstraction, which led to the complete saturation of the categories. Some categories merged, becoming properties of those categories, while others became interchangeable with the major categories. Three major categories that emerged from the data were: *practicing*, *transitioning*, and *reconciling*. This process stopped when the basic social process emerged. The core category that emerged from the data to explain the critical factors that

influence the attitudes, beliefs, and perceptions of foreign educated physicians caring as nurse professionals is the *acculturating pathway to practice*.

Phase II of this study started with the emergence of the core category. Phase II consisted of a focus group interview involving five FEPs who had 5 or more years' experience in a nursing role and minimally held a Doctor of Nursing Practice (DNP). This sample group was part of the theoretical sampling for this study. As stated earlier, the purpose of theoretical sampling is either to confirm or deny the core category that emerged from Phase I data collection process.

Sample Description

Data collection consisted of two phases: phase I individual interviews and phase II focus group interview. Phase I consisted of 17 participants that self-identified as a FEP with a registered nurse license or a nurse practitioner who had been employed minimally for 6 months within a nursing role. The participants included 10 females and 7 males. Phase II included self-identified FEPs who had obtained minimally a doctorate degree and had been employed within a professional nursing role minimally 5 years.

All participants completed a researcher-developed demographic survey tool. The information collected consisted of age, ethnicity, country of birth, place where medical degree was obtained, years practiced as medical doctor and specialty, year RN and/or ARNP licensure was obtained, had becoming a medical doctor in the U.S. attempted, setting and current role within the nursing profession. The demographic data aided the researcher in learning the differences and similarities of the general characteristics of the research participants. The fact that the demographic survey had questions related to their past medical degree and their current education allowed the researcher to gain a better

understanding of the participants experience and achieved a better understanding of their situated context. The information obtained was also a manner in which the credibility of this study was amplified. All participants were instructed to choose a pseudonym to maintain confidentiality and protect their identity.

Demographic Characteristics

Eleven different demographic characteristics relevant to this study were obtained from the participants. The details of the study and the informed consent were explained to each of the participants before the interviews began and the demographic questionnaire was completed. The participants all resided within Miami-Dade and Broward counties. Table 2 lists the overall demographic information collected from the participants in phase I as it related to this study. Of the participants, 10 were female (59%) and seven (41%) were male.

Table 2

Demographic Characteristics of Participants in Phase I (N = 17)

Characteristics	**Range**	**N**	**%**
Age	35-44	5	29
	45-54	3	18
	55-64	8	47
	65 or above	1	6
Race/ethnicity	African American	2	12
	Hispanic	14	82
	Caribbean Islander	1	6
Country of birth	Colombia	2	12
	Cuba	7	41
	Dominican Republic	3	18
	Haiti	1	6
	Jamaica	1	6
	Nigeria	1	6
	Nicaragua	1	6

	Venezuela	1	6
Country where medical degree was obtained	Colombia	2	12
	Cuba	7	41
	Dominican Republic	3	18
	Haiti	1	6
	Jamaica	1	6
	Nigeria	1	6
	Nicaragua	1	6
	Venezuela	1	6
Medical doctor specialty	Cardiology	1	6
	Dermatology	2	12
	Nephrology	1	6
	OB/GYN	1	6
	Pediatrics	2	12
	Primary/Family Medicine	9	52
	Surgery/Primary Medicine	1	6
Years practiced as medical doctor	2 – 3 yrs.	4	23
	5 – 6 yrs.	5	29
	7 – 9 yrs.	3	18
	10 – 12 yrs.	3	18
	13 yrs.	1	6
	24 yrs.	1	6
Year RN licensure obtained	1987 - 1993	2	12
	1995 - 2003	2	12
	2006 - 2008	6	35
	2009 - 2014	5	29
	2016	2	12
Year ARNP licensure obtained	2008 - 2013	2	33
	2014 - 2015	3	50
	2016	1	17
Did you consider studying medicine (medical doctor) in the U.S.?	YES	8	47
	NO	9	53

Current unit/setting of practices	Academic Institution	2	12
	Community Health	1	6
	Behavioral Health	1	6
	Hospital Acute Care	11	64
	Medical Office/Clinic	2	12
Role at your institution	ARNP	5	29
	Case Manager	2	12
	Charge Nurse	1	6
	Educator	4	23.5
	Nurse Manager	1	6
	Staff Nurse	4	23.5

Table 2 consists of the demographic characteristics of the participants in phase I. Eleven items were assessed in the participants. Of the 17 participants, five were between the age range of 35-44 years old, three were between the age of 45-54 years, eight where between the age of 55-65 years of age, and one was over 65 years of age. Most of the participants self-identified as being Hispanic: 14; two identified as African American, and one identified as Caribbean Islander. The 17 participants were asked to disclose their country of birth and the country they obtained their medical degree, the following are the results: Colombia = 2, Cuba = 7, Dominican Republic = 3, Haiti = 1, Jamaica = 1, Nigeria = 1, Nicaragua = 1, and Venezuela = 1. The 17 participants had varied specialties, including: cardiology = 1, dermatology = 1, nephrology = 1, OB/GYN = 1, pediatrics = 2, primary/family medicine = 9, and surgery/primary medicine = 1. The participants were asked to disclose how many years they practiced within their specialty as a medical doctor, most practiced between 5 to 12 years, and one participant reported practicing for 24 years.

The FEPs disclosed the year they obtained their RN licensure; 13 participants obtained their licensure between 1995-2014, two between 1987-1993, and two in 2016. Out of the 17 participants, only six had obtained their ARNP. The participants were also asked if they had considered studying medicine in the U.S.; of the 17 participants, eight stated yes, while nine stated no. The participants' current work setting varied from academic institutions to acute care and community health/behavioral health settings. Their roles were also diverse and ranged from ARNP in acute and clinic settings to hospital nursing positions to academic professors. The demographic questionnaire captured the richness and diversity of the participants in phase I.

Individual Characteristics

This section will consist of each participant's characteristics being described. The descriptions were obtained from the demographic survey the participants completed and from the actual individual interviews themselves. The names used are the pseudonyms the participants chose to safeguard their confidentiality and identity.

Beatrice. Beatrice is an African-American woman who practiced medicine in her native country of Haiti for 10 years as a pediatrician. Her age range is 65 or above and she has been a nurse for 24 years and an educator for more than a decade. She currently works in a cardiac-vascular unit in an acute care setting and is adjunct faculty at local colleges. She did attempt to study medicine in this country; however, when she did not pass the initial certification exam and was asked about what motivated her to choose nursing she stated:

> I have to add that at the time I already had my children and I needed to work. I can't just sit down and wait to pass the exam. I needed money to take care of

them and I saw that the opportunity was right there for me to get a good job; something that I like to do. That's it.

Johnny. Johnny is a Hispanic male from the Dominican Republic and is within the age range of 55-64 years of age. He currently practices as a ARNP for a OB/GYN surgical office. He practiced as an OB/GYN in his native country for 9 years. He obtained his RN licensure in 2008 and his ARNP licensure in 2014. He did attempt to become a medical doctor in this country and when asked what motivated him to choose nursing, he stated the following:

> I got a job as an operating room assistant at the Mercy hospital of the community, Mercy hospital in Springfield, Massachusetts. Then my wife and I…she started working in the women and children department and we were both working. We take the kids to the daycare and we work, study, and father. Then I took my boards. I took the USMLE. It was not USMLE in those days, it was the first step, step one, step two but I didn't pass it. I remember that I had to pay around $600 the first time I study for my…through a special…one of those preparation courses. I took those courses, I spend around $1500 on those courses but it's not easy to study, be a father, and all of that. Then I didn't pass it a couple of times but that was money. I couldn't continue taking exams if every day I got more expenses. [...] then when I had the opportunity that one of the schools in Puerto Rico opened a program MD to RN…it's in Sagrada Corazon in Puerto Rico then I started taking that opportunity and I went through the school. I didn't have to take all the courses because they validate me a lot of things and I finally got through that. That was the original reason. I didn't decide immediately to go

> through the nursing but because of the economic factor that's one of the reason that I went sadly through the nursing career and then when I finished I enrolled in the nursing program and then I finished and I don't regret at all.

Ms. O. Ms. O is a Hispanic female who is between the age range of 55-64 years of age and is from the Dominican Republic where she practiced as a primary/family practitioner for 3 years. She obtained her nursing license in 2008 and currently works as a staff nurse on an obstetrics floor. She stated she never attempted to practice medicine in the U.S. and when asked what motivated her to choose nursing as her second career, she stated:

> Well trying to be more in the medical field since I have been working since I arrived in the United States in office work as a support of pregnant moms in different community programs. I wanted to be more hands on …I found out that they have a program for foreign physicians to become RNs, so I said that's something I can do.

Halo. Halo is a Hispanic female from Colombia who practiced as a primary/family health physician for 3 years in her native Colombia. Her age ranges from 35-44 years old. She obtained her nursing licensure in 2016 and her ARNP in 2017. She currently works as a nurse case manager for a large community hospital. She shared she never pursued becoming a medical doctor here in the U.S. and when asked what motivated her to choose nursing, she stated:

> The original motivation was to be able to use my knowledge and my experience to be able to help patients, to help people, and the role of the nurse in this country is completely different to our country. I like it. It's more bedside. It takes more

> care of the patient than the nurses in our country. My idea was wrong, and I liked what I saw of the job of the nurses. That is really really the professional that is taking care of the patient all the time that is what I really like.

Jackie. Jackie is a Hispanic female from Cuba who practiced as a pediatrician for 2 years in Cuba. Her age range is from 35-44 years of age. She obtained her nursing licensure in 2006 and her ARNP in 2008. She currently is employed as a nurse practitioner at a large acute care hospital in a neurology unit. She stated she did attempt to become a medical doctor in the U.S. and when asked what motivated her to choose nursing, she stated:

> It was getting difficult to get into my medical practice because you need to go through three and later on four tests that require time to study, which I didn't have because I needed to support my family. At that point, the hospital where I was working offered a possibility to transition from foreign physician to BSN in nursing. They paid for it, so I enrolled, and I spent two years in the program. That was in a local university. I graduated and then I went back to work for that specific hospital that paid for the education.

Amaury. Amaury is a Hispanic male from Colombia who is between the age range of 45-54 years. He practiced as a primary/family practitioner and surgeon for 5 years in his native country. He obtained his nursing license in 2010 and is employed at a large college where he is full-time nursing faculty. When asked if he considered studying medicine in the U.S., he stated no and shared his motivation for choosing nursing as:

> As a foreign educated physician, when I came into the United States in 2001 I checked the possibilities of taking the USMLE, the examination to become a

> doctor in this country. I realized that it was going to take a long time, probably two or more years to do that. By that time, I needed to have some income because I had family. I had family to provide for here and in Colombia. I decided to do something to start working and then as a medical doctor I wanted to work in the medical field. I decided to work as someone taking care of older people and then I realized that the FIU School of Nursing offers a program for foreign educated physicians and the program was about to…it was going to be about two years considering some of my previous transcripts from Colombia from my medical career. I decided to go into that program and the way I fulfilled my duties of taking care of people was by becoming a nurse instead of becoming a doctor. I considered the possibility. I just didn't do it because I needed to produce money for my family.

Cris. Cris is a Hispanic female from Cuba who practiced as a primary/family physician in her native country for five years. Her age range is from 35-44 years of age and she obtained her nursing licensure in 2016 and her ARNP in 2017. She currently works in a nursing simulation lab as supervisor. She stated she never considered studying medicine here in the U.S. and stated the following when asked about what motivated her to choose nursing:

> For me it was the short way…a shorter way that I found to emerge in the medical field. I think it was…the product was good when I did my research. I saw that it would only be three years and I would have more possibility to get a job after I finish. That made me think and compare if I decided to take the board and then

> apply for residency. It's a way that no one can tell me if they are going to accept me in some place to do my residency. I feel like this way was more secure.

Catira. Catira is a Hispanic female from Venezuela who practiced as a primary/family physician for 1 ½ years in her native country. She obtained her nursing licensure in 2008 and currently works as a per-diem community health nurse. She stated she did attempt to practice medicine and shared the following when asked what motivated her to choose nursing:

> Actually, I would say probably being very busy and when you come to a different country you have to adapt. You have to help your children grow healthy by all means. They were little. My little one was two years old and my oldest was seven. I really was very busy, and I had a full-time job, so I try to study with all those barriers. I had a lot of motivation, but I couldn't make it. It was overwhelming. […] I think my desire to serve people, to learn more, to be able to reach more people and practice since I wasn't able to practice medicine. I thought that was a great opportunity to do what I love most, help people.

Sam. Sam is an African-American male from Nigeria who practiced as a primary/family physician in his native country for 10 years. He obtained his nursing licensure in 2010 and his ARNP in 2016. He currently works as an ARNP at an orthopedic doctor's office and stated he did attempt to practice medicine in this country. When asked what motivated him to choose nursing, he stated:

> I came from Nigeria in 2005. In the beginning, I tried to take the test; the medical boards test and the TOFL then I did not pass. I tried again—I wasted a lot of money and I really had to work hard: the studying, working as a valet parker and

> in the hospital as a nursing assistant. This was very hard for me because all I knew to do was be a doctor… was be in healthcare. I was lost for a while … I met a nurse who was going to school to become a nurse and she was doing her clinical [rotation] and she needed some help with a patient and I helped her and she thought I was a nurse already. When I told her, I was a nursing assistant she told me I should be a nurse. That was when I first thought of becoming a nurse. Before that I was very discouraged- I … I did not think that was an option… it changed my life.

Maria. Maria is a Hispanic female from Nicaragua who was a dermatologist in her native country for 12 years. Her age range is from 45-54 years of age. She obtained her nursing license in 2003 and her ARNP in 2015. She currently works in a physician's office as the office ARNP. She stated she did attempt to study medicine in this country and stated the following as her motivation to choose nursing:

> I think in my case it was that I needed to do the quickest way to get into healthcare. If I would have gone and tried to take all the exams and then move forward there was no definite, chance to get a residency. I tried one time, took the test and failed. I needed assurance of a job when I finished school and if I had gone that route, I had no guarantee. The fact I needed to support my family it made me think and really think about deciding to take the medical board exams and then apply for residency with the hopes to get it. I felt that nursing was more secure for my family and me.

Luis. Luis is an African-American male from Jamaica whose age range is from 55-64 years of age. He practiced as a primary/family physician for 7 years in Jamaica.

He stated he obtained his nursing license in 1987, and he currently works as a nurse manager in a large acute care hospital. He did attempt to practice medicine in the U.S. and shared the following as his motivation for choosing nursing:

> The reason I enrolled in the nursing program was really, because I always wanted to work with patients and I wanted to use my knowledge and my experience to be able to help people. At first, I did not think because the job of the nurse in this country is completely different to our country. I like it. How I thought a nurse would be, was nothing like back in my country in Jamaica. Here nurses are really a profession. I needed a job, I needed to support myself and my family and I did not have the money and time to go through the whole process of becoming a physician here in the U.S.

Pedro. Pedro is a Hispanic male from Cuba who practiced as a nephrologist in his native country for 5 years. His age range is from 55-64 years of age and he obtained his nursing license in 1995. He currently works as charge nurse on a neurology unit. He stated he did attempt to practice medicine in this country and shared the following when asked what motivated him to choose nursing:

> Well since I came from Cuba, I wanted to be more hands on. Up to now I was working at a clinic, so when I ran into a friend from Cuba and he told he was at FIU. I found out that they had a program for foreign physicians to become RNs, so I said that's something I can do. And my friend told me he was almost done and I wanted to be back where I felt comfortable in the hospitals with patients. I said yes. I had to make more money, and I had already failed the test one time

> and I was really depressed so… I talked it with my wife and she said go for it and I did.

Obdulia. Obdulia is a Hispanic female from Cuba who practiced for 6 years in her native country as a primary/family physician. Her age range is from 35-44 years of age. She obtained her nursing license in 2014 and currently works as a staff nurse for an intensive care unit at a large acute care hospital. She stated she did not attempt to practice medicine in the U.S. and when asked what motivated her to choose nursing she stated the following:

> I never considered being a physician in the United States. When I was in Cuba, before I came here, I decided I didn't want to be a doctor anymore, I'm going to start doing nursing and become a practitioner later and then I can work with the experience I had before, the same as a doctor, but I don't feel that I can take the test to do my license. I chose nursing because I can apply the knowledge that I have. It's easier for me to study something that I already know stuff about and then I can become a nurse practitioner that is the short-term story related to if I have to take my test or do the residence. I have family, I have daughters so I want to take care of my family also so I prefer…this is the reason I chose to do nursing.

Kikosam. Kikosam is a Hispanic male from Dominican Republic who was a primary/family physician in his native country for seven years. He first obtained his nursing licensure in 2006 and currently works as full-time faculty for a college of nursing in South Florida. His age range is from 55-64 years of age. He stated he never tried to become a medical doctor in the U.S., and when asked what motivated him to choose nursing, he stated:

> The practice of medicine in the United States is really detached from the patient. That's why I found that nursing is more aligned with what I used to do as a physician in Santo Domingo, taking care of all patient needs as a physician back then. I was a substance abuse counselor initially. I found myself just doing that and at the end of the day I was doing nothing, just going home around 3:45 in the afternoon and doing nothing with my life. One day I decided why not go back to nursing or into nursing? Recycle some of my knowledge that I have in medicine and put it to some use in nursing. I decide to join the Board of Manhattan community college in an associate's program doing one course at a time. I thought it was going to take me my whole life, that at least when I was buried I was going to be RN as opposed to a substance abuse counselor. I stayed there for a while until 11/99, that's the healthcare union in New York came up with a program recruiting foreign physicians to get them into a nursing program with a bachelor's degree. The reason that I was able to do it was because the grant that they had, they were able to pay me the whole salary, remove me from work and receiving the whole salary as a counselor which allowed me to pay my rent and my bills and in addition to that the grant included paying tuition, books, uniform, utensils, metro card. All I needed to do was sit in the classroom and that was all

Pablo. Pablo is a Hispanic male from Cuba who was a dermatologist in his country for 24 years. His age range is from 55-64 years of age. He obtained his nursing license in 2008 and his ARNP in 2013. He currently works as a staff nurse in the operating room in a large acute care hospital. He stated he never attempted to become a

medical doctor in the U.S., and he stated the following when asked what motivated him to choose nursing:

> When I came, I came with my family, it really was not an option as I knew it could take a long time to pass the boards. I knew it would be very difficult for me as I had a family to support. I thought about the nursing career when I saw a commercial on TV. Then I started to research the options and I told myself "take the option of nursing." To become a doctor here you have to pass the boards—that's hard but, it's more difficult to obtain the residency program. And that is because of my age. The nurse practitioner programs, when I was doing my research seemed like something very near to the physician role. I really do enjoy very much caring for the patients and I think it was the best option for me to get back to what I wanted to do: care for the patients and be back in the healthcare field.

Pelusa. Pelusa is a Hispanic female from Cuba who practiced as primary/family physician in her native country for six years. Her age range is from 35-44 and she currently works as a nurse case manager for an insurance carrier. She obtained her nursing license in 2014 and she stated she never considered studying medicine to become a physician in the U.S. When asked what motivated her to choose nursing, she stated the following:

> The main issue to try to obtain the license in the United States is regarding Cuba does not release our documentation from the university in the proper way, in the way that the Board of Medicine requests from the United States. They are not willing to release those documents and because of that we are unable to take our

> license or go through our boards in United States. Then having to experience in clinical settings the only way to go back in a similar setting is doing nursing. It's the closest profession to the physicians that we used to be. Nursing was something familiar to me. I was very familiar with the nursing concept and actions and it was easier to get the knowledge, not medical knowledge but nursing knowledge. It was easier to finish the nursing studies and go through the boards. If I had chosen for example pharmacy or another career it would be difficult I think.

Caring. Caring is a Hispanic female from Cuba whose age range is from 55-64 years of age. She practiced as a cardiologist in Cuba for 13 years. She obtained her nursing license in 2009 and her ARNP in 2014. She stated she never attempted to become a medical doctor in the US and when asked what motivated her to choose nursing, she stated the following:

> When I came, I came with my family, two boys. It takes a long time to pass the boards of medicine and it was difficult for me. I thought about the nursing career and then I study for the board. Then my age and my family was first. Then I take the option of nursing. To pass the boards, it's difficult to obtain the residence program with my age. I think the advanced programs like a nurse practitioner is something very near to the physician role and I love to care for the patient and I think it was a good way to my final goal to take care of the patient again.

The participants' background was varied, and they obtained their RN licensure from 1987 to 2016. Their specialties within medicine was diverse; however, they all shared their struggle in fulfilling their financial obligations while attempting to enter

healthcare again. Their demographic characteristics are rich with diversity, yet at the same time, they have similarities that begin to describe their path into the nursing profession as a second career.

Results

Basic Social Process and Supporting Conceptual Categories

Based on the analysis of the data, the basic social process identified is *the acculturating to practice*. The *acculturating pathway to practice* is explained by three categories: *practicing, transitioning, and reconciling.* The categories that will be reviewed in this section emerged at the end of phase I data collection. A total of 17 participants participated in phase I, and theoretical saturation was reached after 12 participants were interviewed; however, to fully saturate the categories and to ensure no new categories emerged, five more interviews were carried out, which validated saturation had been achieved. These categories and the concepts that describe the basic social process will be reviewed in detail and the supporting voices of the participants.

Practicing

According to the American Nurses Association ANA (2018), nursing and its practice is the "protection, promotion, and optimization of health and abilities, prevention of illness and injury, facilitation of healing, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, groups, communities, and populations" (para. 1). Having a need to be practicing in healthcare is one of the major categories that emerged from this study. The participants incessantly expressed both indirectly and openly their drive and desire to once again be caring for patients as their driving force and motivation to enter healthcare. However,

they shared initially they did not consider nursing as an option as they had many misconceptions about the profession. The participants shared a strong belief regarding the ever-present necessity and longing to be back caring for people. This desire to be practicing and entering the world of healthcare drives them to enquire and research their options as they all share their need to use their medical knowledge and not let it go to waste. Most participants shared their own self-concept as never being anything else than an employee within the healthcare field in the future and their struggle in finally reaching their goal of caring for patients again.

Most individuals would not disagree with the progressive accomplishments of medical technology and the increasing specialization in healthcare. Nevertheless, when nursing examines caring it is more than a cure. Caring goes beyond being patient-centered. It is in the caring practicing aspect of nursing that every person is identified as a human being whose experiences touch their health and wellbeing. This desire and need to practice with this caring philosophy shapes their future and their decisions in their adopted country. The following quotes from the participants support this concept of need to practice:

Beatriz stated: "…All I know how to do is healthcare. I saw that the opportunity was right there for me to get a good job; something that I like to do."

Johnny also remarked:

> I did my master's in health service administration through [a local university] in order to try to get into some kind of job with my medical background and then with a master in health service administration I was planning to get some kind of job in the health care system of the hospital that I was already working…I want to

transfer information. I want to teach my experience through the years. Remember I graduated as a medical doctor in 1982. I've been…I recently celebrated our 35th year of medical school class and I think I have…and I've been in the hospital environment in this country 21 years…I can bring to the nursing environment the knowledge of another point of view, so they can follow and continue and persist and be engaged in the life.

Ms. O also shared:

Well trying to be more in the medical field… [Having the previous knowledge of being a physician and] knowing how the doctor is thinking I can complement, I can approach, it's an easier transition. I found since I knew where he [the doctor] was coming from, I know his education…the knowledge I had, had to be used not wasted.

Halo also commented:

The original motivation was to be able to use my knowledge and my experience to be able to help patients, to help people, and the role of the nurse in this country is completely different to our country. I like it. It's more bedside. It takes more care of the patient than the nurses in our country. My idea was wrong and I liked what I saw of the job of the nurses. That is really really the professional that is taking care of the patient all the time that is what I really like.

Jackie also stated:

Basically, I see here the nursing as more of a profession. That is my point of view when compared with nursing in Cuba. Medical here yes, they do treat patients, but I see nursing as a truly advocating for patients more than doctors. I went into

> medicine because I love pediatrics. I love medicine, I love to treat [care for] people. I don't remember trying to be anything else. I wanted to be a doctor here to be sincere. It's not that my first shot was to become a nurse, but I do not regret at all becoming a nurse. Now as a nurse practitioner I feel that I have accomplished both. Maybe not economically, maybe not financially because it's not comparable, but I feel as a nurse practitioner I can be the doctor that I want to be. That's how I see it.

Amaury also remarked:

> I decided to go into that program and the way I fulfilled my duties of taking care of people was by becoming a nurse instead of becoming a doctor. I considered the possibility. I just didn't do it because I needed to produce money for my family. Later on, I realized that I loved the profession, I fell in love with nursing and then I decided to go into further specialty and then I went to the master's program. I'm doing a lot more than doctors do because not only do I care for patients I also teach other people how to care for patients. In that way, I'm fulfilling all the reasons I became a health provider in the first place.

Cris also indicated:

> I just wanted to be in the medical field. Whatever I needed to do I would do it. That was the first impression that I had. I hope to bring my knowledge and also the skills that I learned before I came here to this country. My love for the profession. I'm using my education as a physician to be a nurse practitioner.

Catira also shared:

> I think my desire to serve people, to learn more, to be able to reach more people and practice since I wasn't able to practice medicine. I thought that was a great opportunity to do what I love most, help people. I think deep in my heart I wanted to be a doctor to help people but actually the profession of medicine is yes caring for patients and everything, but nursing was in my heart and it was hard for me to understand many of the things about the medicine profession and then nursing actually…or with nursing I discovered this is what I am. I'm a person that loves to care deeply about patients and nurses do that.

Sam also remarked:

> …all I knew to do was be a doctor…was be in healthcare…I was lost for a while…I saw that the chance was there to get a good job; something still in healthcare and I did it.

Maria also stated:

> As nurses, we are closer to the patient than as a doctor. We care more… no that's not fair, we care differently more…I, more, more holistically. I think it's how it should be. It feels good to care that way. It's something we learn in nursing school, which was different from medical school. Initially before, I knew what nursing was really as if I just thought to myself- 'you want to be in healthcare, it is going to have to be this.' I don't forget that I was a doctor before, it helps me now as a nurse practitioner.

Luis also commented:

> The reason I enrolled in the nursing program was really, because I always wanted to work with patients and I wanted to use my knowledge and my experience to be able to help people. I have brought to the nursing profession is my passion for patient care. I am old, and nursing has changed a lot in the last years, but caring is still the same.

Pedro also indicated:

> I really got into nursing by accident. I worked as coordinator at a clinic…I wanted to get back into patient care but did not know how. I already told you how I learned of the nursing program. I was lucky because I was able to put my medical knowledge and what I learned in the clinic into nursing. I was able to get back to patient care.

Obdulia also shared:

> When I was in Cuba, before I came here, I decided I didn't want to be a doctor anymore I'm going to start doing nursing and become a practitioner later and then I can work with the experience I had before…I have the knowledge to make it right...similar regarding the patient because the patient is a patient whether you're a doctor or you're a nurse you're trying to do the best for the patient.

Kikosam also remarked:

> The practice of medicine in the United States is really detached from the patient. That's why I found that nursing is more aligned with what I used to do as a physician in Santo Domingo, taking care of all patient needs as a physician back then…One day I decided why not go back to nursing or into nursing? Recycle

> some of my knowledge that I have in medicine and put it to some use in nursing. I decide to join the Board of Manhattan community college in an associate's program doing one course at a time. From the very beginning actually…actually what had happened was I feel grateful that I was able to move from substance abuse counselor to be a nurse. It was something closer to what I wanted to do. Yes, I did medicine but what I wanted to do was to be able to help the patient that was sick. Nursing allows me to do that.

Pablo also commented:

> I really do enjoy very much caring for the patients and I think it was the best option for me to get back to what I wanted to do: care for the patients and be back in the healthcare field. [did that your prior knowledge as a physician helped you in the nursing role?] …my background from medicine was really important in nursing, my background is important to nursing. From the medical patho and pharmacology perspectives it really helped me.

Pelusa also indicated:

> …caring for patients was all I ever wanted to do- nursing seemed very familiar as nurses did that…Having the knowledge [previous medical knowledge] plus the good pay for the profession is something pushing you to go ahead and get your degree.

Caring also remarked:

> I love to care for the patient and I think it was a good way to my final goal to take care of the patient again…the knowledge I had as a physician was key and it

helped me in the nursing role, I did not want to lose that knowledge, I wanted to use it.

Caring is a sensitivity that also needs an act. The National League for Nursing (2007) and American Association of Colleges of Nursing (2008) has recognized caring as a fundamental value for nursing. All the participants in this study revealed a desire to care for patients while not losing their prior medical knowledge. The struggle of not knowing where to go and how to navigate the system did not deter them from looking for ways to practice again the art of caring. Developing a framework and providing funding for support and educational initiatives to educate the FEPs on how to enter the healthcare arena again would assist them in fulfilling their goals.

Transitioning

As individuals change within their social contexts, they go through transitions, which involve a person's reaction through a passage of time. A transition transpires during time and involves change and adaptation—for instance developmental, individual, social, situational, group or environmental, but not all change involves transition (Meleis et al., 2000). Transition is the manner people react to change over time. People experience transition when they need to acclimate to new situations or circumstances to integrate the change event into their lives (Schumacher & Meleis, 1994). Transition is a concept that is important to nursing.

The road map of the participants transitioning into nursing professionals and the ease or lack thereof an easy transition was one of the major categories that emerged from this study. For the participants, it meant that the information needed to consider nursing an option was not readily available and the limited information they had was filled with

misconceptions. Many stated there was not a clear road map to discover the information needed, and much time was spent researching all the options. As the participants experienced their transition and their acclimation and acculturation to new situations or circumstances, the lack of information, assistance, and support did not allow for a smooth adaptation and transition into the nursing profession. Many reported they wasted many years trying to pass the medical entrance exams, while still having many family responsibilities. The participants reported that once the information about nursing as a second career was gained; transitioning into nursing professionals was easier than that of transitioning to become a medical doctor in the United States. Many of the participants expressed that in their research of nursing as an option as a second career, they felt a sense of relief at knowing the time frame of completing their new degrees. All participants expressed they had more opportunities within the nursing profession than other possibilities as a foreign physician. The participants shared a respect and an acceptance of the values of nursing as their own.

Their transition into nursing professionals along with the other major categories were all critical factors that together influenced their attitudes, beliefs, and perceptions in entering nursing as a second career.

Beatriz remarked:

> When I came in at first, I tried to take the test; the medical test and then I missed by like two points. This is the time when they had the nursing shortage and all I know how to do is healthcare, so I said okay let me try nursing. They had this accelerated option; like ten months for an associate degree so I took it. I have to add that at the time I already had my children and I needed to work. I can't just sit

down and wait to pass the exam. I needed money to take care of them and I saw that the opportunity was right there for me to get a good job; something that I like to do.

Johnny also stated:

It was medicine and OBGYN, but when I came in 1991 with my wife and two little kids and we came to Massachusetts it was really difficult to support the family, work, and study for the boards…I was with my complete legal resident status, and they told me that I was over qualified. That's the answer. It means everything was fine, but you are over qualified. I would take any job... I had to pay around $600 the first time I study for my…through a special…one of those preparation courses. I took those courses, I spend around $1500 on those courses but it's not easy to study, be a father, and all of that. Then I didn't pass it a couple of times but that was money. I couldn't continue taking exams if every day I got more expenses…I had the opportunity that one of the schools in Puerto Rico opened a program MD to RN…it's in Sagrada Corazon in Puerto Rico then I started taking that opportunity and I went through the school…I didn't decide immediately to go through the nursing but because of the economic factor that's one of the reason that I went sadly through the nursing career and then when I finished I enrolled in the nursing program and then I finished and I don't regret at all. I always say that my only regret was not doing it before. It means I am completely satisfied with the nursing career at this point and I'm sorry I couldn't do it before. If I was a properly oriented when I came here and that's the key that I think you should mention. There is a lack of proper orientation. I waste time

> from 1991 until 2006, it means almost six plus nine, over ten years that I was undecided exactly what to do and finally I got it. I could have had my nursing practice done, that I just finished now in 2014 I could have been done like ten years before because of lack of right orientation. I've been finding things stepping down and falling down. I didn't have absolutely any information.

Ms. O also indicated:

> Well trying to be more in the medical field since I have been working since I arrived in the United States in office work as a support of pregnant moms in different community programs. I wanted to be more hands on so when FIU…I found out that they have a program for foreign physicians to become RNs, so I said that's something I can do.

Halo also mentioned:

> I learned from speaking to my 'doctor' colleagues and from looking for ways to go back into healthcare about my particular program. In our particular program, we get into the program with the goal of getting the nurse practitioner done. Our program is an accelerated program that we start taking classes from the masters since the beginning with the initial classes for the nursing program. We always have that in the mind that we're going to be nurse practitioners…I have seen before studying nursing so many classes for nursing school. That's what helped me out; to see other nurses, teaching and that helped me to understand.

Jackie also remarked:

> It was getting difficult to get into my medical practice because you need to go through three and later on four tests that require time to study which I didn't have

> because I needed to support my family. At that point, the hospital where I was working offered a possibility to transition from foreign physician to BSN in nursing. They paid for it, so I enrolled and I spent two years in the program. That was in a local university. I graduated and then I went back to work for that specific hospital that paid for the education.

Amaury also indicated:

> As a foreign educated physician, when I came into the United States in 2001 I checked the possibilities of taking the USMLE, the examination to become a doctor in this country. I realized that it was going to take a long time, probably two or more years to do that. By that time, I needed to have some income because I had family. I had family to provide for here and in Colombia. I decided to do something to start working and then as a medical doctor I wanted to work in the medical field. I decided to work as someone taking care of older people and then I realized that [a local university] offers a program for foreign educated physicians and the program was about to…it was going to be about two years considering some of my previous transcripts from Colombia from my medical career…I considered the possibility.

Cris also stated:

> I found to emerge in the medical field [the nursing profession]. I think it was…the product was good when I did my research. I saw that it would only be three years and I would have more possibility to get a job after I finish. That made me think and compare if I decided to take the board and then apply for residency. It's a way that no one can tell me if they are going to accept me in

some place to do my residency. I feel like this way was more secure as I had financial obligations and responsibilities.

Catira also commented:

I would say probably being very busy and when you come to a different country you have to adapt. You have to help your children grow healthy by all means. They were little. My little one was two years old and my oldest was seven. I really was very busy and I had a full-time job, so I try to study with all those barriers…I think nurses here have more options, more opportunities. There's different sub-specialties in the same nursing degree and that I like. In my country, the nurses are definitely on a different level. They do a lot of things that nurses do here yes, the practice itself, but then you have the opportunity here to have other certifications that will position yourself in a different arena.

Sam also expressed:

I came from Nigeria in 2005. In the beginning, I tried to take the test; the medical boards test and the TOFL then I did not pass. I tried again—I wasted a lot of money and I really had to work hard: the studying, working as a valet parker and in the hospital as a nursing assistant. This was very hard for me because all I knew to do was be a doctor…was be in healthcare…I was lost for a while…I met a nurse who was going to school to become a nurse and she was doing her clinical and she needed some help with a patient and I helped her, and she thought I was a nurse already. When I told her, I was a nursing assistant she told me I should be a nurse. That was when I first thought of becoming a nurse. Before that I was very discouraged. I … I did not think that was an option…it changed my life. I really

did not think about being a nurse till this student told me I should. I already had my family responsibilities, kids, rent, food, you know, and I needed to work. I just could not wait to pass the exam again. I needed money to take care of my family and I saw that the chance was there to get a good job; something still in healthcare and I did it. I think the biggest struggle was finding the information, how do I get to where I want to? Who can help? How can I help myself? A lot of schools but some just want your money and they are not accredited and they give you no credit or anything and you ask, and people do not know anything. There is really nothing anybody can do to help you. You just have to reason with yourself and help yourself. I have helped a lot of my peers who were in my same situation. I encourage them and tried to show them the way. I try to teach by example.

Maria also remarked:

If I would have gone and tried to take all the exams and then move forward there was no definite, chance to get a residency. I tried one time, took the test and failed. I needed assurance of a job when I finished school and if I had gone that route, I had no guarantee. The fact I needed to support my family it made me think and really think about deciding to take the medical board exams and then apply for residency with the hopes to get it. I felt that nursing was more secure for my family and me...I only started the nursing program because another doctor I had gone to medical school in Nicaragua told me to do it. At first, I was: 'what, nursing? You are crazy.' In my country nursing is very different. The nurse has no autonomy; they are just there to fulfill the doctor's orders. The nurse is only

> there to change the patient not to make any decisions for patient care. Nursing here is a real profession, not completely independent but as the nurse and as the nurse practitioner I can do things for the patient.

Luis also indicated:

> At first, I did not think because the job of the nurse in this country is completely different to our country. I like it. How I thought a nurse would be, was nothing like back in my country in Jamaica. Here nurses are really a profession. I needed a job, I needed to support myself and my family and I did not have the money and time to go through the whole process of becoming a physician here in the US…. Well, as I said the nurses in my country practice more in a secondary role. They work hard, but the advancement and the autonomy is not like here. I did nursing part-time because I had to hold two jobs

Pedro also shared:

> I was working at a clinic, so when I ran into a friend from Cuba and he told he was at [a local university] … I found out that they had a program for foreign physicians to become RNs, so I said that's something I can do. And my friend told me he was almost done and I wanted to be back where I felt comfortable in the hospitals with patients. I said yes. I had to make more money, and I had already failed the test one time and I was really depressed so…I talked it with my wife and she said go for it and I did. It was hard, going to school fulltime, working, and the kids even though my wife did most of their care, it was still hard. But I did it.

Obdulia also remarked:

> I never considered being a physician in the United States. When I was in Cuba, before I came here, I decided I didn't want to be a doctor anymore, I'm going to start doing nursing and become a practitioner later and then I can work with the experience I had before, the same as a doctor, but I don't feel that I can take the test to do my license. I chose nursing because I can apply the knowledge that I have. It's easier for me to study something that I already know stuff about and then I can become a nurse practitioner that is the short-term story related to if I have to take my test or do the residence. I have family, I have daughters so I want to take care of my family also so I prefer…this is the reason I chose to do nursing.

Kikosam also mentioned:

> Well I was a substance abuse counselor initially. I found myself just doing that and at the end of the day I was doing nothing, just going home around 3:45 in the afternoon and doing nothing with my life. One day I decided why not go back to nursing or into nursing? Recycle some of my knowledge that I have in medicine and put it to some use in nursing. I decide to join the Board of Manhattan community college in an associate's program doing one course at a time. I thought it was going to take me my whole life, that at least when I was buried I was going to be RN as opposed to counselor. I stayed there for a while until 1999, that's the healthcare union in New York came up with a program recruiting foreign physicians to get them into a nursing program with a bachelor's degree. The reason that I was able to do it was because the grant that they had, they were able to pay me the whole salary, remove me from work and receiving the whole salary as a counselor which allowed me to pay my rent and my bills and in

addition to that the grant included paying tuition, books, uniform, utensils, metro card. All I needed to do was sit in the classroom and that was all

Pablo also stated:

> When I came, I came with my family, it really was not an option [become a physician in this country] as I knew it could take a long time to pass the boards. I knew it would be very difficult for me as I had a family to support. I thought about the nursing career when I saw a commercial on TV. Then I started to research the options and I told myself "take the option of nursing." To become a doctor here you have to pass the boards—that's hard but, it's more difficult to obtain the residence program. And that is because of my age.

Pelusa also remarked:

> The main issue to try to obtain the license [medical doctor] in the United States is regarding Cuba does not release our documentation from the university in the proper way, in the way that the Board of Medicine requests from the United States. They are not willing to release those documents and because of that we are unable to take our license or go through our boards in United States. Then having to experience in clinical settings the only way to go back in a similar setting is doing nursing. It's the closest profession to the physicians that we used to be. Nursing was something familiar to me. I was very familiar with the nursing concept and actions and it was easier to get the knowledge, not medical knowledge but nursing knowledge. It was easier to finish the nursing studies and go through the boards. If I had chosen for example pharmacy or another career it would be difficult I think.

Caring also voiced:

> When I came, I came with my family, two boys. It takes a long time to pass the boards of medicine and it was difficult for me. I thought about the nursing career and then I study for the board. Then my age and my family was first. Then I take the option of nursing. To pass the boards, it's difficult to obtain the residence program with my age. I think the advanced programs like a nurse practitioner is something very near to the physician role.

Career transitions occur often in any adult's life. As per a 2012 U.S. Department of Labor Bureau of Labor Statistics report, the typical number of employments in a lifetime is 11.4 jobs for men and 10.7 for women between the ages of 18 to 46 (during the years 1957 to 1964) for the Baby Boomer generation (Bureau of Labor Statistics, 2017). From 1978 to 2010, these statistics increased in an independent BLS study that indicated men held an average of 11.6 jobs and women 11 jobs during their employed lifetimes (BLS, n.d.). It is easy to see how individuals in today's workforce often are faced with having to change careers. Then it is quite understandable how these participants, who are not native to the U.S., experienced an increased hardship and difficulty in finding resources to guide them in changing careers. Most participants had experiences of a former physician who was now in the nursing profession sharing with them how they eased into and transitioned into members within the nursing profession as a second career. All participants were impacted from a financial perspective, in that they all had responsibilities and families to support. These critical factors affected their road towards the nursing profession. They succeeded by researching their options, speaking with

colleagues, and collaborating within their professional networks to reach their final destinations.

Reconciling

The term '*reconciliation*' is used to refer either to a process or to an outcome or goal. Reconciliation, as an outcome, is an improvement in the relations among parties formerly at odds with one another (Dawyer, 1999). At the greatest conceptual level, reconciliation can be considered as an advancement in the connection between two or more entities who were formerly in conflict (Dawyer, 1999). According to Dawyer (1999), an association with additional individuals contain models of collaboration, the positions an individual manages to take toward those individuals, and the expectations of and beliefs about the other that one makes. According to Hirsch (2010), accepting or continuing constructive reactions and attitudes, such as shared respect, empathy, love, and a mutual sense of identity or solidarity, with a recommitment to a joint set of moral norms are all components of reconciliation.

The participants expressed a feeling of finding their place and reconciling their previous role as a medical doctor to their current professional nursing one. The participants' reconciliation between their previous career and their newfound nursing profession represented the culmination of the long journey the participants faced in reaching their summit of being able to care for patients again. The participants recognized the difference between how they wanted to care for patients and how their current second career within the nursing profession gave them that opportunity. The participants expressed a commitment to the nursing profession and a recommitment to caring again for patients in their adopted country. They shared how different being a

medical doctor was in their country for most when compared to a medical doctor in the United States. The participants shared how they related to the *newness* of the patient being more than a diagnosis, a disease, how they longed to be able to care for the entire patient from a holistic approach and how the nursing profession gave them that opportunity.

Most participants shared their surprise at the nursing profession being considered a *profession* with autonomy and their own knowledge base: something very different when compared to their native countries. They shared how they had transitioned and had positive responses and outlook from patients and had experienced a mutual sense of identity or solidarity with nursing professionals. The participants expressed a healthy transition into the nursing profession and a respect and admiration for the profession as most considered themselves a *hybrid* or a *mixture* of their past as a medical doctor and currently as a nursing professional.

The following quotes from the participants support this concept of reconciling. **Beatriz** stated:

> Well I think that what I did was to reason it and see the new role that I'm in and look at the nursing part and see the beautiful aspect of nursing. That's what helped me. I just look at it…ways to take care of the patients. It's different from being a physician. In my opinion it's that I like the nursing aspect better than being a physician because when you're a physician you're always in a hurry looking at thousands of patients. You don't really have time to dedicate specific time to listen to them and understand them really for sure. You're just looking at one, two, three, four and that's it. As a nurse, you really put them together and

find out what is the real problem that the person is facing. Like the physician come and the patient and they have all these tests and everything but they're not really looking at the patient whereas as a nurse when I come in I sit down and I ask can you tell me a little bit about your life? At this point as an advocate you will tell the physician…have told them before…doc can you please do a different approach. I'm doing this this time because this is what I want to do, this is what I like to do. That's why I'm here. It's not because I can't pass the medical board that I'm here.

Johnny also remarked:

It's a different world. I've been both sides and I can tell you that we, us as nurses, we are more focused and more dedicated to the patients because it's not just the patient, it's everything that is around the patient. Family. Environment. Everything is much better. The medical profession is more focused on solving the disease and giving a treatment to that disease but just the disease. It's not around the environment…completely environment. I can see these days…that I work in an office and when I see my patients I talk to the patient and I identify everything that is around the patient and how I can do more preventive medicine from my point of view as a nurse practitioner. When I was in medical school we were trained to mainly focus in what I just told you, solve the problem solve the disease. Never I thought that I was going to be really thinking about anything else besides the disease because that's the way the doctor is trained, to solve the disease. When I came over here [US] and I found out that there are a lot of things that you can help, a lot of ways that you can help the patient with the disease then

that's when I realized that that was much better. Some doctors, friends of mine, sometimes they ask me, "How do you feel?" and I feel much better than doctor and they sometimes they hate me

Ms. O also shared:

Well the medical doctor is very direct into the curing and treating the disease and only looking at that part of the patient. The nurse is more about the patient and the surrounding of the patient and the family. What is affecting the patient? Not just the disease. We have that community to identify the whole picture; not just the disease and how to treat it. […] in my country nursing is not the same as here. Here nurses are well prepared well educated. In my country, it is a three-hour course and if you know how to put an injection you're a nurse. So, it's a different set of skills. Especially here because the physician doesn't look at the whole picture. we have to have that time with the patient and knowing the patient from another perspective than just the treatment. I only practice in my country as a doctor. It's different there because you have more time with the patient. Here doctors don't have a lot of time to spend with the patients because they have to do the computer, they have to do paperwork, they have to do so much but again when I was seeing patients I was only concentrated on what is your problem, this is what you need to do, you need to follow up with me on this day and you need this lab work or you need this. I prefer to see the patient as a nurse to be able to dedicate more time to understand the patient and not just see the patient in a flash. If I had to do it all over again I would start as a nurse becoming a nurse

practitioner. I would prefer to have done that instead of being a doctor. If I had the opportunity to do both again.

Halo also commented:

I'm a good hybrid. Yes. Yeah. I have the best of the two worlds. I can have the caring for the patient of the nurses and I can have the practicality and the get to the point of the physicians and let's resolve the issue. I think it's that. To be able to think in the two ways and to understand this is the key. I can understand the two feelings, the different worlds. It makes it easier to interact with the different professionals. To see a patient…like in the holistic way. A patient with a family, a patient with an environment, a patient with education. I mean the duty that the nurses have to educate patients is huge and we…I mean physicians don't put too much attention to that. [We, the] nurses really educate. So, it's more complete. Here the nurse I think…I feel are closer to the patient. The patient has freedom to say things to the nurses that they would never mention to a physician. I feel like that.

Jackie also stated:

I study because I like to help people. I like to learn. I like to be a clinician. I didn't have any problem transferring from one role to the other. I know my place. I know that I'm a nurse practitioner. I know that I have a supervising physician. When I go to my patients…years of working here…some people probably would not know my background as a physician. I think the people that have more trouble transitioning are the ones who still want to be a physician and go to the patient and behave an act as such but in a way of being at the top, being the leader

than just applying knowledge to the situation. As a doctor, you care for the patient more in the medical decisions? As a nurse, you care the patient in…and sometimes we as nurses abuse this term but we're more holistic. We truly are more holistic. When we're more holistic we're considering the social aspect of patient care. The care manager aspect, the true care manager not the discharge care manager and never stay, the true…what is beyond a discharge, what is beyond what you see in the medical field…in a medical situation. The interaction with the wife, the daughter, with the…you have insurance, no insurance. Your medication, who is going to purchase the medication? You integrate more the whole. The financial, the social aspect of the patient. When you are seeing a patient in a nursing…and nurse practitioner perspective. As a physician, I just write the order, write the prescription. I took the time to get involved whatever resources I have available plus other family members on the case. I don't think the doctor is doing that. That's the nursing position that you get the whole picture.

Amaury also indicated:

Nurses, we are the ones that really do the care, take the time, and the real needs of the patients are fulfilled by nurses. That's the big difference. In the doctor's role, we can see 120 patients a day, but we don't really take care of anyone. We just give orders for them and that's probably not someone we're going to see again, but as a nurse we're worried about if this patient is satisfied with our services, are really taken care of and are really improving with any problem that they have. A lot of differences between, especially the autonomy that you as a nurse have here.

> I came from a country…used to really give orders to the nurses to follow and then here I find that nurses really have an important role making decisions, have a really important role in making decisions for the patient for the improvement of the conditions of the patient. As a nurse practitioner, you have to use both, you are the nurse but at the same time you have to come to the medical model and just try to accommodate the patients' medications and treatment the best way possible. Actually, I'm doing both things at the same time. I'm looking at the big picture now as a nurse practitioner. I have to still think as a nurse and I see the holistic point of view of the patient in which the patient's needs are not just what is the illness process at this moment but also the whole circumstances of this patient including social, including economic, including family, including all the difficulties in managing that disease process. I come back to the big picture because it's just the holistic approach that they need to see, and they need to see the patient's problems and the patient's needs. I don't regret for a second taking this pathway to become a nurse. It's not really about becoming a wealthy person but also about fulfilling yourself in your job and that's how I feel. I feel that I am proud of the role of taking care of patients in the hospital. Now I'm doing the role of leading people to do the same thing I did in the hospitals when I teach.

Cris also remarked:

> As a nurse, I think we take care of the patient more, their feelings. We educate the patient more than as a doctor I think…we have more time to interact with the patient. We are closer to the patient than as a physician. I think when I became a doctor I thought it would be something like that but in real life it's not. You don't

have so much time to interact with patients like a nurse has in a hospital or wherever they work. I didn't know that when I first started studying medicine. Initially when I started in this program it was because a friend of mine recommended it to me. I was still living in Cuba and in Cuba it's totally different the work as a nurse. The nurse job description is different than here, totally different. There the nurse only does what the doctor says what the doctor orders and there is only one level of nurse and she has to do everything. The nurse here does mostly what I did as a primary care physician in my country which was take care of the patient, assess the patient, the physical exam, check what labs the patient needs and you talk to the doctor. They work as a team as I did when I was a resident in my country and I talk to the specialist and we would make our arrangements for that patient to take care of the patient. I think the nurse does mostly what I used to do in my country. [I'm a] nurse practitioner. I don't want a patient to call me Dr. because I'm not Dr. here…. at the same time when you're in the nurse practitioner role you pull from your physician knowledge to care for your patients. Yeah that's my role. I accept that.

Catira also shared:

Nurses have the direct contact with the patients and by all means. Doctors do too but doctors are more like okay I came, I prescribed, I assessed, goodbye. Nurses are there for the compassion, for talking to that patient one on one, for helping them and that was me. I couldn't find that in medicine and that probably in the back of my mind that was something throwing me off from medicine and not fighting enough. That I realized now but not then. I like the holistic…that part

> that you don't learn in medicine even though it is in the didactics and everything but it's not what we see in real world. You see more of that in nursing than in medicine I think but treating my patients as a doctor I always gave my whole me and I do the same with the patient in nursing. I love to treat the person, not only the condition, the person. I would have been doing that with both professions. That connection that nurses have, and I think that's what I told you before. I learned to respect this profession so much and now I am one of them, so I guess I encourage other physicians to become nurses. I didn't want to do that initially and then when I went there I learned what a beautiful path.

Sam also commented:

> …as a nurse, you have more time with the patient to listen, sit, and talk to them. You get to really find out where they are coming from. As a nurse, we have time to understand them, and as a doctor if you see something wrong, if they have symptoms you can straightaway identity those symptoms and escalate it. I use my medical knowledge to help me as a nurse. I suppose I just had to think about what I was now- a nurse. And look at the nursing part and see the good parts of nursing. That helped me. I did not think I would like being a nurse and now a nurse practitioner but I really like it. Being a nurse practitioner is very different…when you are a medical doctor you are always in a hurry, you do not have time to be with patients. It is like being in a factory. You do not really have time to give time to listen to the patients. As a nurse practitioner, I really get to put it all together and find out what is wrong with the patient. I remember a professor telling me 'your patient is more than a disease' and that is the way I see

> it. I learned to be an advocate for the patient and you will tell the physician can you please do a different tactic, like maybe calling in a consult with another doctor, a specialist, or maybe a social service to help that patient at home, or to get medicine, or help. Nursing is being a teacher, a helper, an advocate for the patient, giving more than just a prescription or a test.

Maria also stated:

> Medicine is the same, but nursing is very different. I think they have many things in common. It works really nice to put together what I learned as a doctor and what I learned as a nurse. When I finished my nurse practitioner program all of us were trying to put both of the good things we learned in from each together to get a ½ and ½ of each. Being a nurse practitioner and being a doctor before is hard bit I remember my scope and role and I am ok with it. I am satisfied with it. As a physician is hard to focus on the patients' problem and all the other things they are dealing with. All those other things make the difference when you take care of a patient. It is very important to know your patient's needs so their health could improve. the nurse does most if not all the educating and preventative teaching, and the coordinating of the care. but as the nurse practitioner I look past what they have now, to how I can help them not get back here. I learned a lot, but I am now a nurse practitioner. That is my role and I accept it and I like it. I am satisfied in what I do.

Luis also indicated:

> I believe I have the better of my two worlds. I cared as a doctor, but it is more complete as a nurse. And then I can have the medical knowledge and can have

> the expediency and then get to the point of the physicians and that lets me resolve the issue. I think it is that. To be able to think in the two ways, but to know where you need to be. I can understand the two professions, the two different worlds. As a nurse, I see a patient in a holistic way. A doctor sees a patient, but most forget that patient comes with a family, with an environment, with other problems. I really think what has kept me at the bedside all these years is that as a nurse and now as a nurse manager I can really care for all. As a doctor, I would see my patients, yes in my country I would talk to them more than most doctors do here, but my focus was to diagnose and treat. Here as a nurse, I get a chance to treat every aspect of the patient. The nurse has many responsibilities and physicians don't put too much attention to the other things that are part of the patient's world. I think that's the main difference of how I care for patients now as a nurse. I see the patients as their nurse, but I cannot forget my physician training and knowledge. You have to be both. So, it is a mixture of both. I know I am no longer a doctor here, but the knowledge I cannot forget. So, it is both.

Pedro also remarked:

> The medical doctor is focused on treating the disease and diagnosing. As a nurse, we care about the entire patient. As nurses, we look at the whole picture; not just the disease and the medication. I really believe in this country the nurses have such a big role in health, much bigger than a doctor does. My thing is that I am where I need to be. I find that I found my place. I enjoy it so very much. If I was born in this country I would have become a nurse practitioner, not have gone into medical school. I like the patient contact and care nurses have here. I really did

not see the difference when I was a doctor. Nurses look at the entire patient. Nurses see more than just the patient's diagnosis. The nurse cares for the entire patient. That is the big difference I think, as a doctor I worried about making the right diagnosis. I bring my knowledge and more than the knowledge of being a physician, I bring the love I have for the nursing profession. I have been at the bedside for a long time. I have seen a lot. I bring my love of the patient and how that translates into caring.

Obdulia also commented:

The point of view is totally different here because here the work has protocols. You have some autonomy. You can be a little bit autonomous so that's a good thing. Now I'm working ICU I feel a little better […] I feel better because we do a lot of stuff here that we can manage our self so that makes me feel more comfortable and also, I like to learn. I'm learning a lot because it's a different point of view. I think I gained studying nursing.

Kikosam also shared:

In nursing, I have the opportunity to ask the patient how you are feeling today and that has been my concern when I became a physician in Santo Domingo, making sure that the patient feels better today. You don't have that opportunity as a physician here in the United States. You may have that opportunity as a nurse and that's why I chose nursing. That's why I feel happy being a nurse. The day that I passed the NCLEX I was home by myself and when I went to check for the license I was crying. I was "Thank you Jesus, thank you God." I'm getting a little tearful now as I'm saying that. It was a big thing for me. [Nursing] It

> allows me to get back to my original point, getting in contact with the patient, trying to help the patient in a more legal way. I was able to do it before, like educating patients about substance abuse but not the same contact that you have with the patient in nursing. Also, it helped me to get a better salary. My life changed in many ways. I can help the patient in any way and nursing provides me with that. Like I said before, nursing here and medicine in Santo Domingo were almost the same. As a nurse, I can be as competent as you Dr. So, I feel fine saying that I'm a nurse.

Pablo also stated:

> I have more time to teach the patient about their procedure, recuperation, follow up, their nutritional regimen, and their medication. I think the NP (nurse practitioner) in this case focusses more on all the aspects that touch the patient's lives than the doctors do. Here in the United States because in Cuba I'm working at another level, I'm working as a physician, but the way I care for patients and all of their issues, even if they are not medical is more like in my country. In medicine, in this country- you focus mainly on the disease and the medications or in our case in the OR you focus on the surgical intervention to correct the problem. Nursing is more encompassing of the things that tough and affect the patient's lives. I am their nurse practitioner. I am the person that is going to help them travel their road to better health. I am their confidant and their teacher. I can even mentor them to better health. It really is a fantastic profession. I loved being a medical doctor but, in this country, I really love being an NP.

Pelusa also indicated:

> I am a nurse. I can't think of what I used to be, I am a nurse now. Now I am nurse just like anyone that grew up in this country or did nursing as a first career. I am a nurse. I am happy that I was able to complete the nursing. I can go back in the hospital setting, in the patient management. I am happy.

Caring also shared:

> I'm working in family practice and primary care where both are very important because the nurse provides more education to the patient. I think I have more time and in my career the bachelors and master's program primary education is very very important, diet, exercise, attention to the medication, everything that the nurse focus more than the doctors really. As a physician, it's more medical, more focused on how you need to take this medication. The disease and everything. Here it's more about diet, change lifestyle. In medicine, you focus on the disease all the time at the hospital level. In primary care, it's different that I'm doing care now. For this reason, I see different. Now I love that I'm doing that now. For my age for my time this is the best for me.

The participants in this study were all in agreement that their road led them to a better place and that they were in a profession where their past medical knowledge was being utilized. They had reconciled and improved the conflict amongst their relationship between their two professions: previously a medical doctor and currently a nursing professional. They all shared a struggle in learning which path would take them to their goal of caring for patients again in their adopted countries and the lack of timely information to reach that goal. They all referred to and considered themselves nurses and wanted to be included within their numbers as they reconciled their two roles (their

previous one as a medical doctor and their current one as a nursing professional). The participants all believed they were practicing within healthcare as they were meant to and as they wanted to. Their reconciliation into nursing brought the profession added resources and individuals who had a genuine respect for the role: they reconciled their prior role as a medical doctor with their current one as nurses and/or nurse practitioners.

The categories depicted: *practicing, transitioning,* and *reconciling,* together supported the basic social process of *acculturating pathway to practice.* The constant comparative examination and conceptualization of the data made it feasible to unravel and abstract the idea the participants were trying to share regarding the critical factors that influenced the attitudes, beliefs, and perceptions of their practice within a nursing role and allow the acculturating pathway to practice as the theoretical social process to emerge.

Focus Group Characteristics

The focus group confirmed the basic social process and the conceptual categories. The focus group consisted of a total of five FEPs who were experts in the field to confirm the theory. The focus group was made up of three males and two females, for a total of five participants. Originally, seven were invited and scheduled to participate in the focus group discussion; however, two had emergencies/last minute schedule conflicts and were unable to attend as scheduled. All participants had obtained their ARNP and were working as nurse practitioners. All participants had doctorate degrees, not PhDs. Three participants had full time teaching academic roles within accredited schools of nursing, one had an adjunct role within an accredited school of nursing, and one worked solely at the clinical sites. All participants worked utilizing their ARNP licensure, at least on a

part-time basis. Four of the participants taught within an ADN, BSN, and MSN programs.

Nan

Nan is a Hispanic female from Argentina who has resided in the United States (US) for 17 years. Her age range is between 55-64 years if age. She practiced as an internal medicine/nutritionist in her native country for 18 years. She obtained her RN licensure in 2008 and her ARNP in 2014. She obtained her doctorate in 2017. She stated she did attempt to practice medicine here in the U.S. She has worked within a professional nursing role for 9 years and currently works as an adjunct nursing professor for an accredited BSN/MSN program and as an ARNP doing home visits.

C

C is a Hispanic male from Colombia who has resided in the US for 22 years. His age range is between 45-54 years of age. He practiced as a general/family physician for 3 years in his native country. He obtained his RN licensure in 2003 and his ARNP in 2008. He obtained his doctorate in 2012. He states he never attempted to practice medicine in the U.S., and he has been within a professional nursing role for the last 14 years. He currently works full time at an accredited nursing school within their ADN program and part time at another accredited nursing school within their MSN program. He also works in an ICU setting as an ARNP.

OA

OA is a Hispanic female from Cuba who has resided within the U.S. for 17 years. Her age range is between 45-54 years of age. She practiced as a general/family physician for 10 years in her native country. She obtained her RN licensure in 2012 and her ARNP

in 2013. She obtained her doctorate in 2015. She shared she did not attempt to practice medicine in the U.S. and has practiced within a professional nursing role for the last 9 years. She currently works as an ARNP-clinical liaison with a local hospice agency.

JC

JC is a Hispanic male from Colombia who has resided in the U.S. for 19 years. His age range is between 45-54 years of age. He stated he did attempt to practice medicine in the U.S. He worked as a general/family physician and within public health for five years in his native country. He obtained his RN license in 2011, his ARNP in 2013, and his doctorate in 2008. He has practiced within a professional nursing role for the last 7 years. He currently works as a professor at an accredited school of nursing in their MSN program and as ARNP in family practice.

Dr. Brito

Dr. Brito is a Hispanic male from Cuba who has resided in the U.S. for 22 years. His age range is from 45-54 years of age. He stated he did not attempt to practice medicine in the U.S. He worked as a pediatrician for 5 years in his native country. He obtained his RN license in 2004, his ARNP in 2015, and his Doctorate in 2017. He has practiced within a professional nursing role for 13 years. He currently works as an associate director and professor of a local school of nursing. He also works in long-term care/home health as an ARNP.

Confirmation of the Discovered Theory

Once the categories were saturated, the core category emerged. At this time, phase II of the study continued. Theoretical sampling advanced to completely saturate and validate the core category that emerged from the first phase of data collection. The

following section describes the discussion by the focus group participants during this part of the confirmatory process of the *acculturating pathway to practice* and its three supporting categories: ***prac****ticing*, *transitioning*, and *reconciling*.

Practicing

This concept struck a very sentimental and enthusiastic chord with all the members of the focus group. They all believed that this concept was what motivated and propelled them down the uncertain road into their transition to nursing. They spoke of constantly looking for opportunities to enter back into the healthcare field, as caring for patients again was their final goal. All the participants agreed that their past medical knowledge had to be used and not sit idly on a shelf as a memory. The participants agreed that this category was essential to the core category, as it fueled their desire and need to enter back into the healthcare arena. As we discussed this concept, the following are some of the quotes from the focus group participants:

Dr. Brito stated:

> For example, in my case I never ever tried because I realized that my objective… I decided to…no matter what I had to do to get into the nursing field as a way to start practicing in healthcare which was my main goal here in this country…For example, Nan she practiced as a medical doctor for17 years when she was in Argentina. Could you imagine that she could forget almost 20 years of practicing as a medical doctor even when she is a nurse? That's impossible. In my case I practiced for five years but I was really involved in my specialty. I graduated as a medical doctor and then I went to my residency and I became a pediatrician, so I practiced for two years as a medical doctor specializing in pediatrics. That's

> impossible that I can forget all that information that I got in the past even though we start in the nursing field. As you said [Nan] we start at the beginning just as a way to introduce the healthcare field but then we have passion for this [nursing] because we have the caring.

Nan also remarked:

> I have been working as a doctor for 18 years, that is not for me but then I realize it was for me. At this time, I did not know anything about what is was, nurse practitioner, nothing. Really really nothing so I think that it was the possibility to be inserted into the healthcare area. That's why but it was not only doing a new thing. It was continuing with the knowledge that I had, with the practice that I had was different. I wanted to continue using my knowledge. I know that my knowledge, I have two different degrees. I have a degree in internal medicine in my country and in nutrition in my country. I had it all in my mind but not in my heart yet. When we are in the classroom we have all of our knowledge and we can discuss with our students about the knowledge that we have that is not only about nursing or nurse practitioner but also knowledge we carry from the school of medicine.

C also said:

> We see nursing as a way to come back to practice. I'm not quite sure that nursing bedside is the final destination, it's just the bridge to get where we want to go and then become a nurse practitioner and care for patients again.

OA also indicated:

> First, we love to work as a clinician- nurse practitioner- because it is what we like and it's a personal passion for each of us. Second you have to think about how to support your family too.

JC also remarked:

> I think that's something extra for us, looking at those opportunities. Those chances. I mean everybody here finishes a master's degree and what they did immediately was to go for a doctoral degree. That shows a lot. We all are looking for ways to use our knowledge and enter back into the healthcare field, which for most of us is the only thing we have ever done.

Transitioning

The focus group unanimously supported and emphatically confirmed the concept of the participants transitioning into nursing professionals. The participants all depicted how they transitioned into their new profession. They all shared that the road to the nursing profession was plagued with many turns and even some setbacks. They validated that the path to nursing offered them a lot more stability and opportunity than medicine would have offered them. They corroborated that transitioning to nursing was at times made more difficult due to the lack of information (as they had no road map on how to get there) and their added family and financial responsibilities. The focus group participants all shared that within the context of opportunity was the prospect to be part of a profession that was respected and allowed them to have financial stability. As the participants discussed this concept, the following are some of the quotes from the focus group participants:

Dr. Brito stated:

> I can summarize the way that you broke down the three elements that you are investigating, and I totally agree. Number one if we go over the need to practice it is exactly the way that we as a foreign physician are constantly looking at things. We arrive in this country to get into the healthcare field and it is the easiest way, definitely. We have a lot of problems or requirements in order to practice as a…or not to practice to get into the stats to become a licensed medical doctor. Nursing offered us foreign physicians a transition back into healthcare.

Nan also remarked:

> My experience is a little different. I have been a medical doctor in my country for 18 years. When I came here I did not think I could continue to do the same thing, but it was a big barrier for me, the age. When I started with step number one to be a medical doctor here I was with the counselor, the counselor said to me, "hey do you know what would be your next step?" I said yes of course, the steps of medicine. No. It's not true for you. Do you know that you have in front of you the new students that are younger than you and they have more possibility than you? It was really really something like I was not hoping on that. He said the only possibility I can see for you is nursing. In my country nursing is at the bedside of the patient, is the person that is in charge of the walking of the patient, feeding the patient. Doing something but very limited. It was the only possibility. At this time, I did not know anything about what is was, nurse practitioner, nothing. I started doing the nursing. I don't think it was an easy transition for me because at the beginning I did not realize that it was the best way

> for me. It was the only one but not the best way is what I thought at the beginning. At the beginning, it was not an easy transition but yes later I saw that I had the opportunity. With nursing, I had the opportunity because being in nursing school I knew the opportunity to get my master. I did not know about that before so that's when I thought it was the best possibility to do something like I was doing in my country. I was doing the correct thing to get the same position that I was in my country. I had a family that I had to manage with children so maybe I can't do…yes you can. We can all do that. I think that it was one of the ways that led me financially to support my family.

After Nan's statement, all the focus group participants nodded their head and verbalized multiple variations of "yes, that was my initial perception of nursing," "yes, the best possibility," "very true," "yes, exactly," but as all where speaking at once it was difficult to discern who stated what.

C also remarked:

> When we finish medicine and we come to this country most likely most of the people you're going to find are people in the late 30s, 40s, 60s with family responsibilities, either here or somebody to support back there. That's why another motivation like she said we are clear that if you are more than 40 or close to 40s it's unlikely that the Board of Medicine will give you residency even though you go through all the steps and you pass all your tests…people that have all the tests ready to do residency and basically, they didn't give it to them because they are too old and too old for them is 40. Nursing gave us better opportunities.

OA also stated

> I agree with your ease of transition, that it was easier for us to transition into the nursing profession, we got more opportunity and we were all having to support our families in a new country. The road map like everyone has said could have been easier- but once we figured it out it made a lot of sense as it, nursing is very close to what we were doing in our country.

The participants all discussed that if there was a clear road map and guide for the foreign educated physicians who enter this country and assistance for them to acquire their ARNP, the health of the country would improve dramatically. In addition, the participants shared that having an awareness and understanding of the opportunities within the nursing profession would help alleviate their worry of how they are going to support their families in this country. They also discussed how an easier road map and transition may help to alleviate the nursing shortage within the US.

Reconciling

This concept was by far the most discussed within the focus group. All the participants believed was the pot of gold at the end of their road. The researcher purposefully did not introduce the words socialization and role transition in order to determine if the focus group participants would come to utilize those words. All of the participants agreed vehemently that there was a pronounced difference in how medical doctors practiced in the U.S. and how they themselves practiced within their nursing roles. They all agreed and shared examples of how their own nursing practice was rooted on a holistic, whole patient approach. This approach they stated was a missing link within the medical model here in the U.S. The participants all agreed that they had

transitioned to and socialized to the professional nursing role with a genuine passion and respect for the profession. They all agreed they had found their place within the nursing profession as a hybrid practitioner. The following are some of the quotes from the focus group participants:

Dr. Brito stated:

> We consider that we are a hybrid professional… we start at the beginning just as a way to introduce the healthcare field but then we have passion for this because we have the caring that the nursing field has that is not the same that we as medical doctors provide. That is the holistic approach which the most important thing that we as medical doctors found in this profession. In other words, summarize as I said I 100% agree with those comments that you have here [about the found their place category].

JC also remarked:

> Also, a couple of concepts that maybe are going to sound like devil's advocate about all these things we're talking about. The first thing that I would like to refer to is some of the terminology that you have in the documents. When I revise them I really like the way you set everything up, the sequence and everything. One thing I would recommend it's on the third factor, Found Their Place, is to come with more objective wording when you say fell in love with nursing.

Dr. Brito interjected and stated the work "passion."

JC continued:

> When I read it, I said fell in love with a profession, articles and journals. Articles from psychology journals talking about the process of falling in love but nothing

> like that word in a relationship to a profession. I would say something like recognizing yourself in the new profession related to values or concepts.

Dr. Brito interjected again and stated:

> …in love really should be what we feel, basically you feel socialized with the profession…you identify with it…we have transitioned to nursing.

JC also started the discussion on the terminology of the hybrid clinician which should be hybrid practitioner. The following are quotes from that discussion:

JC began by saying:

> So, I did my little survey in this little time to see what people understand about hybridization, but I also break it down the definition, so by definition clinician refers to the dictionaries and the definition is somebody that runs a clinic or someone that practices with patients in the category of medical, psychology, and something else, like three categories the physician, the psychologist, and somebody else but not a nurse. A nurse is not listed as a clinician here.

C interjected and stated:

> It can be easily replaced as a hybrid *practitioner* which is what we are. It comes down to we accept that we are nurses, but nobody can deny that we may have more knowledge than your regular nurse. When we practice, we practice with the nursing scope of practice but always knowing something else…Funny because when I finished physician and medical school I remember my graduation I said this is it, this is all I'm going to do. I was concerned that I was trained to go to the hospital, assess patients, make diagnosis, write down the prescription and leave. I was concerned what happened to that prescription? Did that patient receive that

> prescription? Where did that prescription go to? As nurses yeah, you're practicing and you're receiving the order but you're actually carrying out the order, so you know it's continuing. Somehow when you practice as nurses it compliments that role of physician that stops when you write down the prescription. You actually give it to the patient and you actually monitor the patient after giving that medication and then you know if it's getting better or worse. That's why I believe it's true that it is growing bigger and bigger the spiral [referring to the depiction of the conceptual model] because you are complimenting knowledge with practice and you see the whole process from beginning to end.

OA also remarked:

> Even though we had the medical background which is very good, at least for me I feel very good doing nursing practice because the nursing practice here has the same focus as we have as a physician in our country. Its patient centered more than the physician. The MD is less…they see the patient and like he said prescribe and leave. We are closer to the patient, more complexity, we follow more. I like that part of the nursing practice here.

C also voiced:

> I have this serious issue that when I go to my doctor he just looks at numbers. He looks at the labs, he doesn't look at me, he doesn't do an assessment. I'm waiting for him to do that, to focus on me. At least look at my eyes and that doesn't happen. It is a U.S. educated physician. His concern is he has another patient in 15 minutes and we need to talk about everything in 15 minutes and then show me

> the labs. We really talk to you, see you, what you're dealing with, assessing your lungs, assessing your heart, assessing your abdomen and then we sit down and say well in addition to physical you have your high cholesterol or your blood glucose and let's talk about what we want to do about this. That I see a huge difference and again it comes from the culture. The way that we were also trained as a physician in our countries is that clinical is first and then labs. Health assessment, I mean interview, health assessment comes first and then you check your lab. I don't see…that's the culture that we grew up with and I don't see that culture in American trained physicians.

Nan also remarked:

> Here I am a nurse and we know we can do more…As a nurse practitioner we have the knowledge of nurse practitioner, we have the knowledge of a physician in our country so in some ways I don't feel like every clinician I feel like a practitioner.

Dr. Brito also commented:

> People see you as a hybrid practitioner. It is the way that you identify yourself as a hybrid because she perfectly said you carry on with you that physician knowledge that you cannot separate. When you think as a nurse you need to wait wait wait I need to start thinking how I'm going to implement this and this order. How I'm going to follow up with this patient, how I'm going to educate or advocate for this patient which is our holistic approach that we're talking about. It is a difficult…a completely different way when you're thinking as a physician compared to when you're thinking as a nurse. The approach is definitely holistic,

> and you see the patient as a whole. You are taking care of all the details that the physician is not taking care of.

All participants verbalized their support of their commitment to practice in a holistic manner, caring for the patient in a different way when compared to the American medical doctors. Dr. Brito went on to share an exemplar to illustrate the point.

Dr. Brito stated:

> I need to add something that is important. It's a comment but it's going to support your work here. I t's that we're able to spend time with patients. One of the most common comments that I received from our graduates, from my classmates, and from my friends that are practicing as a nurse practitioner is the contradiction they have when they start working in physician offices or in any setting that they need to practice the time constraint. They have 15 minutes. Sometimes they are allowed to see the patients no more than 15 minutes apart. So, they have to run, run, run. There's definitely no way that you can practice in the way that you are trained. One of the most common complaints is that one, that there is no time to practice as they should, as they would love to.

Nan also remarked:

> That's why I'm doing patients at home because I have enough time with the patient. I don't have a boss with me saying next patient. No no. It's the whole time that I need and if I need a whole hour with the patient, not only to do a complete assessment but to check all the medication, to check all the surrounding of the patient at home because it's very very important for us. We need time…That's why I don't like it. I prefer to go to the patient's home. It's the

extra mile because you need to move and sometimes you need to move to places but it's not a problem. You have all the time with the patient, all the time with the surrounding of the patient which is very very important. It's the holistic. It's very important for the next step that you will impart in this patient or the next step for the treatment. You need time. In 15 minutes, there's too much things that you cannot arrive.

Dr. JC offered a summation of the findings that all the participants verbalized and nodded agreement to:

I can summarize and say that the three categories are the need to practice, the roadmap and then the ease of transition that may not have been so easy are very true for the FEP and we practice as hybrid practitioners because of those two parts: the road map and transition with the need to be back in the healthcare field but what it's more important is the incorporation of the socialization and the transition into the profession, and we have found our place. We have again socialized and adapted to that transition of the new profession of nursing. And just a thank you that nurses from scratch from the heart are the ones who keep writing about the topic of foreign educated physicians.

Restatement of the Research Question

- What are the critical factors that influence the attitudes, beliefs, and perceptions of foreign-educated physician as they practice in the professional nursing role in the United States?
- How do FEPs differentiate their role in nursing as compared to their physician role?

Connection to Theory

The theory of *acculturating pathway to practice* is supported by three conceptual categories: practicing, transitioning, and reconciling. These categories interact in a continuous manner. The named concepts/categories are processes that contain the process of the FEP's acculturating pathway to practice. The three conceptual categories explained the theoretical basic social process of *Acculturating Pathway to Practice.* The progress is continuous and integrated. After the FEP has immigrated into the U.S., they have many questions and many things to accomplish. One ever-pressing need for this group is how to enter back into the world of healthcare and care for patients again. They do not have a clear understanding of their opportunities within the nursing profession and most do not ever realize that is an option initially. As they connect with other individuals that have passed through the same situation, they feel more comfortable with their acquired knowledge in reference to their next steps. This knowledge comes in the form of a road map and a list of opportunities within the nursing profession. These properties are central to the category of practicing. Their progression is incremental in that as they learn the steps to follow to fulfill their constant, ever pressing need to care for patients. Through the process of becoming nursing professionals, nurses develop core values and beliefs. Norms learned in nursing school and as they are practicing are instilled into these professionals.

As the conceptual category of transitioning is considered, it is important to note that positive transitions and role identity are related concepts of socialization. As a person experiences the socialization process, he or she is also experiencing responses to the transition of events. As stated by Meleis (2007), in positive transitions feelings of

distress are substituted with a sense of security and mastery of a change event. As individuals are socialized to new situations and roles, how effectively they transition impacts their socialization process and their success in their new role. As the FEP have searched for ways to enter healthcare again, to care for patients holistically and have learned of the nursing profession as their point of entry, the transitioning process has begun. They become *practicing* nursing professionals *transitioning* into the profession. These practitioners consider themselves practicing as hybrids as they have medical knowledge that they will not discard; instead, this past medical knowledge makes them a savvier practitioner within the nursing profession. Within the final category of *reconciling*, the FEPs have integrated and reconciled their beliefs, values, and morals becoming nursing professionals. There is a delicate stability between the three categories during the time the FEPs are finding their way into the nursing profession. The three categories/concepts work in unison producing the acculturation of the FEPs into the nursing profession. The further the FEP gets into the pathway to practice, the more these three categories interact and blend into one.

The acculturating pathway to practice is the process for resolving the main concern of how foreign-educated physician enter the nursing practice and transition into the professional nursing role in the United States. Finding the road map to ease the transition and transitioning into the nursing profession, their need to practice and enter again into healthcare, coupled with them reconciling their place within the nursing profession leads to their practice acculturation with the blending and fusing of their practice and socialization within the nursing profession.

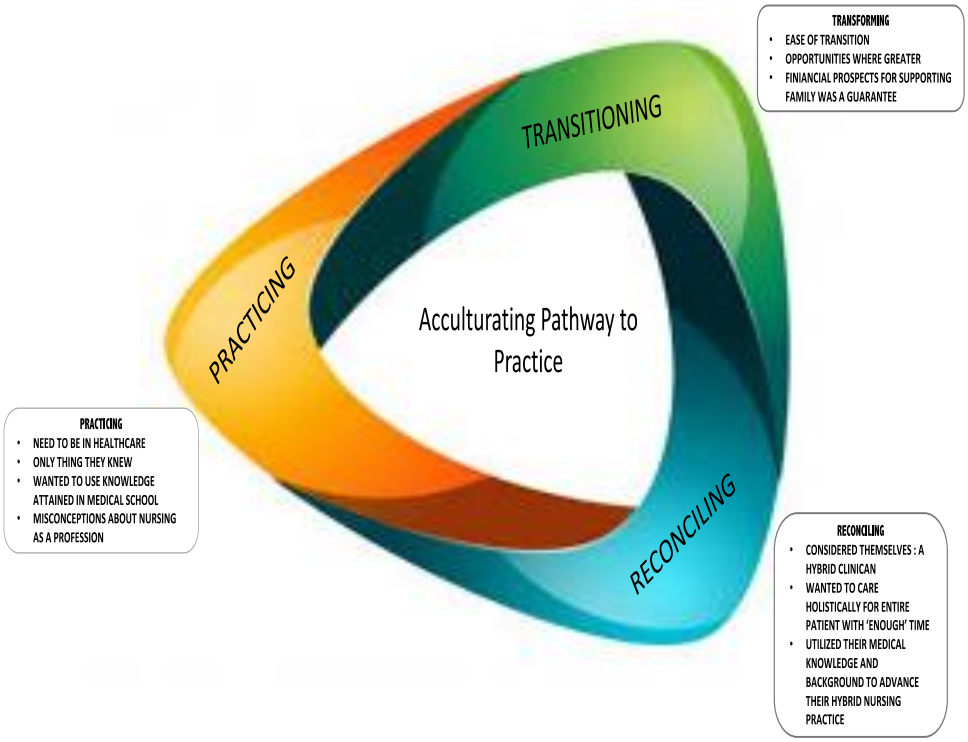

Figure 2. Initial conceptual model: Acculturating pathway to practice. (Hernandez-Pupo, 2018*).*

The figure above demonstrates the basic theoretical social process and the core category of the *acculturating pathway to practice*. The acculturating pathway to practice depicts the changes that occur within the FEPs as a result of contact with culturally different people, groups, and social influences. Though these variations can occur as a result of nearly any intercultural interaction, acculturation is most frequently experienced by individuals living in countries other than where they were born—for example, in immigrants, refugees, asylum seekers.

Acculturation was initially conceptualized as a unidimensional process in which retaining of the heritage culture and attainment of the accepting culture were thrown as conflicting ends of a single area (Gordon, 1964). As per this one-dimensional model, as

immigrants obtained the beliefs, practices, and views of their host countries, they were anticipated to abandon those from their national heritage. However, since the 1980s, cultural psychologists have recognized that obtaining the beliefs, views, and practices of the host country does not inevitably mean that an immigrant will abandon (or reject) the beliefs, views, and practices of their country of origin (Berry, 1980).

The data from this study revealed that these individuals have accepted and have acculturated to their newfound profession without resentment or prejudice. Instead, the participants bask in the glow of being able to practice in the way they have always desired to do so, as they have reconciled their previous role as a medical doctor and their current one within the nursing profession. They can separate and differentiate between their second career as a nurse professional and their prior one as a medical doctor, while reconciling both and transitioning into their new roles. Their role transition led them into the nursing profession where they integrated new knowledge, changed their actions, and thus changed their definition of themselves within their social context without abandoning their prior medical knowledge. The participants voiced their acceptance and respect for the nursing profession; for what it has brought to their lives and what they have learned from it.

Chapter Summary

In this chapter, the results from the data collection and analysis of this inquiry were discussed. It included 17 individual interviews involving FEPs who had an RN or an ARNP and worked within a professional nursing role. Phase II results were also discussed and explained. Phase II consisted of a focus group interview with five participants who served as part of the theoretical sample to confirm the basic social

process and the major categories and the core category that emerged from phase I. The major categories are ***transitioning***, ***practicing***, and ***reconciling***, and they allow the core category/basic social process to emerge, which is the conceptual model of the ***acculturating pathway to practice***.

CHAPTER FIVE

DISCUSSION AND CONCLUSION OF THE INQUIRY

The purpose of this classical grounded theory study was to discover a substantive theory explaining the process of foreign-educated physicians (FEPs) experience as they transitioned from their original role as physicians in their country of origin, to their new role as nurse professionals in the United States. The theory of *acculturating pathway to practice* is grounded in data gathered regarding the critical factors influencing the attitudes, beliefs, and perceptions of FEPs who have entered nursing as a second career.

The registered nurse profession is expected to increase from 2.71 million in 2012 to 3.24 million in 2022, which turns into an upsurge of 526,800 or 19% ("Nursing shortage," 2016). Various educational institutions are considering nontraditional sets of individuals are a representation of an existing source of health care professionals with clinical expertise. Foreign-educated physicians (FEP) are one set of nontraditional sets who are entering the nursing profession as second career individuals within the United States. However, a dearth of research exists about how effectively this group assimilates the professional nursing role. Before this study, there was a gap in the current body of knowledge on how foreign-educated physicians were socialized and assimilate into the nursing role, how they saw themselves as practicing nurses, and how they came to realize that professional identity was unknown. All students who enter the nursing profession should expect nursing education that prepares them to successfully socialize into the profession. Socialization into a professional role is affected by how the individual understands and assimilates the norms, values, and traditions of that discipline. Second career students, such as FEPs, experience unique challenges in adapting to their new role

as a nurse. Little was known about the social process of FEPs transitioning to the professional nursing role. By understating the key factors influencing this transition process, nurse educators can successfully educate FEPs to the professional nursing role and healthcare institutions will be able to retain them at the bedside. There may also be a risk to the FEP-RN of practicing outside the scope of professional nursing practice and may also jeopardize the quality of nursing to clients.

The information from this study will aid the FEPs in their transition and acculturation into the nursing role. Nursing's social contract requires the profession to provide safe, holistic nursing care to promote the health and well-being of the public. This classical grounded theory yielded a substantive theory explaining the process of foreign-educated physicians (FEPs) experience as they transition from their original role as physicians in their country of origin, to their new role as nurse professionals in the United States. The theory was grounded in data gathered regarding the critical factors influencing the attitudes, beliefs, and perceptions of FEPs who have entered nursing as a second career.

This chapter will discuss the significance of the results from this study including the assumptions of the theoretical framework and the relationship between the variables that emerged from the study's data. An evaluation of the basic social process and the supporting categories with the current literature will be discussed. The significance of the study and the implications to nursing practice, education, research, and health and public policy will be discussed. This chapter also will highlight the study's strengths and limitations as well as recommendations for future study.

Before beginning this study, earlier studies revealed that as a response to the ever-growing shortage of registered nurses, many school officials and administrators have looked for innovative approaches to recruitment and have begun to look at nontraditional groups ("Nurse workforce", 2001). Even though these non-traditional groups were discussed in the literature, only a few studies made specific references regarding FEP transitioning to the registered nurse role. Grossman and Jorda (2008) collected data on several program outcomes, such as "socialization to nursing, critical thinking skills, and NCLEX-RN pass rates on first attempt" (p. 549). The authors concluded there was widespread support for the program, but there was also doubt in reference to the viability of transitioning and socializing of the FEP to the nursing role (Grossman & Jorda, 2008, p. 549). Simon (2010), utilizing the theoretical framework of Meleis' experiencing transitions theory, examined the socialization process of FEPs (N = 177), as they transitioned to the nursing role, when compared to other nurses who graduated from a diploma/associate degree program, BSN, and/or Master of Science in nursing program. Simon (2010) utilized a "cross-sectional nonexperimental correlational design," and data were collected from the "demographic questionnaire," where it was analyzed for their effect on the dependent variable using multiple regression (Simon, 2010, p. 48). This study's results concluded no "significant differences between the groups", and none of the null hypotheses were rejected" (Simon, 2010, pp. 62-72).

Vapor and Xu's (2011) phenomenological study reported on the lived experiences of eight "self-identified Filipino physicians-turned nurses working in Las Vegas in the United States" (p. 210). This study reported on the difficulty Filipino physicians have in transitioning into their new roles as nurses (Vapor & Xu, 2011, p. 221). In this study, the

MD to RN participants concluded "that bedside nursing was neither professionally nor personally rewarding" (Vapor & Xu, 2011, p. 221). Two other studies that confirmed Vapor and Xu's 2011 findings were Pascual et al. (2005) and Poblete (2007). These limited studies revealed several issues regarding the socialization of these participants into nursing; however, the very scarce studies present did not answer the critical factors of this population of second career nurses and their practice within the nursing profession.

To increase the body of knowledge, the researcher explored the critical factors that influence the attitudes, beliefs, and perceptions of FEPs who have entered nursing as a second career. Three major categories evolved from this study—*practicing*, *transitioning*, and *reconciling*— and a basic social process of *acculturating pathway to practice*— as the factors that influence the attitudes, beliefs, and perceptions of FEPs who have entered nursing as a second career.

Exploration of the Meaning of the Study

The philosophical underpinnings that guided this study was the social constructionism and interpretive worldview. Constructionism is an epistemology represented in several theoretical viewpoints (Crotty, 1998, p. 3). Constructionism claims that meanings are constructed by human beings as they engage with the world they are interpreting. Constructionism discards the idea of objective truth waiting for the individual to uncover it (Crotty, 1998, p. 8). Before there was consciousness on earth capable of interpreting the world, the world held no meaning at all (Crotty, 1998, p. 42-43). From the constructionist viewpoint, therefore, meaning (or truth) cannot be described simply as objective. By the same token, it cannot be described simply as

subjective (Crotty, 1998, p. 43). In this perception of knowledge, it is evident that various people may construct meaning in multiple ways, even in association with the identical phenomenon (Crotty, 1998). Constructivist research often addresses the "processes" of interaction among individuals. This researcher's intent, then, sought to make sense of the meanings the FEPs had about their second career within the nursing profession.

The interpretivist approach, "looks for culturally derived and historically situated interpretations of the social life-world" (Crotty, 1998, p. 67). Interpretivist research is "guided by the researcher's set of beliefs and feelings about the world and how it should be understood and studied" (Denzin & Lincoln, 2005, p. 22). In the interpretive paradigm, knowledge is proportional to specific situations— "historical, temporal, cultural, subjective"— and occurs in several "forms" as representations of reality. Interpretivists accept multiple meanings and ways of knowing (Munhall, 2012; Crotty, 1998). The interpretive paradigm emphasizes mainly the recognition and describing of the meaning of human experiences and actions (Fossey et al., 2002). Pragmatism conveys the theoretical viewpoints that emphasizes the real world, giving supremacy to practicality over theoretical knowledge; as such, the objective is transformative (Seigfried, 1998). According to the pragmatist perspective, truth has to be increased inductively with constant empirical verification instead of through deductive reasoning from priori theory (Munhall, 2012, p. 228).

Grounded theory, a qualitative research methodology that pursues to inductively refine concerns that are significant to a particular group of people, producing meaning through analysis and creation of a theory was utilized to research the phenomenon of

interest (Glaser & Strauss, 1967). Grounded theory is a research approach developed by Glaser and Strauss in 1967. Of the qualitative methodologies to investigation, grounded theory is perhaps the most systematic in its approach (Munhall, 2012, p. 230). Grounded theory offers helpful and relatively easy-to-remember designs to understand world phenomena better (Glaser, 1978).

Glaser was chosen because of its openness that would allow the data to speak. Glaser (1978) divided the data coding process into two sections: substantive coding and theoretical coding. Substantive coding includes open and selective coding and theoretical coding in the last phase of Glaser's process, which is centered on one core, fundamental phenomenon that has developed from the data (Glaser, 1978). It is this coding process, that exposes the central themes/ideas, the casual conditions connected to the central theme/idea, the approaches used during interaction, and the consequences of approaches. Comparisons are used to reveal differences and patterns in categories, to connect concepts in the developing theory, and to prompt research reflexivity. As soon as the core category is recognized, the sampling will become theoretical (Glaser, 1978).

The grounded theory method was beneficial as the researcher sought to develop a theory that described human actions in their social environment (Strauss & Corbin, 1998). Symbolic interactions are used to explore the truth about an individual's behavior, making this framework a good fit for grounded theory. This method used data that was systematically collected from the participants, which led to the understanding of the phenomenon in question, and then the data was analyzed utilizing a scientific method (Strauss & Corbin, 1998). Since the focus was human behavior and the meanings these behaviors represented in social contexts are the focus of the researcher's inquiries,

individuals who meet the inclusion criteria were invited to participate in the study. The researcher accomplished continuous comparative analysis making comparisons between the data available, the structure of the evolving theory, and the need for further data to further develop the theory (Strauss & Corbin, 1998). It is in making the comparisons that the researcher identified a process and linked concepts to the development of the theoretical framework: *the acculturating pathway to practice*. Acculturating pathway to practice emerged from the data to answer and explain the road FEPs travel in acculturating, socializing, and transitioning to nursing as a second career. The collaborative processes that explain the acculturating pathway to practice are the major categories that merged from the data: practicing, transforming, and reconciling. The acculturating pathway to practice is the spine that holds these processes together.

Interpretive Analysis of the Findings

In the preceding chapters, an introduction to this study was made. Chapter One described the background of the study. The problem statement, purpose, the philosophical underpinnings were described. In Chapter Two, a literature review was rendered, which contributed to a summary of the historical context of the experience of individuals socializing to and transitioning into professions. A broad overview of different individuals changing careers and their path to socialization, including second career nurses was also presented to put this study in perspective. A majority of the literature reviewed prior to data collection supported the deficiency of knowledge of FEPs socialization and transition to nursing as a second career, which advanced the purpose of this study, which was to explore the critical factors that influence the attitudes, beliefs, and perceptions of FEPs who have entered nursing as a second career.

The results in this study emerged after the researcher completed the interviews and analyzed the data following as closely as possible to the tenets of classical grounded theory analysis the individual and focus group interviews. From the data analysis, three major categories emerged in this study: practicing, transforming, and reconciling. The final analysis of the data revealed the core category and theoretical framework of *acculturating pathway to practice*, as the social process of FEPs who have entered nursing as a second career. This framework describes the dynamic and somewhat tumultuous road FEPs must travel to practice within the healthcare arena in the United States. The following paragraphs will present the findings of this study with supporting literature and dialogue from the participants.

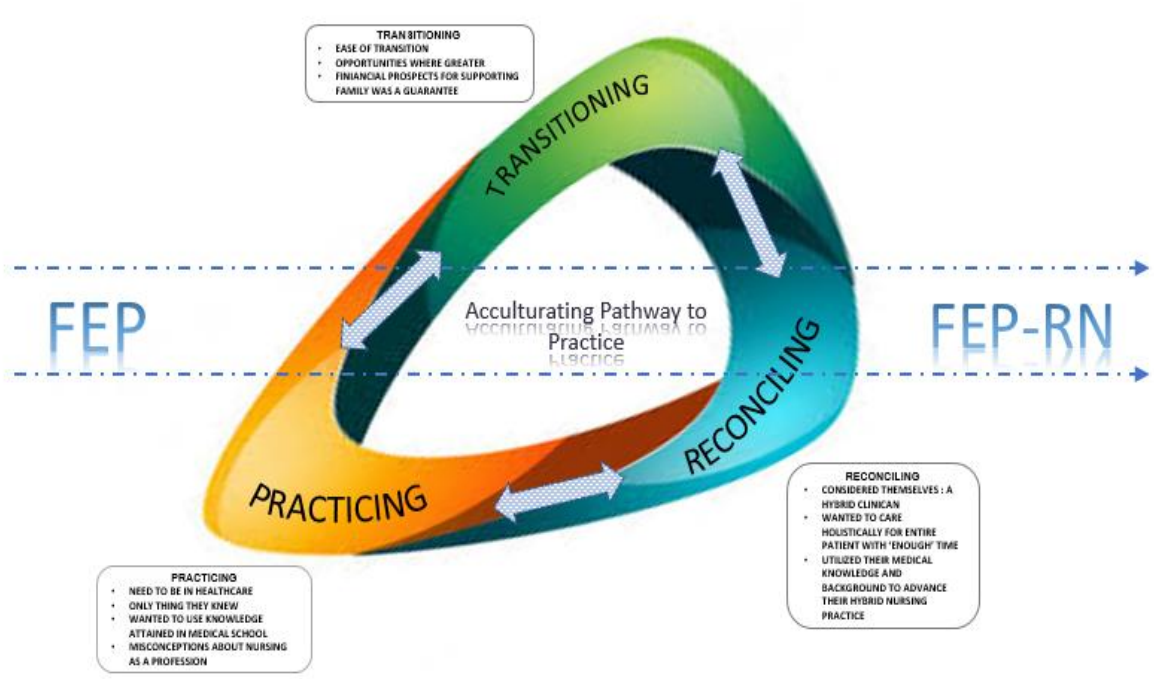

Figure 3. Major categories of acculturating pathway to practice. (Hernandez-Pupo, 2018).

Practicing

Practicing was one of the major categories that emerged from the data. The FEPs shared a need to be practicing within the healthcare field caring for patients once again. The participants identified their need to care for patients holistically and completely as a key motivator to enter back into the healthcare practice and to identify with the nursing profession. In nursing, caring is more than a cure and goes beyond being patient centered. It is in the caring practicing characteristic of nursing that every individual is acknowledged as a human being whose experiences touch their health and wellbeing. This aspiration and need to practice with this caring philosophy prompted their decisions in their adopted country. The following are excerpts from the participants that support this major category:

When asked how she would described her practice as a nurse when she compared it to her previous one as a physician, **Beatriz** stated:

> It's different from being a physician. In my opinion it's that I like the nursing aspect better than being a physician because when you're a physician you're always in a hurry looking at thousands of patients. You don't really have time to dedicate specific time to listen to them and understand them really for sure. You're just looking at one, two, three, four and that's it. As a nurse, you really put them together and find out what is the real problem that the person is facing.

Johnny also echoed Beatriz's feelings with his statement:

> I can tell you that *we, us as nurses,* we are more focused and more dedicated to the patients because it's not just the patient, it's everything that is around the patient. Family. Environment. Everything is much better. The medical profession

> is more focused on solving the disease and giving a treatment to that disease but just the disease. It's not around the environment…completely environment. I can see these days…that I work in an office and when I see my patients I talk to the patient and I identify everything that is around the patient and how I can do more preventive medicine from my point of view as a nurse practitioner… Those types of the things is not taught by the physician to the patient. That's my job. We're going to get to the same point which is the full recovery of the patient but he does something and I do something completely different that he doesn't spend time doing that.

Amaury put it very eloquently as he stated:

> I decided to go into that program [nursing] and the way I fulfilled my duties of taking care of people was by becoming a nurse instead of becoming a doctor [here in the U.S.]. I considered the possibility. I just didn't do it because I needed to produce money for my family. Later on, I realized that I loved the profession, I fell in love with nursing and then I decided to go into further specialty and then I went to the master's program

Because of the FEPs' struggle to be back to caring for patients, *practicing again* emerged as one of the major categories. The findings from this nontraditional set of nursing professionals as having the need to practice, to be able to make a difference by caring for others is supported by the works of Cook, Gilmer, and Bess (2003) who also stated that the nursing students they studied who were starting their nursing core courses (traditional nursing students) identified their desire to help others as a major reason for choosing nursing as a career. Within nursing the professional identity is significant to the

nursing practice. The FEPs referred to themselves as nurses and included themselves within their numbers, as is evident from the comments above.

OA indicated: "First, we love to work as a clinician—nurse practitioner—because it is what we like and it's a personal passion for each of us. Second you have to think about how to support your family too."

Dr. Brito shared: "As you said [Nan] we start at the beginning just as a way to introduce the healthcare field but then we have passion for this [nursing] because we have the caring."

The theme of needing to care for individuals as a component to nursing identity was highlighted in several studies and the early conceptualization of an identity in nursing may contribute to students' success. The notion that nursing is more caring focused, while medicine is cure focused was a factor in the FEPs' road to acculturating into the nursing profession in the United States. This difference in models of care was echoed by all participants and is supported by Ryan and McKenna (1994). Ryan and McKenna's (1994) comparative study examined the attitudes of nursing and medical students to aspects of patient care and the nurses' role in said care. This study supported the FEPs' perception and belief that medicine is focused on curing while nursing is focused on caring for the patients. All but two of the FEPs who participated in this study would choose nursing over medicine if they had to do it again. However, all FEPs expressed a desire to practice holistically and care for the entire patient versus just diagnose the disease as stated by the following comments:

OA shared:

> Even though we had the medical background which is very good, at least for me I feel very good doing nursing practice because the nursing practice here has the same focus as we have as a physician in our country. It's patient centered more than the physician. The MD is less…they see the patient and like he said prescribe and leave. We are closer to the patient, more complexity, we follow more. I like that part of the nursing practice here.

Beck (2000) utilized Colaizzi's (1978) phenomenological method to describe the meaning of nursing students' experiences of choosing nursing as a career (N = 27). The results of this study produced 107 significant statements/formulated meanings, which categorized into eight themes. This study concluded that the nursing students all had a strong need and sincere love of helping others as a major reason for choosing nursing as a career (N = 22) and their profession in nursing was as a perfect match for their desire to help and care for others which is consistent with this study. **Kikosam** had this to say about his sincere love for helping others and nursing being a perfect match for him:

> The practice of medicine in the United States is really detached from the patient. That's why I found that nursing is more aligned with what I used to do as a physician in Santo Domingo, taking care of all patient needs as a physician back then. In nursing I have the opportunity to ask the patient how are you feeling today and that has been my concern when I became a physician in Santo Domingo, making sure that the patient feels better today. You don't have that opportunity as a physician here in the United States. You may have that

opportunity as a nurse and that's why I chose nursing. That's why I feel happy being a nurse.

This category is also supported by the principle of self-efficacy, in that all participants within this study stated they had the ability to make a difference within their patients' lives, which speaks to the social cognitive career theory (SCCT) (Lent, Brown, and Hackett, 1994). The participants continuously stated their yearning to once again be caring for patients as the pushing force to enter healthcare. This desire to be practicing and working again in healthcare thrusts them to research all possible options, even some that would not have been an option in their native country: nursing. Some of the participants expressed misconceptions about entering the nursing profession initially as nursing in their native country is not seen as a profession. All participants share their need to use their medical knowledge and not let it go to waste. Most participants shared their own self-concept as never being anything else than working within the healthcare field in the future and their struggle in finally reaching their goal of caring for patients again. This desire and need to enter healthcare shapes their future and their decisions in their adopted country.

Catira said: "I think my desire to serve people, to learn more, to be able to reach more people and practice…I thought that was a great opportunity to do what I love most, help people."

Transitioning

The FEPs descriptions of their motivation for entering the nursing profession and their assumptions related to nursing both support previous research and provide implications for recruitment and retaining future FEPs within the nursing profession. The

road map of the participants transitioning into nursing professionals and the ease or lack thereof an easy transition was one of the major categories that emerged from his study. Many of the participants shared that the information needed to consider nursing an option was not easily available and the incomplete information they had was filled with misconceptions. As the participants considered nursing an option and began their transition to nursing, the opportunities, values, and beliefs of the profession were not readily shared. Many had financial responsibilities and shared they had "kids to feed" or "had to work to provide for family."

Many participants stated there was not a clear road map to learn the information needed and much time was spent researching all the options. Their transition was filled with many instances of struggle, disinformation, and hardship, but once they entered the nursing profession, they discovered their solidarity with the profession and the fulfillment of their professional goals.

Johnny had this to share about this road into the nursing profession:

> I always say that my only regret was not doing it before. It means I am completely satisfied with the nursing career at this point, and I'm sorry I couldn't do it before… If I was a properly oriented when I came here and that's the key that I think you should mention. There is a lack of proper orientation. It means because I didn't have the right orientation sadly about what to do, I waste time from 1991 until 2006, it means almost six plus nine, over ten years that I was undecided exactly what to do and finally I got it. I could have had my nursing practice done, that I just finished now in 2014 I could have been done like ten years before

because of lack of right orientation. I've been finding things stepping down and falling down. I didn't have absolutely any information.

Pedro added the following:

I do not think I had any real challenges except the fact that I did not get any guidance in my options. So, the biggest challenge I faced would have to be the difficulty I had getting into nursing. When I first came to this country I tried to become a doctor again, but it was so difficult. So many tests, so much money and I had to work to support my family. I really got into nursing by accident. I worked as coordinator at a clinic, I knew someone who worked there and they hired me because they knew I was a doctor and I coordinated care for patients with therapy and stuff. I liked it but it was not being a doctor. I wanted to get back into patient care but did not know how. I already told you how I learned of the nursing program. I was lucky because I was able to put my medical knowledge and what I learned in the clinic into nursing. I was able to get back to patient care

Many of the participants described how they wasted many years trying to pass the medical entrance exams, while still having many family responsibilities causing their transition to suffer. The participants conveyed that once the information about nursing as a second career was gained transitioning into nursing professionals was easier than that of transitioning to become a medical doctor in the United States.

Nan shared the following:

My experience is a little different. I have been a medical doctor in my country for 18 years. When I came here I did not think I could continue to do the same thing, but it was a big barrier for me, the age. When I started with step number one to

be a medical doctor here I was with the counselor, the counselor said to me, "hey do you know what would be your next step?" I said yes of course, the steps of medicine. No. It's not true for you. Do you know that you have in front of you the new students that are younger than you and they have more possibility than you? It was really really something like I was not hoping on that. He said the only possibility I can see for you is nursing. In my country nursing is at the bedside of the patient, is the person that is in charge of the walking of the patient, feeding the patient. Doing something but very limited. It was the only possibility. At this time, I did not know anything about what is was, nurse practitioner, nothing. I started doing the nursing. I don't think it was an easy transition for me because at the beginning I did not realize that it was the best way for me. It was the only one but not the best way is what I thought at the beginning. At the beginning, it was not an easy transition but yes later I saw that I had the opportunity. With nursing, I had the opportunity because being in nursing school I knew the opportunity to get my master. I did not know about that before so that's when I thought it was the best possibility to do something like I was doing in my country. I was doing the correct thing to get the same position that I was in my country. I had a family that I had to manage with children so maybe I can't do…yes you can. We can all do that. I think that it was one of the ways that led me financially to support my family.

One such study by Lily Dongxia, Willis, and Jeffers (2014) revealed that insufficient rules and resources used to recruit, organize, and develop immigrant nurses at national and healthcare organizational levels can become organizational limitations on

their adaptation to professional nursing practice and integration into the workforce in a host country. A lack of studies depict the struggle of FEPs in their transition into nursing as a second career; however, the FEPs recognized that their first year of employment was the most difficult and brought multiple challenges in dealing with cultural shock, conflict resolution, and intercultural communication while adapting their nursing knowledge and practice to the host culture. The participants shared they had to transition into their second career. Kumaran and Carney (2014) focused on role transition that had already occurred among newly qualified nurses and found that "supportive staff and good team working were identified as the most important factors is easing the transitions" (p. 610). As the FEPs transitioned and found their road map into the nursing profession, they stated they had a lack of support. Kumaran and Carney (2014) stated that during the transition period:

> There are disconnections from previous social connections and supports, absence of familiar reference points, the appearance of new needs, the inability to meet old needs in accustomed ways, incongruence between former sets of expectations and those that prevail in the new situation. (p. 606).

This statement supports the participants' accounts of their transitioning into second career nurses.

Catira described some of her challenges in transforming into nursing as a second career:

> I would say probably being very busy and when you come to a different country you have to adapt. You have to help your children grow healthy by all means. They were little. My little one was two years old and my oldest was seven. I really

> was very busy, and I had a full-time job, so I try to study with all those barriers. I had a lot of motivation, but I couldn't make it. It was overwhelming.

Sam's statements bring to life that transformational period of finding the road map and transforming into a second career nurse:

> I came from Nigeria in 2005. In the beginning I tried to take the test; the medical boards test and the TOFL then I did not pass. I tried again—I wasted a lot of money and I really had to work hard: the studying, working as a valet parker and in the hospital as a nursing assistant. This was very hard for me because all I knew to do was be a doctor… was be in healthcare… I was lost for a while.

Many of the participants expressed that in their research, once nursing had been identified as an option as a second career, they felt a sense of relief. All participants stated they had more prospects within the nursing profession than other possibilities as a foreign physician.

OA also stated:

> I agree with your ease of transition, that it was easier for us to transition into the nursing profession, we got more opportunity and we were all having to support our families in a new country. The road map like everyone has said could have been easier- but once we figured it out it made a lot of sense as it, nursing is very close to what we were doing in our country

The motivating factors to enter nursing shared by the FEPs were supported by several studies. In Kelly, Shoemaker, and Steele's (1996) study, the participants described a wide assortment of pragmatic as well as more selfless reasons which included the prospect of finding employment, job opportunities and flexibility, diversity,

proficiency, autonomy, and the wish to help people. These sentiments were echoed by the FEPs in this study.

Maria made this statement:

> I think in my case it was that I needed to do the quickest way to get into healthcare. If I would have gone and tried to take all the exams and then move forward there was no definite, chance to get a residency. I tried one time, took the test and failed. I needed assurance of a job when I finished school and if I had gone that route, I had no guarantee. The fact I needed to support my family it made me think and really think about deciding to take the medical board exams and then apply for residency with the hopes to get it. I felt that nursing was more secure for my family and me.

Pablo added:

> I came with my family, it really was not an option as I knew it could take a long time to pass the boards. I knew it would be very difficult for me as I had a family to support. I thought about the nursing career when I saw a commercial on TV. Then I started to research the options and I told myself "take the option of nursing."

Beatriz shared:

> When I came in at first, I tried to take the test; the medical test and then I missed by like two points. This is the time when they had the nursing shortage and all I know how to do is healthcare, so I said okay let me try nursing. I have to add that at the time I already had my children and I needed to work. I can't just sit down and wait to pass the exam. I needed money to take care of them and I saw that the

opportunity was right there for me to get a good job; something that I like to do. That's it.

Elibol and Harmancı Seren's (2017) study included 352 nursing students who were selected from four medical vocational high schools in Istanbul. A demographic questionnaire and the "Nursing Image Scale" (NIS) were used for gathering data. The data analysis consisted of independent sample t-test and chi-square tests. The authors reposted the average age of the students was 16.7±0.785, with most of the students being female at 87.2% and in their fourth year of their academic studies at 42.6%. The results of this study support what the FEPs shared. Most of the students had chosen nursing for the *ease* of guaranteeing a job at 46.9%.

As individuals transition within their social contexts they go through evolutions, which involve a person's response through a passageway of time. A transition emerges during time and includes change and acculturation, for instance developmental, individual, social, situational, group or environmental, but not all change involves transition (Meleis et al., 2000). People experience transitions when they need to acclimate to new situations or circumstances to integrate the change event into their lives (Schumacher & Meleis, 1994).

Reconciling

The participants voiced a sense of finding their place and reconciling their previous role as a medical doctor to their current professional nursing one. They shared how they wanted to care for the entire patient holistically, as this was the only profession they know. Professional socialization is documented as an active process of understanding a professional role that is subjective by an assortment of experiences over

time (Davis, 1975; Olesen & Whittaker, 1970). Professional socialization by characterization is more detailed to the recognized progression of learning values, attitudes, and behaviors essential to accomplish professional roles that begins during formal instruction. As these FEPs transitioned, they reconciled their previous role as medical doctors to the current one of a professional within the nursing profession. The final goal of nursing education is to impart on the student the ability to reason and behave like a nurse, to perceive the health care organizations via the lens of nursing and to answer to the effects of both educational and clinical experiences by allowing professionalism to emerge.

The participants' reconciliation between their previous career and their newfound nursing profession represented the end to a long journey. **Amaury** shared how his practice started to reconcile to his new profession of nursing:

> I started looking at all the patients trying to get a diagnosis… a medical diagnosis and trying to get the medication that patient needed and then probably thinking about the possibility of continuing services out of the place. As a nurse, you never do this approach. You care for the patient…feeling well feeling better within your hours of service. Specifically, when I went to my practice hours…my clinical hours it was a bit of a shock. I was wondering what is this patient doing here, why is this patient not being taken care of at home? Like a doctor would say. As a nurse, I would find many many needs for these patients and that was difficult for me to do this transition. Fortunately, I had a professor who really took care of me and then she started to show the way that I was setting a care plan was totally wrong because I was not thinking with diagnosis, with real problems like nurses

do. I was just thinking about the illness process the patient has, as doctors do. That was the difficult transition, to stop thinking…making medical diagnosis and really going into what are the problems and needs of the patient which is what nurses do…Yeah specifically with the respiratory conditions, a lot of times I'm thinking that those conditions could be managed by probably receiving a bronchial medication and an antibiotic medication, and some kind of respiratory treatments just so the patient can be discharged and continue working on their treatment at home. Several times I wonder why is this patient here? This patient has a lot of risks, a lot of risks for upper infections, risk for like bad lungs that the patient…would complicate under any other conditions, but that is because I was thinking still as a doctor. When you start thinking about the real needs of that patient, what are the conditions at home, that patient is probably not in the best. Probably they are in an environment that give them more difficulty breathing and getting treatment is very difficult. They don't have the company that they need to get the treatment at times etcetera. As a nurse, you have that perspective because you start thinking of the big picture and that's how you really help those patients. A lot of times Nora I find myself thinking about as a doctor what would I do for this patient. What medication I would provide for that patient. Sometimes I question the treatments that are ordered by physicians because I think another treatment would be better, would work better for a patient. Yeah there's a lot of situations where I still…after almost thirteen years doing this a lot of the times I still think about why this patient is not receiving the treatment that I think is the best. Then I have to get used to the fact that I'm a nurse practitioner now. As a

> nurse practitioner, you have to use both, you are the nurse but at the same time you have to come to the medical model and just try to accommodate the patients' medications and treatment the best way possible. Actually, I'm doing both things at the same time.

Results from this study supported Purnell's (2009) identified themes of struggle, discovery, hope, humility, and spirituality. Purnell (2009) evaluated 99 studies performed from 2003 to 2008 in order to evaluate the current nursing research on caring. The author accomplished this by asking patients, students, nurse administrators what caring means and how it can be improved; measured and evaluated. The FEPs identified that their desire to care for the patient holistically, completely as an indispensable attribute of their nursing profession and as the emphasis of their subsequent reconciliation of nursing actions. The FEPs referred to the care they gave patients as *hybrid* in nature as they had the best of both worlds: their past medical knowledge with their newfound nursing profession to be able to care for the patients as they should be. **Halo** stated:

> I have the best of the two worlds. I can have the caring for the patient of the nurses and I can have the practicality and the get to the point of the physicians and let's resolve the issue. I think it's that. To be able to think in the two ways and to understand this is the key. This is great to be able to work with the different professionals. It is a different relationship than the one that the pure NP has with the physicians than the one I can have with the physician or the one that I can have with the nurses. I can understand the two feelings, the different worlds. It makes it easier to interact with the different professionals…To see a patient…like in the holistic way. A patient with a family, a patient with an environment, a

patient with education. I mean the duty that the nurses have to educate patients is huge and we…I mean physicians don't put too much attention to that

Sam referred to his reconciliation process in this fashion:

I consider it is a little bit of the two perspectives because as a nurse, you have more time with the patient to listen, sit, and talk to them. You get to really find out where they are coming from. As a nurse, we have time to understand them, and as a doctor if you see something wrong, if they have symptoms you can straightaway identity those symptoms and escalate it. I use my medical knowledge to help me as a nurse… I suppose I just had to think about what I was now- a nurse. And look at the nursing part and see the good parts of nursing. That helped me. I did not think I would like being a nurse and now a nurse practitioner but I really like it… As the physician in Nigeria where I worked for 10 years as a family doctor I would come and see the patient and send them to have tests and then see what came back and order medications or more tests. Sometimes I could sit and talk to them more- but not many times. I was the only doctor for a very large area and I had many patients to see every day. Today, I like it much better, I see the patient and still order tests and everything, but I can come in and sit down and I ask them about 'them', how they are doing outside of their disease about their lives. When I first started nursing, I remember a professor telling me 'your patient is more than a disease' and that is the way I see it. I learned to be an advocate for the patient and you will tell the physician can you please do a different tactic, like maybe calling in a consult with another doctor, a specialist, or maybe a social service to help that patient at home, or to get medicine, or help.

> Nursing is being a teacher, a helper, an advocate for the patient, giving more than just a prescription or a test.

Dr. Brito stated:

> We consider that we are a hybrid professional… we start at the beginning just as a way to introduce the healthcare field but then we have passion for this because we have the caring that the nursing field has that is not the same that we as medical doctors provide. That is the holistic approach which the most important thing that we as medical doctors found in this profession. In other words, summarize as I said I 100% agree with those comments that you have here [about the found their place category].

The participants recognized how they wanted to care for patients and how their current second career within the nursing profession gave them that opportunity. They shared how contradictory being a medical doctor was in their country for most when equated to a medical doctor in the United States. The participants communicated how they related to the *novelty* of the patient being more than a diagnosis, a disease. In their acculturating pathway to practice they realized and rejoiced that the nursing profession gave them the opportunity to care for the patients holistically, completely. Most participants admitted to having misconceptions about nursing being considered a *profession* with autonomy and their own knowledge base: something very different when compared to their native countries.

C had this to say about the reconciling:

> It can be easily replaced as a hybrid practitioner which is what we are. It comes down to we accept that we are nurses, but nobody can deny that we may have

> more knowledge than your regular nurse. When we practice we practice with the nursing scope of practice but always knowing something else…Funny because when I finished physician and medical school I remember my graduation I said this is it, this is all I'm going to do. I was concerned that I was trained to go to the hospital, assess patients, make diagnosis, write down the prescription and leave. I was concerned what happened to that prescription? Did that patient receive that prescription? Where did that prescription go to? As nurses yeah, you're practicing and you're receiving the order but you're actually carrying out the order, so you know it's continuing. Somehow when you practice as nurses it compliments that role of physician that stops when you write down the prescription. You actually give it to the patient and you actually monitor the patient after giving that medication and then you know if it's getting better or worse. That's why I believe it's true that it is growing bigger and bigger the spiral [referring to the depiction of the conceptual model] because you are complimenting knowledge with practice and you see the whole process from beginning to end.

The *acculturating pathway to practice* allowed the participants to articulate their transition, socialization, and acculturation into the nursing profession with a respect and admiration for the profession. What is interesting to note is that the findings of this study correlate with that of the traditional students. The FEPs shared the same need to care and practice for the patients following the nursing tradition of providing holistically patient centered care.

Relationship of the Theory as It Relates to Contingency Theory of Socialization

Acculturating pathway to practice resonates closely with the contingency theory of socialization. Socialization is the progression by which persons acquire social rules and turn into contributors of groups (Blais & Hayes, 2015). It involves learning to conduct oneself in a manner that is consistent with the actions of other persons residing in the similar role. "The goal of professional socialization is to internalize a professional identity that includes the norms, values, attitudes, and behaviors of the profession" (Blais & Hayes, 2015, p. 22). "Professional socialization transmits values, norms, and ways of viewing a situation that are unique to the profession and provide a common ground that shapes the ways in which work is conducted" (Blais & Hayes, 2015, p. 17). This common ground enables the members to effectively communicate; therefore, the socialization process yields the formation of "an individual's professional identity, the self-view as a member of a profession with the requisite knowledge, skills, responsibilities, and obligations" (Blais & Hayes, 2015, p. 17). Role socialization is influenced by the manner in which the role is conceptualized, and nurses educated at various levels may not have common values, language, or a common understanding of the multiple roles of the professional nurse: interprofessional team member, educator, mentor, and research scientist (Blais & Hayes, 2015). Consequently, nurses may have diverse viewpoints relative to what constitutes professional practice.

The definitive objective of professional socialization is to advance a professional identity, whereby each of these qualities turn into a portion of a nurse's personal and professional self-image and behavior (Haynes et al., 2004). Professional socialization is the outcome of contact with various socialization agents who are the persons beginning

the socialization process (Blais et al., 2006). As a consequence of professional socialization, students' predetermined values are substituted with the values of the nursing profession. The transformation in an individual's values will consequently end in a modification in comportment and attitudes. Finally, a person's self-concept is altered with the end product of that growth being a professional identity (Blais et al., 2006; Creasia & Parker, 2007).

The participants in this study were all in accord that their road led them to a better place and that they were in a profession where their past medical knowledge was being applied. The participants all recalled their struggle in discovering which path would take them to their goal of caring for patients again in their adopted countries and the lack of appropriate information to reach that goal. The participants shared how they had transitioned and socialized to their new profession, a profession they stated gave them the opportunity to care for patients again in a holistic manner. They referred to themselves as nurses and wanted to be included within their numbers as they reconciled their two roles (their previous one as a medical doctor and their current one as a nursing professional).

The actions exhibited by these participants closely align themselves with the contingency theory of socialization. This seminal research developed a model that conceptualized the socialization process outlining the phases of socialization, the actions engaged in each stage in the process, and potential effects of the socialization experience (Feldman, 1976).

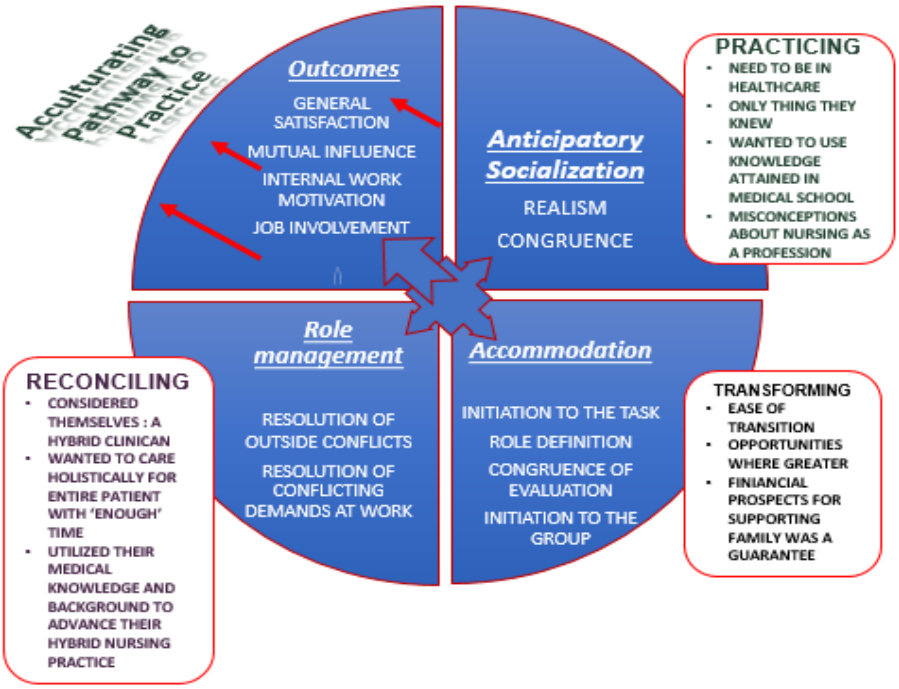

Figure 4. Hernandez-Pupo's (2018) representation of process and outcome variables of socialization adapted from Feldman (1976).

According to Feldman (1976), the model clearly conceptualizes the socialization process. It distinguishes the stages of socialization, the actions involved in at each stage in the process, and probable results of the socialization experiences. The research also discussed the empirical evidence that confirmed which variables effect whether individuals continue through socialization easily and achieve outcome of the process (Feldman, 1976).

Feldman (1976) described that there were several assumptions about the causal order of variables in developing a contingency model of socialization (Figure 4). Initially, anticipatory socialization consists of two process variables: realism and congruence. Realism is related to the extent to which individuals have a complete and accurate picture of what the organization is like. Congruence, on the other hand, is

related to how effective the individuals have been in making choices about their occupation. The information needed to consider nursing an option was not readily available and the limited information was filled with misconceptions. Many stated there was not a clear road map to discover the information needed and much time was spent researching all the options. Subsequently, accommodation is the second stage and the period in which the individual sees what the organization or employment is truly like and tries to become a contributing member of it. There are four process variables in this stage: initiation to task, initiation to the group, role definition, and congruence of evaluation. These four main activities entail the socialization of the individuals as they engage learning new tasks, establishing new interpersonal relationships with coworkers, clarifying their roles within the organization, and evaluating their progress in the organization. As the information about nursing as a second career was gained transforming into nursing professionals was easier than that of transitioning to become a medical doctor in the United States. Many of the participants expressed that in their research of nursing as an option as a second career, they felt a sense of relief at knowing what was to come. The third stage is role management. During this stage, the individual has to reconcile conflicts between their work group and other groups, which may put strains on them. The participants reconciled between their previous medical career and their newfound nursing profession. They recognized the difference between how they wanted to care for patients and how their current second career within the nursing profession gave them that opportunity. Finally, only those procedure variables of the role management stage are presumed to affect the attainment of outcomes. The participants

managed their new role and where able to appreciate the difference from being a medical doctor in their country and a nursing professional in the United States.

Within the contingency theory of socialization progress is determined to be effective at any time if individuals can continue in obtaining more proficiency in the activities or settling the conflicts of their current stage. Conversely, if this person is individually not capable or organizationally inhibited from attaining progress at a specific stage, then this individual's socialization is not successful (Feldman, 1976). In the model of *acculturating pathway to practice*, the three concepts *practicing, transitioning, and reconciling* must work in unison for the participants to reach practice acculturation.

Significance of the Study

The present study led to an increase in the body of knowledge and in the understanding of socialization and factors that relate to it from the perspective of FEPs entering the nursing profession as a second career. This new knowledge can be used to make interdisciplinary connections between other professions that are experiencing individuals transitioning as second career. Interdisciplinary and varied disciplinary professions would benefit from the knowledge obtained in designing their orientation within their varied workforce to allow these second career individuals to make connections within the new discipline, among contents and situation within their current life, and between their learning and experiences. This grounded theory study provided a theoretical framework of the acculturating pathway to practice, which is the initial step toward testing a theory that could potentially explain and assist multiple disciplines to better understand the importance of socialization of individuals to their new professions.

Significance to Nursing

Changing professions is a normal incidence in today's global economy and market. To adapt to midlife career change individuals must make changes in their "cognitive, emotional, and behavioral realms" (Barclay et al., 2011, p. 388). Nursing is a lively profession where new knowledge and progressing roles require constant adaptation. Consequently, professional socialization, like knowledge is constant, collaborative, and lifelong process (Conway, 1984). Examining the relationship between these FEPs successful socialization/transition to nursing is an important process, it is possible to develop a professional identity. The literature surrounding FEPs and their socialization and transition to nursing is limited. This prominent study describes the current factors that impact FEPs as they practice within the nursing profession as a second career. Based on the findings, it is recommended that nurse leaders take proactive actions in developing resources and initiating activities that will facilitate positive intergroup interactions between the FEP nurse professional and the traditional nurse professional and prepare nurses with leadership in multicultural, interdisciplinary patient care teams. The role advancement of all nurses is a significant component of their success as nurses, and as health care becomes more global the FEP numbers within the profession is likely to increasing. All nursing professionals influence the profession and it is important that the contributions of all nurses be considered, including second-career.

Implication for Nursing Education

The education of nurses today must prepare them for a progressively complex and changing society and may require an assortment of educational experiences in areas not instructed in the current curricula. Nurses that have socialized effectively into the

nursing profession are more flexible when faced with changes in their roles. Recognizing that current curricula may lack content in areas foundational to nursing socialization, role socialization, is another implication of this study in that courses should be developed for students throughout their curriculum with information related to professional socialization, transitions to the nursing profession, and professional identity. In addition, nursing education must consider factors that motivate the sense of fitting in and professional identity in nursing as this could have a distinct influence on professional socialization.

Implication for Nursing Practice

The information obtained from this grounded theory study added to the scarcity of knowledge that exists on FEPs and their socialization process and struggles in entering nursing as a second career. This study helped in filling the gaps of how FEPs developed within the nursing role. Employment permanence and the choice to remain in the profession can be affected when socialization to the profession is undermined. Successful role transition and acculturation to practice is important for FEPs practicing within a professional nursing role to become efficient and effective providers as confidently as possible. Barnes (2015) noted that poor transition experiences result in nurse practitioners leaving positions. With the knowledge from the *acculturating pathway to practice*, educators and organizational educators and leaders could modify clinical prerequisites and assignments in preparing FEPs for practice. The utilization of orientation programs may well direct to the creation of settings that are most suitable to assist the FEPs during role socialization and role transition. Appreciating the difference between the transition of a second career FEP to that of a traditional nurse professional is

significant because these FEPs may vary in their needs for support during the transition period.

Implication for Nursing Research

The critical factors that influence how FEPs are practicing within the nursing profession were absent from the current nursing knowledge; however, the results from this study presented the theoretical framework of *acculturating pathway to practice* as the active process to describe these critical factors. This framework needs to be tested and further explored with a larger, more diverse study population to significantly confirm its categories. Further research to develop teaching strategies to promote competence and stimulate investigations of best-practice strategies to support the FEPs' socialization, acculturation, and practice within the nursing profession would benefit the profession.

Implication for Health/Public Policy

Health care is becoming more global, and the number of FEPs as second-career nurses are increasing; many educational institutions are competing for government and private funds for their academic programs. Enhancing socialization and collaboration is especially important as the health care systems respond to the changing demographics of the nursing population and introduces new models to meet the growing complexity of nursing shortage. Intervening earlier, through early professional socialization initiatives and policies can address some the issues that may arise and help the healthy acculturation to practice of the FEPs. Currently, there are no substantial health policy assisting the FEPs who wish to enter nursing. The policies currently in place are of immigration and visa requirements. It is the responsibility of health/public policy to promote a culture of inter-professional respect and collaboration during early socialization that extends to

educational and practice environments. The creation of policies to aid in the education and recruitment of these professionals would improve the overall health of the U.S. patient.

Strengths and Limitations

Every study has strengths and limitations. One of the greatest strengths of this study was that the researcher allowed the voices of the participants to speak, to provide rich, descriptive data that served to allow the theoretical framework of *acculturating pathway to practice* to emerge. Maintaining theoretical sensitivity and ensuring research rigor added to the strength of this study. Memoing and reflexive journaling throughout the data collection and analysis ensured conformability. The researcher accomplished continuous comparative analysis of data characteristics in the grounded theory design, which assisted the researcher to shift from identifying patterns to a conceptual level and then to a level of abstraction. This rigor of the grounded theory analysis is one of the strengths of this study. Themes in this study were saturated after 12 interviews, and the researcher verified themes as she interviewed five more participants, for a total of 17 in phase I. The basic social process was also verified by an expert focus group panel of participants. Member checks were conducted with every participant. The researcher also sought the counsel of the dissertation chair and committee members as needed. The utilization of a focus group enhanced credibility. Corroboration of the results of this study where sought in the literature.

Limitations of this study include limiting the study to the South Florida region, and the participants had varying years of professional nursing experience. With increasing years since their socialization and transition to nursing, some participants may

not accurately remember their nursing role transition/acculturation experiences and may have forgotten the positive or negative aspects of their practice acculturation. A limitation may be that the participants may refuse to answer certain questions and may not be completely truthful when they do answer. The fact classical grounded theory may not have been the best-grounded theory approach to investigate the phenomenon of interest may also be a limitation. The study being conducted by a novice researcher may be a limitation. The researcher not having control of who volunteers to participate in the study may be a limitation to the study and a small sample size. Another limitation of the study may be not utilizing grounded theory methodology to its fullest potential, such as the fact that no direct observations of the participants were conducted by the researcher. The literature review

Recommendation for Future Study

All students, regardless if they are entering nursing as a second career, should expect nursing education that prepares them to successfully socialize into the profession. Socialization into a professional role is affected by how the individual understands and assimilates the norms, values, and traditions of that discipline. Second career students, such as FEPs, experience unique challenges in adapting to their new role within the nursing profession. Understating the key factors influencing this transition process is important to facilitate their acculturation into their nursing practice. This study produced a theoretical framework— *acculturating pathway to practice* — that emerged from this study using classical grounded theory method. The subsequent step for this researcher is to test this theoretical framework. This may be done by utilizing already developed instruments that will test the concepts that explain the *acculturating pathway to practice*,

which consists of *practicing, transforming, and reconciling*. The future studies should include larger groups of FEPs from different parts of the country and utilize different research designs to be able to investigate these factors in bigger detail.

Conclusion

The principal aim of this study was to explore the critical factors that influenced the attitudes, beliefs, and perceptions of foreign-educated physicians (FEPs) who had entered nursing as a second career. Classical or Glaserian grounded theory design was utilized to answer the research questions and allow the theory to emerge from the data. Purposive, snowball sample of 17 individual participants who met the inclusion criteria was used in Phase I of the study. A focus group consisting of five doctorate-prepared FEPs who met the inclusion criteria was used to provide theoretical verification of the categories which emerged from the analysis of the data in phase I interviews. Three main categories emerged from the data: *practicing, transforming, and reconciling.* These categories where supported by the literature. *Acculturating pathway to practice* emerged as the social process describing the overall phenomenon of interest. Strengths and limitations of the study were noted. Implications for nursing education, practice, research, and health/policy were considered. Suggestions for future research were proposed.

REFERENCES

American Association of Colleges of Nursing (AACN). (2016a). Page name. Retrieved from http://www.aacn.nche.edu/education-resources/bsn-article

American Association of Colleges of Nursing. (2016b). Nursing shortage. Retrieved from http://www.aacn.nche.edu/media-relations/fact-sheets/nursing-shortage

American Nurses Association. (2018). Page name. Retrieved from http://www.nursingworld.org/EspeciallyForYou/Whatisnursing

Annelis, M. (1997). Grounded theory method, part I: Within the five moments of qualitative research. *Nursing Inquiry*, *4*, 120-129.

Barclay, S. R., Stoltz, K. B., & Barry Chung, Y. (2011, September). Voluntary midlife career change: Integrating the transtheoretical model and the life-span, life-space approach. *The Career Development Quarterly, 59*, 386-399.

Barnes, H. (2015). Exploring the factors that influence nurse practitioner role transition. *Journal for Nurse Practitioners, 11*(2), 178-183. doi:10.1016/j.nurpra.2014.11.004

Beck, C. T. (2000). The experience of choosing nursing as a career. *Journal of Nursing Education*, *39*(7), 320-2. Retrieved from https://search-proquest-com.contentproxy.phoenix.edu/docview/203948096?accountid=134061

Benoliel, J. (1996). Grounded theory and nursing knowledge. *Qualitative Health Research*, *6(3*), 406-428.

Berry, J. W. (1980). Acculturation as varieties of adaptation. In E. A. M. Padilla (Ed)., *Acculturation: Theory, models, and some new findings* (pp. 9-25). Boulder, CO: Westview.

Blackwell, W. (2014). *The handbook of language socialization*. In A. Duranti, E. Ochs, & B. Schieffelin (Eds.). Malden, MA: John Wiley and Sons.

Blais, K. K., & Hayes, J. S. (2015). *Professional nursing practice: Concepts and perspectives* (7th ed.). New York: Prentice Hall.

Blais, K. K., Hayes, J. S., Kosier, B., & Erb, G. (2006). *Professional nursing practice: Concepts and perspectives* (5th ed.). Upper Saddle River, NJ: Pearson Education.

Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Englewood Cliffs, NJ: Prentice-Hall.

Blumer, H. (1986). *Symbolic interactionism: Perspective and method*. Berkeley and Los Angeles, CA: Univ. of California Press.

Brown, D. (1995, September). A values-based approach to facilitating career transitions. *The Career Development Quarterly*, *44*(1), 4-11.

Bureau of Labor Statistics. (2012). Occupations with the largest projected number of job openings due to growth and replacement needs, 2012 and projected 2022. Retrieved from http://www.bls.gov/news.release/ecopro.t08.htm

Bureau of Labor Statistics. (2015). Occupational handbook: Registered nurses. Retrieved from https://www.bls.gov/ooh/healthcare/registered-nurses.htm

Bureau of Labor Statistics. (2017). Number of jobs, labor market experience, and earnings growth among Americans at 50: Results from a longitudinal survey. Retrieved from https://www.bls.gov/news.release/pdf/nlsoy.pdf

Burke, P. J. (2006). Identity change. *Social Psychology Quarterly*, *69(1*), 81-96. http://dx.doi.org/204.51.69.243

Charmaz, K. (2006a). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage.

Charmaz, K. (2000b). Grounded theory: Objectivist and constructionist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (2nd ed., pp. 509-533). Thousand Oaks, CA: Sage.

Charmaz, K. (2000c). *Grounded theory, objectivist and constructivist methods*. Thousand Oaks, CA: Sage.

Clausen, J. A., & Social Science Research Council (U.S.). Committee on Socialization and Social Structure (1968). *Socialization and society*. Boston, MA: Little, Brown.

Conway, M. E. (1984). Socialization and roles in nursing. *Annual Review of Nursing Research*, *1*, 183-208.

Creasia, J. L., & Parker, B. J. (2007). *Conceptual foundations: The bridge to professional nursing practice* (4th ed.). St. Louis, MO: Mosby Elsevier.

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five traditions* (3rd ed.). Thousand Oaks, CA: Sage.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Thousand Oaks, CA: Sage.

Davis, F. (1975). Professional socialization as subjective experience: The process of doctrinal conversion among student nurses. In C. Cox & A. Mead (Eds.), *A sociology of medical practice* (pp. 116-131). London: Collier McMillan.

Dela Cruz, F. A., Faar, S., Klakovich, M. D., & Esslinger, P. (2013). Facilitating the career transition of second-career students into professional nursing. *Nursing Education Perspectives*, *34*(1), 12-17.

Denzin, N., & Lincoln, Y. (2005). *The SAGE handbook of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.

Duska, R. F. (1974). *Moral Development Guide to Piaget and Kohlberg* (1st ed.). Mahwah, NJ: Paulist Press.

Dwyer, S. (1999). Reconciliation for realists. *Ethics and International Affairs, 13*, 81-98.

Elibol, E., & Harmancı Seren, A. K. (2017). Reasons nursing students choose the nursing profession and their nursing image perceptions: A survey study. *Nursing Practice Today*, *4*(2), 67-78.

Encyclopedia.com. (2003). Role theory. Retrieved from http://www.encyclopedia.com/doc/1G2-3406900365.html

Encyclopedia.com. (2003). Symbolic interactionism. Retrieved from http://www.encyclopedia.com/topic/Symbolic_Interactionism.aspx

Encyclopedia Britannica. (2015). Socialization Retrieved from http://www.britannica.com/topic/socialization

Encyclopedia Britannica. (2016). Pragmatism. Retrieved from http://www.britannica.com/topic/pragmatism-philosophy

Fain, J. A. (2004). *Reading, understanding, and applying nursing research* (3rd ed.). Philadelphia, PA: F.A. Davis.

Feldman, D. C. (1976, Sept.). A contingency theory of socialization. *Administrative Science Quarterly, 21*(3), 433-452. Retrieved from http://www.jstor.org/stable/2391853

Finlay, L. (2002). Outing the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research, 12,* 531-545. http://dx.doi.org/Retrieved from

Florida Center for Nursing. (2013). The Florida nursing shortage. Retrieved from http://www.flcenterfornursing.org

Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian and New Zealand Journal of Psychiatry, 36*, 717-732.

Fowler, M. D. (2015). *Guide to the code of ethics for nurses with interpretive statements* (2nd ed.). Silver Springs, MD: American Nurses Association.

Guillemen, M., & Gillam, L. (2004). Ethics, reflexivity, and ethically important moments in research. *Qualitative Inquiry, 10,* 261-280. http://dx.doi.org/10.1177/1077800403262360

Given, L. M. (2008). *The Sage encyclopedia of qualitative research*. Thousand Oaks, CA: Sage.

Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. Mill Valley, CA: Sociology Press.

Glaser, B. G. (1992). *Basics of grounded theory analysis: Emergence vs. forcing*. Mill Valley, CA: Sociology Press.

Glaser, B. G. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley, CA: Sociology Press.

Glaser, B. G. (2001). *The grounded theory perspective: Conceptualization contrasted with description*. Mill Valley, CA: Sociology Press.

Glaser, B. G. (2003). *The grounded theory perspective II: Description's remodeling of grounded theory methodology*. Mill Valley, CA: Sociology Press.

Glaser, B. G., & Strauss, A. (1967). *The discovery of grounded theory: An approach to qualitative research*. Chicago, IL: Aldine Publishing Company.

Gordon, M. (1964). *Assimilation in American life*. New York, NY: Oxford University Press.

Grbich, C. (2013). *Qualitative data analysis: An introduction* (2nd ed.). Thousand Oaks, CA: Sage.

Grossman, D., & Jorda, M. (2008). Transitioning foreign-educated physicians to nurses: the New Americans in nursing accelerated program. *Journal of Nursing Education*, *47*(12), 544-551.

Haynes, L., Butcher, H., & Boese, T. (2004). *Nursing in contemporary society: Issues, trends, and transition into practice*. Upper Saddle River, NJ: Pearson Education.

Higginbottom, G., & Lauridsen, E. I. (2014, May). The roots and development of constructivist grounded theory. *Nurse Researcher*, *21*(5), 8-13.

Hirsch, A. K. (2011). Fugitive reconciliation: The agonistics of respect, resentment, and responsibility in post-conflict society. *Contemporary Political Theory*, *10*(2), 166-189.

Holton, J. A., & Walsh, I. (2017). *Classic grounded theory: Applications with qualitative and quantitative data*. Los Angeles, CA: Sage.

Hurrelmann, K. (1988). *Social structure and personality development: The individual as a productive processor of reality*. Cambridge, UK: Cambridge University Press.

Inkeles, A. (1968). Socialization and society. In J. A. Clausen (Ed.), *Society, social structure, and child socialization* (pp. 74-125). Boston, MA: Little, Brown, and Company.

Kedrowicz, A. A., Fish, R. E., & Hammond, S. (2015). Relationship between anticipatory socialization experiences and first-year veterinary students' career interests. *Journal of Veterinary Medical Education*, *42*(1), 18-27. http://dx.doi.org/10.3138/jvme.0814-483R

King, N., & Horrocks, C. (2010). *Interviews in qualitative research*. Thousand Oaks, CA: Sage.

Kohn, P., & Truglio-Londrigan, M. (2007, September). Second-career baccalaureate nursing students: A lived experience. *Journal of Nursing Education*, *46(9*), 391-399.

Kumaran, S., & Carney, M. (2014). Role transition from student nurse to staff nurse: Facilitating the transition period. *Nurse Education in Practice, 14*(6), 605-611. doi:10.1016/j.nepr.2014.06.002

Langley, A. (1999). Strategies for theorizing from process data. *Academy of Management Review*, *24*(4), 691-710.

Laurent, J. S. (2015). The pathway to making change: How parents promote health for their overweight or obese child. In M. De Chesnay (Ed.), *Nursing research using*

grounded theory: Qualitative designs and methods in nursing (pp. 29-73). New York, NY: Springer.

Leddy, S. K. (1998). *Conceptual bases of professional nursing* (4th ed.). Philadelphia, PA: Lippincott-Raven.

Lent, R. W., Brown, S. D., & Hackett, G. (2000). Contextual supports and barriers to career choice: A social cognitive analysis. *Journal of Counseling Psychology, 47*(1), 36-49. http://dx.doi.org.contentproxy.phoenix.edu/10.1037/0022-0167.47.1.36

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

Lincoln, Y. S., & Guba, E. G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 163-188). Thousand Oaks, CA: Sage.

MacIntyre, R., Murray, T., Teel, C., & Karshmer, J. (2009). Five recommendations for pre-licensure nursing education. *Journal of Nursing Education, 48*, 447-453.

McEvoy, P., & Richards, D. (2003). Critical realism: A way forward for evaluation research in nursing? *Journal of Advanced Nursing, 43*, 411-420.

Encyclopedia.com. (1968). Mead, George Herbert. Retrieved from http://www.encyclopedia.com/doc/1G2-3045000787.html

Meleis, A. I. (2007). *Theoretical nursing: Development and progress* (4th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Meleis, A. I. (2010). *Transitions theory: Middle-range and situation-specific theories in nursing research and practice*. New York, NY: Springer.

Meleis, A., Sawyer, L., Im, E., & Schumacker, K. (2000). Experiencing transitions: An emerging middle-range theory. *Advances in Nursing Science, 23(1*), 12-28.

Mondal, P. (2015). Top 3 important concepts related to socialization. Retrieved from http://www.yourarticlelibrary.com/sociology/top-3-important-concepts-related-to-socialization/35086/

Moreland, R. L., & Levine, J. M. (1982). *Socialization in small groups: Temporal changes in individual-group relations*. New York: Academic Press.

Munhall, P. L. (2012). *Nursing research: A qualitative perspective* (5th ed.). Sudbury, MA: Jones & Bartlett Learning.

National Health Policy Forum. (2001). Nurse workforce: Condition critical. Retrieved from http://www.nhpf.org/library/Topics/cfm/Workforce

National League for Nursing. (2007). Core values. Retrieved from http://www.nln.org.aboutnln/corevalues.htm

Ochs, E. (1988). *Culture and language development: Language acquisition and language socialization in a Samoan village*. Cambridge, UK: Cambridge University Press.

Olshansky, E. F. (2015). Overview of grounded theory. In M. De Chesnay (Ed.), *Nursing research using grounded theory: Qualitative designs and methods in nursing* (pp. 1-8). New York, NY: Springer Publishing.

Pascual, H., Marcaida, R., & Salvador, V. (2005). Reasons why Filipino doctors take up nursing: A critical social science perspective. *Philippine Journal of Nursing*, *75*(1), 2-12.

Pitkala, K. H., & Mantyranta, T. (2003). Professional socialization revised: medical students' own conceptions related to adoption of the future physician's role – A qualitative study. *Medical Teacher, 25(2*), 155-160.

Poblete, J. (2007). *Masculine maneuvers: Filipino nursing-medics and the American dream* (Unpublished undergraduate research). University of California at Berkeley, Berkeley, CA.

Polit, D. F., & Beck, C. T. (2006). *Essentials of nursing research: Methods, appraisal, and utilization* (6th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Purnell, M. J. (2009, April). Gleaning wisdom in the research on caring. *Nursing Science Quarterly, 22*(2), 109-115.

Radzik, L., & Murphy, C. (2015). The Stanford encyclopedia of philosophy. In E. N. Zalta (Ed.), *Reconciliation*. Retrieved from https://plato.stanford.edu/archives/sum2015/entries/reconciliation

Rotherman, M., & Phinney, J. (1987). Introduction: Definitions and perspectives in the study of children's ethnic socialization. In J. Phinney & M. Rotherham (Eds). *Children's ethnic socialization: Pluralism and development* (pp. 10-28). Beverly Hills, CA: Sage.

Ryan, A. A., & McKenna, H. P. (1994). A comparative study of the attitudes of nursing and medical students to aspects of patient care and the nurse's role in organizing that care. *Journal of Advanced Nursing, 19*, 114-123.

Schumacher, K., & Meleis, A. (1994). Transitions: A central concept in nursing. *Image: Journal of Nursing Scholarship, 26(2*), 119-127.

Schwandt, J. W. (2003). Three epistemological stances for qualitative inquiry; Interpretivism, hermeneutics and social constructionism. In N. Denzin & Y. Lincoln (Eds.). *The landscape of qualitative research: Theories and issues* (pp. 292-331). Thousand Oaks, CA: Sage.

Seidi, A. H., & Sauter, D. (1990, January). The new non-traditional student in nursing. *Journal of Nursing Education*, *29*(1), 13-19.

Seigfried, C. H. (1998). A companion to feminist philosophy. In A. Jaggar & I. Young (Eds.), *Pragmatism* (pp. 49-57). Malden, MA: Blackwell.

Simon, S. R. (2010). *A comparison of transitions to the nursing profession among foreign-educated physicians and nurses with master's, baccalaureate, and associate* degrees (Doctoral dissertation). Retrieved from Barry University Library, 1-106

Simpson, I. H. (1967). Patterns of socialization in the professions: The case of student nurses. *Sociology Inquiry*, *1*(1), 47-54.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research. Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.

Strauss, A. L. (1987). *Qualitative analysis for social scientists*. New York, NY: Cambridge University Press.

Utley-Smith, Q., Philips, B., & Turner, K. (2007). Avoiding socialization pitfalls in accelerated second-degree nursing education: The returning-to-school syndrome model. *Journal of Nursing Education*, *46*(9), 423-426.

Vapor, V. R., & Xu, Y. (2011). Double whammy for a new breed of foreign-educated nurses: Lived experiences of Filipino physicians-turned nurses in the United States. *Research & Theory for Nursing Practice, 25*(3), 210-226. doi:10.1891/1541-6577.25.3.210

APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL

Barry University
Division of Academic Affairs

Institutional Review Board
11300 NE 2nd Avenue
Miami, FL 33161
P: 305.899.3020 or 1.800.756.6000, ext. 3020
F: 305.899.3026
www.barry.edu

Research with Human Subjects
Protocol Review

Date: July 6, 2017

Protocol Number: 170618

Title: The critical factors influencing the attitudes, beliefs and perceptions of foreign-educated physicians (FEPs) who have entered nursing as a second career

Meeting Date: June 21, 2017

Name: Ms. Nora Hernandez-Pupo
Address: [redacted]

Faculty Sponsor: Dr. Jessie Colin - Nursing

Dear Ms. Hernandez-Pupo:

On behalf of the Barry University Institutional Review Board (IRB), I have verified that the specific changes requested by the convened IRB on June 21, 2017 have been made.

It is the IRB's judgment that the rights and welfare of the individuals who may be asked to participate in this study will be respected; that the proposed research, including the process of obtaining informed consent, will be conducted in a manner consistent with requirements and that the potential benefits to participants and to others warrant the risks participants may choose to incur. You may therefore proceed with data collection.

As principal investigator of this protocol, it is your responsibility to make sure that this study is conducted as approved by the IRB. Any modifications to the protocol or consent form, initiated by you or by the sponsor, will require prior approval, which you may request by completing a protocol modification form.

It is a condition of this approval that you report promptly to the IRB any serious, unanticipated adverse events experienced by participants in the course of this research, whether or not they are directly related to the study protocol. These adverse events include, but may not be limited to, any experience that is fatal or immediately life-

threatening, is permanently disabling, requires (or prolongs) inpatient hospitalization, or is a congenital anomaly cancer or overdose.

The approval granted expires on July 14, 2018. Should you wish to maintain this protocol in an active status beyond that date, you will need to provide the IRB with an IRB Application for Continuing Review (Progress Report) summarizing study results to date. The IRB will request a progress report from you approximately three months before the anniversary date of your current approval.

If you have questions about these procedures, or need any additional assistance from the IRB, please call the IRB point of contact, Mrs. Barbara Cook at (305)899-3020 or send an e-mail to **dfeldman@barry.edu.** Finally, please review your professional liability insurance to make sure your coverage includes the activities in this study.

Sincerely,

David M. Feldman, PhD
Chair, Institutional Review Board
Barry University
Department of Psychology

Cc: Dr. Jessie Colin

****

Note: The investigator will be solely responsible and strictly accountable for any deviation from or failure to follow the research protocol as approved and will hold Barry University harmless from all claims against it arising from said deviation or failure.

APPENDIX B

BARRY UNIVERSITY

INFORMED CONSENT FORM

This section contains individual and focus group consent forms

Appendix B
Barry University
Individual
Informed Consent Form

Your participation in a research project is requested. The title of the study is "The Critical Factors Influencing the Attitudes, Beliefs, and Perceptions of Foreign-Educated Physicians (FEPs) Who Have Entered Nursing as a Second Career". The research is being conducted by Nora Hernandez-Pupo, a student in the College of Nursing and Health Sciences at Barry University, and is seeking information that will be useful in the field of nursing, education, institutional policy/procedures. The aim of this grounded theory research is to add to the body of knowledge and identify factors influencing FEPs who have entered nursing as a second career. In accordance with these aims, the following procedures will be used: recorded interviews. The first interview will be conducted face-to-face using open ended questions related to the topic of FEPs who have entered nursing as a second career. The first individual participant interviews will last approximately one hour and in addition they will be asked to completion the demographic questionnaire which will take no more than 10 minutes. After the individual interview is transcribed by a transcriptionist, (who will sign a third-party confidentiality agreement), the researcher will verify accuracy of transcription by listening to the audiotape and reading the transcript. The interview transcripts will be sent to you via fax, mail, or e-mail to you for you to review for accuracy and then a follow-up interview via phone or face-to-face will be requested to go over the transcription. The second interview, which will be approximately 30 minutes, will be conducted in a face-to-face meeting or via telephone. The purpose of the second interview is for clarification and verification of data collected during the first interview. The total commitment for both interviews will be approximately 90 minutes plus no more than 10 minutes to complete the demographic questionnaire. A total time commitment of 100 minutes is requested. It is anticipated a maximum of 30 participants in this phase of the study.

If you decide to participate in the research, you must meet the following criteria:

1) Self-identify as a foreign-educated physician FEP-.
2) Be licensed as an RN or ARNP in the United States.
3) Be employed for more than a six-month period in a nursing role.
4) Be fluent in English.
4) Be willing to share your attitudes, beliefs, and perceptions about your new role as a RN or ARNP.
5) Be willing to participate in an audiotaped interview, which will be transcribed.
6) Have access to a computer, email, and a phone.
7) Be willing to review and return the transcriptions of your individual interview

A token of appreciation in the form of a Walmart gift card in the amount of $20.00 will be offered to you, as a participant. You may keep this gift even if you withdraw from

the study. You will be asked to do the following: complete a demographic questionnaire, participate in an individual audiotaped interview at a mutually agreed upon location. The digital recording of the first interview will be transcribed and you will be asked to review the transcription for accuracy in a second interview within 2 weeks. The second interview will last approximately 30 minutes.

Your consent to be a research participant is strictly voluntary and should you decline to participate or should you choose to drop out at any time during the study, or decline to answer any question(s) there will be no adverse effects.

There are no known risks of involvement in this study. There are no known benefits to your participation.

As a research participant, information you provide will be held in confidence to the extent permitted by law. The researcher will explain to you the steps in maintaining confidentiality: you will be asked to provide your own pseudonym, which will be used on their demographics and interview transcripts to maintain confidentiality. The researcher will safeguard your confidentiality by keeping the transcripts in a specific locked file cabinet in the researcher's home office indefinitely after the study. Any published results of the research will be in aggregate form using pseudonyms. Consents will be kept separate from other data in a locked file cabinet in the researcher's home office. Digital recordings will be destroyed after transcription is verified. All data will be kept indefinitely in a locked file cabinet in the researcher's home office.

If you have any questions or concerns regarding the study or your participation in the study, you may contact me, Nora Hernandez-Pupo at [redacted] or nora.hernandez-pupo@mymail.barry.edu, my supervisor, Colin, at 305-899-3830 or jcolin@barry.edu, or the Institutional Review Board point of contact, Barbara Cook, at (305)899-3020 or bcook@barry.edu. If you are satisfied with the information provided and are willing to participate in this research, please signify your consent by signing this consent form.

Voluntary Consent

I acknowledge that I have been informed of the nature and purposes of this experiment by Nora Hernandez-Pupo and that I have read and understand the information presented above, and that I have received a copy of this form for my records. I give my voluntary consent to participate in this experiment.

_____ _____

Signature of Participant *Date*

_____ _____ _____ _____

Researcher *Date* *Witness* *Date*

(Witness signature is required only if research involves pregnant women, children, other vulnerable populations, or if more than minimal risk is present.)

Appendix B
Barry University
Focus Group
Informed Consent Form

Your participation in a research project is requested. The title of the study is "The Critical Factors Influencing the Attitudes, Beliefs, and Perceptions of Foreign-Educated Physicians (FEPs) Who Have Entered Nursing as a Second Career". The research is being conducted by Nora Hernandez-Pupo, a student in the College of Nursing and Health Sciences at Barry University, and is seeking information that will be useful in the field of nursing, education, institutional policy/procedures. The aim of this grounded theory research is to add to the body of knowledge and identify factors influencing FEPs who have entered nursing as a second career. In accordance with these aims, the following procedures will be used for the focus group interview: an audiotaped semi-structured focus group interview using open-ended questions related to the topic of FEPs who have entered nursing as a second career. The completion of a demographic questionnaire will take no more than 10 minutes. The anticipated number of participants will be a maximum of 7. In addition, the focus group participants will be given 1 hour over the course of 2 weeks to review categories and emerging theory prior to the focus group interview. Total time commitment for the focus group interview will be as follows 160 minutes or approximately 2.6 hours (10 minutes for demographic questionnaire, 90 minutes for focus group interview, and 1 hour (over the course of 2 weeks) for reviewing the manuscript of the emerging categories and developing theory prior to the focus group.

If you decide to participate in the research, you must meet the following criteria for Phase II:

1) Self-identify as a FEP –DNP/PhD (RN or ARNP)
2) Be employed for a minimum of 5 years in a professional nursing role.
2) Be willing to review and reflect on the usefulness and fit of the emerging theory.
3) Be fluent in English.
4) Be willing to participate in an audiotaped focus group interview, which will be transcribed.
5) Have access to a computer, email, and a phone in order to contact the researcher of his/her willingness to participate in the study.

A token of appreciation in the form of a Walmart gift card in the amount of $20.00 will be given to you. You may keep this gift even if you withdraw from the study

If you decide to participate in this research, you will be asked to do the following: complete a demographic questionnaire, meet in person with up to 7 experts, and spend no more than 90 minutes in an audio recorded interview at a mutually agreed time and location. Digital recording of the interview will be transcribed for analysis by a transcriptionist (who has signed a third person confidentiality agreement). The purpose of

the focus group interview is to confirm findings, concepts, and the initial draft of the substantive theory.

Your consent to be a research participant is strictly voluntary and should you decline to participate or should you choose to drop out at any time during the study, or decline to answer any question(s) there will be no adverse effects.

There are no known risks of involvement in this study. There are no know benefits to you.

Although the researcher guarantees to keep all information obtained from the group confidential, the focus group participants will be advised that to the extent provided by the law, the researcher will maintain confidentiality. However, due to the nature of the group processes, the group will be informed that confidentiality cannot be guaranteed. The researcher will explain to you the steps in maintaining confidentiality: every participant will be asked to provide their own pseudonym, which will be used on their demographics and interview transcripts to maintain confidentiality. The researcher will attempt to safeguard your confidentiality by keeping the transcripts in a specific locked file cabinet in the researcher's home office indefinitely after the study. Any published results of the research will be in aggregate form and pseudonyms will be used. Transcripts of recordings will be kept in a locked file cabinet in the researcher's home office. Digital recordings will be destroyed after transcription is verified. Your signed consent will be kept separate from the data. All data will be kept indefinitely.

If you have any questions or concerns regarding the study or your participation in the study, you may contact me, Nora Hernandez-Pupo at [redacted] or nora.hernandez-pupo@mymail.barry.edu, my supervisor, Colin, at 305-899-3830 or jcolin@barry.com, or the Institutional Review Board point of contact, Barbara Cook, at (305)899-3020 or bcook@barry.edu. If you are satisfied with the information provided and are willing to participate in this research, please signify your consent by signing this consent form.

Voluntary Consent

I acknowledge that I have been informed of the nature and purposes of this experiment by Nora Hernandez-Pupo and that I have read and understand the information presented above, and that I have received a copy of this form for my records. I give my voluntary consent to participate in this experiment.

_____ _____

Signature of Participant *Date*

_____ _____ _____ _____

Researcher *Date* *Witness* *Date*

(Witness signature is required only if research involves pregnant women, children, other vulnerable populations, or if more than minimal risk is present.)

APPENDIX C

LETTER OF REQUEST FOR ACCESS

Date

Name and address of facility

Dear_____,

My name is Nora Hernandez-Pupo; I am a doctoral student at Barry University College of Nursing and Health Sciences. I am conducting a study entitled: "The critical factors influencing the attitudes, beliefs, and perceptions of foreign-educated physicians (FEPs) who have entered nursing as a second career". This study is for my dissertation in partial fulfillment of a PhD. The purpose of this study is to explore the critical factors influencing the attitudes, beliefs, and perceptions of foreign-educated physicians (FEPs) who have entered nursing as a second career. It is expected that the results from this study will generate a theory, which may facilitate understanding of the FEPs in their socialization and transition to the nursing role.

I am writing today to ask for your authorization and assistance in gaining access to FEPs RN/ARNP who work or study within your organization. The first group of participants will be asked to participate in individual audiotaped interviews that will last about one hour. This will be followed by a 15 to 30-minute session one to two weeks after the initial interview. This second interview is to review and confirm the theory developed from Phase I data collection and analysis. The total time will be approximately 100 minutes. The second group (focus group) will require no more than 7 participants who are FEPs-DNP/PhD (RN or ARNP) but have been working within a professional nursing role for at least 5 years, to be interviewed together in a group for approximately 90 minutes.

Attached are copies of the flyer. The Institutional Review Board (IRB) of Barry University in Miami, Florida approved this study. The anticipated date of this study in July, 2017. I will comply with all the requirements of your establishment.

Thank you for your consideration of access and assistance to recruit volunteers for this study.

Please contact me at [redacted] or email: nora.hernandez-pupo@mymail.barry.edu for any questions or concerns. You may also contact my faculty sponsor, Dr. Jessie M. Colin at (305) 899 3830, or email at jcolin@mail.barry.edu. The IRB contact is Ms. Barbara Cook who can be reached at (305) 899 3020 or email at bcook@barry.edu. I look forward to your response at your earliest convenience.

Yours Respectfully,

Nora Hernandez-Pupo MSN, RN

APPENDIX D

BARRY UNIVERSITY

RECRUITMENT FLYERS

This section contains individual and focus group flyers.

APPENDIX D

BARRY UNIVERSITY

PHASE I FLYER

Appendix D
Barry University

Barry University

YOU ARE INVITED TO PARTICIPATE IN A STUDY TO EXPLORE:
The attitudes, beliefs, and perceptions of foreign-educated physicians (FEPs) who have entered nursing as a second career.

Phase I **Maximum 30 Participants** **To be Considered**

1) Self-identifies as a foreign-educated physician (FEP).
2) Licensed as an RN or ARNP in the United States.
3) Employed for more than a six-month period in a nursing role.
4) Fluent in English.
4) Willing to share his/her attitudes, beliefs, perceptions about his/her new role as a RN or ARNP.
5) Willing to participate in an audiotaped interview, which will be transcribed.
6) Has access to a computer, email, and a phone.
7) Willing to review and return the transcriptions of individual interview

Total Approximate Time 100 minutes.. *You will receive a $20 Walmart Gift card in appreciation for your participation in the study.*

FOR QUESTIONS, CONCERNS, AND TO VOLUNTEER PLEASE CONTACT:

NORA HERNANDEZ-PUPO, MSN, RN

(DOCTORAL STUDENT AT BARRY UNIVERSITY SCHOOL OF NURSING AND HEALTH SCIENCES)

PHONE: [redacted]
EMAIL: nora.hernandez-pupo@mymail.barry.edu

Barry University Faculty Supervisor
Dr. J. Colin, PhD
Phone Telephone Number: 305-899-3830
E-Mail Address: jcolin@barry.edu

Barry University IRB Contact
Barbara Cook
Phone: 305-899-3020 or 800-756-6000
E-Mail Address: bcook@barry.edu

APPENDIX D

BARRY UNIVERSITY

PHASE I FLYER

Appendix D
Barry University

YOU ARE INVITED TO PARTICIPATE IN A STUDY EXPLORING THE TRANSITION OF FEPS (FOREIGN EDUCATED PHYSICIANS) TO A NURSING ROLE.

Barry University

Phase II Limited to 7 Participants To be Considered

1) Self-identifies as a FEP- DNP/PhD (RN or ARNP).

2) Employed for a minimum of 5 years in a professional nursing role.

2) Willing to review and reflect on the usefulness and fit of the emerging theory.

3) Fluent in English.

4) Willing to participate in an audiotaped focus group interview, which will be transcribed.

5) Has access to a computer, email, and a phone in order to contact the researcher of his/her willingness to participate in the research study

Approximate time for face-to-face focus group interview 90 minutes.

You will receive a $20 Walmart Gift card in appreciation for your participation in the study.

FOR QUESTIONS, CONCERNS, AND TO VOLUNTEER PLEASE CONTACT:

NORA HERNANDEZ-PUPO, MSN, RN

(DOCTORAL STUDENT AT BARRY UNIVERSITY SCHOOL OF NURSING AND HEALTH SCIENCES)

PHONE: [redacted]
EMAIL: nora.hernandez-pupo@mymail.barry.edu

Barry University Faculty Supervisor:
Dr. J. Colin, PhD
Phone Telephone Number: 305-899-3830
E-Mail Address: jcolin@barry.edu

Barry University IRB Contact:
Barbara Cook
Phone: 305-899-3020 or 800-756-6000
E-Mail Address: bcook@barry.edu

APPENDIX E

BARRY UNIVERSITY

DEMOGRAPHIC QUESTIONNAIRES

This section contains individual and focus group demographic questionnaires.

Appendix E
Barry University
Demographic Form Phase I

Pseudonym: _____
Please fill in or circle the number next to the best answer.

What range identifies your age?

1. 35-44
2. 45-54
3. 55-64
4. 65 or above
5. other_____

What is your race/ethnic group?

1. White
2. African-American
3. Hispanic
4. Asian
5. Caribbean Islander
6. Other: _____

What is your country of birth?

_____
_____

What country did you receive your medical degree?

_____
_____

What 'specialty' did you obtain in medicine?

_____
_____

How many years did you practice as a medical doctor?

_____
_____

What year did you obtain your RN licensure?

_____
_____What year did you obtain your ARNP Licensure (if applicable)?

_____
_____

Did you consider studying medicine (medical doctor) in the United States?

_____

_____

In what unit/setting do you practice as a nurse?

_____

_____

In your unit what is your role at your institution?

1. Charge Nurse
2. Staff Nurse
3. Per-diem Nurse
4. Supervisor
5. Manager
6. Director
7. Other: _____

Appendix E
Barry University
Demographic Form Phase II

Pseudonym: _____
Please fill in or circle the number next to the best answer.

What range identifies your age?

1. 35-44
2. 45-54
3. 55-64
4. 65 or above
5. other_____

What is your race/ethnic group?

1. White
2. African-American
3. Hispanic
4. Asian
5. Caribbean Islander
6. Other: _____

How long have you been in the United States?

_____

What is your country of birth?

_____
_____

What country did you receive your medical degree?

_____
_____

What 'specialty' did you obtain in medicine?

_____
_____

How many years did you practice as a medical doctor?

_____
_____

What year did you obtain your RN licensure?

_____
_____

What year did you obtain your ARNP Licensure?

_____
_____

What year did you obtain your DNP or PhD degree?

_____Did you consider studying medicine (medical doctor) in the United States?

How many years have you practiced as a nurse?

In what unit/setting do you practice and what would you say your role is?

Have you published any articles in the last 3 years? If so, in what journal and what was the topic?

APPENDIX F

BARRY UNIVERSITY

PHASE I: INDIVIDUAL INTERVIEW GUIDE QUESTIONS

The following open-ended questions will be used to guide this study.

1. Can you please describe what motivated you to enroll in the nursing program as a foreign-educated physician?

2. What is your point of view about the two professions (nursing and medicine (MD))?

3. Did you face any challenges or barriers in your new nursing role? (Probing: Can you describe what barriers have you faced in your nursing role/what has helped?

4. What comes to mind when you think about being a RN who was once a physician?

5. What does it mean to you to care as a former physician and now as a nurse?

6. Can you describe to me or give me an exemplar of you caring and use that same example for both ways that you would care (as a physician and as a nurse)?

7. What do you bring to the nursing profession?

Appendix F

Barry University

Phase II: Focus Group Interview Guide Questions

1. What are your thoughts regarding the categories that emerged from the analysis of the interviews?

2. How does the theory resonate with your experience as a former FEP now practicing as a DNP (RN/ARNP) or PhD (RN or ARNP)?

APPENDIX G

BARRY UNIVERSITY

NIH CERTIFICATE OF COMPLETION

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Nora Hernandez-Pupo** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 03/13/2017.

Certification Number: 2350613.

APPENDIX H

BARRY UNIVERSITY

CONFIDENTIALITY AGREEMENT

Appendix H
Barry University

Confidentiality Agreement

As a member of the research team investigating Critical factors influencing foreign-educated physicians practicing as nurses, I understand that I will have access to confidential information about study participants. By signing this statement, I am indicating my understanding of my obligation to maintain confidentiality and agree to the following:

- I understand that names and any other identifying information about study participants are completely confidential.
- I agree not to divulge, publish, or otherwise make known to unauthorized persons or to the public any information obtained in the course of this research project that could identify the persons who participated in the study.
- I understand that all information about study participants obtained or accessed by me in the course of my work is confidential. I agree not to divulge or otherwise make known to unauthorized persons any of this information unless specifically authorized to do so by office protocol or by a supervisor acting in response to applicable protocol or court order, or otherwise, as required by law.
- I understand that I am not to read information and records concerning study participants, or any other confidential documents, nor ask questions of study participants for my own personal information but only to the extent and for the purpose of performing my assigned duties on this research project.
- I understand that a breach of confidentiality may be grounds for disciplinary action, and may include termination of employment.
- I agree to notify my supervisor immediately should I become aware of an actual breach of confidentiality or situation which could potentially result in a breach, whether this be on my part or on the part of another person.

Signature	Date	Printed Name
[signature]	1/9/18	Crystal Portocarrero
Signature	Date	Printed Name

VITA

Nora Hernandez-Pupo

Education

1996 Florida International University Miami, Florida Bachelor in Science of Nursing

2011 University of Phoenix Miramar, Florida MSN

2018 Barry University Miami Shores, Florida PhD. Nursing

Employment

08/2015- Present Barry University
BSN Nurse Faculty Instructor

08/2013- 8/2015 Miami Dade College
Nurse Faculty Instructor

04/2013- 8/2013 Miami Dade College
Part Time Nurse Faculty

12/2012-6/2013 Palmetto General Hospital
Registered Nurse, Charge Nurse Emergency Room

11/2012- 8/2013 City College
Nurse Faculty

10/2010- 10/2012 Baptist Outpatient Services
Plaza Manager

02/2008-10/2010 Baptist Outpatient Services
Sr. Supervisor

02/2007-02/2008 Osceola Regional Medical Center
Clinical Nurse Manager Cardiac Progressive Care Unit

04/2007- 02/2008 Valencia Community College
Adjunct Nurse Faculty

08/2006-02/2007 Osceola Regional Medical Canter
Registered Nurse, Charge Nurse Emergency Room

2005-2006 Osceola County Health Department
Sr. Registered Nurse/Charge

2003-2005 Osceola Regional Medical Center
Registered Nurse-ER

2002-2004 RNNetwork Nurse Traveling Agencies
HPO Healthcare Staffing TELE/Trauma;Tele/PCU; NICU Trauma Level I and II facilities; PCU/ICU;Cardiac Intervention Units

2001-2002 Aventura Hospital and Medical Center
Nursing Supervisor, Admitting Nurse
1999-2001 Aventura Hospital and Medical Center
Registered Nurse-Day Surgery/Outpatient Dept.

1997-2001 Cedars Medical Center
Registered Nurse, Charge Nurse-Neuro Tele; NICU

1998-2001 Pan American Hospital
Registered Nurse, Progressive Care Unit

1997-2001 Larkin Community Hospital
Registered Nurse, CCU/ICU Per Diem

Activities/Contributions
8th Annual South Region Florida Nurses Association Symposium 4-14-2018 Three Poster presentations:
a) *A college and a University Collaborates on the "Moving on" project reducing childhood obesity in Hispanic and Non-Hispanic children.*
b) *Human Trafficking Crisis.*
c) *Foreign-educated physicians turned nurses: An integrated literature review.*

Sigma Theta Tau International's 28th International Nursing Research Congress,
Oral Presentation Title: A College and a University Collaborating on "Moving On" Project; Reducing Hispanic Childhood Obesity :ID#: 84336
Dublin, Ireland July 18-August 1Sigma Theta Tau International's 28th International Nursing Research Congress

May 2017 ICN Scientific Program Committee we have great pleasure to inform you that your abstract number: ICN17-EN-ABS-7208 entitled - ""Moving On": Reducing Obesity in Los Chiquitos & Las Chiquitas"

STTI: Research Conference-February 8, 2017
Nursing: A Catalyst for Global Healthcare Re-Structuring through Advocacy, Policy, Philanthropy and Life-Long Learning"
Presented Poster: FEPs turned Nurses: An Integrative Literature Review

"Moving "Niños Obesos" Project: Reducing Obesity in Hispanic and non-Hispanic Children." Oral presentation. July 21-25, 2016, Cape Town South Africa, Sigma Theta Tau International's 27th International Nursing Research Congress.

"The Alarming Impact of Socioeconomic Factors on Population Health Indicators." Podium presentation. February 24, 2016, Lambda Chi Chapter STTI Research Conference 2016.

"The Alarming Impact of Socioeconomic Factors on Population Health Indicators." Poster presentation. April 9th, 2016, FNA 6th Annual South Region Symposium and Awards Ceremony.

"Promoting Quality and Safety Competencies from Academia to Practice: Moving towards a Real World Dissemination of Evidence Paradigm Shift." Poster presentation. April 9th, 2016, FNA 6th Annual South Region Symposium and Awards Ceremony.

NAHN Muevete for Mexican Children on Cinco de Mayo Day to Reduce Obesity 11/7/15-11/11/2015 _STTI 43rd Biennial Convention NAHN Miami Chapter

Reducing Obesity in Hispanic Children 7/23/15-7/27/15 26th STTI International Nursing Research Congress NAHN Miami Chapter

National Hispanic Nurses Association
Miami Chapter President 2018-2020
Miami Chapter President Elect 2016-2017
Miami Chapter Secretary 2015-2016

Work with NAHN to promote the profession and health prevention, services, and education to the community by various activities. Participated in the Organization and Presentation of the National Conference 2015, MueveteUSA 2014-2016 Initiative promoting healthy eating and lifestyle for underserved children in the community. Listed as one of the contributing author of abstract of research presented to Sigma Theta Tau.

Community Service

Relay for Life American Cancer Society 2010, 2011
Kidney Foundation Walk 2010, 2011
Corporate Run 2011
Wellness Screenings at Local Community Centers
IronMan 2010 and 2012 Athlete First Aid/Medical Tent Coordinator

Licensure and Certifications

Registered Nurse State of Florida RN 3264572
Basic Life Support (BLS)
Advanced Cardiac Life Support
Pediatric Advanced Life Support

Professional Affiliation

NAHN National Association of Hispanic Nurses – Nationals and Miami Chapter
Florida Nurses Association - Member
American Nurses Association – Member
Sigma Theta Tau International – Lambda Chi Chapter – Member
Sigma Theta Tau International – Omicron Delta Chapter -Member

Language Proficiency

Fluent in Spanish (able to read and write)