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The Learning Experiences of Immigrants Who Are Graduates of An Entry-Level Baccalaureate Nursing Program in Minnesota

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THE LEARNING EXPERIENCES OF IMMIGRANTS WHO ARE GRADUATES OF AN ENTRY-LEVEL BACCALAUREATE NURSING PROGRAM IN MINNESOTA

BY

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This dissertation is approved as a credible and independent investigation by a candidate for the Doctor of Philosophy degree and is acceptable for meeting the dissertation requirements for this degree. Acceptance of this dissertation does not imply that the conclusions reached by the candidate are necessarily the conclusions of the major department.

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This dissertation is dedicated to my mother, the late Arlene L. Burns, RN.

You discouraged me from becoming a nurse,

yet encouraged me towards life-long learning in nursing.

You were a proud parent who,

in your final days was delighted to present me to your nurses as

“my daughter, the one getting a PhD in Nursing.”

As these final pages are typed, I feel your loving hand over mine.

I love you forever.

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LIST OF ABBREVIATIONS

1. Affirming At-Risk Minorities for Success (ARMS)
2. American Association of Colleges of Nursing (AACN)
3. American Nurses Association (ANA)
4. Computer Aided Qualitative Data Analysis Software (CAQDAS)
5. Cumulative Index to Nursing and Allied Health Literature (CINAHL)
6. Chief Nursing Officer (CNO)
7. Department of Health and Human Services (DHHS)
8. Ethnically diverse immigrant registered nurse (EDIRN)
9. Ethnically diverse immigrant registered nurses (EDIRNs)
10. Ethnically diverse immigrant student nurse (EDISN)
11. Ethnically diverse immigrant student nurses (EDISNs)
12. Ethnically diverse nurse (EDN)
13. Ethnically diverse nurses (EDNs)
14. Ethnically diverse nursing student (EDNS)
15. Ethnically diverse nursing students (EDNSs)
16. Entry-level baccalaureate nursing program (ELBNP)
17. Entry-level baccalaureate nursing programs (ELBNPs)
18. English Language Learner (ELL)
19. Health Resources and Services Administration (HRSA)
20. Institutional review board (IRB)
21. Learning Achievement Program (LAP)
22. Medical Literature Analysis and Retrieval Online (MEDLINE)

23. Minority Academic Advising Program (MAAP)

24. National Council Licensure Examination for the Registered Nurse (NCLEX-RN)

25. National Council of State Boards of Nursing (NCSBN)

26. National League for Nursing (NLN)

27. PubMed-National Center for Biotechnology Information (PubMed-NCBI)

28. Recruitment and Retention of Alaska Natives into Nursing (RRANN)

29. Registered nurse (RN)

30. Saint Cloud State University (SCSU)

31. Success in Nursing Individuals Pathways Program (SLIPP)

32. South Dakota State University (SDSU)

33. United States (U.S.)

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ABSTRACT

THE LEARNING EXPERIENCES OF IMMIGRANTS WHO ARE GRADUATES OF AN ENTRY-LEVEL BACCALAUREATE NURSING PROGRAM IN MINNESOTA

MARCIA L. SCHERER

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The United States faces an immigrant population explosion with more foreign-born residents compared to any country in the world. Each immigrant enters with individual and cultural health beliefs and, as they seek health care, often prefers to receive care from someone who understands and supports their cultural beliefs and customs. Nurses comprise the largest segment of healthcare providers. Within this population of nurses, the number of ethnically diverse nurses continues to stagnate at astoundingly low levels. The literature reviewed neglected to identify interviewing immigrants separate from ethnically diverse nursing students. Understanding the immigrant's nursing education experiences is essential to addressing future ethnically diverse immigrant nursing student success in entry-level baccalaureate nursing programs. Thus, this qualitative study provided insight into the learning experiences from the perspective of five entry-level baccalaureate prepared ethnically diverse immigrant registered nurses soon after graduation. Heidegger and Gadamer's hermeneutic phenomenological approach were instituted through immersion in dialogue and interpretation of transcripts. The interpretations were guided by Dr. Isaacson and the Hermeneutic Circle. The overarching theme was "being on the outside." Their stories demonstrated five subthemes that described their learning experiences and coping

mechanisms as an outsider. In hermeneutics, the fluidity and movement among the subthemes assisted in identification of the overarching theme, "being on the outside." The participants' stories demonstrated resilience to being oppressed and provide an explanation for being successful in their nursing program through competent coping mechanisms and adaptation techniques. Open dialogue, coming to know yourself prior to understanding someone else, and uniting through collaboration were all suggested by Gadamer (1992) in achievement of solidarity. Roberts (1983) proposed that nursing as a profession is oppressed as defined by Freire (1970/2011). Walker (1997) offered an explanation of insider and outsider with a line that separates these two dichotomies where people cross the border or experience both entities. Canales (2000) described inclusionary and exclusionary othering as terms that coincide with power use and abuse. In concluding, solidarity versus solitary, oppressor versus oppressed, insider versus outsider, and inclusionary versus exclusionary othering are different means of describing what is occurring within nursing education and the profession as a whole.

Chapter 1: Introduction and Background

The United States (U.S.) is in the midst of an immigrant population explosion. With roughly 104,000 immigrants and refugees arriving daily, the U.S. has more foreign-born residents than any country in the world (Martin & Midgley, 2010). Per the 2010 U.S. Census, 17% of the foreign-born population has arrived since 2005 (Grieco et al., 2012; U.S. Census Bureau, 2011). Immigrants enter the U.S. in search of improved living or refuge from sustained political oppression. They also enter expecting appropriate healthcare accommodation and empathy from professional nurses. Each immigrant arrives with specific individual and cultural health beliefs, adding considerable diversity within the healthcare system. With a generous increase in the foreign-born population, the healthcare system requires more healthcare professionals specifically skilled at serving immigrants and refugees entering the U.S.

When the new culture encounters the primary culture, "misunderstandings and misinterpretations" occur (Cobb, 2010, p. 80). Many immigrants hold a distrust of Western medicine due to poor experiences with the U.S. healthcare system (Martin, 2009). Reasons for this distrust are lack of communication, language barriers, and misunderstandings of the immigrant's culture (Carroll et al., 2007a; Carroll et al., 2007b; Chen & Bakken, 2004; Cobb, 2010; Hasnain, Connell, Menon, & Tranmer, 2011; Pavlish, Noor, & Brandt, 2010; Shah, Ayash, Pharaon, & Gany, 2008; Tirodkar et al., 2011).

Communication and language are barriers between the nurse and the immigrant. For example, Pavlish et al. (2010) identified a person of Somali background who stated, "Even though you speak perfect English, they [healthcare providers] think you don't

understand, you are dumb and they will not explain to you what is happening" (p. 357). Cultural beliefs create additional barriers impeding health care. For example, Carroll et al. (2007a) recognized that Somali women often prefer a female provider even when competent male providers are available. Carroll et al. (2007a) gave an example that a Somali woman stated, "If you have a choice, prefer female. It is good for you." (p. 341). Opinions and belief systems of both the nursing staff and patient intersect in these vulnerable moments.

Immigrants add a unique perspective in health care through diversification of health beliefs and cultural health traditions. Every immigrant has an individual perspective of health, which is influenced by their primary culture, newly introduced culture, health definition or conception, religious affiliation, spiritual convictions, previous healthcare experiences, cultural traditions, and their traditional health care. All directly or indirectly influence health behavior when approaching U.S. health care (Carroll et al., 2007a; Carroll et al., 2007b; Garces, Scarinci, & Harrison, 2006; Hasnain et al., 2011; Rogers, 2010; Sanchez-Birkhead, Kennedy, Callister, & Miyamoto, 2011; Shah et al., 2008; Yosef, 2008). As immigrants seek health care, they often prefer to receive care from someone they believe will understand and support their customs and cultural health beliefs (The Sullivan Commission, 2004). Nurses play an integral role in providing and directing appropriate cultural health care for an increasingly diverse population. As such, a call for an increase in practicing ethnically diverse immigrant registered nurses (EDIRNs), specifically within the immigrant community, is essential in reflecting the needs of a diversifying population.

Within the literature, the terms *minority*, *ethnically diverse nurse* (EDN), *ethnically diverse nursing student* (EDNS), and *underrepresented minority nurse* are often used interchangeably (Ackerman-Barger, 2010; Loftin, Newman, Dumas, Gilden, & Bond, 2012; Noone, 2008). The EDN and the EDNS acknowledged in the literature as nurses and nursing students are those who self-identify with a particular ethnicity or minority, yet, the authors did not clearly specify whether they were immigrants or refugees that have relocated to the U.S. Further, multiple ethnicities in the literature were recognized such as African American, Native American, Asian American, Latino or Hispanic, Nigerian, Eastern Indian, Alaska Indian, Pacific Islander (Ackerman-Barger, 2010; Amaro, Abriam-Yago, & Yoder, 2006; Gardner, 2005c; Noone, 2008; Phillips & Malone, 2014; Yurkovich, 2001). The stratification of immigrants from U.S. born minority persons was not clearly stated when nurse researchers identified their participants in the articles associated with barriers to success and interventions trialed with ethnically diverse nursing students (EDNSs), minority, or the underrepresented with the exception of one, Yoder (1996), who identified one immigrant born in Palau. Thus, ethnically diverse nurses (EDNs) and EDNSs as identified throughout the extensive literature review are those racial and ethnic minorities who could be U.S. citizens or immigrants and refugees. Because the literature review demonstrated that immigrants were not specifically identified, this study explicitly targeted this population, the ethnically diverse immigrant registered nurse (EDIRN).

Racial minority and ethnically diverse representation within the U.S. Nurses are the largest segment of health care professionals providing direct and indirect nursing care to the U.S. population (American Association of Colleges of Nursing [AACN],

2011). Ideally, the proportion of working EDNs and EDIRNs within the U.S. would mirror the influx of immigrants. However, even with the increasing number of immigrants, statistics indicate the numbers of EDNs have risen slowly without reflecting the changing demographics of the population (AACN, 2014; Phillips & Malone, 2014; The Sullivan Commission, 2004). Statistical percentages separating numbers of EDIRNs from overall EDNs are unavailable or have not been reported in nursing registries or national employment statistics. Statistics from the AACN (2014) revealed that EDNs represented only 19% of the total registered nurse (RN) workforce, while the U.S. Department of Commerce (2014) revealed 39% of the U.S. population is identified as ethnic and racial minorities. A 20% discrepancy exists with insufficient numbers of EDNs providing care to the increasing diversity of patients. Phillips and Malone (2014, p. 46) concurred by comparing the U.S. population of 65.6% non-Hispanic white with 83.2% of the RN population as being non-Hispanic white.

One recognized strategy to reduce health disparities, improve quality of care, and increase longevity among minority populations is to increase the number of health care professionals within each distinct cultural and immigrant population (Fleming, Berkowitz, & Cheadle, 2005; The Sullivan Commission, 2004). Through an increase in practicing EDNs including EDIRNs, racial and ethnic minority persons will have the opportunity to experience culturally congruent and safer health care (The Sullivan Commission, 2004). However, there continues to be difficulty in retaining EDNSs within nursing programs (Gilchrist & Rector, 2007; Harris, Rosenberg, & O'Rourke, 2014; Newton & Moore, 2009; Symes, Tart, Travis, & Toombs, 2002).

A literature review of EDNSs' education offered unique insight into underrepresentation of practicing EDNs. Attrition affects the success of nursing students prior to completion of the nursing program. Attrition is defined "as a departure from a nursing program without successful completion of the program, but also can be defined to include students who are delayed in their progress toward program completion" (California Postsecondary Education Commission, 2003, p. 10). While there are significantly fewer EDNSs in entry-level baccalaureate nursing programs (ELBNPs) than non-Hispanic white students, there are also higher attrition rates for EDNSs (Gilchrist & Rector, 2007; Harris et al., 2014; Newton & Moore, 2009; Symes et al., 2002). The enrollment of EDNSs in an ELBNP has slowly risen from 24.1% in 2005 to 30.1% in 2014 (AACN, 2015); however, attrition rates for EDNSs enrolled in ELBNPs range from 15% to 85%, thus reducing the number of graduating and practicing EDNs (Gilchrist & Rector, 2007, p. 277). Since the late twentieth century, the potential causes of attrition for EDNSs from nursing programs have been extensively studied using qualitative (Amaro et al., 2006; Barton & Swider, 2009; Bond et al., 2008; Evans, 2008; Gardner, 2005a; Loftus & Duty, 2010; Love, 2010; Taxis, 2006; Yoder, 1996; Yurkovich, 2001) and quantitative means (Loftus & Duty, 2010). One identified barrier was language, which presents to the EDINS as a significant obstacle in completing a nursing program and contributes to attrition (Amaro et al., 2006; Evans, 2008; Gardner, 2005a; Loftus & Duty, 2010). Barriers identified by previous authors (Amaro et al., 2006; Barton & Swider, 2009; Bond et al., 2008; Evans, 2008; Gardner, 2005a; Loftus & Duty, 2010; Love, 2010; Taxis, 2006; Yoder, 1996; Yurkovich, 2001) laid the foundation in the

development and implementation of specific programs or strategies to potentially decrease attrition rates of EDNSs.

Identification of barriers and interventions. Several articles addressed barriers that potentially influenced attrition rates of EDNSs. Barriers included: (a) financial (Amaro et al., 2006; Barton & Swider, 2009; Bond et al., 2008; Evans, 2008; Gardner, 2005a; Loftus & Duty, 2010; Taxis, 2006), (b) loneliness (Gardner, 2005a; Loftus & Duty, 2010; Love, 2010; Taxis, 2006; Yurkovich, 2001), (c) feeling unwelcome (Barton & Swider, 2009; Evans, 2008; Gardner, 2005a), (d) difficulty with English language (Amaro et al., 2006; Evans, 2008; Gardner, 2005a; Loftus & Duty, 2010), (e) pressure to assimilate into white society (Love, 2010; Taxis, 2006), (f) overwhelming nursing workload (Amaro et al., 2006; Evans, 2008; Loftus & Duty, 2010), and (g) lack of support from nurse educators (Bond et al., 2008; Evans, 2008; Gardner, 2005a; Loftus & Duty, 2010; Love, 2010; Yurkovich, 2001).

Gardner's (2005a) phenomenological study identified barriers such as "loneliness and isolation" (p. 156). One respondent stated, "Minority students should be expecting to be alone. I feel lonely and isolated because students don't want to talk to me. When students feel alone, they are more likely to want to drop out of the nursing program." (Gardner, 2005a, p. 157). Amaro et al. (2006) recognized communication difficulties experienced by EDNSs by reviewing the work of Yoder (1996) and conducting further interviews. The article by Amaro et al. (2006), a student's response led these researchers towards acknowledgement of language challenges. "It took me longer to study and get reading done. The writing, I also struggled with that, and you know, lectures are fast, and some of the words couldn't come into my head" (Amaro et al., 2006, p. 250). Bond et al.

(2008) addressed financial issues as another barrier. A student confided, "Financial is a big barrier especially with a private institution. Could I afford to stay there, could I afford to pay my way through?" (Bond et al., 2008, p. 138). The EDNSs referred to in these articles are not specifically identified as immigrant participants or if they were included.

Upon identification of barriers the following researchers created and implemented interventions based on those barriers in hopes of retaining EDNSs in nursing programs. Interventions noted in the literature included (a) mentoring (Anders, Edmonds, Monreal, & Galvan, 2007; Cantu & Rogers, 2007; Condon et al., 2013; Edwards, Radcliffe, Patchell, Broussard, & Ogans, 2009; Escallier & Fullerton, 2009; Fletcher et al., 2003; Nugent, Childs, Jones, & Cook, 2004; Rearden, 2012; Valencia-Go, 2005, Yates et al., 2003); (b) community awareness and partnerships (Amos, Green, & McMurray, 2003; Gordon & Copes, 2010); (c) peer or nursing tutors (Brown & Marshall, 2008; DeLapp, Hautman, & Anderson, 2008; Guhde, 2003; Noone, 2008; Sutherland, Hamilton, & Goodman, 2007); (d) module development and counseling on success strategies and stress management (Gardner 2005b; Hesser, Pond, Lewis, & Abbott, 1996; Stewart, 2005); (e) cultural competency training for faculty (Bagnardi & Perkel, 2005; Swinney & Dobal, 2008; Wilson, Andrews, & Leners, 2006); and (f) linguistic modifications (Abriam-Yago, Yoder, & Kataoka-Yahiro, 1999; Bosher & Bowles, 2008; Carr & Dekemel-Ichikawa, 2012).

Some authors have analyzed and synthesized a group of published articles on barriers identified and interventions trialed resulting in integrative reviews on barriers (Alicea-Planas, 2009; Loftin et al., 2012), interventions (Loftin, Newman, Gilden, Bond,

& Dumas, 2013; Noone, 2008; Torregosa & Morin, 2012), or a combination of both barriers and interventions (Ackerman-Barger, 2010). In Alicia-Planas' (2009) metasynthesis, she acknowledged that nursing education has not grown to embrace ethnicity over the past 25 or more years and urges nurse educators to implement sustainable interventions. These interventions require the university, nursing department, and nurse educators of each higher educational institution to embrace an approach in meeting the needs of all students (Ackerman-Barger, 2010). These articles provided further insight into recognized barriers and interventions with evidence to enhance the retention of EDNSs.

Subsequent interventions were implemented by nurse educators based on the identified barriers adding richness to the interventions. In analyzing this new with previously reviewed interventional research, I used an integrative literature review approach (Scherer, 2014) in reporting a mixture of positive and negative retention and graduation rates (Banister, Bowen-Brady, & Winfrey, 2014; Bagnardi & Perkel, 2005; Brown, 2008; Brown & Marshall, 2008; Condon et al., 2013; DeLapp et al., 2008; Edwards et al., 2009; Gardner, 2005b; Georges, 2012; Hesser et al., 1996; Nugent et al., 2004; Ormeaus & Redding, 1990; Stewart, 2005; Sutherland et al., 2007; Valencia-Go, 2005). Researchers reported seven positive results while eight conveyed adverse results in 15 interventional studies using quantitative data relating to retention, graduation, and National Council Licensure Examination for the Registered Nurse (NCLEX-RN) pass rates for EDNSs. Positive results reported increased NCLEX-RN first-time pass rates to 97-100% (DeLapp et al., 2008; Georges, 2012; Ormeaus & Redding, 1990; Stewart, 2005), 100% retention of EDNSs (Banister et al., 2014; Gardner, 2005b), and increased

graduating EDNSs (Edwards et al., 2009). The negative implications noted were continued low academic achievement, decreased graduation rates, and persistent low NCLEX-RN pass rates (Bagnardi & Perkel, 2005; Brown, 2008; Brown & Marshall, 2008; Condon et al., 2013; Hesser et al., 1996; Nugent et al., 2004; Sutherland et al., 2007; Valencia-Go, 2005).

In spite of the literature published related to barriers faced by EDNSs and interventions integrated into nursing programs aimed at EDNSs, there remain unanswered questions. A significant gap in the literature exists by not specifically identifying immigrants within the published articles; therefore, a lack of knowledge explicitly relating to immigrants in nursing programs persists. A second gap is that this type of study has not been completed within the state of Minnesota, which has a large immigrant population. Thus, understanding the learning experiences lived by immigrants who came from another country and relocated to the U.S. would significantly add to the science of nursing.

Statement of the Problem

Given that the literature does not differentiate between EDNs and EDIRNs, an important step was to review the statistics related to EDNs in the U.S. because that statistic included EDIRNs. As previously noted, evidence indicates that there continues to be a 20% discrepancy between 39% of the U.S. population identified as ethnic and racial minorities (U.S. Department of Commerce, 2014) and the number of practicing EDNs. The EDNs or ethnically and racially diverse nurses constitute 19% of the total RN workforce (AACN, 2014). There is an interval of time between the population changing, especially with refugee immigration and the time individuals from those

populations can prepare for and complete a college education. Even with an expected time lag between immigration and graduation from an ELBNP, this indicates that the numbers of EDNs and EDIRNs have not kept pace with the increasing diversification of the U.S. population.

Further, researchers have provided studies that identified barriers and evaluated interventions; however, the research published over the last 30 years does not expose an understanding of the EDISN's learning experiences during completion of an ELBNP. Exploration of this area may result in detection of additional barriers or the further development of interventions. Understanding learning experiences directly from the EDIRN may lead to a greater appreciation for overall EDISNs learning experiences.

More than 20 years ago, Yoder (1993) studied the responses by nurse educators to EDNSs. Yoder (1993) also interviewed ethnic minority nurses who had previously graduated from undergraduate nursing schools in California, of which only one was a Palauian immigrant. Her study was in response to the continued low enrollment and attrition rates of EDNSs in California (Yoder, 1993). Yoder (1993) identified white non-Hispanic nurse educator differences and difficulties in successfully educating the EDNS. Her conclusions indicated that EDNSs face learning barriers in their education related to the nursing faculty (Yoder, 1993). Thus, nurse educators' teaching methods may be a potential barrier to current and future EDNSs' learning experiences. Nurse educators may be culturally competent, but may still require assistance in integrating culturally appropriate instructional methods or building curricula that are more familiar for the EDNS.

In a new era, questions are raised as to whether Yoder's results and recommendations remain relevant for the EDISN. Is there another method to improving the attrition rates of EDISNs that will also affect the EDNS? An approach to studying the issue that has not been reported or published is in understanding the learning experienced by the EDIRN recently graduated from an ELBNP. In understanding EDIRNs' nursing school learning experiences in Minnesota, a new perspective on this issue may be brought into focus with nurse educators having the ability to adjust nursing curriculum and teaching strategies accordingly.

Purpose of the Study

While the literature in the review extensively covered the EDNS while in nursing school, current research is remiss in exploring EDIRNs post-graduation and in understanding what their learning experience was like in a Minnesota undergraduate environment. These graduates may relay positive and negative stories concerning their experiences. By immersing myself into the EDIRNs' stories, a clearer understanding of their learning experiences was achieved, specific to substantial barriers and teaching strategies incorporated by nurse educators. The EDIRN and I, together in dialogue and immersion, allowed me a unique perspective about their struggles and how they overcame these difficulties. The purpose of this study was to understand the learning experiences of EDIRNs and the strategies used to successfully complete an ELBNP in Minnesota. This information introduced a new perspective and provided information from EDIRNs to the state of nursing science.

Research Questions

1. What are the overall learning experiences of EDIRNs who have graduated from a private or public ELBNP in Minnesota within the last 3 years?
2. What strategies were employed by the EDIRN in completing the ELBNP?
3. What helped or hindered the EDIRN in completing their nursing program?

Significance

An increase in EDIRNs in Minnesota and across the U.S. is essential to meet the demands of an ever-growing diverse U.S. population. The U.S. Department of Commerce (2014) estimates 39% of people completing a census survey and living legally in the U.S. comprise different ethnicities or minority groups. This estimate is over one-third of declared U.S. citizens. All states within the U.S. have some diversity within their populations. Minnesota is one such state reporting 18.9% diversity among its 5,457,173 inhabitants (U.S. Department of Commerce, 2014).

Minnesota's immigrant population. Minnesota's population remains predominantly non-Hispanic white totaling 4,524,062 with all other races being 779,863 (U.S. Census Bureau, 2011). While Minnesota's immigrant population (7%) is significantly lower than the national average (13%), the number of immigrants entering this state is growing more rapidly than the national average (Wilder Research, 2015), with the number entering Minnesota almost tripling from "2.6% in 1990, to 5.3% in 2000, to 7.3% 2011" (American Immigration Council, 2014, p. 1). The origin of this population is spread across 10 countries: "Mexico, India, Laos, Somalia, Vietnam, Thailand, China, Korea, Ethiopia, and Canada" (Wilder Research, 2015, p. 1).

Approximately 80% of immigrants live in Minneapolis, Saint Paul, or in their surrounding cities (Wilder Research, 2015).

Minnesota's quickest and largest immigrant population is arriving from Somalia (Weiland, Morrison, Cha, Rahman, & Chaudhry, 2012). The largest percentage of the Somali immigrant population within the U.S. resides in Minnesota (Pavlish, et al., 2010). The U.S. Census Bureau estimates the number of Somalis living in Minnesota to be nearly 32,000, which includes Somalis immigrating to the state and their children (Williams, 2011). Immigrants are rapidly settling in communities such as Saint Cloud, the eighth largest city located in Central Minnesota (Banaian & Garcia-Perez, 2014). In Saint Cloud, 4,484 foreign-born people reside; with the largest group represented by 1,182 Somalis (Banaian & Garcia-Perez, 2014). Since the beginning of the ELBNP at Saint Cloud State University (SCSU) in 2001, the nursing school has only admitted, graduated, and passed the NCLEX-RN one Somali immigrant to date. This graduate is a practicing RN who is employed at Saint Cloud Hospital. With a large segment of Somali population residing in Saint Cloud, SCSU should be admitting and graduating diverse nursing students more representative of the population in this city. As the Somali population grows in Minnesota, so could their health disparities by continued attrition of EDISNs from ELBNPs (Gilchrist & Rector, 2007; Harris et al., 2014; Newton & Moore, 2009; Symes et al., 2002).

Minnesota resident diversity is also rich with African Americans (5.7%), American Indian or Native Alaskan (1.3%), Asian American (4.5%), Hispanic (5.0%) and those with two or more races (2.3%) per the U.S. Census Bureau (U.S. Department of Commerce, 2014, p. 1). With a large diverse population, health disparities abound

among the underserved and ethnic minorities (The Sullivan Commission, 2004). The state of Minnesota also experiences a "low per capita public health funding" which is extensively needed for immigrants and refugees entering Minnesota (American Public Health Association, 2014, p. 1). Supervisor Zelenak for the Health Protection and Promotion Unit and Supervisor Leraas for the Family Health Unit at the Stearns County Public Health Department were adamant that without enough funding for public health programs and social media announcements, immigrants and refugees may not be privy to all preventative care and services (personal communication, November 24, 2015). While Minnesota does have federal and state programs as well as Catholic Charities and Lutheran Social Services to assist immigrants and refugees, these services also encourage more immigrants and refugees to reside in Minnesota than in other states (Hohmann, 2014).

The National Research Council (2003) noted that even after accounting for socioeconomic disparities, health care continues to be poor for ethnic minorities. Again, immigrants are not specified and may be included in their term "racial and ethnic minorities" (National Research Council, 2003, p. 1). In 2002, the Institute of Medicine suggested that in order to decrease or eliminate disparities, education is needed for healthcare providers to gain cultural competency. A more appropriate approach would be to increase the number of EDNs for each ethnic minority and immigrant population (The Sullivan Commission, 2004). Statistics dictate that a "diversity gap" (The Sullivan Commission, 2004, p. 2) continues to exist between the numbers of ethnic and racial minorities living in the US. (U.S. Department of Commerce, 2014) and the volume of EDNs serving this population (AACN, 2014). The Sullivan Commission (2004)

recommended diversification of healthcare providers as a step towards congruent health care that benefits the entire U.S. population.

Without EDIRNs caring for culturally, racially, and ethnically similar patients, there remains a potential for patient dissatisfaction from misunderstandings through miscommunication or cultural beliefs between the nurse and the patient (The Sullivan Commission, 2004). Increasing an ethnically diverse nursing workforce that includes immigrants within the U.S. will decrease the healthcare disparities and improve patient outcomes among diverse populations (The Sullivan Commission, 2004). Ultimately, understanding the positive and negative learning experiences while recognizing strategies the EDIRN used or the nurse educator used for successful completion of an ELBNP, is one way to address future EDIRN retention in an ELBNP.

Definitions

Ethnically diverse immigrant registered nurse. For this study, the EDIRN refers to any foreign-born person who enters the U.S. legally on a visa, through employment or a nursing program of study, or as a relative of someone and can become a naturalized citizen after living and working in the U.S. for 5-years (Martin & Midgley, 2006). Registered nurse corresponds with a healthcare provider who has completed his or her nursing education in the U.S., specifically Minnesota for this study, and has successfully passed the NCLEX-RN.

Ethnically diverse immigrant student nurse. The EDISN is any foreign-born person who enters the U.S. legally on a visa, through employment or education, or as a relative of someone and can become a naturalized citizen after living and working in the

U.S. for 5-years (Martin & Midgley, 2006). He or she is enrolled in an entry-level baccalaureate nursing program of study.

Ethnically diverse nurse. The EDN represents an ethnic minority who was born and resides in the U.S. or its territories, completed a nursing program in the U.S., and successfully passed the NCLEX-RN.

Ethnically diverse nursing student. The EDNS represents an ethnic minority who was born and resides in the U.S. or its territories, and is in the process of completing any undergraduate nursing program.

Entry-level baccalaureate nursing program. There are many levels of nursing. For this study, the nursing student begins his or her education in a 4-year program located in an institution of higher education such as a university. This does not include the practical nurse, diploma, or associate degree nursing programs nor ladder programs, such as the practical nurse to RN and RN to baccalaureate nurse.

Learning experiences. For this study, learning experiences are defined as the process by which EDISNs engage themselves toward understanding nursing knowledge and practicing nursing skills through actions, observations, and reflections by interactions with nursing peers, nurse educators, mentors, and clinical preceptors. Each EDIRN will recall specific moments of their learning experiences, whether positive or negative, occurring throughout their nursing education.

Retention. Retention of EDISNs within this study is defined as the student remaining in and completing the nursing program (Cameron, Roxburgh, Taylor, & Lauder, 2011). Shelton (2013) proposes a model with definition of goals for student retention. The student must persevere "or choose to remain in an academic program,

maintain successful academic performance, or achieve the academic standards that are required to continue in a program and ultimately to graduate" (Shelton, 2013, p. 2). Retention is challenged when internal and external variables influence student success (Shelton, 2013). For the EDNS and EDISN, these mediator variables consist of the perceived barriers to a successful completion of a nursing program.

Chapter 2: Review of Literature and Conceptual Framework

Introduction

In coming to know or seeking the truth regarding a phenomenon or research question, there must be a foundation of knowledge from which to build. Establishing this groundwork is accomplished through an extensive literature review. The literature search identified perceived barriers to student learning and interventions implemented to increase retention of the EDNS. The literature did not clearly differentiate EDNSs from EDISNs. Thus, the reader cannot be sure that EDISNs were or were not a part of each study originating in the published literature.

While this research is not concerned with retention per se, this is the key term under which the intervention literature related barriers to EDNSs were found. Overall, the literature indicated an indirect relationship between retention and barriers. When barriers are recognized and attended to, retention increases; whereas, if barriers are ignored, retention decreases. This indicates that college and university administration, general education faculty, and nurse educators at institutions of higher learning should pioneer different teaching strategies to decrease barriers and increase retention of EDNSs.

A purposive sampling of the literature was conducted with the explicit intent to focus the search related to perceived barriers to a nursing education and trialed interventions. Electronic databases searched included PubMed-National Center for Biotechnology Information (PubMed-NCBI), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Scopus, and Medical Literature Analysis and Retrieval Online (MEDLINE) using the terms “underrepresented nursing students,” “ethnic diversity,” “immigrants,” and “recruitment and retention.” Duplication of articles

occurred among the databases. Inclusion criteria used for deciding appropriateness of articles comprised English language, peer-reviewed, published articles between 1990 and 2015. In addition, foci on perceived barriers and interventions that provided qualitative or quantitative data pertinent to EDNSs' baccalaureate nursing education were incorporated as part of the inclusion criteria. The databases generated 131 articles and after incorporating the inclusion criteria 81 usable articles were retained. Articles based solely on commentary or other professions were also eliminated. Of the 81 articles, 55 were utilized for this study as they related to EDNS barriers to retention and development of corresponding interventions with or without testing. Twenty-three of the 55 articles suggested interventions; however, they did not implement or test the recommended strategies; thus, were eliminated from the literature review. Interventional articles containing descriptions of the intervention with some type of results given were divided into three categories; programs implemented (17), single or separate interventions such as mentoring, linguistic, and accent modification (10), and a variety of interventions trialed together (5) for a total of 32 usable published articles.

The search also uncovered six literature reviews that identified interventions used in the retention of EDNSs (Ackerman-Barger, 2010; Beacham, Askew, & Williams, 2009; Gilchrist & Rector, 2007; Loftin et al., 2013; Noone, 2008; Torregosa & Morin, 2012). Of the 52 articles cited through these six literature reviews, 28 were included for this literature review using the same criteria outlined above. All articles found through a database search or from preexisting literature reviews focusing on perceived barriers and trialed interventions with identified findings are presented in this literature review.

A secondary and additional sampling of the literature was completed to assure that all published articles specific to EDISN retention had not been overlooked or newer articles written. This search incorporated the electronic databases of PubMed-NCBI, CINAHL, Scopus, and Health Source: Nursing/Academic Edition. The terms entered included "interviews," "structured interviews," "education," "baccalaureate education," "nursing," "baccalaureate," "ethnic groups," "nurses," "minority groups," and "immigrants." This search resulted in 10 articles of which six were doctoral dissertations and four were journal articles written by Evans (2004), Yoder (1996, 2001), or supported by Yoder (Amaro et al., 2006). All dissertations with the exception of one (Yoder, 1996) focused on EDNs or a combination of EDNs and EDNSs without specifying immigrants. One doctoral dissertation interviewed EDISNs upon completion of their first semester in an associate degree nursing school (Gapper, 2006). Thus, the literature search revealed a distinct shortfall of information related to EDISNs in an ELBNP. This literature review was framed integrating Freire's (1970/2011) philosophy of oppression, Yoder's (1993, 1996) research recognizing nursing educators' "patterns of responding" to EDNSs (p. 319), and Amaro et al.'s (2006) follow-up of EDNS perceived barriers.

Framing the literature review using Freire's methodology. Freire's experiences and observations helped to promote understanding of perceived barriers of the EDNS as portrayed through lived oppression. Paulo Freire's (n.d.) lived experiences as an oppressed person in Brazil reverberated throughout his book, *Pedagogy of the Oppressed* (1970/2011). The concept of oppression as described in Freire's methodology was integrated throughout the process of reading each published article for the literature review. By reading each article relating to perceived barriers, I was aware of various

struggles EDNSs faced. Incorporating Freire's methodology in interpreting the stories as told through the published articles, identified further barriers and interventional strategies that would increase retention and success of the EDNS. The articles obtained for this literature review are based on nursing pedagogy as related to EDNSs' education in a nursing program.

Freire related oppression to its perpetuation in pedagogy. He conveyed oppression of the Brazilian people using the dichotomy of humanization and dehumanization (Freire, 1970/2011). Freire (1970/2011) described how the oppressed become dehumanized through, "injustice, exploitation, oppression, and violence of the oppressors" (p.44). A central theme throughout the book involved the oppressed taking back humanity through independent cognition. This theme is expressed and addressed as a turning away from the "banking concept" or passive learning where the educator acts as parent bird feeding its young (Freire, 1970/2011, p. 72). The learner slowly becomes his or her own person with the capability to creatively, intuitively, and independently make decisions in leading a self-directed life. In understanding and exploring EDNSs' perceived barriers and the implemented interventions through the literature review, I came to know oppression through the reality of the EDNS.

Oppression is observed everywhere such as in abuse, bullying, racism, ageism, sexual orientation, and mental illness (Freire, 1970/2011). Anyone viewed as "different" such as an ethnic minority, those marginalized, and underserved can be a victim of oppression. Some may even view oppression as an expectation or "normal" way of life (Freire, 1970/2011).

Freire's influence on educating the oppressed. Freire (1970/2011) defined oppression as "any situation in which 'A' objectively exploits 'B' or hinders his and her pursuit of self-affirmation as a responsible person" (p. 55). The educator then acts as "humanist and libertarian" through pedagogy which employs two phases (Freire, 1970/2011, p. 54). In the first phase, the oppressed reveal their existence in a world of oppression and are compelled in transforming this reality (Freire, 1970/2011). Once this transformation is completed, the second phase begins with the oppressed no longer owning the oppression as all people through dialogue continue together through the course of permanent emancipation (Freire, 1970/2011).

Freire (1970/2011) articulated that educators have a choice to perpetuate violence among the underserved culturally diverse communities or to live and work together in liberating the oppressed and the oppressor through pedagogy and dialogue. Rather than the educator imposing his or her cultural views, values, and attitudes on EDNSs, the nurse educator encourages the EDNS through dialogue whereby, students become the educators. Educators have a tendency to adopt the lexicon of the oppressor and unreflectively indoctrinate EDNSs into the system that oppresses them (Freire, 1970/2011). For example, nurse educators may refer to "reservations" when discussing where Native Americans live, while actually Native Americans view their origination as being from a nation.

Nurse educators can break the bond of oppression by dialoguing with EDNSs and traveling together on an educational journey that promotes a fair chance to learn (Freire, 1970/2011). Dialoguing with an attitude of respect, faith, and love for the other's verbal contribution is a requirement for change to occur. Oppression is reinforced by comments

such as, “That girl, she barely understand English” and “Why so many ESL students admitted in this program?” (Donnelly, McKeil, & Hwang, 2009, p. 138). African American nursing students believe that if they behave like a white person they are treated like a white nursing student as implied by an African American nursing student, “so that’s why I’m acting White for another year, and after that I can be Black,” (Love, 2010, p. 347). Students and nurse educators alike are prized for contributions to the dialogue. Inclusion requires a dialogue of the community to “challenge the attitudes and conditions that determine who is worthy of being educated” (Jones, Fauske, Carr & White, 2011, p. 7). In addition, Yoder (1993) illustrated how this oppression may unknowingly be encouraged by nurse educators’ interactions with EDNSs.

Framing the literature with Yoder’s substantive theory. Yoder’s (1993) theory was illustrated in her dissertation, “Process of Responding to Ethnically Diverse Nursing Students” (p. 86). This theory evolved from grounded theory research where she examined the perceptions of nurse educators elicited from sampling 27 nursing faculty with 17 self-identified ethnically diverse nurse educators (Yoder, 1996, p. 316). This effectively identified five “instructional responses” of faculty in educating EDNS (Yoder, 1993, p. 86). Yoder’s (1993) study also interviewed EDNS’ perceptions of the “actions and interactions” with nurse educators (p. 7). This study identified perceived barriers by EDNSs (Yoder, 1993, p. 86). While Yoder (1993) interviewed nurse educators and EDNSs, the main premise was the identification of a continuum with levels of cultural awareness by nurse educators. From the themes, Yoder (1996) constructed a model (see Appendix A) that illustrated the essence of instructional responses of nurse educators to EDNSs.

Yoder's substantive model published in 1996 and confirmed by Amaro et al. (2006), identified four categories of perceived EDNS barriers to learning, "personal, academic, language, and cultural" (Yoder, 1996, pp. 250-251). Through synthesis of each article that identified the overarching barriers to achieving a nursing education, subsequent categories were updated and added to after I completed an integrative literature review. After analysis of the literature, incorporation of Yoder's (1996) research, and synthesis of the numerous perceived barriers by EDNSs in the literature, categories of perceived learning barriers were identified and the changed model as first described by Yoder (1993/1996) now encompasses more barriers with explicit defining characteristics. Two of Yoder's (1996) barriers to learning were retained, personal and cultural. Categories identified from the literature are similar to Yoder's (1996), but changed from academic to educational, language to communication, and an additional fifth category, discrimination, is discussed last.

Personal. The personal theme describes specific facets relating to a person's private life. The person's private life in this instance incorporates barriers encompassing financial limitations, family responsibilities, lack of emotional support from family, fear of failure, necessity of working through school, loneliness and isolation, stress, and self-doubt (Amaro et al., 2006; Bond et al., 2008; Evans, 2008; Gardner, 2005a; Loftus & Duty, 2010; Love, 2010; Sanner, Wilson, & Samson, 2002; Taxis, 2006; Vélez-McEvoy, 2010; Yurkovich, 2001). The personal category contains antecedents describing a specific set of perceived barriers. These antecedents hinder a positive nursing education experience.

Cultural. This is another category that impedes education. The cultural category designates perceived barriers that surround ethnicity and cultural values, attitudes, and beliefs of the EDNS. Through the literature review, EDNSs identified lack of role models, non-assertiveness or being soft-spoken, living bi-culturally, pressure to assimilate, and values different than the non-Hispanic white person (Amaro et al., 2006; Bond et al., 2008; Evans, 2008; Gardner, 2005a; Love, 2010; Sanner et al., 2002; Taxis, 2006; Vélez-McEvoy, 2010; Yurkovich, 2001). Learned cultural approaches such as non-assertiveness may lead to the idea the student is not actively engaged or fails to be a strong "advocate."

Educational. Educational factors comprise difficulties of EDNSs' experiences in their learning, specifically those that affect learning. The perceived barriers by EDNSs in the educational category include: poor preparation for college, heavy course workload, limited study groups or tutors, feeling unwelcomed, inadequate time management skills, poor study habits, nurse educators' lack interest, misunderstandings from pronunciations or thick accents between nurse educators and the EDSN, and unfamiliarity with diverse assessments (Amaro et al., 2006; Bond et al., 2008; Evans, 2008; Gardner, 2005a; Loftus & Duty, 2010; Love, 2010; Sanner et al., 2002; Taxis, 2006; Vélez-McEvoy, 2010; Yurkovich, 2001).

Communication. Communication is a major element in nursing. Students communicate verbally, electronically, or through the written word with nurse educators, fellow students, health care providers, and with patients and their families. Students who require English Language Learner (ELL) courses may have more difficulty with vocabulary, grammar, syntax, context, accents, or dialects (Bosher & Bowles, 2008).

Where there are communication or language differences, there may be potential for cultural bias when the nurse educators and the EDNS do not share the same contextual view of the world (Carr & DeKemel-Ichikawa, 2012; Kossman, 2009). Miscommunication between the nurse educator and the EDNS can derail a successful nursing education (Carr & DeKemel-Ichikawa, 2012; Kossman, 2009). Within the communication category, EDNSs state that translating from their native language to English comprises an enormous effort (Amaro, et al., 2006; Gardner, 2005a; Loftus & Duty, 2010; Vélez-McEvoy, 2010). Due to accents or other language complications, the research demonstrates that EDNSs are afraid to speak as miscommunication may occur with patients, peers, and nurse educators (Carr & DeKemel-Ichikawa, 2012; Vélez-McEvoy, 2001).

Discrimination or Incivility. Amaro et al. (2006) described cultural barriers as "communication, assertiveness, and lack of ethnic role models" (p. 251). Examples given under cultural barriers did not sufficiently describe or define acts of discrimination as experienced by the EDNS. Cultural barriers omitted obstacles such as insensitivity and discrimination by peers and educators as described by student comments, "They (minorities) should expect to try to act like one of the (majority) people and think less about where they came from" (Gardner, 2005a, p. 159) and "I just think that there was some unevenness and I really reconsidered whether or not I was at the right place" (Bond et al., 2008, p. 141). Discrimination is defined for this newly developed category as denying participation to groups of people based on prejudice. EDNSs felt discriminated through many different avenues as reported by several researchers (Amaro et al., 2006;

Bond et al., 2008; Evans, 2008; Gardner, 2005a; Love, 2010; Taxis, 2006; Yurkovich, 2001).

Another aspect of discrimination lies within a specific set of beliefs described as the "monolithic culture" (Veal, Bull, & Miller, 2011, p. 324). Veal et al. (2011) defined this specific culture as "values, perspectives, and beliefs that exist in a predominately white educational institution where there is an absence of ethnically diverse students and faculty and an absence of diverse perspectives in the classroom and at social events" (p. 324). Examples of discrimination experienced by EDNSs include refusal of care by white patients (Amaro et al., 2006), barring the way to success by white nursing educators (Amaro et al., 2006; Evans, 2008), perpetuating stereotypes (Bond et al., 2008; Love, 2010; Taxis, 2006; Yurkovich, 2001), disregarding cultural differences by peers, and neglecting EDNSs from class activities and study groups (Gardner, 2005a; Love, 2010).

Identification of an overarching barrier related to EDNS retention. There are many barriers found within each of the five categories that EDNSs face when in a nursing program as addressed throughout the published articles. An underpinning premise was identified that connected all categories, personal, cultural, educational, communication, and discrimination (Alicea-Planas, 2009; Loftin et al., 2012; Yoder, 1993/1996). This overarching premise: *Cultural Awareness and Sensitivity Amongst All* was observed throughout the literature review. Cultural awareness and sensitivity should dwell within nursing educators, students and peers, and practicing nurses, as highlighted by Campinha-Bacote (2010) and Yoder (1993/1996). Cultural awareness barriers spanned across all categories as represented by Euro-American nursing faculty and nursing student peers'

unawareness of immigrant language, financial issues, family problems, cultural health beliefs, discrimination due to ignorance of each immigrant's culture. Cultural awareness along with acknowledging cultural differences remain the keys to EDNS retention (Campinha-Bacote, 2010; Campbell & Davis, 1996; Davidhizar & Shearer, 2005; Davis, Davis, & Williams, 2010; Gardner, 2005a; Snead, 1983; Terhune, 2006; Yoder, 1996). In a broader sense, respect for all people is necessary to demolish the barriers between all people.

Literature Review

The integrative literature review contributed to understanding the perceived barriers and interventions incorporated in educating EDNSs. This review focused on the EDNS's educational experiences or identification of barriers and interventions employed or trialed to improve retention in a nursing program. The literature further emphasized the deficiency of nursing faculty in cultural awareness and proposed that since over 80% of nurses and nurse educators are white middle-class women they may have difficulty thinking and performing outside their comfortable cultural zone (Snead, 1983; Terhune, 2006; Yoder, 1997). Nairn, Hardy, Harling, Parumal, & Narayanasamy's (2012) phenomenological study explored culture and suggested racism in nursing programs from interviewing eight white nursing faculty with open-ended questions related to culture and racism. Their research suggested cultural differences are not easy to discuss yet, can encourage cultural competence by nurse educators (Nairn et al., 2012).

The nurse educator's worldview is restricted to his or her lived experiences within Western institutional settings (Getty, 2009). In understanding EDNS' educational needs, the nurse educator immerses herself in a worldview other than her familiar and

comfortable Western ways (Getty, 2009). Childs, Jones, Nugent, and Cook (2004) suggested that nursing curriculum move away from Eurocentric views and thread cultural awareness throughout the nursing program. Changing nursing curricula towards improving student cultural awareness and involving EDNSs through sharing their culture increases a sense of belonging for EDNSs, leading to retention of EDNSs in nursing programs (Childs, et al., 2004).

Barriers to retention of EDNSs were addressed in published articles and dissertations (Amaro, et al., 2006; Bond et al., 2008; Evans, 2008; Gardner 2005a; Guhde, 2003; Loftus & Duty, 2010; Love, 2010; Sanner et al., 2002; Taxis, 2006; Velez-McEnvoy, 2010; Yurkovich, 2001). Authors identified barriers from a wide range of ethnic minorities within the US: Native Americans, Hispanics or Mexican Americans, African Americans, Asian Americans, and East Indians (Amaro et al., 2006; Gardner, 2005c; Yurkovich, 2001). While identification of barriers was pursued as the primary goal, nursing educators and researchers recognized the need to increase the number of EDNs (Ackerman-Barger, 2010; Alicea-Planas, 2009; Amaro et al., 2006; Beacham et al., 2009; Bond et al., 2008; Childs et al., 2004; Gardner, 2005c; Giddens, 2008; Gilchrist & Rector, 2007; Harris et al., 2014; Loftin et al., 2013; Loftus & Duty, 2010; Love, 2010; Taxis, 2006; Terhune, 2006; Veal et al., 2011).

Interventions incorporated for retention of EDNSs. Numerous authors addressed individual interventions such as *general programs* aimed at the overall educational experience for EDNSs (Abriam-Yago, et al., 1999; Bagnardi & Perkel, 2005; Brown & Anema, 2007; Brown & Marshall, 2008; Condon et al., 2013; DeLapp, et al., 2008; Edwards et al., 2009; Fletcher et al., 2003; Gordon & Copes, 2010; Harris et al.,

2014; Hesser et al., 1996; Igbo et al., 2011; Ormeaus & Redding, 1990; Parkes & Kirpatrick, 1996; Peter, 2005; Rearden, 2012; Stewart, 2005; Sutherland et al., 2007; Symes et al., 2002; Trossman, 2009; Valencia-Go, 2005). Other interventions were specifically focused on EDNSs' perceived educational barriers (Bosher & Bowles, 2008; Brown, 2008; Cantu & Rogers, 2007; Carr & Dekemel-Ichikawa, 2012; Cotalillo, 2007; Escallier & Fullerton, 2009; Guhde, 2003; Hill, Lawson, & Rhodes, 2008; Nugent et al., 2004; Stokes, 2003; Wilson, Sanner, & McAllister, 2010). *Focused interventions* specifically targeted one barrier such as communication or cultural awareness. Other programs entertained *a variety of strategies* that attempted to cover as many barriers as possible to retain EDNSs within the nursing school (Anders et al., 2007; Edwards et al., 2009; Gardner, 2005b; Georges, 2012; Klisch, 2000; Newman & Williams, 2003; Nnedu, 2009; Swinney & Dobal, 2008). Generalized programs, focused interventions, a variety of strategies, as well as untested teaching strategies were identified among the published articles. A few of the incorporated interventions included: financial support, mentoring, living communities, and tutoring. Each section is further discussed.

Generalized Programs. Programs such as Affirming At-Risk Minorities for Success (Sutherland et al., 2007), Baccalaureate Enrollment and Success Tactics for RNS (Brown & Marshall, 2008), Consortium to Advance Nursing Diversity and Opportunity (Igbo et al., 2011), Embracing the Challenge (Swinney & Dobal, 2008), Getting Assistance in Nursing (Ormeaus & Redding, 1990; Valencia-Go, 2005), Learn for Success (Peter, 2005), Minority Recruitment Academic Advising Program (Hesser et al., 1996), Minority Recruitment and Retention Initiative (Fletcher et al., 2003), Recruitment Enhancement Cultural Affirmation Project (Edwards et al., 2009), Success in Nursing

(Stewart, 2005), Success in Nursing: Individiualized Pathways Program (Condon et al., 2013), Student Success Program (Symes et al., 2002), The Cummins Model (Abriam-Yago et al., 1999), The Growth and Access Increase for Nursing Students Project (Valencia-Go, 2005), and The Learning Achievement Program (Bagnardi & Perkel, 2005) were established to provide a solution or solutions to EDNSs perceived barriers. Each program, while slightly different, was developed to address barriers and therefore, increase retention of EDNSs. All programs typically implemented more than one strategy to cover several perceived barriers identified through previous research. For example, The Cummins Model suggested integrating 11 strategies that encouraged the EDNS to become adept in English through social and academic communication (Abriam-Yago et al., 1999). These strategies were accomplished through encouragement of the EDNS to speak about themselves and their world, expression of culture to faculty, nursing staff, peers, and patients when caring for those of the same culture (Abriam-Yago et al., 1999). Each of these interventions concentrated on a specific aspect of the nursing program for the EDNS retention.

Components of most programs consisted of assigned nurse educator mentors or advisors (Bagnardi & Perkel, 2005; Edwards et al., 2009; Igbo et al., 2011; Nugent et al., 2004; Peter, 2005; Swinney & Dobal, 2008; Sutherland et al., 2007), allocated practicing EDNs as mentors (Condon et al., 2013; Escallier & Fullerton, 2009; Evans, 2004; Fletcher et al., 2003; Hesser et al., 1996; Nugent et al., 2004; Trossman, 2009) devoted campus housing to EDNSs (DeLapp et al., 2008; Rearden, 2012), offered workshops on study, writing, stress, time management, and test taking techniques (Condon et al., 2013; Hesser et al., 1996; Igbo et al., 2011; Ormeaus & Redding, 1990; Peters, 2005; Stewart,

2005; Sutherland et al., 2007; Symes et al., 2002; Trossman, 2009), socialization to the nursing role through modeling (Brown, 2008; Brown & Marshall, 2008; Igbo et al., 2011), developed and dispersed newsletters (DeLapp et al., 2008; Hesser et al., 1996; Rearden, 2012;), student orientation (Bagnardi & Perkel, 2005; Edwards, et al., 2009; Hesser et al., 1996; Igbo et al., 2011;), preparatory courses (Condon et al., 2013), computer support (Escallier & Fullerton, 2009; Sutherland et al., 2007; Trossman, 2009), study groups (Condon et al., 2013; Peters, 2005), linguistic help (Brown, 2008; Brown & Marshall, 2008; Symes et al., 2002; Trossman, 2009), stipends, (Condon et al., 2013; DeLapp et al., 2008; Rearden, 2012; Edwards et al., 2009; Evans, 2007; Nugent et al., 2004; Ormeais & Redding, 1990; Stewart, 2005; Trossman, 2009), peer tutors (DeLapp et al., 2008; Rearden, 2012; Peters, 2005), social events (Bagnardi & Perkel, 2005; Brown, 2008; Brown & Marshall, 2008;), and educator development towards cultural awareness of EDNSs (Anders et al., 2007; Bagnardi & Perkel, 2005; Brown & Marshall, 2008; Edwards et al., 2009; Georges, 2012; Klisch, 2000; Nugent et al., 2004; Stewart, 2005; Swinney & Dobal, 2008; Wilson et al., 2010). Prominent intervention crossover among the reported programs highlighted employing nurse educators as mentors and advisors, soliciting practicing community nurses as mentors, offering workshops related to stress, time management, learning styles, and test-taking strategies.

The programs developed as stated above were evaluated using number of graduates, first time NCLEX-RN pass rates, and retention statistics. The results for the programs were mixed. The Recruitment and Retention of Alaska Natives into Nursing (RRANN) program graduated 46 EDNSs with all but one passing the NCLEX-RN the first time (DeLapp et al., 2008; Rearden, 2012), while 96% of EDNSs from Recruitment

Enhancement Cultural Affirmation Program passed the NCLEX-RN (Edwards et al., 2009). Escallier and Fullerton (2009) had 100% retention rate; however, their mentorship portion was unsuccessful. Igbo et al. (2011) identified a significant retention rate increase from 56% to 77%. Bagnardi and Perkel (2005), claimed that 14 of 20 EDNSs graduated in 2002 and 19 of 20 EDNSs in 2003 graduated. First time NCLEX-RN pass rates for EDNSs in the BEST RN program was 0% with a 50% pass rate the second time around (Brown, 2008; Brown & Marshal, 2008). Condon et al. (2013) reported an 87% retention rate with 83% passing the NCLEX-RN. For further results please refer to Table 2.1 (see Appendix B).

These specific programs were designed at differing times within the last 25-years with most funded by the U.S. government through grants or other entities such as the Robert Wood Johnson Foundation (2016). The majority of the research conducted was funded through the Department of Health and Human Services (DHHS) and Human Resources and Services Administration (HRSA). Seven studies did not identify any source of funding, while one admitted to lack of funding. Three studies were funded by other grants outside of the federal government. Table 2.1 (see Appendix B) contains information on funding for each of the studies reviewed through the literature search.

Developing a sound intervention requires a foundation guided by conceptualizations and understandings of phenomena (Polit & Beck, 2012). Only two programs developed interventions that were designed and guided by a specific model (Condon et al., 2013) or theoretical framework (Brown & Marshall, 2008). All other programs either did not integrate a guiding theoretical framework or did not include one in the published article. Programs and interventions built without accurate or insufficient

knowledge and understandings are potentially unreliable and unsound (Polit & Beck, 2012).

When reviewing articles regarding the program development and testing, only two authors studied the same program. DeLapp et al. (2008) created the RRANN program with results confirmed by Rearden (2012) that demonstrated the importance of programs designed to increase retention. Rearden's (2012) research explored student attitudes and viewpoints on programs offered specifically to increase retention. Rearden (2012) emphasized the scarcity of published research inquiring about the new EDN's perception of the program implemented in the nursing school of graduation.

Programs created and integrated into schools of nursing may improve retention and graduation rates of EDNSs; however, EDN post-graduation perspectives must be collected to garner the EDNS's opinion. While these programs might continue to exist and demonstrate positive results, the nurse educator may not understand what the EDNS encounters in a more personal manner.

Focused interventions. Some strategies from the established programs were treated as single interventions such as mentoring and linguistic assistance. Single interventions focused on particular barriers such as verbal and written language skills (Bosher & Bowles, 2008; Guhde, 2003) or communication and accent alteration (Brown, 2008; Carr & Dekemel-Ichikawa, 2012), absence of empowerment (Stokes, 2003), and deficiency in healthcare knowledge and experience (Hill et al., 2008).

For example, "Gatherings" offered EDNSs the opportunity to meet as a group with faculty on a regularly scheduled basis to improve communication, share stories, clarify educational questions, and empower students (Stokes, 2003, p. 80). Nurse

educators facilitating the gatherings noted the helpful feedback given to peers from peers, identifying non-professional behaviors, and providing support to one another through faculty led EDNS meetings (Stokes, 2003). Student comments about the meetings included: "It serves as a source of support to others" and "Please continue the gatherings" (Stokes, 2003, p. 82). A similar intervention, a "collaborative co-op," was suggested between partnering hospitals and the nursing school with the intent of hiring prospective and concurrent nursing students to provide additional clinical time and mentoring from minority nurses (Hill et al., 2008). This suggestion was not trialed.

Other interventions concentrated on communication skills since nursing requires a high ability to speak, understand, and interpret interactions with the patient, the patient's family members, and healthcare professionals. Communication interventions were twofold, assisting the EDNS to improve their written and verbal English language ability (Abriam-Yago et al., 1999; Guhde, 2003) and "accent modification" (Carr & DeKemel-Ichikawa, 2012, p. 79). Improving language skills integrated several strategies into tutoring sessions such as "reading aloud, writing a nursing note, speaking words from a list upon hearing them, and listening to a taped nursing report while transcribing onto a prepared form" (Guhde, 2003, pp. 114-115). Students engaged in improving their language skills through this strategy increased participation in classes and stated that understanding English had improved (Guhde, 2003).

These strategies gave the opportunity to hear, see, speak, and write using many of the EDNSs' senses to incorporate and feel comfortable using the English language in a safe environment. The accent alteration strategy required assessment for hearing impairments and speech-language impediments prior to attendance once a week for an

hour with a speech and language graduate student (Carr & DeKemel-Ichikawa, 2012). Communication and classroom participation improved with integration of accent modification sessions (Carr & DeKemel-Ichikawa, 2012).

Mentoring took several forms, ranging from a student tutor (Cantu & Rogers, 2007), a practicing nurse in the community (Banister et al., 2014), or a nurse educator (Wilson et al., 2006). Mentors are those who assist the student through role modeling, emotional or academic support, and professional socialization (Escallier & Fullerton, 2009). Banister et al. (2014) incorporated mentoring EDNSs with a practicing nurse to solve a high attrition rate. Upon utilization of mentoring, there was zero attrition and decreased employment turnover (Banister, 2014). Cantu and Rogers (2007) incorporated a mentoring program where second semester students mentored first semester nursing students. The program grew from 20 to 104 students and 100% of the participants graduated with all successfully passing the NCLEX-RN (Cantu & Rogers, 2007, p.126). Nurse educators also acted as mentors in research conducted by Wilson et al. (2010). Faculty were trained to mentor in three areas, "role modeling, caring, and academic success" (Wilson et al., 2010, p. 147). Students who were mentored by nurse educators felt supported an understood nursing professionalism; this assisted the EDNS to improve studying, note-taking, and test-taking strategies (Wilson et al., 2010). Another strategy was to integrate multiple mentors for students in experiences before settling on a single mentor during the nursing program (Noone, 2008).

A single university capitalized on mentoring through development of a "community" of graduate nursing students helping undergraduate students (Cantu & Rogers, 2007, p. 124). A similar type of mentoring is senior baccalaureate nursing

students mentoring and tutoring nursing students who are in their first four semesters of the nursing program. Through a grant (Scherer, 2013) funded by the Saint Cloud State University Center for Excellence in Teaching and Learning, this nursing program made available nursing mentors and tutors from the senior class for all nursing students including EDNSs. Students found that they could readily find assistance in the nursing program, respected the knowledge of mentors, and found mentors helpful in prioritizing and maximizing study time. Mentoring is a single entity used in assisting the EDNS towards success, while other interventions offer added assistance in achieving the goal of becoming a professional nurse.

A variety of interventions. Although not labeled a program, the use of a variety of interventions becomes a category unto itself. Just like articles describing formal programs, many strategies were identified among each published article. However, the combined strategies were not labelled as a "program." For example, taking into consideration the barriers they face, Anders et al. (2007) combined multiple interventions such as tutors, financial assistance, nursing mentors, faculty cultural awareness, and social events for EDNSs. Students who entered this nursing school and incorporated these multiple interventions, graduated, and passed the NCLEX-RN (Anders et al., 2007). Gardner (2005b) designed a range of interventions to decrease EDNS attrition. By implementing a mentor network, hiring a retention coordinator, pairing ELL students with primary English speakers, holding family nights for students and family, and beginning a support group for EDNSs, 100% retention was achieved (Gardner, 2005b).

Untested teaching strategies. Some researchers advised an approach integrating multiple instructional methods to satisfy the learning needs for all students thereby,

increasing the probability of success and retention of EDNSs (Campbell & Davis, 1996; Davidhizar & Shearer, 2005; Giddens, 2008). Others suggested that becoming culturally competent and incorporating self-reflection through dialogue with EDNSs increased awareness of the potential discriminatory environment while developing appropriate teaching methods for all students (Terhune, 2006; White, 2003). Giddens (2008, p. 80) postulated that designing learning strategies or planning "multicontextual" instruction for all students in a course, allowed education from a cultural and cognizant perspective that benefits all nursing students. One way to do this is to focus on student-centered learning rather than educator-centered and content-centered learning to allow cultural awareness to permeate the learning environment.

Article reviews for barriers and interventions. Literature reviews related to barriers and interventions incorporated were conducted by Loftin et al. (2013) and Torregosa and Morin (2012) who reviewed interventions studied in the retention of the EDNS. While Loftin et al. (2013) synthesized 11 quantitative articles and program evaluation reports between the years of 2000 and through 2011, Torregosa and Morin (2012) included 22 representative articles over this same period that covered qualitative studies as well. Only four research articles were duplicated between both integrative reviews. Each review provided a comprehensive table identifying the intervention examined and results obtained. For this study, 28 articles allocated to retention of EDNSs were included that elicited either qualitative or quantitative data. Four articles not previously analyzed in the literature were also considered and included (Banister et al., 2014; Bosher & Bowles, 2008; Carr & DeKemel-Ichikawa, 2012; Georges, 2012) as they focused on newer information regarding interventions for ELL and mentoring from a

different perspective. From the studies found, few were conducted using a quasi-experimental or experimental approach (Ghude, 2003; Hesser et al., 1996; Klisch, 2000; Sutherland et al., 2007).

Sutherland et al. (2007) incorporated a Likert scale to measure "student responses to the mentoring, tutoring, and Seminars in Success, as well as a summative program evaluation" between groups of students who participated and those who did not in the Affirming At-Risk Minorities for Success (ARMS) program (p. 350). This program incorporated faculty-student advising and mentoring, tutoring, provided a laptop with software, and workshops on how to be successful (Sutherland et al., 2007). Findings indicated that ARMS students did not perform any better than non-ARMS students (Sutherland et al., 2007).

Hesser et al. (1996) compared two groups of students—African American and all other nursing students. By incorporating a quasi-experimental approach, these researchers identified that the program, Minority Academic Advising Program, had a positive effect on African-American students (Hesser et al., 1996). The Minority Academic Advising Program included counseling, provided a study skills expert, advising meetings, newsletters, African-American role models, and summer orientation to the nursing program (Hesser et al., 1996).

Ghude (2003) studied improving English language skills of ELL students. A pre- and post-test was administered to the students for listening and taking notes (Ghude, 2003). Statistics indicated that pre-intervention, students were able to correctly record 25% of the information dictated (Guhde, 2003, p. 115). Post intervention, these same students could accurately write down 40% of the dictation (Guhde, 2003, p. 115).

Klisch (2000) conducted a post-test to evaluate a variety of interventions such as enhancing faculty and student cultural competence, presented language tutoring, provided assertiveness training, offered extended test time, and encouraged social support with others. The results indicated that students were satisfied with the variety of methods used to support their learning (Klisch, 2000). These data were supported by statistics showing 23 EDNSs graduated with a 91% first-time NCLEX-RN pass rate (Klisch, 2000, p. 24).

Other quantitative articles contained data comparing retention, graduation rates, and NCLEX-RN pass rates before and after the interventions. Of these articles, 19 reported positive results after implementing the intervention (Anders et al., Bagnardi & Perkel, 2005; Banister & Bowen et al., 2014; Brown & Marshall, 2008; Carr & DeKemel-Ichikawa, 2012; Condon et al., 2013; Edwards et al., 2009; Escallier & Fullerton, 2009; Evans, 2004; Gardner, 2005b; Georges, 2012; Nugent et al., 2004; Ormeaus & Redding, 1990; Peter, 2005; Rearden, 2012; Stewart, 2005; Swinney & Dobal, 2008; Trossman, 2009; Valencia-Go, 2005). Please see Table 2.1 (Appendix B) for specific results. Four other authors used a mixed evaluation method where interventions were trialed and subjective information was elicited from participants, along with data on retention, graduation, or NCLEX-RN pass rates from the nursing school (DeLapp et al, 2008; Fletcher et al., 2003; Igbo et al., 2011; Symes et al., 2002). A limitation, the Hawthorne effect, may be present when researchers elicited a verbal or subjective response from participants as EDNSs may want to please the faculty member or researcher (Polit & Beck, 2012). Again, these researchers integrated a combination of evaluation techniques from EDNSs to nurse educators.

Several studies utilized a qualitative approach where researchers were interested in the feelings of EDNSs after an intervention was completed (Bosher & Bowles, 2008; Cantu & Rogers, 2007; Stokes, 2003; Wilson et al., 2010). Bosher and Bowles (2008) conducted an exploratory study with ELL nursing students who found difficulty answering exam questions. Researchers collected data through interviews pre- and post-exam completion with the five ELL participants (Bosher & Bowles, 2008). The author's (2008) study concluded that nurse educators should linguistically modify exams and observe the results for all nursing students.

At the University of Texas, Cantu and Rogers (2007) implanted a mentoring program for underserved nursing students. While this interventional study focused on results by numbers of students enrolled in the mentoring program and pass rates of the NCLEX-RN, Cantu and Rogers (2007) also gathered comments from students that were mentored. All comments obtained by Cantu and Rogers (2007) were positive.

"Gatherings" is an intervention to increase contact with faculty and minority or international nursing students (Stokes, 2003, p. 80). This strategy brought together faculty and students to discuss concerns, support each other, and share ideas (Stokes, 2003). Through solicitation of participants in the gatherings, Stokes (2007) asked students to "describe the role that gatherings played in your success" (p. 81). Again, positive comments were relayed by student participants who partook in the gatherings. Stokes (2003) used a qualitative descriptive method to elicit an evaluation of the intervention.

Wilson et al. (2010) used thematic analysis to evaluate a mentoring program instituted to decrease attrition and increase the diversity within the nursing workforce.

Two focus groups were interviewed, nursing faculty mentors and nursing students mentees (Wilson et al., 2010). Three faculty themes were identified, "role modeling, caring, and academic success" (Wilson et al., 2010, p. 147). Nursing student perceptions of the mentoring program contained three themes, "support system, enhanced perception of the nursing profession, and academic enrichment" (Wilson et al., 2010, p. 147). Each theme gave examples of participant responses to questions asked within the focus groups (Wilson et al., 2010). These authors concluded that mentoring programs where students were mentored by nursing faculty, were apt to increase the diversity in the nursing workforce (Wilson et al., 2010).

Each of these qualitative studies did not identify the lived learning experiences or stories of EDNSs' post-graduation. There was very little commentary in each of these articles with the exception that the EDNSs relayed positive comments. These optimistic comments support the possibility of the Hawthorne Effect by EDNS participants in an attempt to please and respect the nurse researcher and decrease disruption in his or her learning experiences.

Why are so few studies conducted to determine the effectiveness of interventions in teaching EDNS? Some researchers such as Nairn et al. (2012, p. 207) suggested this may be due to "racism within the classroom." This sentiment was also felt by Davis et al., (2010); Gardner, (2005a); Snead, (1983); and Terhune, (2006). Interventions required extra effort, increased workload, and commitment by nurse educators without further recognition or compensation that led to abandonment of the interventions (Valencia-Go, 2005). Another plausible explanation for abandonment of interventions is a lack of current funding by educational institutions and federal government grants in

promoting, incorporating, and sustaining programs and strategies within nursing programs. Only one strategy continues to receive funding with program sustainability, "Success in Nursing: Individualized Pathways Program" (Condon et al., 2013). Another program called "The Growth and Access Increase for Nursing Students Project" (Valencia-Go, 2005) stated that funding ended; however, the mentoring intervention continued. No other authors identified whether their programs or interventions continued with or without funding.

The published research cited within this literature review differs from the current study as I come to understand through immersion, the struggles EDIRNs encountered while in an ELBNP. The articles found did not reveal an understanding of why there are barriers and the extent to why these programs or individual interventions may not always work for all EDISNs. This proposed research will enter the EDIRN's worldview of learning experiences after completion of an ELBNP.

Summary. With the identification of barriers and implementation of interventions to retain EDNSs, the central question remains: Why do the numbers of practicing EDNs remain low, marginal, or stagnant with the growing ethnically and racially diverse immigrant population? Yoder (1996) examined nurse educator interactions with the EDNS and emphasized the need for change in nurse educator teaching methods and responses to EDNSs. Nursing educators continue to struggle with development and implementation of teaching strategies and curricular changes that benefit primarily EDISNs and as such specific attention should be directed to this venue. This study eliminated interviews with nurse educators, but sought to understand specific learning experiences of the EDISN post-graduation. Yoder's (1996) qualitative research

study discussed the cultural awareness of educators and was the impetus for this research study.

Completing a literature review was essential in assessing recognized barriers and interventions trialed. Through constant comparison of the data previously viewed through literature reviews (Ackerman-Barger, 2010; Beacham, et al., 2009; Gilchrist & Rector, 2007; Loftin, et al., 2013; Noone, 2008; Torregosa & Morin, 2012) and articles never before included in an integrated literature review, a model (see Appendix C) was created with a central focus. The literature review centered on the development, implementation, and evaluation of interventions for EDNSs by Euro-American nursing researchers; however, there are ongoing confounding barriers. Being cognizant of these extraneous interferences may improve the success of further interventional development and implementation. Nurse educators have much to contemplate going forward in the retention of EDNSs and EDISNs.

Obtaining firsthand information created a greater understanding of learning experiences from EDIRNs which will lead to further research studies in developing a substantive theory, identifying, introducing, and evaluating further interventions, and instituting curriculum changes. The results of this study encourage nurse educators to self-examine and reflect on educational and learning barriers they witness in EDISNs. Nursing faculty cannot and should not expect the EDISN or the EDNS to conform to traditional teaching methods or instructional responses (Davidhizar & Shearer, 2005). The recently graduated EDIRN can elucidate strategies he or she incorporated that assisted or hindered them in their learning through their stories.

Understanding the learning experiences and the identity of specific educational and learning roadblocks may assist in the development of different instructional methodologies or strategies that would be valuable to nursing students. Authors' studies identified in this literature review did not utilize the methodological approach of hermeneutic phenomenology in understanding learning experiences and strategies that the EDISN used to be successful in nursing school. Using phenomenology as the philosophical foundation with a hermeneutic emphasis offers new insight into EDIRNs learning experiences and strategies with the potential to develop interventions that are appropriate and sustainable for nursing school success. Heidegger believed that hermeneutic phenomenology was the beginning and the end of all philosophy. He noted that there are many "entities" available to the world, but "*Dasein's* Being" matters since this concept of the human being's essence of existence is unique to only humans (Heidegger, 1927/1962, p. 32). Chapter 3 provides the reader with a review of hermeneutic phenomenology emphasizing the philosophical and methodological portion crucial to this study.

Conceptual Framework

In purist phenomenology, the idea of a conceptual framework or model supporting the research is irrelevant (Munhall, 2012). Munhall provided a broad overview of hermeneutic phenomenology without being specific to a single philosopher. While hermeneutic phenomenology is recognized as a philosophical approach, it also provided a methodological guide to increase truthfulness through understanding a phenomenon not previously understood or misunderstood (Munhall, 2012). Understanding the meaning of Being through human situations, characteristics, context,

and experiences is the quintessence of hermeneutic phenomenology (Heidegger, 1927/1962). All individuals are unique and perceive world realities differently through social, educational, cultural, and communication avenues. Thus, the philosophy and methodology of Heidegger and Gadamer was pursued as a combined hermeneutic phenomenological approach to this study.

The nursing discipline and hermeneutics. Hermeneutics and nursing are appropriately mutually inclusive. In the nursing profession, communication is required that can change not only our Being in the world, but Being in another's world as well. The verbal and non-verbal communication between nurse and patient, nurse and family, nurse and nurse becomes a part of the Hermeneutic Circle as in the past, present, and future. How a patient, family, or nurse responds to present communication is dependent upon insight, history, and expectations. Recognizing a merger between the nursing discipline and hermeneutics is essential because nursing extensively and vigorously communicates. Nursing does this by integrating active listening and dialogue with the patient, family, colleagues, students, healthcare professionals, and many others. This achieves an understanding from others' past, present, and future worldview perceptions.

Reed (1995) recommended that the word "nursing" came to purport the discipline as a "process of well-being, inherent among human systems" (p. 76). Reed (1995) identified a new definition of "nursing process" as, nurses closely working with individuals towards achieving a "sense of well-being" (p. 76). The second portion identified the meaning of "human systems" to parallel "human beings" (Reed, 1995, p. 77). As a nurse and educator, this definition supports active dialogue, empathy, and

interpretation through language and context with the individual. Thus, this definition supports hermeneutic phenomenology.

The American Nurses Association (ANA) also addressed the definition of nursing. The ANA (2010) identified vital elements within the definition of nursing in their published book, *Nursing's Social Policy Statement: The Essence of the Profession*. One element within nursing was identified by the ANA (2010) as, "Attention to the range of human experiences and responses to health and illness with the physical and social environments" (p. 9). This feature within nursing lends itself to hermeneutic phenomenology as this methodology grasps truth by attending to the participants' human experiences and responses to their Being-in-the-world through dialogue. As a nurse, dialogue is an essential element in understanding human responses.

In keeping with that essential element that defines a portion of nursing, the ANA (2010) recognized the nurse as being present or attentive to human social and environmental experiences. According to Zyblock (2010), presence is being entirely attentive physically, mentally, and spiritually to another regardless of time. White and Whitman (2006) also recognized that merely 'being present' is not enough. Being present influences a mirage of core values such as dignity, honesty, and politeness towards others. These fundamental life values increase sensitivity, positivity, and receptivity through listening and caring for each other (White & Whitman, 2006). Savett (2011) succinctly defined presence as to "practice deliberate silence, engaged listening, and restrained response" in providing for a prosperous dialogue (p. 173). Benner (1985) articulated that "health and illness are lived experiences and are accessed through perceptions, beliefs, skills, practices, and expectations" (p. 1). This statement was

interpreted to cover the fore-structure or essentials within the Hermeneutic Circle, fore-sight, fore-having, and fore-conception. Individual meanings of experiences in the world are influenced and altered by vernacular, ethos, and annals.

Summary. Understanding the lived experience of EDIRN learning while in an ELBNP is integral to nursing's state of the science. Framing the literature review with Yoder's (1996) identified EDNS barriers and Freire's (1970/2011) theory of oppression, structured the literature review for analysis and synthesis. The terms EDNSs and EDNs include EDISNs and EDIRNs unless specified. I unequivocally focused on interviewing EDIRNs to dialogue and understand their perceptions and experiences of learning while in an ELBNP in Minnesota.

The reviewed literature identified nursing students as ethnic minorities, ethnically diverse nursing students, and ethnically diverse nurses without delineation between participants born in the U.S. or born in a foreign country. The integrated literature review provided background information on perceived barriers and integration of interventions for EDNSs without specific demarcation of EDISNs. The published articles recognized that the numbers of EDNs have stagnated with the proportion of immigrants entering the U.S. A gap within the literature lies within the possibility that immigrants living in the U.S. were not part of the published studies. The purpose of this study was to apply hermeneutic phenomenology grounded in the philosophy and methodology of Heidegger and Gadamer to understand the learning experiences of EDIRNs recently graduated from an ELBNP in Minnesota.

Chapter 3: Method and Procedures

Introduction

The purpose presented for this research reflected the desire to understand the learning experiences of EDIRN's when they were in an ELBNP, to come to know the positive and negative learning strategies the EDIRN incorporated for his or her successful completion of the ELBNP, and add to an area of nursing that has yet to be explored. This study contributes to the nurse educators' awareness of the EDIRNs' struggles, invisibility, and resilience required to successfully complete the nursing program. Other areas this study will potentially influence are changes to nursing curricula, formation of new teaching strategies, and improving dialogue among nurse educators in method development to increase retention of EDISNs in ELBNPs.

My philosophical views influenced the research questions, and provided the rationale for implementing hermeneutic phenomenology as the choice of methodology. I answered the research questions through this approach and concentrated on a postmodern interpretivist ontological paradigm that aligned with my philosophical view. Also, this approach recognized the participants' perceptions of the world based on their unique life experiences, occurrences, and circumstances (Wojnar & Swanson, 2007). This ensured a robust research design.

The design chosen was hermeneutic phenomenology integrating Heidegger and Gadamer's methodology. This methodology enhanced story comprehension and derived ultimate meaning, while putting aside my stereotypes, biases, and assumptions. Hermeneutic phenomenology helped and discovered meaning without decontextualizing to achieve an understanding of the phenomenon.

Postmodern era beginnings. Postmodernism began early in the 20th century and developed from philosopher unrest because pure science and knowledge development through "objectification" was considered the absolute truth (Omery, Kasper, & Page, 1995, p. 91). Instead, postmodernism seeks knowledge through inductive reasoning while looking at the whole language, economic, or psyche structures (Jones, 2008). The postmodern philosophies arising from the break with empiricism are phenomenology, hermeneutics, feminism, critical theory, and post-structuralism (Omery et al., 1995). Postmodern philosophies provide a qualitative method to explore phenomena that are quantitatively immeasurable "such as caring, intuition, suffering, spirituality, support" (Dzurec, 1995, p. 239). Hermeneutic phenomenology is a postmodern philosophy and methodology rising from Husserl's descriptive phenomenology, but with a radical twist by adding interpretive understanding by Heidegger.

Philosophical foundation. Husserl, Heidegger's mentor, contemplated how to explain the essence of the subject or object using transcendental phenomenology (Dreyfus, 1991). As the "father of modern phenomenology," Husserl's assumption was that all individuals' worldly experiences are unique, yet the essences of these experiences are common to all (Polifroni, 2011). By connecting mind with body and rethinking the worldview, consciousness is not just present, but always already exists (Harman, 2007). *Always already* as defined by Husserl and continued by Heidegger asserted that being aware is connected to a relationship with the world which they called, "intentionality" (Harman, 2007, p. 79). A person's experience was defined by Husserl as his or her own interpretation of the world, followed by a confirmation or denial of that interpretation that formed the individual's identity (Dooley & Kavanagh, 2007). Husserl's phenomenology

demonstrated that "true being of a thing lies in the way it is present in our minds" (Harman, 2007, p. 23). Thus, *always already* means that once a certain place in time is achieved, the being of places in time earlier than that place is transient. For example, after I complete doctoral courses in nursing, from then forward, I have *always already* known the information, and the time before I entered the doctoral program, being now past, was or is always past. In simpler terms, a person matures from birth to death and everything learned, lived, and experienced throughout this time period becomes part of that person's Being. As human beings we are unable to refute to ourselves that which we know, a priori knowledge. The term *always already* ridicules the idea of tangible concepts, while recognizing that we are bound by our assumptions and nature, and not knowledge. This action ushered in the postmodern era with further development and expansion of hermeneutic phenomenology through Husserl's student, Heidegger.

Development of Heideggerian hermeneutic phenomenology. Philosophical hermeneutics began over 2000 years ago with Plato and Aristotle (Annells, 1996) through interpretation of Homer and other Greek poets (Saks, 1999). The Greek name Herme means "messenger of the gods" that delivered messages from the deities to the humans (Lawn, 2006, p. 45). The full Greek term *hermeneuein* constitutes a verb meaning to interpret. The term hermeneutic stems from the Greek root *hermeneia* suggesting "bringing to understanding particulars where the process involves language" (Leonard, 1989, p. 50). Hermeneutics was resurrected again during the Reformation when scholars and theologists interpreted the *Bible* (Saks, 1999). Phenomenology is derived from two Greek words, *phainomenon* and *logo*, meaning "the study of human experience and the way in which things are perceived as they appear to consciousness" (Langdridge, 2007, p.

10). Previously, art and the written word were the only items interpreted (Lawn, 2006). Hermeneutics was revived again during the postmodern era with Husserl and expanded by Heidegger to include interpretation of events experienced by humans that fully encompassed ontology. Hermeneutic phenomenology highlights how people experience the world in an everyday pre-theoretical way (Munhall, 2012).

Heidegger, a follower of Dilthey, developed fundamental differences with Husserl's phenomenology (Harman, 2007). Heidegger felt that researchers and philosophers placed all of their faith in science, theory, and objects as Husserl's phenomenology reduced perceptions of the world to mere awareness without meaning (Harman, 2007). In *Contributions to Philosophy, From Enowning* written by Heidegger (1989/1999), he noted "the alignment of philosophy with the sciences is shortsighted…must be given up completely" (p. 31). This represented Heidegger's furthermost separation from Descartes' metaphysics and Husserl's ontic phenomenology.

Heidegger (1927/1962) defined phenomenology as a "methodological conception" (p. 50). Hermeneutic phenomenology offered a unique perspective into a specific human experience or situation through the participant's interpretation of the world (Cohen, 2000). Heidegger (1927/1962) further clarified that phenomenology "does not characterize 'the what' of the objects of philosophical research as subject-matter, but rather the how of that research" (p. 50). This represented Heidegger's furthermost separation from Cartesian dualism, Descartes' metaphysics and Husserl's ontic phenomenology. Logical positivism or scientific research measures and explains the world through subjects and objects, while phenomenology seeks to understand "Being-in-the-world" through humans who experience the world with a mind and spirit (Heidegger,

1927/1962, p. 13). This mind and spirit which all human beings possess is an entity within *Dasein's* Being (1927/1962). *Dasein* provides a philosophical foundation by immersing the investigator into the participant's world of Being (Moran, 2000).

Heidegger provided a solid ontological foundation by redefining the true meaning of Being as more than just present, descriptions, and generalizations (Harman, 2007). "Being aims… at ascertaining the *a priori* conditions not only for the science…, but also … of those ontologies themselves which are prior to the ontical sciences and which provide their foundation" (Heidegger, 1927/1962, p. 31). Dithley broadened Heidegger's scope by including the nature of human beings and their actions (Harman, 2007). Heidegger (1927/1962) contributed to this new ontological paradigm through knowledge that originated from understanding interpretations or meaning of existence.

In Heidegger's treatise, *Being and Time* (1927/1962), he contemplated the question, "what is the meaning of Being" (p. 1). Heidegger (1927/1962) revisited this question since epistemological research or logical positivism ignored this question in favor of scientific inquiry, theoretical testing, and generalizations of things. Heidegger (1927/1962) expanded Husserl's philosophy further by redefining the word "*phenomenon* as it signifies that which shows itself in itself" or simply expressed "entities" (p. 51).

Heidegger (1927/1962) referred to Being as an "entity" that each person inherently possesses (p. 32). A person can have multiple entities as witnessed in the human behavioral sciences, but an entity can also be "*Dasein*, a different kind of 'entity'" (Heidegger, 1927/1962, p. 32). Heidegger (1927/1962) was specifically interested in "*Dasein's* Being" as an entity and explained as, "*Dasein*, in its Being, has a relationship towards that Being – a relationship which itself is one of Being" (p. 32). A distinct

characteristic of *Dasein* is an understanding of Being as itself (Heidegger, 1927/1962). *Dasein's* Being is expressed and transmitted through language or lack thereof (Heidegger, 1927/1962). Heidegger (1989/1999) wrote, "*Language*, whether spoken or held in silence is the primary and broadest humanization of beings….and thereby the grounding of *Dasein*" (p. 359). Other entities are realities by appearance and falsely lead the philosopher into thinking they understand, yet they only have the ability to describe or explain the entity (Heidegger, 1927/1962).

Through Being, the shift from the world viewed as an object in reality became the world as the "totality of involvements" over time (Heidegger, 1927/1962, p. 116; Ironside, 2014a). Thus, *Dasein* understands Being as existing "in a world" and finds meaning in "historicality" or past experiences and entities (Heidegger, 1927/1962, p. 33). The hermeneutic phenomenology researcher must come to understand and know their "Temporality of Being" prior to understanding other matters of concern (Heidegger, 1927/1962, p. 40). The "Temporality of Being" consists of past, present, and future knowing.

Heidegger's phenomenology exemplified a deeper understanding of *Dasein's* Being, not simply the essence of present existence. Human *Dasein* exists as an experience, situation, or event of reality which cannot be observed from the outside world, yet can be understood through language interpretation (Harman, 2007). "Unconcealment" in the Greek language means "drawing from something forgotten into visibility" (Harman, 2007, p. 92). This is specific to human beings only because humans can always already "conceal and reveal themselves" (Harman, 2007, p. 92) or unintentionally forget (Heidegger, 1927/1962). The essence of truth comes from the

interplay between opposite realities such as human concealing and revealing. "Understanding is the existential Being of *Dasein's* own potentiality-for-Being" (Heidegger, 1927/1962, p. 184). This occurs because *Dasein's* Being is always "projecting" itself to understand as "it *is* its possibilities as possibilities" (Heidegger, 1927/1962, p. 185). The power indicated in Heidegger's written statement exists in the "*is"* (Ironside, 2005). There is no subject or object in hermeneutic phenomenology, instead only possibilities for meaning (Ironside, 2005).

"Language arises from be-ing and therefore belongs to it" (Heidegger, 1989/1999, p. 352). Language is the world interacting with entities (Harman, 2007). In discourse, *Dasein* expresses itself and because *Dasein's* Being is always already "Being-in-the-world," the "intonation, modulation," and rhythm of the voices speaking relinquishes the present "state-of-mind" for the people conversing (Heidegger, 1927/1962, p. 205). Human life as *Dasein's* Being incorporates temporalities in understanding and seeking the truth (Harman, 2007). These temporalities constitute how an individual encounters existences that always allows from past learning or experiences and openness of existential possibilities for present and future activities, events or experiences. Truth then, is an unconcealment of understanding through Being temporally present in the world and openness to all possibilities (Heidegger, 1927/1962).

With this being said, hermeneutic phenomenology is a philosophy and methodology with me understanding my own existence through temporality or the Hermeneutic Circle, allowing me to finitely open up to the matters of concern and possibilities.

Gadamer. Gadamer (1960/2004), as Heidegger's student, agreed that language encompasses human Being. "What we call experience and acquire through experience is

a living peculiar fusion of memory and expectation into a whole" (Gadamer, 1960/2004, p. 217). Hence, experience is never wordless and through reflection seeks to understand and express itself (Gadamer, 1960/2004). The world is represented through language because "man is primordially linguistic" (1960/2004, p. 440). Language lives within itself and "bears its own truth within it…allows something to 'emerge' which henceforth exists" (Gadamer, 1960/2004, p. 385). Knowledge is based on understanding the interpretation as a consequence of historical, cultural, and societal perspectives (Polkinghorne, 1983).

Gadamer (1960/2004) wrote, "Understanding occurs in interpreting" and "All understanding is interpretation, and all interpretation takes place in the medium of a language" (p. 390). This allows the experience, situation, or matter of concern to transform into the verbal or written words of the interpreter (Gadamer, 1960/2004). The involvement of the participant and me through immersion in discourse or dialogue with both coming to understand together begins Gadamer's shift from Heidegger. The dialogue between each contains similar historical subjects or matters of concern. Once begun, the discourse integrates the Hermeneutic Circle as a never ending circle of questions very similar to philosophy where the search for truth continuously revolves around questions or language. Gadamer (1960/2004) stated that "the essence of the question is to open up possibilities and keep them open" (p. 298). Ironside (2005) explained that that the participant and I will "understand the "questionableness of what is being said" (p. xiv).

Through interpretation of the textual dialogue completed after the interview I further built on Gadamer's immersion. He claimed that the written word, "texts,"

"always express a whole (Gadamer, 1960/2004, p. 392). This text taken and interpreted by me brought a process of self-dialogue and understanding of myself by a fusion of historical horizons combined with the present horizon (Gadamer, 1960/2004). The hermeneutic experience then, is verbally and textually oriented. During the interviews I focused on conscious linguistic exchange, continued interpretation, and understanding. Post-interview, I reread and began to reexamine parts of the transcript's text by recognizing both the participants and my own "prejudice, linguisticity of understanding, historicity, and the fusion of horizons" (Annells, 1996, p. 707).

Gadamer agreed with Heidegger that thought from the mind and spirit encompasses true Being only in conversation with others (Gadamer, 1960/2004; Heidegger, 1989/1999). Through language, the "world" is revealed to all human beings who dialogue with each other. "For language is by nature the language of conversation; it fully realizes itself only in the process of coming to an understanding" (Gadamer, 1960/2004, p. 443). Gadamer (1960/2004) identified the only similarity between conversational and textual interpretation stems from a conversation between people concerned with the same subject matter. The difference between conversational and textual interpretation appears when Gadamer continued to interpret the dialogue post-interview through text and incorporated the context of non-verbal language in coming to understand (1960/2004). Heidegger (1927/1962) wrote that a conversational interpretation is not understanding, but "rather the working-out of possibilities projected in understanding" (p. 189). Gadamer (1960/2004) wrote, "Understanding occurs in interpreting" (p. 390). Words, or the meaning of words, are dependent upon the context in which they were said (Fjelland & Gjengedal, 1994). Gadamer expected that questions

asked will open up the possibilities for further question development, which in itself, became a circle of questions that lead to more questions (Ironside, 2005). Incorporating the Hermeneutic Circle enriched the participants' past experiences and enlightened my coming to understand (Moran, 2000).

The Hermeneutic Circle. The entity of time as known to objective reality or the scientific world as a clock or categorization is not the Time of which Heidegger spoke. Heidegger labeled this Time as a "temporality"; meaning that Being is understood by the unity of the always already past, present, and future that occur simultaneously as "entities in time" (Harman, 2007; Heidegger, 1927/1962, p. 40). Heidegger (1927/1962) revealed that *Dasein's* Being captured three formidable categories entwined simultaneously within temporality, "fore-having, fore-sightedness, and fore-conception," that he termed "existentials" (pp. 41 & 191).

These existentials or categories are represented in Heidegger's (1927/1962) Hermeneutic Circle where they form a triangle with Being present in all three categories. Temporalities, fore-structure, or existentials provided the context for Heidegger's (1927/1962) philosophical view of pre-conceived notions that all human beings have always already developed, "fore-having, fore-sight, and fore-conception" (Dreyfus, 1991, p. 198; Gadamer, 1960/2004, p. 269; Heidegger, 1927/1962, p. 191; Plager 1994, p. 72). Heidegger (1927/1962) defined each category as how each influences a person's worldview or perception. Fore-having represents information or a worldview that is already understood (Dreyfus, 1991; Heidegger 1927/1962, p. 191). Fore-sight refers to an understanding prior to interpreting the spoken or written word (Dreyfus, 1991; Heidegger 1927/1962, p. 191). Fore-conception designates expectations the researcher

may have prior to interpreting the interview (Dreyfus, 1991; Heidegger 1927/1962, p. 191). Heidegger (1927/1962) pointed out that an individual experiences each of these categories through temporalization. Temporalization focuses on the interplay of these existentials or "timeframes" of past, present, and future (Harman, 2007).

The world as explained by Plager (1994) existed prior to birth, and with time, the person comes to understand the world through previous events, experiences, and shared life practices. For example, if a person is presented with a new employment opportunity while currently employed at a different company, he faces a new situation yet, remembers past experiences. In the present, they list pros and cons of changing employment, and list all of the future possibilities when making a decision. A similar situation occurs with objects or things (Harman, 2007). For example, a person has been given a knife and this has already occurred and is in the past, fore-having. What this person decides to do with the knife in the present, fore-sight, is influenced by the activities currently occurring with the person. Fore-conception opens up numerous future possibilities or decisions such as, placing it in a kitchen drawer, cutting a peach, opening a box, selling it, etc. These examples constitute the Hermeneutic Circle as a working model in determining truth through dialogue and interpretation subjected to the fore-structure.

During the study, the participants and I engaged in the interplay of discourse among the pre-given and the interpretations discovered. This means that the questions I asked the participants and their responses were not evaded as I kept asking questions in understanding the participants' past, present, and future perceptions. In other words, the participant and I integrated the Hermeneutic Circle throughout the interviews.

The hermeneutic phenomenological approach developed by Heidegger and expanded by Gadamer, came to be known as the Hermeneutic Circle (Lawn, 2006). Gadamer (1960/2004) agreed with Heidegger that before we know ourselves, we always already knew ourselves through "family, society, and state in which we live" (p. 278). Thus, the Hermeneutic Circle provides a basis for understanding the influences through temporality and the existentials. These are influences that Gadamer (1960/2004) termed "prejudices" and are values of more positive connotation than negative (p. 273).

Prejudices are defined by Gadamer (1960/2004) as "a judgment that is rendered before all the elements that determine a situation have been finally examined" (p. 273). I incorporated the Hermeneutic Circle as a methodological strategy in recognition of my prejudices when I interpreted dialogue, context, or language with the participants (Lawn, 2006).

The Hermeneutic Circle represents interpretation of Being-in-the-world through a circular arrangement of interactions shared between people (Conroy, 2003). Use of the Hermeneutic Circle in understanding EDIRNs' learning in an ELBNP was essential to understand any preconceived notions the participants and I had. Utilizing Heidegger's philosophic view of the Hermeneutic Circle, I questioned each participant, interpreted the participant's responses, and in reply, restructured questions to understand and immerse myself further into the participant's experience as the interview proceeded (Diekelmann, 2005). Gadamer continues the Hermeneutic Circle within the interpretation of the transcripts, context, and field notes. Thus, the Hermeneutic Circle is laced throughout Heidegger and Gadamer's philosophical and ontological underpinnings of phenomenology (Ironside, 2005).

The Hermeneutic Circle was integrated throughout the study. I kept a journal that included historical events in my personal and professional life, thoughts and ideas before and after each interview, when transcribing and interpreting, and as I documented the findings. This action was necessary since temporalities existed throughout the entire study. The Hermeneutic Circle was incorporated throughout the study with Dr.Isaacson, during the interviews, journaling, interpreting the transcripts, and when writing the findings and analysis.

Hermeneutic phenomenology does not follow a prescriptive linear method since the interview and interpretations are completed integrating the Hermeneutic Circle (Hein & Austin, 2001). Questioning and interpretation never ends. Technically a saturation point in hermeneutic phenomenology is non-existent (Hein & Austin, 2001) since an infinite number of meanings can be derived from the data collected and interpretation (Gadamer, 1960/2004; Hein & Austin, 2001). From a practical standpoint, saturation was indicated by repetition of information among the five participants (Polit & Beck, 2012) and confirmed by a member checker.

Summary. Hermeneutic phenomenology as philosophy and method was chosen to meet the intentional research questions, fully understand EDIRN's learning experiences, and to add to the nursing discipline's knowledge base. According to Heidegger (1927/1962), hermeneutic phenomenology is the beginning of all research study efforts and the most important philosophical perspective from which to gather unbridled truth. Understanding meaning through another's Being-in-the-world opens up possibilities upon possibilities of true diverse worldviews. Rearden (2012) emphasized the scarcity of published research inquiring about the new EDN's perceptions of the

strategies implemented while in nursing school. Interpreting EDIRN stories allowed for a different dimension omitted from published literature. Gadamer's hermeneutic phenomenology focus provided the methodological approach for interpreting verbal and textual data into understanding and meaning. So, rather than confirming Yoder's (1993) study, this study is an extension of her work by reading the current literature and by understanding of the EDIRNs' learning experiences.

The results of this study will not only benefit the participants, but also nurse educators and nursing programs. The most valued gift one person can give another is understanding (Munhall, 1994). How many times has a student stated, "I don't understand?" When "I understand" is heard after giving an explanation or telling a story, the person who hears this phrase feels good. Don't we all wish to be understood?

The recently graduated EDIRNs elucidated stories of their learning experiences that included strategies they used to be successful. From the obtained and analyzed data from the participants, nurse educators are able to read the study and identify areas for instructional changes while focused on enhanced student-centered learning for all. Understanding the EDIRN's learning experiences led to discovery of implications and ideas for further research.

Research Design

From Heidegger's (1927/1962) existential ontological viewpoint and Gadamer's (1960/2004) focus on interpretation, I bridged the horizons between and within the participants and me. The participants' learning experiences when in nursing school conveyed greater mindfulness and acknowledgement. Hermeneutic phenomenology was compatible with the research questions, which examined the "contextual features" of the

EDIRN's lived experience (Wojnar & Swanson, 2007, p. 177). The hermeneutic phenomenological methodology nicely interfaced with the participants since they volunteered and desired to tell their nursing school stories.

When using Heidegger along with Gadamer's methodology, I considered and compiled the following group of assumptions:

1. People interact with the environment and other human beings.
2. The EDIRN's lived experience occurs prior to any kind of understanding.
3. I must recognize and acknowledge all preconceived attitudes, judgments, values, beliefs, and biases in an effort to pursue commonality using language between cultures.
4. Instituting dialogue with full active participation and immersion by both the participant and me must occur to commence understanding and begin interpretation of meaning.
5. Understanding comes to be recognized through interplay of the Hermeneutic Circle that is always already within each person—fluid, peripatetic, and dynamic (Plager, 1994).
6. Questioning continues throughout the reading and rereading of the transcripts with my mind continuously kept open, attentive, and thoughtful (Hein & Austin, 2001).
7. Understanding will be broadened by fusing the horizons of all participants' past history, cultural traditions, and initial intention with what I interpret from the transcripts (Gadamer, 1960/2004).

Hermeneutic phenomenology remained close to the participants' experiences in articulating understanding and deciphering meaning of their experiences through dialogue, interview observation, and interpretation of the transcript. The chosen methodology required me to be immersed in each participant's experience by asking open-ended questions in an unstructured format; while, I carefully considered each response (McConnell-Henry, Chapman, & Francis, 2011; Munhall, 2012). Together in full involvement, the participant and I immersed ourselves in dialogue that brought meaning and responses of the EDIRN's experiences. For example, if I had asked, "What does it mean to experience a terminal illness?" I am unable to comprehend the participant's experience unless diagnosed with a terminal illness. However, through questions asked and responses summarized, I began to understand their experience. Immersion into the participant's worldview of the lived experiences with the participant and me experiencing the stories together started the process of understanding.

Hermeneutic phenomenology is a different manner of thinking (Smythe, 2005), that some phenomenologists titled a "phenomenological attitude" (Finlay, 2009, p. 12). Gadamer (1960/2004) revealed that, "without such openness to one another there is no genuine human bond" (p. 355). Prior to each interview, I transformed my state of mind into an "unknowing or openness" towards the participant's responses, leading the participant to share in an uninhibited way (Munhall, 2012, p. 138). This occurred during my drive to the mutually agreed upon site for the interview. I actively listened without prejudice or bias to understand everything from the participant's view (Diekelmann & Diekelmann, 2009). When I cleared my mind I was able to view the world differently and fuse with the participant's horizon.

Gadamer (1960/2004) recognized that "prejudice" as known by human beings is a negative opinion, thought, or feelings about a situation without basis in reason or experience. He (1960/2004) described "prejudice" in hermeneutics as, "not necessarily meaning a false judgment, but part of the idea is that it can have either a positive or a negative value" (p. 273). Grondin (1994) wrote that the Hermeneutic Circle is in play and begins with me working through my own fore-conceptions or "prejudice" (Gadamer, 1960/2004), while bringing those thoughts and ideas to interpretation. I recognized my own Being prior to being present, or coming to know and understand meaning through others' Being-in-the-world (Heidegger, 1927/1962; Gadamer, 1960/2004).

Each interview combined collaborative and an open non-structured approach to elicit a more intimate and elaborate data collection with full immersion of the participant and me since each person approaches the interview equally (Creswell, 2013). The unstructured interview began with a single open-ended statement or question. This allowed the participant's story to emerge as the hermeneutic interview sought to hear and understand the experiences, while allowing for co-creating realizations of the phenomenon (Wojnar & Swanson, 2007). The one-on-one unstructured interviews contained questions developed from participant answers to recognize details of the experiences they may have forgotten or repressed (Heidegger, 1927/1964). Figure 3.1 (Appendix D) displays the use of the Hermeneutic Circle as described when interviewing each participant. The journal I kept provided a context through field notes of the information given by the participant (Heidegger, 1927/1927; Gadamer, 1960/2004). Immersion in dialogue and contextual observation provided a rich base of information that allowed me to gain insight by metaphorically "walking in the participants' footsteps"

(Conroy, 2003, p. 5). These two elements supported immersion during the dialogue between the participant and me into the verbally transmitted and non-verbally observed.

The interviews were each conducted over 1-2 hours in a place of the participant's choice as recommended by Wilson & Hutchinson (1991). The conversation relaying the matters of concern Gadamer (2004) stated is, "only a means to get to know the horizon of the other person" (p. 302). My easily influenced horizon that could influence the dialogue was safely unreachable through immersion in verbal and non-verbal communication and by understanding the participant's horizon.

Hermeneutic phenomenology also proposes a different way of thinking when interpreting the transcript by examining the whole of an experience versus individual parts (Diekelmann & Diekelmann, 2009). For example, rather than examining barriers to a nursing education or studying interventions as singularities within the transcript, I came to understand the totality of the learning experiences from participants as lived in an ELBNP. The Hermeneutic Circle "recognizes the inherent circularity of all understandings: the fact that one can understand the parts only in terms of the whole, and the whole in terms of the parts" (Saks, 1999, p. 4). When transcribing and interpreting I constantly moved between the whole and the parts (Ironside, 2014). This philosophical stance committed me to understanding "shared practices and common meanings" among my participants (Ironside, 2014, Slide 11).

Participants

According to Langdridge (2007), hermeneutic phenomenology is conducted with specific individuals who have certain homogenous characteristics. The homogenous characteristics for this study were outlined in the inclusion and exclusion criteria. The

inclusion criteria for a potential participant included: (a) completion of an ELBNP within Minnesota; (b) finished the program within the last 3-years; (c) was born in a country outside of the U.S.; (d) passed the NCLEX-RN; (e) resided in the state of Minnesota; and (f) currently works as a RN in Minnesota. Each participant chosen met these inclusion criteria. The participant self-identified as entering the U.S. as a child or adult. The RN license was verified for each participant through the Minnesota Board of Nursing website, https://www.hlb.state.mn.us/mbn/Portal/DesktopDefault.aspx?tabindex=2&tabid=42.

Exclusion criteria successfully provided for the homogenous sampling. The exclusion criteria were instituted in this study to eliminate potential participants that might skew the data. These criteria included: (a) completion of a nursing program other than an ELBNP; (b) had not finished the program or finished over 3-years ago; (c) born in the U.S.; (d) did not pass the NCLEX-RN; (e) resided outside of Minnesota; and (f) currently is employed outside of Minnesota. Several potential participants were turned away due to graduation from a RN to Bachelor of Science nursing program, graduated prior to 2013, had not graduated yet, or was born in the U.S.

Recruitment strategies used. A purposive sampling of EDIRNs was chosen for the pilot and formal studies who answered the "Letter of Invitation" were included (see Appendix E). The three pilot study participants provided practice in conducting an unstructured interview and interpreting transcripts. They also provided meaningful data that produced saturation. The expert in hermeneutic phenomenology, Dr. Isaacson, confirmed that the pilot study data were saturated and that no other participants would be needed. However, requests were sent out to search for other potential participants with

whom I did not have a prior relationship to increase rigor and trustworthiness in the study. I requested the "Letter of Invitation" be delivered to graduates in the last 3-years from colleges and universities in Minnesota that were approved to conduct an ELBNP.

Minnesota has 12 private and six public universities offering an ELBNP. To enlist potential participants for the formal study, I recognized that due to the provisions of the "Family Education Rights and Privacy Act" (U.S. Department of Education, 2015), department chairs or deans were unable to provide the names of graduated EDIRNs. An electronic mail (see Appendix F) with the "Letter of Invitation" inviting alumni were sent to the ELBNP department chair or dean in each of the 18 schools with a request to send the invitation to all graduates of their baccalaureate nursing program who had graduated within the last 3 years (e.g., the graduating classes of 2013, 2014, and 2015). Table 3.1 (see Appendix G) provides a list of schools that were contacted via electronic mail with an attached "Letter of Invitation" for distribution to graduates of their program. Of these schools, six responded with three unable to participate in the formal study. One school stated that EDISNs did not attend the educational institution so alumni were ineligible. Another school could not participate for unknown reasons as indicated by responding, "We are unable to participate at this time, but wish you much success!" (Nursing Dean, personal communication, January 22, 2016). The third school did participate in the pilot study; however, I did not need further participants from that school.

Another form of recruitment utilized was to contact chief nursing officers in healthcare institutions, such as Saint Cloud Hospital, Hennepin County Medical Center, and the University of Minnesota Medical Center-Fairview. I sent out 10 requests (see Appendix H) for permission and assistance in distributing the "Letter of Invitation" to

registered nurses who graduated within the last 3-years. Table 3.2 (see Appendix I) contains a list of the hospitals contacted. Burns and Grove (2009) suggested a way to obtain participants was through "network sampling," or "snowballing" (p. 356). I was unable to use participants from those recruited through snowballing as those referred did not meet the inclusion criteria.

Sample. A purposive pilot sample of three graduates of an ELBNP at which I previously taught was conducted in November and December of 2015. I contacted these graduates verbally and through electronic mail that included the "Letter of Invitation." These three pilot participants met all of the inclusion criteria and consented to an interview. With these three participants I reached saturation; however, to substantiate, increase trustworthiness, and confirm the interpretations, I continued a formal search for other participants who met the inclusion criteria.

Within this formal search, I received 11 electronic e-mails. I contacted 11 potential participants who responded to the invitation for the formal study through electronic mail. I responded to each of the potential participants' electron mail with a second electronic mail to determine if they met the criteria. At this time, I checked with the Minnesota Board of Nursing website to verify his or her license. I discovered that four were ineligible because they graduated from a RN to baccalaureate nursing program. Another was not to graduate until summer 2016. Two potential participants did not identify as an immigrant. While one other graduated in 2011, she was not included because she had not graduated within the last 3-years. Of the three left, I contacted and interviewed those three. The first participant from this search was a previous student I had taught. The second participant was a graduate from a private school. The third

participant contacted me in early May when I had completed interpreting. This participant was interviewed as a member checker to corroborate my findings.

A third electronic mail was sent to all five participants who were eligible to participate that contained the informational sheet, consent form, and "Questions to Ponder" sheet (see Appendix L). This helped to assure that the participant had an opportunity to say, "No" prior to setting up the interview place and time. The information expressed through these documents explained details of the study such as benefits and risks and determined what I was focused on. A fourth electronic mail, text, or phone call was used to contact each individual participant asking for study concerns or questions remaining and to determine a time and location for conducting the interview.

I contemplated how to present myself to each participant. How I represented myself as a researcher and someone U.S.-born could have greatly impacted the participants' responses and demeanor (Fontana & Frey, 2005). Participant responses could also be influenced by the way I dressed and presented myself. I kept this in mind and dressed in business casual attire and displayed a professional attitude. After interviewing the first pilot participant, I became more calm and relaxed. Verbal and physical presentation by me was imperative since the initial impression of the participant remains in his or her mind and contributes to the study's "success or lack thereof" (Fontana & Frey, 2005, p. 707).

Table 3.3 (see Appendix J) contains the participant demographics without the member checker since I did not include her stories in the findings and discussion. The demographic tool (see Appendix K) was created to provide background on each participant. Each participant completed a profile after signing the consent form.

Interviews were thereafter conducted in person with eligible EDIRNs located within the state of Minnesota.

Participant recollection of experiences. Immigrants who have graduated within the last 3-years from a U.S. college or university nursing program need to depend on memory in recalling their learning experiences. There is significant memory decay or bias when adult participants reflect on childhood experiences (Hatch et al., 1999). Emotional memory enhances the experiences involving stressors and unfamiliar events that trigger the release of adrenaline, cortisol, and adrenocorticotropic hormone (Cahil, Prins, Weber, & McGaugh, 1994). These chemicals within the body are released to secure that specific memory; thus, increasing easier recall (Jensen, 1998).

Auditory memories prompt emotional recall from "fear, passion, and rage" (Jensen, 1998 p. 109). Miron-Shatz, Stone, and Kahnerman (2009) completed a study on "memory-experience caps in recollections" (p. 885). Participants recalled more unpleasant and pleasant emotions the day after the emotional events whereby, the recall on the day of the events was minimalized (Miron-Shatz et al., 2009). Unpleasant experiences or events that were amplified lead the researchers to conclude that negative events had a greater impact than positive events (Miron-Shatz et al., 2009).

Memories may also become inaccurate as time passes (Zelig & Nachson, 2012). Zelig and Nachson (2012) completed a study around the memories of victims, witnesses, and television viewers concerning the assassination of an Israeli Prime Minister. Each group were given a questionnaire at 2 weeks, 11 months, and 13 years post-assassination (Zelig & Nachson 2012). Accurate memories diminished by 18% from 2 weeks to 11 months post-assassination and an additional 16% inaccuracy was noted from recall 11

months to 13 years, (Zelig & Nachson 2012, p. 742). Experiences may be embellished or inaccurate, but the stories told by the participants contain their perception of being-in-the-world at that time.

Jensen (1998) suggested that prior to asking participants to recall past information or experiences, that a mental and possibly physical exercise to facilitate recollection be incorporated. I developed an exercise, "Questions to Ponder" (see Appendix L) for each participant to consider up to 1-week prior to the interview. These questions were distributed through electronic mail to each participant. This contemplation exercise was intended to assist the participant in recalling specific experiences they had when in nursing school with the likelihood that these experiences would surface during the interview. The directions for the participants included sitting in a place conducive to accessing positive and negative memories of their learning experiences while in their nursing program. Other suggestions included auditory triggers such as going to work to recall clinical rotations or listening to taped lectures with visual triggers such as reviewing notes, textbooks, and course grades (Jensen, 1998). Writing down portions of each experience during his or her recall assisted in recalling specific events at the time of the interview as they had their notes available. Most participants brought the "Questions to Ponder" sheet with written notes. Some even referred to this sheet on which they had already written.

Instruments

The development of a demographic instrument (see Appendix K) to understand the EDIRN was essential to understand the background in which the interview occurred. Relevant demographic items included gender, age, ethnicity, race, first language, country

in which the participant was born, length of time in the U.S., identification of nursing program and graduation date, and length of practice as a RN. Each participant completed the "Questions to Ponder" prior to the in-person interview (see Appendix L).

Ethical considerations. Internal Review Board (IRB) approval was granted (see Appendix M for the Human Subjects Application) by South Dakota State University (SDSU) (see Appendix N) and an authorization agreement was obtained from SDSU for SCSU in Minnesota (see Appendix O). Recruitment of participants began upon permission from both universities. Other colleges and universities did not request an IRB submission to their educational institution to distribute the letter of invitation to alumni from their nursing school. When a request for employee participation was sent to hospitals, Abbott-Northwestern Hospital (Alina) and Saint Cloud Hospital required approval. IRB applications for these two hospitals were completed online. The IRB application for Abbott-Northwestern Hospital was approved; however, was not sent to me. On February 5, 2016, I presented my research proposal to the research review board at Saint Cloud Hospital and was approved. Saint Cloud Hospital retained this for their records. All of the other hospitals that I requested distribution of the "Letter of Invitation" either did not require this or did not respond to my inquiry for assistance.

Eligible participants who contacted me were sent an informational sheet via electronic mail about the study (see Appendix P). This sheet included benefits and risks to participating in this qualitative study. The benefits and risks were also verbally read to each participant prior to signing the consent form. Benefits included the opportunity to tell their story and know that this information could benefit future EDISNs. A potential risk was participants' reliving unpleasant memories they had in nursing school that may

include situations of discrimination or misunderstandings between themselves, peers, nursing educators, tutors, preceptors, and administrative personnel. If a participant relived a painful experience that resulted in emotional distress such as crying, I responded by allowing time for composure and asked the participant if he or she would like to continue or end the interview. One participant began crying when talking about potential future treatment of a close relative due to being a large black male who is mentally challenged. I offered a tissue and allowed her a reprieve to compose herself. Then I asked if she wanted to stop the interview. She shook her head no and continued to relay her perceptions of living in the U.S. All participants were assured that they could withdraw from the study at any time without penalty or retaliation. After reading the information, each participant agreed to engage in the study, at which time I verbally reviewed the consent form. The participant and I signed the consent form (see Appendix Q). Then, I directed the participant to complete the demographic tool.

On the demographic tool, participants first selected a pseudonym in place of their given name to maintain the confidentiality of their stories. The pseudonym was acknowledged at the beginning of each interview and incorporated in all study aspects from that point forward. The consent forms, audiotaped interviews, and two jump-drives are stored in a fire proof locked safe in my home office and will be kept for a maximum of 3-years. Confidential information will not be stored on the hard drive of the computer.

Upon completion of the interview, the participant was given a thank you acknowledgement of a $40.00 Amazon gift card for completion of the study. I received a $400.00 graduate student scholarship from Kappa-Phi-At-Large located in Saint Cloud, MN on October 28, 2015. This paid for the recording microphone, WavePad Masters

Edition by NCH software – Fastfox 2.35, transcribing foot pedal, and six Amazon gift cards at $40.00 each.

Study Setting

A convenient mutually agreed upon Minnesota location was chosen by each participant. Locations were discrete, quiet, and without interruptions for the participant to unobtrusively share their experiences and for immersion of me into those shared experiences. The first interview conducted was carried out at my home when no one else was around. The second setting was in an unused dining area at her place of employment. Another quiet setting was my office at SCSU where I was able to close the door in a small setting. The fourth interview was completed at a community center in a designated "quiet room." The fifth setting was at Caribou® in a room used for conferences that had a door to close it off from the other busy and noisy section. These settings allowed for reflection by both the participant and I; while allowing me observation of each participant's body language.

Study Procedure

I immersed myself in understanding the learning experiences as told through the worldview of the participants. The phases within this study included locating participants, maintaining contact with the participants, reviewing the eligibility criteria, obtaining consent, completing and transcribing the interviews, and interpreting, journaling, and dialoguing with Dr. Isaacson using the Hermeneutic Circle.

Interviews. The interview commenced using a digital handheld recorder and WavePad Masters Edition by NCH software® that recorded the conversation through my Toshiba laptop computer. Each interview began with this lead-in statement:

"Understanding your learning experiences in nursing school is important to me. Please tell me about your learning experiences in nursing school." Another statement that elicited more stories was, "What was it like to be a nursing student in the nursing program you attended?" From this beginning point, I incorporated questions suggested by Munhall (2012) to encourage more in-depth discussion about their experience such as:

1. Could you give me an example of that?
2. Can you tell me about your main concerns?
3. Can you tell me about your strong learning experiences?
4. What did that do for you?
5. Please elaborate more on that (p. 150).

If the participant had difficulty relaying more stories or experiences to tell, I also included the following questions:

1. What did you like best about the nursing program?
2. What did you like least about the nursing program?
3. Tell me what strategies you used to be successful in the nursing program?

By using these types of questions and statements, I eliminated interjections or pre-conceived notions into the participant's experience (Munhall, 2012). This is in alignment with Gadamer's philosophy that questions should lead to more questions. Thus, the interviews were circular in nature and took on a context similar to the Hermeneutic Circle. This is how coming to know and understand the participant's experience formulated the underlying principle of questioning. The first three pilot interviews were transcribed by the beginning of February 2016. The last two interviews were transcribed

the next day while the interview was still fresh in my mind. The Hermeneutic Circle was utilized when interpreting each transcript.

Journaling. A journal was kept that listed current conscious biases, potential future biases, and biases that surfaced during post-dialogue reflection. This list was consulted, reviewed, and added to prior to each interview, immediately after the interview, and during each text interpretation. I was in continuous reflection to perpetually recognize and become aware of prejudices and biases.

The journal for me became a mainstay in conducting a process known as reflexivity (Clancy, 2013). Reflexivity allowed me to reflect on perceived ideas, assumptions, thoughts, and reactions. I became critically aware of my values and beliefs (Clancy, 2013). Coming to understand myself was necessary to eliminate thoughts of prejudice and disbelief in truly understanding the participant's experience. Having read Freire's (1970/2011) book on oppression and Yoder's (1993) research, this information can influence through fore-sight because it became a part of my worldview. Consistent journaling throughout the interview process prepared me to reflect, become aware of repressed thoughts, and interpret each participant's story uninhibited past, present, and future thoughts.

In hermeneutic phenomenology, relinquishing finality to interviewing is difficult as stories continue on as in the Hermeneutic Circle, always already existing (deWitt & Ploeg, 2006). This study demonstrated early on a redundancy between stories or experiences that continued into the last two interviews. Saturation was accomplished with three participants and two additional contributors who provided further examples of similar stories.

Considerations and notions discussed between Dr. Isaacson and I are contained within this journal too. As Dr. Isaacson and I Skyped™, we talked about themes that linked between the five transcripts and how these themes connected to present the overarching or main theme. A discussion related to the use of insider or outsider versus inclusionary or exclusionary othering ensued. We shared ideas on presentation of the information through the findings and final interpretations.

Interpreting. Hermeneutic phenomenology guided me through interpretation of the data since it is a practical philosophy (Gadamer, 1981/1996). I integrated my personal and professional horizons with the Hermeneutic Circle of understanding. Gadamer (1960/2004, 2001b) suggested that a horizon is a view from my past, present, and future. When I interpreted the transcripts, I fused my horizon with that of the participant. The horizon I brought to each of these interviews was the EDISNs' struggles and difficulty each has when reading and writing, taking exams, and integrating with his or her peers. This came from 16-years of nursing education where educational institutions admitted immigrant students who required additional support to be successful. I also read numerous publications and completed a course titled, "Seeking Educational Equity and Diversity." These resources impacted my interpretation by viewing education through the participants' perceptions as told through their stories. These resources broadened my horizons as I continued to teach.

I brought my horizon as a registered, acute care nurse, certified nurse educator, and a Euro-American woman to each participant dialogue, transcript interpretation, and with each interaction with Dr. Isaacson. The literature review conducted and teaching experiences with EDISNs formed my historical horizon. I know that barriers have been

identified for EDNSs in nursing programs, graduation rates continue to stagnate, programs and strategies incorporated for the EDNS do not always produce successful graduates, and Minnesota has more immigrants than immigrant nurses available to provide culturally competent nursing care. An inequality is observed with each new class of nursing students to which immigrants are admitted. Being aware of my prejudgments is required in hermeneutic phenomenology "so that the text can present itself in all its otherness and thus assert its own truth against one's own fore-meanings" (Gadamer 1960/2004, p. 272).

As the interviews were completed, transcribed, and observational notes finished, the interpretations began with identification of "thematic analysis," "identification of stories," and "synthesizing paradigm cases" that teased out the understanding of the lived experience (Leonard, 1994, p. 59). I read and reread many times over to discover themes, exemplars, and paradigm cases. I essentially transformed into the interviewee as the transcriptions were read and reread, and exemplars written and rewritten. The Hermeneutic Circle was included by writing in the journal and discussing my interpretations with Dr. Isaacson in Heideggerian and Gadamerian hermeneutic phenomenology. As I reread each transcript many times over, I, "must accept some things that are against me, even though no one else forces me to do so" (Gadamer, 1960/2004, p. 355). These three interpretive strategies provided some structure in identifying meaning within the learning experiences of the participants' post-undergraduate completion.

Each interpretive strategy as outlined by Benner (1985) and Leonard (1994) created a special role for me during interpretation of the transcripts. Within thematic

analysis, I read through each transcript numerous times. After transcribing each interview, the transcript was read. I highlighted in different colors to identify similar themes between participants the second time reading each transcript. The third time I commented within the margins of each transcript. After the fourth time through each transcript, I summarized each interview into a two page paper that pulled out major themes and exemplars adding in Gadamer's philosophy. These summary papers were sent to Dr. Isaacson as a Hermeneutic Circle participant in a continuation of dialogue that incorporated further interpretation of the stories. Common themes or patterns were recognized throughout the transcripts and noted by citations in my journal and on Post-It Notes® that provided evidence of common meanings. Dr. Isaacson and I identified significant patterns and themes that constituted the key meanings as the participants' stories were analyzed (Diekelmann & Ironside, 1998). At this point I determined with Dr. Isaacson's help, the overarching theme and subthemes.

The goal was to uncover hidden meanings and meaningful terms through themes, paradigm cases, and exemplars or short stories (Benner, 1985). Incorporating Gadamer's (1960/2004) philosophy as well, the creation of new words that described an understanding and ascribed a meaning of the phenomenon under study became entirely acceptable. I accomplished this by a metaphor assimilated to the overarching theme and subthemes. I intended the metaphor to generate an intense profound description of the phenomenon under study and provided a visual for the reader. Thus, the true meaning and understanding was uncovered rather than provided through an exact scrutiny of the participants' stories (Hein & Austin, 2001). "The dialogical process of learning to create, understand, and interpret texts begins with preexisting abilities to understand the world,

read texts for meanings, and extend those everyday capacities with rigor and attentiveness to interpretive research" (Benner, 1994, pp. 102-103).

Rigor and Trustworthiness

Maintaining methodological rigor and trustworthiness throughout the entire research study is the most crucial aspect of hermeneutic phenomenological research. Evaluation methods appropriate for hermeneutic phenomenology are approached differently than scientific research where results are checked for reliability, internal and external validity, and objectivity (Frambach, van der Vleuten, & Durning, 2013; Plager, 1994). Rather than working with numbers where validation is expedited and replicated, participant stories were evaluated for trustworthiness. Researchers have attempted to establish rigor within qualitative research by comparing to quantitative research methods of rigor (Frambach et al., 2013; Lincoln & Guba, 1985; Long & Johnson, 2000; Madison, 1988; Rolfe, 2006; Sandelowski, 1986).

Frambach et al. (2013) designed a model that demonstrated the similarities and differences between quantitative and qualitative research. This group of researchers also provided ways to demonstrate quality and rigor by corresponding quality with quantitative strategies. They demonstrated adequate quality measures for quantitative and qualitative through identification of "quality principles" such as "truth value of evidence," "applicability of evidence," "consistency of evidence," and "neutrality of evidence" that related to both types of research (Frambach et al., 2013, p. 552). There are four overarching quality and rigor themes that surround these principles that are designated only for quantitative research such as "internal validity, external validity, reliability, and objectivity" (Frambach et al., 2013, p. 552). In qualitative research, the

corresponding themes for each of the four principles are "creditability, transferability, dependability, and confirmability" (Frambach et al., 2013, p. 552). For each theme in quantitative and qualitative, the researchers offered specific strategies to increase quality, trustworthiness, and rigor within any type of qualitative research. Not all qualitative methodologies are similar in design or philosophy and thus, using a framework available to all qualitative studies would be a disservice to this study. The framework chosen for determining trustworthiness and rigor must remain consistent with the appropriate research design and philosophical underpinnings of hermeneutic phenomenology to ensure a quality-driven study (Ironside, 2014; Madison, 1988). The framework selected for determining and maintaining quality and a rigorous research study was developed by Lincoln and Guba (1985).

Commanding study rigor in hermeneutic phenomenology. Rigor is especially important in qualitative research as data from interviews, photography, or journaling transcends from language or art through thought by integrating inductive reasoning while maintaining situational flexibility (Burns & Grove, 2009). Language originates from thought and thought originates from language (Gadamer, 1960/2004). This occurs because "language is so uncannily near our thinking" (Gadamer, 1960/2004, p. 370). To accurately portray the hermeneutic phenomenological research results revolving around language and thought through continuous free flowing movement within the Hermeneutic Circle, the use of Lincoln and Guba (1985) was integrated into the study. This assisted in establishing rigor and trustworthiness prior to conducting the study, during the study, and after the study.

Lincoln and Guba (1985) proposed "credibility, transferability, dependability, and confirmability" to support rigor and trustworthiness within naturalistic methodologies (p. 43). These four criteria are ultimately the opposite of positivism validation and rigor criteria. While positivism incorporates instruments and numbers, post-positivism presents a more naturalistic inquiry approach with the instrument being the human being in conversation (Lincoln & Guba, 1985). Lincoln and Guba (1985) believe that "putting queries directly to Nature and letting Nature itself answer" steered the way towards knowing from people (p. 7). Each of these criteria used in a naturalistic approach are further explored to demonstrate rigor and trustworthiness within this study.

Credibility refers to the internal validity of a positivist study (Lincoln & Guba, 1985). Meeting credibility means that I have prolonged engagement with the participants in order to build trust (Lincoln & Guba, 1985). Trust was accomplished with four of the five participants in the ELBNP I taught them in daily. Phone calls and texting two weeks prior to the interview with Ashley, an unknown participant helped both of us to feel comfortable with each other when we did meet. These participants trusted me to maintain their confidences by upholding anonymity. They were eager for me to listen to their perspectives on learning experiences. They were adamant in needing me to listen to the stories by non-verbal language such as leaning forward and making eye contact. All participants were diligent in communicating their frustrations and suggestions. The experience was like reliving each participant's perceptions. Relief settled over each participant as they told their stories, because they had been silent for so long.

Sandelowski (1986) stated that a major threat to credibility and the strategy to use is me "to describe and interpret their own behavior and experiences as researchers in

relation to the behavior and experiences of the subjects" (p. 30). Gadamer (1960/2004) felt that the interviewer is also the interviewee while interpreting the transcripts. I was able to become the interviewee and recognize biases, negative prejudices, preconceptions, and pre-judgments that were written in my journal and revisited often to keep an open mind in understanding the participants' experiences. There are actually many truths viewed through different perceptions of the world during different temporalities (Heidegger, 1927/1962). Conducting only one interview session takes a single space in time for when the participant remembers certain thoughts.

Another form of credibility or internal validity was whether the stories the participants' told were accurate or inaccurate (Plager, 1994). I incorporated communication techniques such as "facilitation, clarification, reflection, confrontation, and interpretation" amongst open-ended, direct, and leading questions (Ball, Dains, Flynn, Solomon, & Stewart, 2015, p. 2). I also clarified, reflected, and interpreted what was heard to make sure I understood each story correctly.

Context as displayed by the participants reveals the nature of the experience that must be preserved (Plager, 1994). During each interview, parts of the conversation that surrounded a word or words permitted existential meaning. Non-verbal body language assisted in understanding the participant's meaning. For example, Ashley cried when talking about her brother and his mental challenges. She was concerned that he would be mistaken by the police and something would happen to him. Genuine fear and sorrow emanated from Ashley through the wiping away of tears from her eyes. Each participant brought historicity and preconceptions to the interview, which became evident at the time of the interview. For example, Omolo entered into dialogue with previous nursing

coursework completed from a practical nursing program. This was presented in the interview as nurse educators questioning his ability to learn. He became angry by leaning forward and voice becoming louder. Thus, suspicions that this would occur again presented itself in the ELBNP to which he was admitted. This fore-structure was noted in the journal as heard and witnessed during the interview.

Questions continued until understanding was reflected by the participant and me. The interview concluded when the information between the participant and I had nothing more to add to the experiences previously relayed. Towards the perceivable end of each interview, I asked the participant "Is there anything else you would like to add?" Using an unstructured question format, questions were designed to meet the needs of both the participant and I in understanding his or her lived experiences.

In interpreting the transcripts, I stayed faithful to the data or the stories as told by the participants. Most of their stories are included in the findings, throughout the discussion, and in the conclusion. These stories were also sent to Dr. Isaacson so a discourse on data collected incorporating the Hermeneutic Circle could begin the interpretations. Others involved in the Hermeneutic Circle are able to offer different ideas and opinions as to what is read in the transcripts. Dr.Isaacson and I came to a consensus when interpreting.

Transferability refers to the external validity of a positivist study (Lincoln & Guba, 1985). Lincoln and Guba (1985) suggested that transferability can be accomplished only by the researcher permitting access to all of the data collected in the interviews. The more data revealed by me the improved ability of the person reading the study makes transferability possible. Chapter 4 has provided a dense data collection in

findings from the interviews to enable another researcher to reach a different or similar conclusion. In hermeneutic phenomenology there are always possibilities upon possibilities. As such, the conclusion drawn by another researcher who interprets and analyzes this same data could be perceived differently when using the Hermeneutic Circle.

The procedure and methodology used in the research commands transparency, congruency, and concreteness (deWitt & Ploeg, 2006). This means that the reader of the research report has enough study design, procedure, and text to participate in their own analysis of the study. The reader has the ability to follow the interpretations as written. I integrated excerpts or exemplars rather than just providing a description of the stories (deWitt & Ploeg, 2006). Each interview was interpreted through identification of commonalities and themes that were woven through and between the transcripts.

Thomas and Magilvy (2011) revealed that to achieve transferability I must "provide a dense description of the population studied by providing descriptions of demographics and geographic boundaries of the study" (p. 153). This was accomplished by development and implementation of a demographic survey that resulted in Table 3.3 (see Appendix J). If a second study were conducted using the same data collection inclusion criteria and produced similar results, "this understanding informs the fit or applicability of the research to practice" (Thomas & Magilvy, 2011, p. 153).

Triangulation is another method that was incorporated to "improve the probability that findings and interpretations will be found credible" (Lincoln & Guba, 1985, p. 305). This was also checked by a literature search to credit or discredit the findings and interpretations. Instituting triangulation with the analysis from outside sources such as

research in the literature, philosophy, or discussion with Dr. Isaacson contributed to rigor and validity.

Dependability or consistency occurred when I took into account the potential for inaccuracy of the interviews, such as not asking the right questions. Long and Johnson (2000) suggested that "type 3 errors" (p. 35) occur in qualitative research by the wrong question being asked. They also claimed that this area within qualitative research is most concerned with validity errors (Long and Johnson, 2000). This is a type of external validity that was conducted between Dr. Isaacson and me within the Hermeneutic Circle of understanding.

Another type of validity assessed throughout each interview was if either the participant or I became fatigued during the interview as noted by the participant pointlessly going on and I haphazardly listening. Potential for fatigue was controlled through observation of the body language for each participant. More frequent movement in the chair with longer silences indicated that the participant was done with the dialogue or tired from speaking for an hour on the same topic. I gave each participant and opportunity to conclude the interview by asking, "Is there anything more you would like to add?" If not, the participant would say no; otherwise, he or she would continue talking.

What concerns hermeneutic phenomenology is the "breakdown in human affairs" (Leonard, 1994, p. 60). In determining the adequacy of the interpretation, I examined how the collapse of human interactions and relationships are resolved or opened an avenue for resolution of the problem. In this case, understanding how the participants' learning experiences unlocked potential possibilities of opportunities for the nurse

educator and the student. The first open-ended question or statement asked was, "Understanding your learning experiences in nursing school is important to me. Please tell me about your learning experiences in nursing school." When a participant did not understand the opening statement, I changed it to, "What was it like to be a nursing student in the nursing program you attended?" Questions were tailored to remain on the human issue of EDIRNs' learning experiences in an ELBNP. This positive or negative human relation issue is a lived experience that continues to this day within nursing programs.

Confirmability determines if the data presented are verifiable (Lincoln & Guba, 1985). To accomplish this, I did a "member check" with a later interview with a participant who had not been previously interviewed and after the findings and interpretations were mostly completed (Lincoln & Guba, 1985, p. 373). Lisa graduated from a private ELBNP in Minnesota. She entered the US 10-years-ago and speaks Swahili and English. Lisa confirmed my findings and interpretations. Feeling "brushed off" by nurses in the clinical setting as a student, she felt alone. *Being on the outside* was significant for her as she was the only African in a class of 48 Euro-American nursing students. She related well with the Haiku poem, "Being on the Outside*."* With each verse, she supplied instances of how each impacted her.

Lincoln and Guba (1985) produced another technique that was utilized throughout the entire study, "reflexive journaling" (p. 327). The reflexive journal activity essentially encompasses all four criteria that Lincoln and Guba (1985) proposed for evaluating rigor and trustworthiness. This activity "provides a base for a number of judgment calls the auditor must make, for example, extent to which the inquirer's biases influenced the

outcomes" (Lincoln & Guba, 1985, p. 327). This journaling contains three sections, "daily schedule and logistics," "personal diary," and "a methodological log" (Lincoln & Guba, 1985, p. 327). Since I am a non-Hispanic Euro-American born in the U.S., have taught many refugees and immigrants in a licensed practical nursing program over 9 years and in an ELBNP over 5.5 years, while practicing as an RN for 36 years, there are biases, prejudgments, preconceptions, and negative prejudices that were explicitly written in my journal. Writing in a diary as needed during this research experience was cathartic when I recorded information about my values, beliefs, and interests.

Projected Analysis

Data analysis was consistent with hermeneutic phenomenology as per Heidegger with a Gadamerian focus. Heidegger wrote, "We are ourselves the entities to be analyzed" (1927/1962, p. 67). Gadamer (1960/2004) continued with "it is not the author's reflective self-interpretation, but in the unconscious meaning of the author that is to be understood" (p. 192). Prior to understanding the participant, I understood my own Being or horizon brought to each interview. This horizon or personal position rendered toward the experiences under study was integrated into the Hermeneutic Circle of understanding. Thus, my horizon entered into the interviews and interpretations of the transcripts that brought an awareness of foreign-born nursing student stress when in an ELBNP. The professional horizon brought to this study is that of issues within nursing education and learning as relayed by foreign-born students. These included difficulty taking exams since EDISNs are ELL, educators spoke too fast, unsure of how to present themselves to a patient, patients misunderstanding them, and educators unwilling to help them learn one-on-one with difficult concepts. The data collected through conversation

related to the matters of concern will bring understanding to the investigator and uncover hidden information unknown to the participant.

Analysis of the data collected through the interviews centered on understanding what the participant unknowingly has hidden about their experiences. I immersed into dialogue during each interview since analysis begins with understanding that occurred during the interview and continued well after the interview was concluded (Cohen, Kahn, & Steeves, 2000). Demographic information was tabulated as description only and placed into a table (see Appendix I). The demographics, notes taken during the interview, and journaling were analyzed and integrated with the interview interpretations.

Inputting data into computer aided qualitative data analysis software (CAQDAS) such as NVivo® is not in keeping with the philosophical underpinnings of hermeneutic phenomenology (Goble, Austin, Larsen, Kreitzer, & Brintnell, 2012). Incorporating a computer program such as NVivo® introduces coding (Goble et al., 2012). Patterns and relationships are lost within coding and the technology breaks the personalization with the data meaningless (Goble et al., 2012) and thus, jeopardizes the study's overall interpretation of meaning. The hermeneutic phenomenological researcher needs to engage on a personal level with the data (Munhall, 2012) incorporating deep cognizance. Data inputted into a CAQDAS program narrows the language, understanding, and separates the researcher from the data (Goble et al., 2012). However, one researcher felt NVivo® was useful in organizing the transcripts while identifying main concepts (Coates, 2010). NVivo® may have been helpful with ease in locating pieces of text in demonstrating a particular exemplar or paradigm case. Computer software was not used in this study.

In meeting the standards of rigor, an interpretation "by hand" with the 20-year-old method as described by Leonard (1994) seemed most appropriate. Each transcript was read many times to identify themes, exemplars, and paradigm cases. Coordination of the themes were developed into an "interpretive plan" with the Dr. Isaacson (Leonard, 1994, p. 59). Individual transcripts were then read again according to the "interpretive plan" to identify "lines of inquiry" (Leonard, 1994, p. 59). The end-product of this thematic analysis resulted in development of an overarching or main theme with five subthemes based on the interview findings.

Emerging events or incidents were analyzed separately and covered the participant's "concerns, actions, and practices" (Leonard, 1994, p. 59). Each interview was examined for events or incidents, blocking similar events together to eventually form "exemplars which are stories that capture the meaning in a situation" and into other similar situations (Leonard, 1994, p. 59). These narratives incorporated quotes from the transcribed interviews and were typed into a Microsoft Word ® document.

The third step in the interpretive analysis involves "identification of paradigm cases" (Leonard, 1994, p. 59). In this step I identified robust examples of specific "patterns of meaning" that provided a richness to the "descriptive information given" by the participants (Leonard, 1994, p. 59). This richness offered meaning and understanding to the phenomenon under study. The identified themes or patterns of meaning with quotes were typed into a Microsoft Word ® document as exemplar interpretations. The exemplar interpretations evolved with each review of transcripts and the addition of existing literature into the final interpretations or discussion. Each of the three steps allowed for the discovery and presentation of meaning and understanding of a

phenomenon. The interpretations that were exposed to the Hermeneutic Circle with Dr. Isaacson cannot be generalized and can be interpreted differently by other researchers.

In the end, this dissertation serves to deliver an assortment of text to the reader who can then become aware of "common practices and shared experiences" among these study participants (Diekelmann & Ironside, 1998, p. 245). The reader is given the opportunity to share in the analysis when reading the report because the report provides specific details of the study design, procedure and produces enough passages from the transcripts (Diekelmann & Ironside, 1998). Questioning of the interviews and analyzed transcripts does not cease with completion of this dissertation, but continues with every reader (Hein & Austin, 2001).

Summary. Heideggerian hermeneutic phenomenology is a philosophy and methodology that introduces a different way of thinking, understanding, and communicating (Diekelmann & Diekelmann, 2009). The literature review exposed a gap when immigrants were not specifically identified as participants in the studies conducted on perceived barriers and integrated interventions for success in nursing programs. Listening and immersing with participants' stories enriched understanding the multiple possibilities of learning experiences. Telling their story permitted the participants to reflect on their experience allowing for undisclosed learning or subconscious awareness as well. "Hermeneutic phenomenology turns on the retrieval of talking with and listening to each other and the world, while opening up always already possibilities and creating never-endings" (Diekelmann & Diekelmann, 2009, p. 480). The phenomenon under study cannot be fully understood due to all of the possibilities or infinite stories, meanings, and perceptions of experiences when conducting the interview and

commencing the interpretations (Hein & Austin, 2001). Stories of lived learning experiences by each participant created learning experiences for me. Each participant accomplished this by addressing his or her perceptions and perspectives focused on learning experiences, suggestions, and feelings that ultimately facilitated an opening into a new realm of research. The findings from the participants' stories are interpreted and provided to illustrate struggles they faced and motivation to succeed in the ELBNP.

Chapter 4: Findings and Discussion

Gadamer (2001b) wrote, "We must find the paths ourselves: the paths of solidarity and of reaching understandings" (p. 80). *Solidarity* means oneness as a group grounded on a community of similar interests, goals, and principles (Solidarity, 2015) Through this hermeneutic phenomenological study I began to understand the experiences and stories as told by the participants. I journeyed through dialogue with each participant singularly bringing a kind of solidarity to our relationship. I endeavored to verbally, mentally, and emotionally connect with each participant into an environment of understanding.

I felt a kinship with the participants as I too settled to Minnesota from Michigan. While this is not the same as emigrating from another country, the experiences may be somewhat similar. As a sheltered young girl, my family moved from Ohio to Michigan. For reasons unknown to me, we were always considered outsiders in this rural farming community. I was regarded as "different" by my classmates and to those around me. This perceived difference brought verbal, emotional, and physical taunting by older students and peers in my primary and secondary education.

When I moved to Minnesota, people asked where I came from as I had a "Michigan" accent. I soon discovered that the way I used and pronounced some words held different meanings in Minnesota than they did in Michigan. My thoughts and ideas were felt to be inconsistent with the majority of nurses and nurse educators and because of this, I built a "wall" or cocoon around myself to prevent from feeling ostracized. Hence, I became an introvert, leery of those unknown around me or those with controlling personalities. Because I knew this about myself, this journey with each

participant was difficult; however, was made somewhat easier as the first three participants were former nursing students of mine.

All participants read the information sheet and consent form. Each participant agreed to engage in the study by signing the consent form and completing the demographic tool. The first three participants prepared me through dialogue and engagement for interviews with participants unknown to me. Upon completion of the "pilot" interviews, I interviewed three other participants for the "formal" interviews. The fourth interview was with a Somali immigrant who was unknown to me. After transcribing and interpreting the fifth interview, I realized that this participant was ineligible because she had graduated from a RN to a Bachelor of Science Nursing program. The sixth participant was another previous student I taught in an ELBNP. Although the last three participants were not needed for saturation, two of those interviews were included in this study as one was unknown to me and both confirmed findings from the first three interviews. The last interview was a participant who became the member checker.

This chapter addresses findings as interpreted from the context of the interview, transcripts, journaling, and incorporation of the Hermeneutic Circle. Gadamer (1981/1996) shared that when people are communicating with one another, then "the participants part from one another as changed beings" (p. 110). I was changed through the participants' stories and mesmerized while fusing their horizon with mine. As each transcript was read through and relived many times over, I entered a state of understanding or coming to know with each participant. Gadamer (1981/1996) further wrote that "we have to acknowledge what is" (p. 111). This is accomplished through the

identification of themes and exemplars. The following section identifies the findings that were analyzed and synthesized from the transcripts. An overarching theme and subthemes were identified and solidified with participant stories. A discussion follows that connects published literature and philosophy with the findings that form a foundation that nursing educators can read and discuss. Gadamer (2001b) suggested that discourse or dialogue with others such as nurse educators and nursing students regarding issues, concerns, or problems brings us to a new vision of ourselves. Gadamer (2001b) believed that "To be in conversation means to be beyond oneself, to think with the other and to come back to oneself as if to another" (p. 13). My hope is that the findings and discussion in this dissertation enlighten and encourage nursing educators and nursing students to commence in a dialogue together in understanding.

Findings

Coming to an understanding regarding the present phenomenon of both positive and negative learning experiences required a connection in dialogue with the participants. Through this exchange, the participants and I delved into stories of their experiences turning my darkness or fear of the unknown into shades of an ever increasing light of understanding. Gadamer (1976/2007) described this process as:

> We adapt ourselves to each other in a preliminary way until the game of giving and taking – the real dialogue – begins…And surely the elevation of the dialogue will not be experienced as a loss of self-possession, but rather as an *enrichment* of our self, but without us thereby becoming aware of ourselves (p. 57).

Learning through the lenses of participants who have completed an ELBNP in Minnesota was a challenging experience for the participant and me. While English is a

second or more language for the participants, English is the only language for me. The challenge faced by the participants was expressing their stories in the English language. My challenge was deciphering their accent pierced English, the structure of their newly learned English, and how language influences our interaction with each other. Clarification and summarization became a valued art form during the dialogues. Gadamer (1960/2004) wrote, "Language is the single word, whose virtuality opens for us the infinity of discourse, of speaking with one another, of the freedom of 'expressing oneself,' and 'letting oneself be expressed'" (p. 553). However, understanding each other was difficult at times.

As stated previously, the first three participants and the sixth participant previously had been students guided in their learning by me. Familiarity with their use of English provided insight into their use of linguistics and connected words with common meanings in English. I periodically clarified, on a limited basis, by integrating English words that could be replaced as a synonym for a word the participant used. For example:

Marcia: When you are in the process of learning…..what things helped you…?

Mary: I cannot repeat and memorize; it's not working for me at all. I really have to understand [the] process, how it works.

Marcia: So you are saying application.

Mary: Yeah

Marcia: If you can apply the concepts, then that's where your learning really occurs.

Mary: U-huh.

Gadamer (2007) insisted that a "common perspective" (p. 244) is always already being formed through a mutual language between the participant and me. Through clarification and summation, an understanding of the participants' natural language began the fusion of our horizons and the inter-mutuality of our involvement in the world. My language, values, and cultural traditions are significantly different from the participants' language, values, and cultural traditions. To fuse my horizon with that of the participants' required an understanding of their accent, pronunciation, and command of the English language. Expansion of a combined worldview through understanding language, ideas, values, beliefs, and truths as relayed from generation to generation is important to understanding (Gadamer, 2007).

Lincoln and Guba (1985) felt that a "natural language" (p. 333) between the participant and the interviewer has the ability to fuse horizons towards understanding of true meaning. The information relayed, transcribed, and interpreted is not a "matter of reduction, but of induction" (Lincoln & Guba, 1985, p. 333). Language, be it indigenous or local, constructs perceptions and understanding of our *Dasein.* These perceptions and understandings are always already formed through language acquired from the environment, culture, history, and interactions with human beings and non-human beings. Language is our mutual existence, projects our realities, and has the ability to share *Dasein* with others.

The EDISNs' stories and experiences have been subdued as they are afraid to speak about their learning and nursing school experiences. Their silence while in school is deafening – they feared that by breaking their silence they would be misunderstood or singled out as "different." Immigrant nursing students are fearful of pronouncing words

incorrectly or using inappropriate words when communicating verbally or through chirography to nurse educators or their peers. They have no desire to be cynosure, which may attract ridicule and condescension. This aspect influenced their learning by remaining silent and looking for information to unrevealed questions through books and online websites where conversation cannot be misunderstood. For most of the participants, to write a paper was a struggle as grammar and sentence structure is different from one language to another. Some would write a paper from three to six times prior to turning it in, which included many hours of work. Omolo stated, "When we were doing our research projects….I wrote it like maybe six or seven times before I could get it to something I could present to the instructor." When the nurse educator misunderstands the EDISN's English accent or translation, the EDISN's frustration burgeons. As Lorde (1984/2007) described:

> You're never really a whole person if you remain silent, because there's always one little piece inside you that wants to be spoken out and if you, if you keep ignoring it, it gets madder and madder and hotter and hotter, and if you don't speak it out one day it will just up and punch you in the mouth from the inside (p. 42).

At times, I had difficulty allowing silence and would be quick to interject a clarification or summation. The silence occasionally was unbearable as the participants tried to think of words to tell their stories. Lorde published a poem in 1978 titled, "A Litany for Survival." This poem underscored and identified conversation between people that brings anxiety about what is meant and what is truly understood. Her eloquently written poem reminded those that by choosing to remain silent or speaking up,

communication or language endure no matter the drawbacks. A portion of one stanza in Lorde's (1978/1995) poem revealed the consequences of continued silence.

and when we speak we are afraid

our words will not be heard

nor welcomed

but when we are silent

we are still afraid

So it is better to speak

remembering

we were never meant to survive (pp. 31-32).

Through play, this poem presents a portion of the phenomenology under question. Gadamer (1980) wrote, "The song of praise in the form of poetic play is shared language, the language of our common concern" (p. 66). In this instance, our mutual unease is silence by the inability to speak up or find the words to accurately portray their experiences with learning. Silence was overcome by the questions I asked and the response received by the participants. Thus, the "mute text" turned to dialogue is a "fertile model" from which to form a fusion of our horizons (Gadamer, 1997/2007, p. 244).

The Hermeneutic Circle

The Hermeneutic Circle began with active participation in dialogue between the participant and me, interview transcription, and continued with interpretation by rewriting in my own words each participant's story. The joining of horizons between the participant and me began with historicity in recognition of similar experiences.

Historicity within the Hermeneutic Circle plays a role in questioning the participant and interpreting the dialogue. This historicity affected the participant and me during the interview. When I interpreted the transcripts, historicity from previously having taught EDISNs in a licensed practical nursing program and an ELBNP was brought forward. In my past, I have encountered immigrant practical nursing students who claimed I was racist to the National Association for the Advancement of Colored People by failing them in didactic, clinical, or skill courses. Because of this instance, I emphasize the need to understand the experiences of EDISNs by actively listening and assisting EDISNs with learning. This illustration is a portion of my past that overarches how I respond to EDISNs. Gadamer (1960/2004) asserted, "If we try to understand a historical phenomenon from the distance that is characteristic of our hermeneutical situation, we are always already affected by history" (p. 300).

The Hermeneutic Circle consisted of an expert and me. We shared personal perceptions of the stories told, explored theme ideas from commonalities found across transcripts, and identified methods to present the findings. Gadamer (1997/2007) explicitly stated:

> To 'understand' the structures and ordering of our world, to understand ourselves with each other in this world, just as much presupposes critique and struggle with what has grown rigid or outdated as it does the recognition or defense of the existing orders of things (p. 97).

This means that as my world changes, so does my view or *Dasein* in the world through stories from others, historicality, and personal insights of others within the Hermeneutic Circle. I began to question struggles I have within myself about how each of the

participants' stories interlock with my cultural orientation and experiences. Gadamer (1997/2007) emphasized that the English definition of the word "prejudice" is inaccurate. He concluded that prejudices, "are simply conditions whereby we experience something—whereby what we encounter says something to us" (p.82). Therefore, "it is not so much our judgments as it is our prejudices that constitute our being" (Gadamer, 1997/2007, p. 82). I did not pre-judge or judge each participant, but fused their perception or reality of their experience into my horizon or orientation of the world.

The Hermeneutic Circle continued as I maintained a journal to write my thoughts, ideas, biases, and discoveries. By doing so, I reflected on each participant, myself as a person, researcher, and nurse educator, and my observations during each interview. This journal represented my interpretation of the stories while I acknowledged past experiences with EDISNs, reviewed my coursework on ethnic diversity and cultural competency, and fused this with the participants' stories. As a nurse educator, my *Dasein* changed when I discovered that being an immigrant or someone who was born outside of the U.S. is challenging. They have to learn English, endeavor to acclimate to a new culture, and feel alone in all of these challenges.

Overarching Theme

Each participant experienced the juxtaposition of being on either the inside or outside with their peers and nursing faculty in nursing school and staff nurses and patients in healthcare institutions. Mostly they felt excluded, ignored, ridiculed, and questioned. Mary felt "excluded from mainstream," while Suzhen experienced a staff nurse who "ignored me the whole time." Omolo stated, "My peers just thought I was just not smart enough. That kind of killed the morale." Each participants' story revealed

being alone in their learning. The overarching theme running through the stories is feeling disconnected from the *insiders* and always *being on the outside.*

The terms *insider* or emic and *outsider* or etic are dichotomous words capturing the status of a person belonging to or not belonging to a community (Ogilvie, Burgess-Pinto, & Caufield, 2008). Ogilvie et al. (2008) and Yakushko, Badiee, Mallory, and Wang (2011) categorized people who share similar backgrounds, values, and beliefs into a community as an insider. The antonym corresponding to inside is outside. Thus, the term outsider refers to a person or persons who are different; therefore, not included in the community. Walker (1997) further identified a definitive line separating insider from outsider. The area surrounding the line became a territory where insider and outsider intermix, called the "borderlands" (Walker, 1997, p. 4). This territory represented the methodical segregation and forbidden heterogeneity; however, there remains crossover from both sides of the line. So, this line of controlling delineation segregates, yet allows for an amalgamation of insiders and outsiders in the immediate area surrounding the line (Walker, 1997). The line inherently separates the insider and outsider, yet human inquisitiveness eventually allows for an intermixing of both insider and outsider. Nurses walk this line and spend most of their time being mutually inclusive as insider or outsider, dependent upon their nursing activities (Walker, 1997). For example, Tim felt included or an insider on his nursing unit, yet some patients refused his nursing care potentially based on race, ethnicity, dreadlocks, and thick accent relegating him to outsider. Tim walked the line between insider and outsider.

All of the participants identified with being born outside of the U.S. and entering as an immigrant, refugee, or international student. Each felt alone in their learning and

ignored by their peers, faculty, and healthcare staff because of their race, communication struggles, ethnicity, cultural beliefs, and learning strategies. These barriers interfered with acceptance by people unwilling to recognize the significance for the participants in entering the nursing profession. Each participant desired to be accepted and respected for his or her differences. Their stories contained a similar theme of *being on the outside* from their peers, nursing faculty, and healthcare staff. This consistent overarching theme was likened to a lone maple tree in a field. The participants were equated to the lone maple tree that feels excluded by the other trees in a nearby forest. These trees are either unable or unwilling to send "shoots" to the lone maple tree. Hence, the participants' stories are told through this metaphor of the lone maple tree that is disconnected from the rest of the trees. They felt all alone, like an outsider, and experienced difficulty becoming an insider in the nursing field during school and in post-graduation employment. This is what the participants' in this study felt, *being on the outside.* To illustrate this phenomenon, I created the following Haiku.

Being on the Outside

Spring began anew
Standing erect in a field
A lone tree unlike.

Feeling cut off,
Viewed as an outlier.
How do I connect?

Weather conditions
Hurtful yet necessary
Add to my growth.

Growth disruptions
Interferes with giving back.
This gains what in life?

Nurturance needed
Fertilizer supplements
Growth continues.

Inspire difference
Forest trees welcome seedlings
Change prevails for all.

When I considered the lone maple tree, unaided observation was insufficient. I needed to tune my other senses that provided answers to my questions: (a) Why is this lone tree still standing? (b) What provides nourishment to the tree? (c) Why did the farmer allow this tree to grow? (d) How does this tree prosper by itself and still manage to produce syrup? (e) How is this tree able to withstand harsh weather conditions and potential infestations or infections? This "attending to" is similar to how I listened to the participants' stories of learning in a foreign environment. Dialogue was required to extract the participants' unknown portion of their unconscious (Gadamer, 1960/2004).

As an inside nurse educator, the primary investigator, and doctoral student, I realized that a fine line is traveled on the road as both insider and outsider. By the participants allowing me to hear and participate in their stories, I relived their perceptions as told. I was allowed to be present, *Dasein*, to their perceptions of the world. We grappled together in understanding their struggles through the telling and interpretation of their stories. As an outsider to their specific differences, I came to know through a fusion of their stories with my historical perception of previous and current events in my life. The lone maple tree or participant described a theme of juxtaposition between dichotomies of insider or outsider and solidarity or solitary. Most nursing students and nursing educators are born in the U.S. and grow up learning and integrating societal norms within their communities. Being on the outside or alone was described by Omolo

as, "It was difficult to get into a clique or different cliques because uh, of the different [*sic*] in culture and language." Mary affirmed these same feelings of being an outsider or alone:

> We really felt excluded from mainstream. And, [it] doesn't matter what you do, doesn't matter how much you want people to be part of the group, no, no you [are] not part of the group. They always exclude you and sometimes want to show you and humiliate you in such a difficult way…It's challenging for somebody who has [a] different background to be part of the group because they just don't want you to be there.

Suzhen was informed by other students, family, and friends that "because you're a foreigner, you need to do much [*sic*] perfect than anybody else because if you make [a] mistake, the consequences for you is much worse than everybody else." Being different through language and culture, a newcomer to a community in the U.S. and English, brought feelings of loneliness into the participants' world view. The participants are that lone maple tree abandoned in a field seeking acceptance, respect, support, and comradery with their peers. They diligently thought about how to create openings into the elite world of nursing as a student and as a new graduate. Each participant developed strategies to be successful and patient with the group of nursing insiders who did not extend a branch from their tree to offer acceptance and shade to protect them from the potential harsh realities of nursing school. Each participant felt forlorn, like the lone maple tree, due in part to language and societal and nursing cultural changes. The totality of the subthemes, described below, contributed to the formation of the central theme, *being on the outside*.

Subthemes

Through their stories, five subthemes were recognized. Metaphorically, these subthemes are events that influence the lone maple tree in growth, acclimation, and proliferation of new trees. The influences or five subthemes are harsh realities, disruptions, nurturance, resilience, and propagation. Although the lone maple tree symbolizes loneliness and unacceptance, it also symbolizes resilience and life when each of the subthemes or parts connects to become a whole. This resilience is the participant allowing the significance of their stories to shine through the tree's leaves.

Harsh realities. Harsh realities of nursing school or harsh weather conditions the lone maple tree faces signify the terminology used by the participants to justify their struggles and reasons for requesting to be treated differently than their peers. Through justification or excuses, these participants unknowingly placed themselves into being on the outside. This is prominent when they identify themselves as being ELL and require more time for exams, reading, and written assignments.

> Marcia: Did learning seem harder for you than your classmates?
>
> Suzhen: Yes, for sure.
>
> Marcia: And, why do you think that is so?
>
> Suzhen: When I started I think because English is not my first language. And then, I really feel like maybe I just don't understand the questions, like they did or take me longer time to understand the question or understand the book or maybe even I understand a better way at interpret [*sic*] that is different. I feel like sometime I got the question wrong because I interpret the question wrong. Yeah.

Suzhen realizes that she needs to learn and understand English because translating English to Vietnamese is difficult as there are few Vietnamese words comparable to English medical terminology. Suzhen emphasized:

> I need to learn it in English and accept it and try to understand the meaning in English instead of translate, because every time I translate it it's harder for me, take more time for me. It's just harder and then it's not sometime it's not even relevant, like when I translate to Vietnamese, I think it is really not what it mean in this context of the book.

Language was a significant obstacle or struggle for four of the five participants. Omolo's primary language is Swahili. When I asked how he taught patients using the generic names of medications he admitted that he still has difficulty pronouncing "generic names of medications" so "I have to spell." Time was an issue for Omolo when translating from English to Swahili or Kikuyu. The importance of this is noted by his body language, as Omolo sat squarely upright in his chair, leaned over the table, looked directly at me, and sincerely expressed:

> I did uh find it difficult tooooooooo (he draws out the word), uh, to get all the homeworks [sic] done on time and all the readings done….But you know, life itself and learning at the same time and in a different culture different language has been a challenge and continues to be a challenge… because cultural shock, uh, learning, I don't call it a disability, but ta, the learning challenge of the language, one is a translation … from my language to the English language and then to the nursing language.

Omolo continued with how he completed assignments by touching the table with his fingers as if he were marking off a "to do" list.

> It took me longer. Like, when we were doing our research projects through the big paper, like we were writing about 15-16 pages that was to convert into three. Uh, I started mine early and then uh, wrote it like maybe six or seven times before I could get it to something that I could uh, uh, present to an instructor. My peers were like, 'Oh, I started it last night, hmmmmm, this morning, doesn't look so well, but I took two or three things and I am done.'

The length of time for Omolo to process information left peers with the perception that, "I cannot contribute enough or equal to ….some of my peers just thought I was just not smart enough to do it." Mary raised information she learned from her education psychology course. Mary leaned forward and looked directly towards me and vigorously stated that her educator said:

> Everybody who is [an] English second learner, they get information a few seconds delay….He said it's normal. And he said that sometimes they consider um, somebody who [is] born from a different country and staying here when they start to study the course is their learning disability because it puts you behind how you process the information. ….You move like everybody else, but you really need a little bit more time because you are processing information a little slower than everybody else.

Mary's solution to help in the learning process is to allow extra time for exams, shorten up assignments, "simplify the book, not to have bias during the exam—bias

questions,…hire the faculty …from a different country or different place would be helpful too."

Tim also experienced difficulty with language in reading textbooks and writing papers using correct sentence structure, and grammar. Tim's primary language is Kikuyu; although, he was taught British English at school in Kenya. He, too, complained that the generic names of medications were difficult to pronounce and gave examples by attempting to say "furosemide and acetaminophen." He rewrote his papers three to four times then, his wife would proof read his papers and say, "No this is not correct." Once, Tim's wife did not proof read a paper prior to turning it in to the nursing professor. Consequently, his nursing professor read it and asked, "Tim, what is this?" She then proceeded to insist he receive help from the Write Place to rework the paper.

Of the participants, Tim, stated that papers were more difficult to write not only due to the language, but from lack of exposure to typing or a computer. Tim clarified:

> In Kenya what we learned was British English…some British words are not the same as American words…also, we were used to writing papers using a pen, not a computer, so typing a paper or typing anything took forever.

His peers would ask if he had his paper finished and he would reply, "No, I'm on page two." Saying that, "They had already did [*sic*] their 12 page paper in like 4 hours."

According to the participants, the formats for exams or tests were essay in their home country. Multiple choice tests were unheard of until they entered the educational system in the US. Suzhen emphasized:

> We don't have multiple choice tests. Like most of them are essay tests. Like if you study biology and then they will have a question just ask you what is the

> structure of a plant and you need to write out all of the plant have [*sic*], leaf and this and that. Or for mathematic you just have to write out [*sic*] do the problem step by step something like that. We don't do multiple choice because it's just multiple choice you have because teacher believe like 25% you can guess right or wrong.

Mary and Tim both agreed that tests or exams were a challenge not only because of the language, but of the time involved through processing each question. Mary specified,

> Exams were challenging too because sometimes, time was not to get to read more of the question options. And it put more stress on you that you had to be on time and then everybody begins starts to turn in a paper, and then you feel like well you were behind.

Tim clarified more about quizzes and exams through incorporation of how British English played a role.

> Most of what I say by British English is how you spell words and it is different. Like issue here is essue there. Or mom versus mum. So, I will try and translate it and you're doing all of this and wasted like 5 minutes. And it's a 15 minute quiz or test at the beginning of class and you only have 15 minutes to do it. So yeah, somebody see somebody walk out then you're like, 'Oh my God, I'm already behind.' Then you start panicking and stressing out.

Tim also experienced language issues when taking the NCLEX-RN.

> Marcia: And it all stemmed from words unknown in English? What kind of words would throw you off?

> Tim: Medical terms, or uh, even a simple [word] like, I'll go back to my boards. Here's my situation with boards, like it said, 'Where would you find the bill of rights in the hospital?'…'Would you see them hanging on the wall?' That I understand. That's easy. Then it would say, 'C…Conspicuously somewhere in a certain place.' So, you lost me by the word 'conspicuously.' So then I'm like, does it mean open or mean somewhere hidden?

Suzhen explained her difficulty with the length of the exam questions. By the time she had completed the four line stem of the multiple choice question, she had forgotten what she had read. And Suzhen asked herself, "What are you asking?"

Could the attrition rates and poor NCLEX-RN pass rates among EDISNs be influenced by language issues such as the use of multisyllabic words or the differences between American and British English? Ashley confirmed that while in her nursing program only three of ten immigrants graduated ending with a 70% attrition rate for the EDISNs in her cohort. Ashley added a lengthy explanation for why these students were exited from the nursing program:

> They failed out on things like um, the math exam before every clinical. You know just simple things like um, simple understandings like they didn't leave the decimal to the tenth, they did it to the hundredth. There is also that simple English understanding and I think a lot of those tests are kinda [*sic*] done to weed those kind of people out...The only people it ever weeded out were people ethnically different or had English as a second language… But, you know, I got these, you know I got the tests back and I have seen a couple of these girls who failed it and they failed on the dumbest things, 10.00 instead of just 10…Like one

> of my friends um, that got weeded out, she was so good, God she was smart…She got an A in patho which was always the worse class and throughout the whole program…she failed it [math test] because of that dumb little thing like that…Now you ask her to draw up a medication, she will draw up 10mls – she is still going to draw up the same 10 mls. She wrote 10.00 and I wrote 10. She's wrong and I'm right. How is that fair? We would have given the exact same dose, the exact same everything. She is one of those people; she follows everything to a T.

Processing a second language, pronouncing words, defining American English grammar and sentence structure, understanding multisyllabic words, and communicating clearly with peers and nursing faculty were the barriers that add to challenges faced by these participants with the potential for attrition as well.

Disruptions. In the life of a maple tree, sometimes growth is slowed due to infestations by insects, fungi, or maybe even drought. Whatever occurred, the tree was hurt, yet recovered through dependency on stored reserves. One disruption in growth and professionalism of the participants' happened during and after their nursing program. Incivility or oppression as Tim stated, "cattiness" between nurses, nursing students, and nursing faculty is disruptive when in the learning environment. He believed this is a "female" characteristic and because nursing is mostly women, "cattiness" occurred frequently. This turmoil brought bumpiness to the road of learning or decreased the numbers of buds produced by the lone tree for the participants.

Clark and Springer (2007b) defined academic incivility as "any speech or action that is disrespectful or rude and ranges from insulting remarks and verbal abuse to

explosive, violent behavior that disrupts the harmony of the teaching-learning environment" (p. 93). Freire (1970/2011) described oppression as becoming dehumanized through, "injustice, exploitation, oppression, and violence of the oppressors" (p.44). The oppressed are dehumanized; while, the oppressors are others on the "inside" perpetuating this continuous cycle. Oppression is observed ubiquitously such as in abuse, bullying, racism, ageism, sexual orientation, mental illness, etc. Anyone viewed as "different" can be a victim of oppression or oppressed with some people recognizing this as an expectation or "normal" way of life.

The participants noted that when incivility or oppression occurred between faculty and faculty, faculty and student(s), and student(s) and student(s) occurred, the participants became anxious, stressed, distraught, and self-esteem was challenged. Learning then became compromised inside and outside of the classroom. Misunderstandings as a result of communication, skin color, and garments worn perpetuated incivility and oppression through stereotyping or assumptions. Ashley, who entered the U.S. when she was 3-years-old and displayed unbroken and unaccented English, relayed an experience between herself and the department chair at the beginning of her nursing program.

> I did post-secondary my last 2-years of high school, had enough college credit to start out, um, paying specifically for the nursing program and within the first year as a freshman I applied to start out the next year. So, I did all that stuff, got accepted, and they have an interview where you meet with um, kind of the head… like the director of the nursing program. So, I met with her… she didn't say two words to me before she said this, but um, I walked in, you see me, I am an African

> woman, and my name says [gave her name] on the application. Um so, she just said, 'Hi, nice to meet you.' She introduced herself and I said my name – that was it… she couldn't even really gauge how well I understood English or I spoke English… the first thing she said to me was, 'So I see that um, you have been accepted to the bachelor of nursing program that is set to start next fall. I am just wondering if maybe um, the associate degree might be a better fit for you seeing as English is your second language.' The first thing I said to her was, 'Who told you English was my second language, cause [*sic*] I don't remember anywhere on that application it [*sic*] asking me …if English is your first language, second language, do you even speak English. No cause [*sic*] those are things already covered by me being a student at the university. I have obviously passed basic English in high school to be a college student.' So, I looked at her and said, 'Um, actually I don't think I am interested in the associate degree program because if I was I could have graduated with my associates before I graduated high school.' …So I said, "No, that's not really an option, um, and I said, 'It might have been a better idea to speak with me before you would have made that assumption that English is my second language.'

Ashley has beautiful smooth dark brown skin and wears a hijab. Stereotyping or creating assumptions is an unnecessary disruption to receiving a nursing education; nonetheless, occurs because nursing student populations remain predominantly Euro-American.

Oppression and incivility continues to occur in the U.S. between all people born in or outside the U.S. The participants were exposed to incivility and oppression. Omolo told of an experience during a clinical day where he was in the breakroom and a peer

directly looked at him and stated, “So, you came from Africa, you know, you brought all of the diseases from there.” He then explained to me what his other peers’ reactions were, “Some of my other peers were upset about it…some brushed it off and you know, that got them.”

Upon entrance to the nursing program, Tim was questioned by peers relaying the following, “Oh, I’ve never seen you. Did you pass the classes [prerequisite courses to be accepted into the nursing program]?” He also stated that as he continued through the nursing program the person who made that statement began to talk and interact with him much to his surprise. Tim remains confused to this day about the sudden change of his peer’s attitude.

Omolo looked at the overall situation of being in nursing school with Euro-American students and faculty and revealed to me that, “At the end of the program… there was a very good understanding and I do not blame some of this [*sic*] peers for this since because it is…cultural shock for them just as much as it was for me.”

Nursing faculty incivility or demonstrated disrespect of the participants occurred throughout their learning experience. Omolo revealed an instance where a nurse educator accused him of cheating on a quiz by looking at the student’s quiz next to him. These type of instances sent Omolo home where he cried.

Ashley had a different kind of experience, yet she too was called into the nursing office for cheating while writing a research paper. To write this paper, groups of two were established. Ashley’s group consisted of her and a friend. Ashley and her friend split their work on the research paper in half. Ashley’s friend then went to another friend and they collaborated to write that second portion of the paper’s last 50%. Ashley wrote

the first 50% of the paper by herself. Consequently, the other half of the paper was identical to another paper turned in by the two friends. She emphatically stated:

> That same lady [department chair] was [sic] really, really, really, really tried her hardest to try and say that the collaboration portion, the cheating part really, academic dishonesty portion, was my part so she just had her heart in it to kick me out of the program.

I continued to question as to how this situation was resolved and who the other two students were that collaborated. Ashley relayed that they were "white." This entire situation caused Ashley great stress and anxiety as she was required to prove she was not involved in the friends' collaboration. She stated:

> So I said [to the department chair], 'How do you know? I don't know the e-mails going between these two girls. The only e-mails I know are the ones going between me and her because we are partners. So, luckily we have what's called Google Docs and um, I didn't use them because Google Docs would've screwed me over. Once we change it, the other changes are gone. I didn't use Google Docs luckily. I did just Word documents. So, I would say there are no changes to um. So, in my e-mail you would see the first two pages I sent as an attachment. And then you know she would revise it and send me back something and you would just see that. So, through that there was proof that I didn't do the last some pages…First they [girls who collaborated] tried to deny it, there were messages and phone calls and everything going like—if so and so asks you, say this didn't happen. I'm like, I don't want no part…I printed off massive e-mails, 50 pages. I said, 'Here is what I sent you.' …And they didn't want to show me what the

> other paper that they said ours looks like…But you know what, they said they were going to kick them out of the program, loop holes academic advising stuff got involved and they graduated me. I can guarantee you 100% if that was me, I would have been kicked out of the program. I would have had some lovely thing put on me. I guarantee it!...I had friends who got kicked out of the program for less or for you know, for suspicion of cheating. There was never enough proof. This is absolute proof—word for word, they did this assignment together. They [peers] badgered me…..And they both get to pass, they save time and energy and they still got to graduate with me!

Ashley was honest, yet due to being on the "inside" and white, the two friends took the opportunity to be dishonest and attempted to make Ashley responsible for their actions. The department chair seemed more apt per Ashley's perception to believe the two friends and blame Ashley.

Nurse educators were also skeptical of learning performance of participants, especially of those who were ELL. Omolo's ability to learn was questioned as he emphatically stated with his face showing disgust:

> I asked the instructor you know, I am ill, really ill, I need a break, here I can come and do this exam at a different time and her perception was that I was trying to avoid the exam because I was not ready for it. Uh, and that makes the hair on the back of my head just rise.

Another common denominator among the participants was feeling like an inconvenience to the hospital nursing staff. Ashley expressed this best, "They [nurse working with her] already think it's going to be a burden on them because they have to

do so much more. Ashley sensed that the nurse was "already…on edge" when the nurse was informed that a student was caring for one of her patients. Ashley internalized that working as a student nurse alongside a hospital staff nurse who emanated superiority as, "She doesn't trust me, like I'm stupid."

Suzhen experienced a disruption in her learning from being ignored by her hospital nurse with whom she was working. Suzhen reported an example that occurred in her Advanced Medical-Surgical clinical:

> I clearly remember CVTU unit somewhere in the new building. And I just, I mean he is a male nurse too. I don't remember his name by this time, but he like I feel like he ignored me the whole time. Like when I introduced myself as a student nurse, he got report, he didn't call me and say 'Oh, you haven't got report, can you call me when you get report.'… my patient told me something that he doesn't feel good or something and I told him and he think my patient discharge that day and I run and call him like, 'oh, patient say something not really feel good.' I don't remember what going on, but he like, 'okay.' And he didn't give any medication or anything like that and then my instructor say, "You can give med with your nurse.' And I say [to the staff nurse], 'oh, if you give med I will be here.' And then after that he give [*sic*] med and he didn't call me.

Suzhen expressed disappointment with the hospital nurse assigned to her patient. With involvement of the nurse, Suzhen could have had a positive learning experience.

Omolo told a story of his capstone clinical and the student – preceptor relationship:

> My preceptor frustrated me. I remember sitting in a parking lot crying. My preceptor really really frustrated me....if I took a blood pressure, a manual blood pressure, and got 138 over 70, she [would] say it was 140 over 68…Things that were subjective…she gave me a difficult time on…I felt like she was setting me up for failure each moment. There was a point I was going to quit the program that was the point and that was the last 2 weeks to get done. That was frustrating.

Nursing hospital staff also questioned the aptitude of the participants to learn or how they managed to be accepted into the nursing program as expressed by Mary:

> During the clinical when you ask questions for example, because it sometimes the technology was confused [*sic*] or whatever, they really didn't give answer and they would laugh at you behind your back if you don't know and try to humiliate you, put you down.

The participants who were proactive in their clinical learning with hospital nursing staff experienced a more positive learning environment. For example, Mary, who is from Ukraine and Caucasian, denied having a bad clinical experience because, "nurses' share with [us] their knowledge and skills…it was awesome and they used some encouragement, positive encouragement, that makes you feel comfortable and you learn more sufficient." Suzhen appreciated the "float nurses" as they encouraged independence and allowed more leeway to care for the patient. Not all hospital nurses reacted positively to nursing students who actively pursued learning as described by Ashley:

> I actually had one lovely interaction with one nurse (Ashley half-heartedly laughs, mimicked sarcasm) who she just didn't want to work with me…'I'm going to be your student nurse working with you today, um, these are the things I am allowed

> to do, these are the things I am comfortable doing, and um, I am wondering if you will let me do the 8 am assessment, noon assessment, and maybe some I's and O's and will you let me be the one to check the IV.' …I would know exactly what I wanted to do, and the things I have to accomplish, I knew the checklist that my professor has to sign off on, and I knew I had a couple of things that I still needed to finish…So 'will you let me do ABC….?' …a lot of nurses I guess, when they have a perception of you, and I felt like they definitely did, where as a student [number] one they already felt like you were kinda [*sic*] beneath them, and you already are a burden to them. I guess me being so open and up front about what I wanted, they kind of felt it was pushy…Maybe she wanted me to beg her to let her do some of these things or be like, 'can I please' or 'since you are so knowledgeable can I please watch you do this?'…He [clinical faculty] always said something where you have to guide your experience, you have to guide your learning, um, you are never going to learn anything until you put yourself in the front that way.

Like the lone maple tree whose growth was slowed, the participants' stories revealed disruptions in their learning through uncivil behavior shown by nurse educators, peers, and hospital nursing staff.

Nurturance. The lone maple tree finds strength to go on living even though at times life is rough. The tree continues to grow, mature, and propagate despite set-backs. The tree's roots pull nutrients and water from the surrounding environment and the leaves transform the sun's rays into plant energy.

Similar to the lone maple tree, the successful participants incorporated several strategies as a means of supporting their learning. Tim asked peers to help him understand words during lectures.

> So, she [nurse educator] can be talking…and all of a sudden you just hear one word and am now lost for the rest of the lecture. My friend Bob, was sitting next to me and he would try to write it down for me, what it means."

Another support for Tim, was his wife, who was born and educated in the U.S. She was able to correct grammar, improve sentence structure, and identify British from American English when Tim wrote papers.

For Ashley, a nursing educator gave her assurance, encouragement, and advice on how to improve her quiz and exam scores, "Buy this book…review the heart and then do the NCLEX questions on it….Don't even read the content. Just do the questions and then read the rationale behind it and just do it." For Ashley, this greatly improved her quiz and exam scores.

When Omolo had difficulties in capstone clinical with his preceptor who he felt was "setting him up for failure," he praised his clinical nursing faculty for her encouragement and reassurance. "Thank God for the instructor I had…, she listened to me and walked me through that." This situation with his clinical preceptor was so devastating for Omolo that he considered leaving the program two weeks prior to graduation.

Suzhen felt the nursing tutor helped her immensely to diffuse the confusion in how to write a care plan.

> She explained really patient [*sic*] and she go [*sic*] over the skill with me. It's just I love her so much and she say like, 'Try to be calm and then just do not panic because you panic [the] patient…and is not good for the relationship. If you don't know, just say I don't know and step out and look it up for you [*sic*].' And I mean I still remember what she taught me that day until I work as a nurse.

Mary sought out videos related to nursing skills to further examine the process. She also made friends with another peer who, "is a brilliant student, she [*sic*] GPA is four plus, she's smart and I quote her and ask questions as how that works." Her peers assisted her through a study group which met in the library weekly as well.

Omolo, Mary, Suzhen, and Tim felt that learning medical and nursing terminology was like learning another language. Omolo stated it best, "The learning challenge of the language, one is translation…from my language to the English language and then to the nursing language." That is three translations leading to increased time in reading textbooks, deciphering exams, and writing assignments. So, all participants had specific study strategies that each used. For example, Mary made note cards for each concept to be learned, took notes during "lecture presentations" to return later to connect them with the textbook, and constructed tables to understand the process.

Note taking went further for Omolo as he typed them upon returning home. He also discussed with his peers their point of view. He paid close attention to nurse educators who repeated or questioned a topic many times as he related that to being on an upcoming exam.

Writing every word down during lecture was tiresome for Tim; however, this practice was learned in Kenya.

> While the teacher was talking, I'd write word for word what the teacher was saying. That's tedious and you are also trying to write fast, but the only advantage is that's how we were taught in Kenya…So, that's how they taught their lectures and you wrote everything that they were saying. So you had to be fast, I was fast!

Just as the tree continues living by becoming dependent upon reserves, so did these participants. Their emotional strength, self-nurturance, positive self-esteem, and motivation were self-sustaining in completing their nursing programs. Participants felt that being in nursing school was like self-learning. Suzhen submitted that, "it seems like we have to learn by ourselves. Yeah, even though we have a lot of support, but [*sic*] it seem[s] like you need to do [the] learning for yourself." Tim blamed that being a husband and parent, working, and attending school contributed to more self-learning as he was unable to attend study groups.

Nurturance, be it by others or self, has a unique relationship with resiliency. The component that substantiates this relationship is how EDISNs cope or adapt to their nursing program, faculty, peers, and clinical nurses. Shimoinaba, O'Connor, Lee, and Kissane (2015) defined coping as how we deal with difficult things or situations. Some of the coping or adapting strategies were identified as "expressing emotions, practicing self-care, and gaining support" (Shimoinaba et al., 2015, p. 507). As previously noted, Omolo cried a few times when accused of cheating and also when he did not meet the preceptor's expectations. Mary offered how she cared for herself, "You just have to shut down and take [a] deep breath and give a [*sic*] room and balance yourself to be ready for

next." These are ways the participants maintained resiliency while in the nursing program.

Resilience. The lone maple tree demonstrates each spring how it returns to reveal life continuing after winter dormancy. The lone tree brings shade from its abundant foliage and grows seedlings. This resembles how the participants recreate and nurture themselves to resume their studies, become resilient to negativity, and eventually prove successful in their nursing program.

Though participants experienced challenging periods of stress and adversity during their nursing program, each developed a way to cope and adapt to their specific situation. Their actions taken to cope and face adversity resulted in their resilience in the program with successful completion. For instance, Omolo, when he was made fun of by his peers, "I took it positively and just jumped back or something and then brushed it down and made a good working relationship with them after." Omolo was a 37-year-old student from Kenya who settled in the U.S. 20-years-ago. He has worked various jobs since arrival and preferred employment where he has contact with people. He decided nursing was his chosen career when:

> I moved to Minnesota I worked in a group home, mentally disabled…patient[s]. Was going to school to make friends and learning about this nursing that I hated before because it was a dirty job and then…from there it was my passion…Nothing better than when my patients...stop by the nursing station and they want to see me even when I am not there.

Omolo also, had strong motivation to complete the program since he paid for his education by working. He had quite a few years of career searching and when he realized what his career should be, nothing was going to stop him.

Mary demonstrated control for her own life. She was well-seasoned; having raised six children and received a degree in education from her country of origin. Being successful for Mary was due to having "a very strong work ethic" and being a life-long learner." When faced with a "threatening environment" by a nurse educator who told her, "We change the test, content of test every single, 2-years, and we make it difficult for you guys and we made its [*sic*] difficult with [*sic*] a reason. We want you to throw up before [the] test, we want you to be in fear and scared." Mary, as a previous educator, understands that this is "not the best learning environment, it's [*sic*] block your brain." Mary dealt with this situation as she admitted, "I am an age when um, I can balance myself. I said to myself, 'I [am] not going to be threatened by you.' And I did wonderful on meditation."

Suzhen looked to inner strength as she felt that she was in this experience on her own. "I'm a person that accepted more than complaining, because like you [*sic*] complaining, you don't get [any] thing done. You just accept it and move on. So, I have to do it on my own." When ignored by her peers, Suzhen told herself, "Okay, I have to let it go and everything will get better, they will get to know me in the next 2 years."

Ashley employed a different approach through her struggles. She expressed this comment, "People only treat you the way you allow them. I am not going to give them the chance to treat me disrespectfully. I demand respect." She learned to "bite her tongue" and "address the things that need to be addressed." She felt, "Do what you have

to do to get done. It's like someone preparing themselves for battle." However, clinical was rewarding for her and working in nursing remains rewarding as the therapeutic relationships she has with her patients contribute to her positive self-esteem.

Tim's attitude was, "You almost want to give up and then you're like, 'I've gotten this far, so I might as well continue'. Then you try to figure things out." He likened learning to "a baby…trying to learn all this stuff." Tim found strength within himself and through his circle of male peers to sustain him in the nursing program since there was one other female immigrant in his nursing class. All five participants relayed resilience with their inner strength, determination, and assistance of supportive peers and nursing faculty. The successful participants were efficacious when they decided to take control over their learning. They demonstrated inner strength like the hardness and hardiness of the maple tree.

Propagation. Spring finally arrives and a farmer visits the lone maple tree and taps the tree for the syrup, boiling it into edible maple syrup. The tree gives back organic food to those who care for it. After spring and into early fall, the lone maple tree produces seedlings to disseminate across the area. Similarly, the participants grew from their nursing school experiences and shared this with me. They suggested strategies that nursing educators could integrate into their classrooms.

Both Mary and Suzhen indicated that increasing the case studies to effectively follow a process or improve their hands-on nursing experience would be helpful. Suzhen gave an example of, "You see a patient passing [*sic*] out on the floor, what [is] the first thing you need to do?" Suzhen stated that her nursing faculty for courses did do case studies; however, they never had time in class to review the group work they did with the

case studies. Mary explained that completing projects such as presentations or having the ability to apply a concept was her most helpful way to understand the nursing material. This allowed her to be creative and ask more questions to improve her knowledge and capability to perform her skills.

A suggestion from Omolo was to have nursing faculty "facilitate aggregation to help the immigrant to get immersed into the culture and class." He also felt that "grouping people with like minds" when completing a group assignment would be beneficial. Omolo's explained what he meant:

> A 37-male non-traditional and a 20-year-old female, even though they are from the same culture, those people think completely differently…But, if you have a 40-year-old male and a 37-year-old male from the same culture, I believe they can fit with each other because both are adults and non-traditional students.

He clarified by stating, "It wouldn't be a question from them coming from different cultures…you couldn't help me really if you put me with five or ten people from my own culture." Omolo also expressed that having a mentor who could guide him through American English and U.S. culture would have benefited him greatly in the clinical and classroom experience.

Suzhen suggested that nurse educators be specific in what they want the student to know at the beginning or end of a lecture with more case studies to exemplify. She also requested a part-time program or summer classes. "Because I have just one class, I feel I learn, not even learn more, it just retained more." These participants felt the need to share their nursing school and work experiences very adamantly and straightforward. They noted that when embraced by their nurse educators, peers, and staff, they flourished

in their career and volunteered to teach new graduates by orienting them to nursing units and skills.

Suzhen spoke of a time she precepted a nursing student at a hospital. Suzhen, although just out of school herself, was self-assured that she could be a positive "role-model for my student." She demonstrated pride as she told me how she assisted the student assigned to her to learn. Finding ways to teach the students brought her gratification and increased her self-esteem.

Working in a very prestigious and busy hospital, Omolo found contentment in orienting new graduates to the cardiovascular-thoracic unit. He identified "with the new graduates and helped them along cause [*sic*] I am also still learning." He confirmed that, "It is scary when you are left to fly alone." Compassion for others is one of Omolo's strengths. His heart swells like the seed as it bursts forth in germination.

Like seedlings from the lone maple tree spreading across the field, the successful participants also enjoy employment and giving back to the community. These participants demonstrated how they overcame obstacles to become successful EDIRNs. They have the ability to distribute constructive criticism, obtain employment, and orient or precept new nurses in a clinical setting. Success sprouted highly intelligent self-assured EDIRNs who willingly shared their insights, suggestions, and assistance with others.

To summarize, in answering the primary research question, *What are the overall learning experiences of EDIRNs who have graduated from a private or public ELBNP in Minnesota within the last 3 years?* five subthemes emerged. The five subthemes that were synthesized from the participants' stories included harsh realities, disruptions,

nurturance, resilience, and propagation. Each of these subthemes constituted the whole of what the participants' concerns were, *being on the outside.*

As I sought to create new understandings, the Hermeneutic Circle provided initiative to read more published literature related to the findings and philosophical position. Working with the expert hermeneutic phenomenologist, we discussed at length text analysis when interpreting the transcripts. Together in interpreting the original texts and reviewing earlier literature, new meanings were discovered along with an appreciation for what each participant experienced. What began as a query into each participant's learning experiences extended to their perception or being-in-the world. Overall, joining each subtheme together produced the overarching theme or main participant concern of *being on the outside.* Additional reading of philosophy and other literature related to the subthemes and attendance at an educational workshop aimed at teaching ELL informed the discussion of the findings.

Discussion

> *"Our first task in approaching another people, another culture is to take off our shoes. For the place we are approaching is holy. Else we may find ourselves treading on another's dream. More serious still, we may forget that God was here before our arrival"* (Warren, n.d., para. 1).

Each participant was affected by *being on the outside*. For most participants, this feeling continued well after graduation and into employment. Some of the same issues faced in their nursing program continued into their career as well. Mary quit her first job as a nurse because of harassment by her nurse manager. Omolo did not care for the first

unit he worked on at a hospital as he was not accepted; however, when he transferred to another unit, he felt supported and welcomed. What Mary and Omolo described was the inability to substantiate belonging or respect from their first employment experiences. These experiences follow Maslow's Hierachy of Needs (1943/2013).

Maslow suggested in 1943 that human beings are motivated toward goal attainment during their life. These goals he placed in ordered levels of attainment or needs that had to be met prior to moving to the next level by the human being (Maslow, 1943/2013). A person begins at the lowest level, "physiological," where nutrition, sleep, and air are required to continue living (Maslow, 1943/2013, p. 68). The second level that a person strives to accomplish is "safety" that includes security, employment, and resources (Maslow, 1943/2013, p. 73). At the third level, a person endeavors to "belong" to a family and community (Maslow, 1943/2013, p. 79). Being part of a community fulfills the human need for acceptance and recognition for the role they play within that community. The participants desired to feel like they belonged with their nursing peers through respect and acknowledgment. The nursing profession is a family and community since nurses work as a team to educate and provide health care. This sense of community should be sought through a recognizable solidarity. A community of nurses in a healthcare facility or a community of nurse educators with nursing students in an educational institution requires caring, compassion, understanding, and teamwork among all.

How does the nursing community accept and respect the EDISN and the EDIRN educated in the U.S.? How does the profession that is predominantly Caucasian connect to EDISNs and EDIRNs to increase solidarity? How do we assist nursing students in

uniting while in nursing school? Gadamer (1981/1996), derived from Plato's overall knowledge in suggesting "that only friendship with oneself makes possible friendship with others" (p. 80). When a human being becomes friends with him or herself by accepting *Dasein* then, this knowledge converts a part of Being into historicity. A sincere solidarity and credible community can be recognized with discourse among each other who always already understands themselves. Gadamer (1981/1996) emphasized by quoting Heraclitus, "The *logos* is common to all, but people behave as if each had a private reason. Does this have to remain this way?" (p. 87). Human beings recognize differences among other human beings.

The participants experienced differentness as they were ELL, encountered difficulties with typing, encumbered by sociolinguistics, and they physically appeared different. For example, Ashley was assumed to be similar to previous Somali nursing students by the department chair. Thus, the department chair already had a preconception of what Ashley could or could not do without speaking to or assessing her first. In Kenya, computers are non-existent leaving Tim to physically take notes and write papers. However, when in a university setting, Tim was expected to know how to use a computer and type. Ashley also relayed that when students with thick accents would ask or answer a question in class, a neighboring student had to repeat it to the nurse educator or the educator just ignored the comment. This explains why the participants felt like they were *being on the outside.* The nurse educator is a role model for nursing students. By nursing faculty taking actions to understand the EDISN's learning strengths and weaknesses, ask questions in relation to how we can best assist them, and be attentive to his or her needs, the EDISNs' peers may begin to accept them into their community.

In 1996, Jordan recognized a gap within the literature. Jordan (1996) claimed "the persistence of the attrition problem" related to epistemological studies neglected the ultimate research question in addressing the real phenomenon (p. 383). Jordan's (1996) ontological question was, "What is the meaning of being black in an educational program that is predominantly white?" (p. 383). By reformatting this question into today's society and nursing education, this question would read, "What is the meaning of being an immigrant new to the U.S. in a nursing program that is predominately white?" *Being on the outside* is influenced by spoken and written language.

Harsh reality through language. As an ELL, communication places immigrant nursing students at higher risk of attrition from ELBNPs in Minnesota. Understanding verbal and non-verbal language is a priori to determining actions to support the EDISN. Gadamer (1960/2004) wrote, "Language is the medium in which substantive understanding and agreement take place between two people" (p. 386). A newcomer to language and culture by entering the U.S. places the immigrant at a disadvantage. Canales (2010) believed that health disparities continue because of "conditions that separate 'us' from 'them': rich and poor, white and black, native and immigrant" (p. 16). In this instance language is one of the main defining characteristics of being different from the predominant majority by the inability to demonstrate fluidity in reading, writing, and speaking English. Linge (2008) suggested:

> The particular language with which we live is not closed off monadically against what is foreign to it. Instead it is porous and open to expansion and absorption of ever new mediated content (p. xxxi).

Gadamer (1996/2008) emphasized understanding the unknown and finding "support of familiar and common understanding" from historicity, interaction, and interpreting the linguistic context and verbally and non-verbally (p. 15). This assists to expand and enhance being present in the world through an infinity of always already existence and openness.

Language in textbooks. Omolo, Mary, and Suzhen all stated in similar fashions that they translated their textbooks from English to their native language and back to English. Learning nursing is like immersing oneself into an entirely new language as well as the English language. Critical thinking or the ability to decipher what the student needs to truly know is nearly impossible when the English language is the prominent barrier and continues to be an obstacle upon graduation. Mary requested extended test-time based on a slower processing time related to being an ELL, while also offering different types of presentations to students. Omolo continues post-graduation to spell generic medications, because of difficulties with pronunciation. Mary suggested that "we have to learn how to think in English…it is not a good idea to translate because we live in a society and we have to function in this society." Suzhen felt that English as a second language was a definite obstacle she realized was necessary to overcome by looking seriously at me and stating, "I need to learn it in English and accept it and try to understand the meaning." Gadamer (1996/2008) concurred:

> But it is nevertheless already speaking, even if perhaps a stammering speaking, for stammering is the obstruction of a desire to speak and is thus opened into the infinite realm of possible expression (p. 16).

Language, no matter foreign or native, represents infinite possibilities of always already learning and expanding knowledge about placement of us and others within the world.

For the participants, language was an enormous obstacle to overcome in learning. According to a literature review completed by Crawford and Candlin (2013), international students or immigrants face challenges of acclimating to Western culture and integrating a more progressive and healthcare specific English. English language learners require more support to increase confidence and usage of English in the classroom and at the bedside. Tim's difficulty with English was related to longer syllabic words like "conspicuously." This word contains five syllables. Gudhe (2003) suggested that ELL entering a nursing program have only grasped spoken English. To understand nursing textbooks requires an advanced intellectual educational aptitude in reading and listening to multisyllabic words.

Omolo stated that "when you get into like medical terminologies and nursing language….that becomes a challenge." To Omolo, learning words in medical terminology and understanding words written in a nursing textbook or verbalized during didactic was like learning another language besides English. When reading the textbooks, Omolo, Tim, Suzhen, and Mary took longer as they translated into their own languages first then back to English. A literature review was completed using CINAHL and Educator's Reference Complete and the words "Grade level of nursing textbooks," "Nursing textbooks and higher level of reading," "Nursing textbooks and difficulty reading," "Determining nursing textbook readability, "post-secondary textbook grade level," "textbook grade level," and "grade level of post-secondary textbooks." Only one article returned through CINAHL, "Medical Textbooks: Can Lay People Read and

Understand Them?" (Baker & Gollop, 2004). Baker and Gollop (2004) maintained that lay people were able to read medical textbooks as the textbooks were given a grade level of 11-12 by the Flesch-Kincaid readability scores. The greatest difficulty found was related to unknown medical terminology. The participants in Baker and Gollop's study (2004) were asked to read and circle words they did not understand. They had great difficulty reading due to the amount of words circled ranging from 1.81% to 6.08% (p. 345). Nursing and medical literature contain words that lay people have difficulty understanding so, what about students at the college level or post-secondary?

I conducted a little experiment with the nursing textbook used in the nursing students' junior year at SCSU. At this point, nursing students should be able to read at a grade 14 to 15. The following passage was randomly selected from the textbook, *Seidel's Guide to Physical Examination* (Ball et al., 2015) that was used in the NURS 303 Holistic Health Assessment Course:

> Determine the regularity of the heart rhythm, which should be regular. If it is irregular, determine whether there is a consistent pattern. A heart rate that is irregular but occurs in a repeated pattern may indicate sinus arrhythmia, a cyclic variation of the heart rate characterized by an increasing rate on inspiration and decreasing rate on expiration. An unpredictable, irregular rhythm may indicate heart disease or conduction system impairment (p. 318).

Note that the second sentence in the passage contains 36 words. The overall passage contains seven 3-syllable words, seven 4-syllable words, and two 5-syllable words. The longer the sentences and the more multisyllabic words used, the increased grade level required to be able to read and comprehend the information (Bosher & Bowles, 2008).

According to the Flesch Reading Ease Test using the website http://www.readabilityformulas.com/freetests/six-readability-formulas.php, this portion of text is difficult to read and very confusing with a score of 27.6 out of a potential 100 points. The scale used ranges from very easy 90-100 all the way to 0-29 as very confusing (Readabilityformulas.com, 2016b). A Gunning Fog test was also included that measures average sentence length and percentage of difficult words into a mathematical equation (Readabilityformulas.com, 2016a). This examination of a portion of the textbook demonstrated a grade level of 18.6 which can be difficult for undergraduates.

Hansen and Beaver (2012) suggested that when ELL nursing students experience difficulty with English they should be required to practice English through reading, writing, listening, and speaking. From the literature, Brown (2008) recommended establishing terminology index cards, recording lectures, and listening to those recordings several times. Mary stated that she made note cards that she took everywhere with her so that "I can repeat" the information. Sanner and Wilson (2008) suggested that students with compromised English skills print off lecture outlines, PowerPoints®, or any other supplemental material since these materials may offer a different way to learn. The participants in this study printed off PowerPoint® lectures and outlines as offered by nursing faculty. Do other healthcare educators have similar experiences with ELL students?

In 2008, Bolderston, Palmer, Flanagan, and McParland explored problems ELL radiation therapy students experienced in the clinical setting through two focus groups. Two focus groups were interviewed. A total of six graduates and students were in the first group. The second focus group interviewed were a combined total of five radiation

therapy staff members and clinical coordinators. The authors reported three overarching themes, "communication, differences: fitting in or not, and dealing with it" (Bolderston et al., 2008, p. 218). The results related to language confirmed similarities between radiation therapy staff and student as well as radiation clinical faculty and student. They declared that participants admitted to occasionally choosing the wrong word or words for a situation, had difficulties understanding the hidden meaning when talking to the patient, staff, or faculty, and translating while listening was demanding and intellectually tiring (Bolderston et al., 2008).

Caputi, Engelmann, and Stasinopoulos (2006) conducted "conversation circles" with seven ELL nursing students, one ELL faculty, and three nursing educators. Out of the three sessions conducted with all participants, ELL students felt that extra time was needed to take exams, they requested case studies or real-life scenarios in allowing the process of nursing to unfold, and educate students on how to relate to a patient from a different culture or behavioral issue (Caputi et al., 2006). In Mary's interview, she requested extra time to take exams due to translating back and forth from English to Ukrainian then back to English. Her reasoning was that as an ELL, "they get the information [sic] a few seconds delay." For Suzhen, exams took longer to complete than her peers because of the translation process that also increases the chance for misinterpretation of the exam question. "I really feel like maybe I just don't understand the question like they did or take me longer time to understand the question…or maybe even I understand a better [*sic*] way at interpret that is different." All participants stated that they always finished taking their exam when time was called by the nurse educator.

Stark (2015) concurred that ELL nursing students are challenged by language barriers. In a grounded theory study, Stark (2015) interviewed 16 nursing educators who made statements like: "Sometimes they get questions wrong because they simply don't have the vocabulary….The language difference is really a significant problem for them when it comes to understanding" (p. 721). Another of Stark's (2015) participants gave an example of an ELL student "who was very very weak in testing and failed a ….course… when she came back to repeat the course she worked so hard…she graduated and passed her boards the first time…the instructor made that difference for her" (p. 722).

Language in exams. Bosher and Bowles (2008) recommended that written exams for all students and specifically ELL nursing students meet the five following criteria: (a) incorporate shorter, easier sentence structure; (b) openly give information needed; (c) institute a question as the stem versus a sentence completion; (d) highlight or bold important words for the student to recognize in answering the question such as Except, One, Only, etc.; (e) speak simply and plainly in more familiar words. Exams for a pathophysiology course were rewritten by the authors that included linguistic modifications that used the five criteria they identified (Bosher & Bowlers, 2008). By integrating these five criteria into exam development, ELL students began to understand what was being asked and how to answer (Bosher & Bowlers, 2008). This strategy to assist ELL nursing students was presented at a Kaplan workshop, October 2012. Attendance to this workshop, "Increasing the Comprehension of Test Items by EAL Nursing Students," demonstrated how to change test items so all nursing students benefit in learning and test-taking. For example:

Original Exam Question:

Repeating a patient's answer is an attempt to:

a. Confirm an accurate understanding.
b. Discourage patient hostility or anger.
c. Teach the patient new medical terms.
d. Test the patient's knowledge.

Revision of Exam Question:

What is the nurse doing when he/she repeats a patient's answer?

a. Confirming a correct understanding.
b. Decreasing patient anger.
c. Teach new medical words.
d. Test the patient's knowledge.

While the stem is slightly longer, there are no more than two-syllable words present. The stem is easy to understand what is being asked in a concise manner. Textbooks typically come with test-banks for nurse educators to incorporate as they see fit. The text-banks are not written to Bosher and Bowles criteria, so the nurse educator who integrates test-bank questions may need to reformat questions.

Lujan (2008) identified that ELL students have difficulty with English because of difficulty with word arrangement in a sentence and verb tenses that intensifies nervousness and apprehension, especially when taking an exam. She suggested that nurse educators review the parts of a multiple-choice question, offer examples of mistakes made, and implement guided practice taking multiple-choice exams (Lujan, 2008).

Information processing. As Mary stated early during her interview, she would have appreciated having more time to take exams and work on assignments. She reflected on information a psychology professor had given to her that required ELL

students more processing time due to translation. Lim and Christianson (2013) identified three significant progressions that occur when translating between languages for the ELL. These three are the ability "to comprehend a source language, to switch between two languages, and to produce in a target language" (Lim & Christianson, 2013, p. 522). However, the quantitative research completed that tested 33 native and 36 Korean non-native speakers for comprehension and reading times through rearranging of syntactic and semantic information suggested that reading times for implausible sentences were significantly longer for non-native than native readers (Lim & Christianson, 2013, p. 527). Liam and Christianson (2013) assumed and derived from cognitive theories that translating from one language to another requires more intellectual capacity and mental awareness in connecting both syntactic and semantic in coordinating fashion. Because of these extra actions in translating, more time is necessary for the ELL. Translation times for the non-native speakers were dependent upon the participant being highly proficient in English or exhibiting a lower proficiency in English.

Oppression and incivility viewed as disruptions. Sanner and Wilson (2008) interviewed three participants about their ELBNP and being ELL. They discovered that the participants preferred to remain silent in class related to their accents (Sanner & Wilson, 2008). According to their participants, language was not perceived as a concern for their learning experiences (Sanner & Wilson, 2008). "Rather, issues involving discrimination and stereotyping emerged as major contributing factors" (Sanner & Wilson, 2008, p. 813).

In some aspects, nurses have gone astray by perpetuating oppression within the profession. For example, nurses and nurse educators are viewed as oppressed groups

(Roberts, 1983). Roberts began a career in investigating oppression within nursing in 1983. She discovered that nurses are an oppressed group because the profession is manipulated by people who have more influence, authority, standing, and prominence over a lesser group of people. Examples of oppressive groups maintaining domination over nurses are healthcare facility administrators and physicians. The predominant gender of nursing by combining RN and licensed practical nursing in the U.S. remains 83.3% female (Health Resources and Services Administration [HRSA], 2013).

In 1971, Cleland identified sex discrimination as the nursing profession's worst enemy. She wrote, "The female can win individual plays but the game itself must be won by the female" (1971, p. 1544). A book written by Friedan (1963/2013) cautioned women who obtained a higher educational degree typically steered towards male driven careers and this was unacceptable. Friedan's book (1963/2013) identified the root of women's difficulties stems from likening themselves to men and their inability to accept their own female nature, "which can find fulfillment only in sexual passivity, male domination, and nurturing maternal love" (p. 36). Cleland (1971) attributed Friedan's (1963/2013) book to continued oppression among women.

Hospital administration and leadership in the U.S. also continues to statistically document more men who predominate in these positions than women (McDonagh, Bobrowski, Hoss, Paris, & Schulte, 2014). Sixty-six percent of male physicians practice in the U.S. while 44% of female physicians remaining steady (Young et al., 2015, p. 13). Through a literature review completed by McDonagh et al. (2014), there continues to be a deficiency of female leaders installed into top professions, executive, and management appointments related to continued typecasts of women in leadership roles. When nurse

leaders are installed in higher positions, they tend to adopt the dominant group's principles and beliefs in an attempt to progress their standing and authority (Matheson & Bobay, 2007). By taking on the oppressor characteristics, female nurse executives become "marginal;" meaning that they deny belonging to the group that are oppressed, nurses (Roberts, 1997). Oppression affects all nurses from women executives to nursing assistants (Roberts, 1997).

Nurses practicing nursing, although somewhat detached from the medical model, continue to disseminate oppression to other nurses. They do this by continuing oppressive behaviors that include: (a) low-self-esteem; (b) negativity; (c) submissiveness; (d) silence; (e) passive-aggressiveness; (f) fear; and (g) turning against each other "horizontal violence" (Roberts, DeMarco, & Griffin, 2009, p. 289). In reviewing the transcripts again, Ashley learned from her colleagues and nursing educators to "bite her tongue." Rather than question her colleagues or nursing educators, Ashley held her feelings in that ultimately increased behaviors of oppression. Is this a side-effect of nurses' and nurse educators' oppressive behaviors upon nursing students?

Potential side-effect of being an EDISN. Cumber and Braithwaite (1996) reflected on what university students meant by cultural diversity. Responses heard were, "All cultures blend, there are no problems, yet diversity remains," and "Respecting the different backgrounds of every person, whatever that means to that person" (Cumber & Braithwaite, 1996, p. 274). These researchers also noted that their participants overwhelmingly identified the multicultural diverse as the racially and ethnically different people born in the domestic U.S. other than Caucasian. The participants in their study did not acknowledge that international students entering the U.S. on an educational

visa or immigrants resettling were not born in the U.S. Study participants were combined together with international and immigrant students. This aspect of acceptance and recognition still continues today. Could it be due to language, accent, or difference from those who are racially and ethnically different who are born in the U.S.? Are these students ignored because of their differences with language and difficulty being able to identify or connect with students outside of their community of difference?

Ethnically diverse immigrant nursing students undergo a stressful and adversarial life in nursing school. Some gather strength from this and cope positively; while, others may develop a "side-effect" of the continuous assumptions or oppression of their person or culture. For example, Ashley seemed very abrasive during the interview with how she responded to questions and how she related to nursing faculty and colleagues at work. When Ashley was approached by the department chair of her nursing program and the nursing faculty suggested she enter the associate degree nursing program, Ashley responded by slyly pointing out the assumption the department chair just made:

> And I said, 'You have children correct?' Cuz [*sic*] I could see she had children in the back and they were probably around my age at the time, I was 18-19. And I said, 'I can probably guarantee that I understand and speak English better than your children. I don't know if you have access to the high school records, but I got a 6 on my writing, I passed 100% on my BSTs for reading.' I have always had a better command of English then people assume that I did just by looking at me. I don't have an accent, so if you spoke with me you would be able to figure out that English might not even be my second language. And I told her, 'Just from me sitting here, my hair is covered, you know, I'm not white, you just make

> that assumption. It did serve you well today.' Is kinda [*sic*] what I told her. Um, I said, 'Unless I fail out of this program I have no intention of giving it up.' So, needless to say we didn't get along well throughout the program.

Ashley believed that nursing faculty tended to think of her "like she [*sic*] one of my past students." By nurse educators linking Ashley with previous EDISNs, they assumed they would face difficulties with her learning; therefore, continuing the oppression cycle. Was Ashley trying to overcome oppression or was she mirroring incivility by nursing faculty? Did the department chair devalue Ashley and make assumptions from past experience?

Randle (2003) identified a major theme with nursing students being bullied by nurses and nursing faculty. Similarly, in Randle's (2003) study, one student stated, "I think I've learnt when to speak and when not to, when to ask questions and also the sort of questions you do ask" (p. 397). Ashley made a statement comparable to that:

> I'm going to bite my tongue while I'm in the program, but I really don't need to be, make more problems for me…feeling that you have to bite your tongue, you can't be honest because of you know, that someone is out to get you.

Ashley became so desensitized to positive comments that she became negative to social interaction with nurse educators and with other nurses. She admitted to being condescending specifically on graduation day by telling the nursing faculty, "Remember me? Oh, you didn't think I'd still be here....Yep. I am graduating people. Did you know that?' I was just so condescending. They deserved it." She continued on with, "Did you happen to page through the program? My name was on there twice…I was under the PAN and BS." Again, this is evident when she revealed, "Things I learned about

myself… it's it's really really really hard to break me…in the nursing program I am happy to say they couldn't break me…I think I did things where [I] broke them."

Freire (1970/2011) conveyed oppression of the Brazilian people using the dichotomy of humanization and dehumanization. Freire (1970/2011) described how the oppressed became dehumanized through, "injustice, exploitation, oppression, and violence of the oppressors" (p.44). The oppressed and their oppressors are in a perpetual cycle of dehumanization with the oppressed only having the ability to cease the cycle (Freire, 1970/2011). Ashley also felt that educators who were tenured were more set in their ways and unwilling to look at her any other way besides an immigrant. She expressed disappointment with her pathophysiology teacher because:

> I hated that professor, she never taught us anything and you could never argue anything and she could never show the point. You would go up and say 'I think this is the answer and I don't see why it is that based on the literature you have put out say this thing it says this which means this and she'll [sic] say that is the answer. A lot of the questions she'll just pull online and they didn't really correspond with our book, but she has been there forever, there's really nothing to do about her.

This abrasiveness has continued to follow Ashley in her employment. "I've been biting my tongue a lot since working." She gave examples of how nursing colleagues at work treat her:

> I worked with LPNs [licensed practical nurses] who thought they were my bosses…They always used to complain to the DON [director of nursing] like oh she's, oh she talks down to us…;whereas, I was having LPNs boss me around

> telling me how to do things because they have been there forever…One of them actually went so far to say, like I went to the DON's office where she told me, 'You know, people are kind of put off that all the time you are always telling them that, Oh I went to _____.' Oh I have a 4-year nursing degree….I never tell anybody until they ask me. Now you are offended that I told you that…So, I dealt with the stupidest things.

This oppression experienced and continued by nurses lingers throughout their career as expressions of anger, yelling, ignoring, constant complaining, negativity, or removal from the nursing team (Roberts, 1983). This also accounts for the "cattiness" between female nurses. Ashley freely offered, "Nurses are known to be catty. They will never say anything to you. They will send e-mails to your manager." Bickel (2014) suggested that women learn as girls to become aggressive and direct negative behaviors towards other girls. She termed these instances as "catfights" (Bickel, 2014, p. 365). For example, girl cliques that occur in middle and high school with the "in crowd" ostracize those outside of their realm or circle. Tim also commented that the women in his cohort were "catty." Ashley relayed that teamwork is non-existent on a unit to which she floats. "There is just no sense of community or working together. You just feel like you are an island of your own."

Jordan (1996) felt that the increased attrition rate is a repercussion of oppression within the learning environment and not beneficial to their education. Believing this, she reasoned that nurse educators who have acknowledged African-American nursing students as "cognitively inferior" were susceptible to poor relations with those students (Jordan, 1996, p. 389). Thus, oppression encompasses nurse educators as well with

transference to nursing students. Staats, Capatosto, Wright, and Jackson (2016) identified "implicit bias" as "attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner (p. 14). Although, people retain implicit biases influencing their behavior, these attitudes or stereotypes are susceptible to change and can be exchanged for new psychological and perceptual meanings (Staats et al., 2016).

This study's participants expressed great sensitivity toward the behavior shown them by their nursing faculty, peers, and hospital nursing staff. Have the implicit biases of faculty, peers and, nursing staff unconsciously risen? Often these behaviors could be classified as incivility or boasting. Omolo commented that his peers "thought I was just not smart enough to do it." Suzhen agreed, "I'm not good enough as my classmates." Ashley felt that "I am already so disadvantaged …there is already these prejudices against me." Implicit biases are unconsciously released by faculty, peers, and health care workers and can be felt as incivility towards EDISNs.

Clark and Springer (2007b) recognized "six themes of uncivil faculty behaviors, faculty condescension, poor communication skills, poor teaching style or method, acting superior or arrogant, criticizing students in front of peers, and threatening to fail students" (p. 96). These are appalling behaviors that students witness and potentially emulate in nursing school or the work place. Students also emulate nursing faculty who demonstrated positive behaviors and displayed attentiveness to students (Clark & Springer, 2007a). Demonstrating a positive open and honest dialogue between the student and faculty will establish a powerful relationship of trust and civility (Jordan, 1996). Ashley had one such experience with a professor who she spoke with about

potentially failing a course after taking the first NCLEX-RN type quiz. This nurse educator sat down with Ashley and explained a strategy to successfully take the course quizzes and exams. Ashley reiterated what this professor said, "I told you, you weren't going to fail out." And Ashley's response was, "I didn't believe you. So now that I have passed, I believe you." Nursing faculty who are verbally and mentally open to students asking for help will increase retention of their students.

Another category that Clark & Spring (2007b) identified and was rated fairly high by nursing students was nursing faculty "acting superior and arrogant" (p. 96). Gadamer (2001b) made a similar statement as he explained that anyone who attempts to validate tradition and authority are sadly mistaken. Thus, peers, nursing faculty, and healthcare nursing staff may believe they have more knowledge and skill capability; however, they cannot possibly know everything. For example, a Caucasian nurse has been assigned to a man from Kenya who speaks only Swahili. The nurse has a colleague working who speaks Swahili. In this instance, the colleague seen as different has more knowledge and skill to communicate with the patient and relay needs to the nurse caring for him. Similar to Ashley, Suzhen commented that she had "a few instructors" in her program "that we really like, we really hope those instructor[s] can stay and continue working with us and for some reason we don't see them anymore."

Further examples were given that acknowledged nursing students treated as "subordinates" with nurses holding power over them (Randle, 2003, p. 397). Hospital nurses and nurse educators who role modeled these negative behaviors were easily recognized by nursing students; however, the students were unable to adequately address this negativity and became anxious and upset (Randle, 2003). Nursing educators who

guided and supported learning were praised by participants. Mary stated, "Thanks to instructors who made this program very a [*sic*] learning experience and a [*sic*] acquire very nice professional skills, I feel very well prepared to work." Students who took an active role in their clinical setting had positive learning experiences when the hospital nurse reacted positively (Vallant & Neville, 2006).

Incivility towards the participants who were different in language and culture was experienced throughout their nursing program and also post-graduation in their employment as a RN. This tendency led to participant low self-esteem, a characteristic of oppression, and the potential to incorporate those same tactics used by their nurse educators, peers, and hospital staff into their practice post-graduation. Randle (2003) conducted a study titled, "Bullying in the Nursing Profession" where she defined self-esteem as, "built up or damaged in social interaction, as people receive feedback about how others view and judge their behavior" (p. 395). Randle's (2003) grounded theory research demonstrated through students enrolled in nursing courses that their self-esteem was sabotaged (Randle, 2003). Suzhen expressed that although she studied hard, "I am not as good as they are." This is indicative of low self-esteem and a beginning characteristic of oppression as identified by Roberts (1983).

Valant and Neville (2006) conducted a study in New Zealand that identified five categories that influenced nursing student and hospital nursing staff relationships. These five categories were derived from the spoken words used by the participants in their interviews and included: "being invisible in the relationship," "not stepping on toes," "lost opportunities for learning," "nurturance," and "reciprocity" (Vallant & Neville, 2006, p. 26).. The first category recognized by the students was "being invisible in the

relationship" (Vallant & Neville, 2006, p. 26). Students viewed this type of relationship as being disregarded, disrespected, and disparaged (Vallant & Neville, 2006). Mary reiterated this by saying, "We really felt excluded….during the clinical when you ask questions…they really didn't give answers and they would laugh at you behind your back…and try to humiliate you, put you down."

Hassouneh-Phillips and Beckett (2003) uncovered four major themes through "the lived experiences of women of color in nursing doctoral programs" (p. 261). These major themes included: "an education in racism," "wearing masks," "maintaining the status quo," and "moving on" (Hassouneh-Phillips & Beckett, 2003, p. 261). Each of these themes represented the demoralization of women of color and attempted to transition them from their ethnic culture to conformity within Euro-American culture (Hassouneh-Phillips, & Beckett, 2003).

Two of the four themes are related to what my participants encountered during their education; such "wearing masks" and "moving on" (Hassouneh-Phillips, & Beckett, 2003, p. 261 "Wearing masks" was represented through the educational institution "paying lip service to diversity in nursing"…however, "maintained status quo of Euro-American dominance in academia" (Hassouneh-Phillips, & Beckett, 2003, p. 262). "Moving on" was difficult and hard work for these women "to meet the challenge of their perceived moral obligations and remain true to themselves, despite ongoing pressure to conform to the scholarly model of traditional, Euro-American academia" (Hassouneh-Phillips & Beckett, 2003, p. 264). Nursing educators expect conformity to rules and regulations of the "Nursing Student Handbook" provided to each student at the beginning of their nursing program. McGregor (2007) identified nursing student perceptions of

changing to please the nurse educator. She titled this "Adopting a Chameleon Cloak" meaning that each student converts himself or herself to each social situation as warranted by the nurse educator (2007, p. 507). Ashley confirmed this by emphatically indicating:

> I know we [her educational institution] market ourselves as a multi-culturally diverse and inclusive community university and blah, blah, blah…well, you know what, it is all a farce because yeah, there is a lot of ethnically diverse students here, but none of them get into your programs, none of them pass, none of them get a degree, none of them get a job in the fields that they want to …so, essentially all you are doing is wasting their time and money.

Hassouneh-Phillips and Beckett's (2003) participants also observed that Euro-American nursing faculty and peers refused to challenge racism. Their participants also wore masks to conceal their exposure to the negative behaviors of nursing faculty and peers against them (Hassouneh-Phillips, & Beckett, 2003). Ashley felt that she had a different learning experience "based on peoples' perception of what I knew and what I didn't know. Based on just looking at me…I kinda [*sic*] felt like the cards were already stacked against me initially." People perceive and judge others by their outside appearance without coming to know the other person's inner self.

Ashley expressed her future fears of crime and U.S. future with:

> I feel like a lot of white crime is just targeted at you because you are not white. That's more scary [*sic*] to me. That I could be walking down the street and someone's like, 'Oh, she's not white what is she doing here?' And I might get hurt. I'm less scared to walk through a whole gang of Asian people because –Hey

> they don't know me, I didn't do anything to them, I will not see their violence, and I will not be subject to it. Now I walk through a group of African-Americans; the most I will probably get is like, 'Hey – look at that ass!' And then I just keep going.

Ashley concluded the interview by stating, "America's gonna [*sic*] be [an] even harder spot to live for someone who's not white."

Tim also expressed concern through a comparison of Kenya with the U.S. He indicated, "There's all these black people and the only way to distinguish is by tribe. So, here [U.S.] it's not tribe, it's skin color. That's the difference." He produced an example of racism in [gave name of city], "Like the guy who chased me out [of his hospital room], all I wanted to do, and it wasn't even my patient. I was going to double check insulin." Another instance he conveyed was when he had a Caucasian patient whose intravenous line dislodged and another had to be started. Tim relayed:

> I had one who was my patient…who did not like black people so it was me as a black nurse and my PCA [patient care assistant] was a colored person…then his IV [intravenous line] went out… so I tried to put in an IV and when I went to put it in, he's like [thinking], you know it will be so close to him. And you know, it is all hands on. Uh, he was like, 'No, no. Tim, I don't trust you.' So, I said that I would call the resource nurse and she went in there and poked him many times and did not get one in. And I was like – well, that is what you get. Payback…But, he did not chase me away, but you could tell every time I walked in the room he had this scare in his face.

Tim vocalized as well that the nursing program he attended was in the city he said others had jokingly nicknamed "White _____." Patients relayed surprise when seeing Tim for the first time. His patients stated, "Oh my God, I've never seen anyone with dreadlocks." Some were excited to see Tim because he was different, while for other patients the outward appearance of Tim took their breath away. Tim demonstrated this by sighing and rapidly inhaling.

Omolo turned emotional as he admitted that "some patients did not care to have an immigrant ….as their student nurse…that uh, was hurtful because I felt inadequate." He bowed his head down as if he were ashamed. Patient responses to nurses who appear different psychosocially affect the nurse in a negative manner.

Brooks (2015) identified curricular changes have attempted to meld race and ethnicity with medicine. Yet, Brooks (2015) provided examples of how her experiences in medical school parallelled other healthcare providers. Textbooks and clinical experiences continue to specifically recognize race and ethnicity alongside language barriers as detriments to culturally competent patient care. Brooks (2015) who is Euro-American believes "that if we refuse to deeply examine and challenge how racism and implicit bias affect our clinical practice, we will continue to contribute to health inequalities in a way that will remain unaddressed in our curriculum and unchallenged by future generations of physicians" (p. 1910). This is true for the nursing profession also.

Ashley wasn't about to conform to Euro-American cultural nursing standards. She identified this by stating, "In the nursing program, I am happy to say they couldn't break me. She continued by asserting that, "I think I did things where [I] broke them."

Ashley has been in the U.S. for 21-years and feels confident enough to be assertive and self-assured.

Nurturing nursing students. Sappington (2003) identified four attributes for the words "to nurture" (p. 10). The attributes were 1) "caring for another"; 2) "promoting growth and development"; 3) "provision for nutrition and feeding"; and 4) "recognizing, assessing, and meeting needs" (Sappington, 2003, pp. 10-12). Nurturing nursing students in their learning is necessary in producing caring and compassionate health professionals. An antecedent to nurturing nursing students is present in absolute and unrestricted recognition (Sappington, 2003). Consequences of nurturing nursing students are meeting their own basic learning needs that increase intellectual, psychological, and social well-being and belonging (Sappington, 2003). Maslow's Hierarchy of Needs (1943/2013) "belongingness" tier is crucial in promoting nurturance. Assessing, recognizing, and acknowledging nursing student learning needs satisfies the concept of nurturance and assists in the student feeling a sense of belonging. A sense of accomplishment and increased motivation was experienced by the nursing student who received attention and also the nursing educator who provided assistance, caring, and compassion to that student nurse (Sappington, 2003). Suzhen went to the nursing tutor for assistance in learning how to improve her care planning skills in her first semester of the nursing program. The nursing faculty who was also the skills laboratory coordinator and tutor was "patient and she go over the skill with me." Clarification of what was meant by "as evidenced by" and "related to" confused Suzhen. This nursing tutor increased her confidence and improved her low-self-esteem; "It's just I love her so much."

Nurturance begins within the self or becoming self-aware (Shimoinaba et al., 2015). When nursing students are acutely aware of their strengths and weaknesses, caring for themselves in a compassionate manner reflects onto other situations. Mary insinuated that younger student nurses have the inability to cope with peers and nursing staff attempting to "humiliate you, put you down." Dealing with these behaviors from others comes from experiencing the world. Mary's reason for the ability to cope and assert her from these attitudes was due to raising six children; she began the nursing program in her "early 50's," and acquiring a previous degree and teaching when she lived in the Ukraine. "I know how to handle this occasion." She reported what she witnessed with the other younger student nurses, "I know people who have a very hard time and they were emotionally close to [a] breakdown."

Omolo incorporated positive emotions to overcome the negative experiences. He stated, "When somebody made fun of me, I took it positively and just jumped back or something and then brushed it down." Integrating emotional cognizance and effective optimistic feelings in a stressful situation can influence and aid in the coping process (Tugade & Fredrickson, 2004). Masten (2001) identified that resilience as an innate portion in each individual in adapting to the environment, human physiology, and interaction within a community or others. This instinctive adaptation system is susceptible to negative life situations and necessitates nurturance in remaining competent and resourceful (Masten, 2001). Remaining vigilant in seeking friendship was Suzhen's way of positively coping. Suzhen felt rejected by her clinical peers in first semester nursing; however, by fourth semester:

> We have the same clinical…and we have [a] long [way to] travel. We have to carpool and during carpool time we talked…They actually comment [*sic*] on me like, [why] didn't I get to know you better, you don't seem like you used to be.

Tugade & Fredrickson (2007) explained that positive feelings create encouraging meanings by demonstrating an open mind. This process improves the likelihood of developing resources leading to resilience (Tugade & Fredrickson, 2007).

Shimoinaba et al. (2015) conducted a grounded theory study with palliative nurses. These researchers wanted to know the process that their participants used to be resilient and continue to work in that field of nursing (Shimoinaba et al., 2015). Results indicated that the participants were "self-nurturing" (2015, p. 504). Four major themes were extracted from the interviews, "knowing the self," "coping adaptively," "validating care," and "accepting limitations" (2015, p. 506). Shimoinaba et al. (2015) identified this as "expressing emotions" and a way to cope positively to circumstances or situations (p. 507). Omolo experienced sadness and disappointment. Omolo cried in private when adversity was challenged. This occurred twice as told by Omolo. "One of my instructors called me to her office and told me that I was looking at my next door, the student next to me for answers. I went home and cried" and "My preceptor frustrated me. I remember sitting in a parking lot crying."

Nurturance is a precursor to resilience as stated by Shimoinaba et al. (2015). Coping strategies are a way to adapt and deal with adversity or challenging circumstances. Through strategies such as expressing outward feelings, identifying sources of support, and committing to self-care, the student nurse can self-nurture that leads to resilience in his or her nursing program and in life. "Both good self-care and a

supportive working environment are necessary to sustain effectiveness in the workplace" (Shimoinaba et al., 2015, p. 509). In this instance, nursing students require commitment to good self-care and support from all of the nursing education environments. Carlson (1997) described this well:

> Something wonderful begins to happen with the simple realization that life, like an automobile, is driven from the inside out, not the other way around. As you focus more on becoming more peaceful with where you are, rather than focusing on where you would rather be, you begin to find peace right now, in the present. Then, as you move around, try new things, and meet new people, you carry that sense of inner peace with you. It's absolutely true that, "Wherever you go, there you are" (p. 134).

The process of nurturance prepares the nursing student in becoming resilient to adversity and conflicting situations. Resilience established and exhibited by the participants in this study contributed to success in graduating from an ELBNP and first-time pass rate for the NCLEX-RN.

Resiliency demonstrated among participants. Yakushko et al. (2011) wrote, "Learning along the way through our challenges seems only to add to our resolve to keep increasing our awareness, self-understanding, and courage" (p. 290). All of the participants had learned or continued to learn throughout their nursing program to be self-aware, take care of themselves, and *Don't Sweat the Small Stuff* as Carlson (1997) stated in his book by this title. As Mary said when she had tough times in nursing school, "You just have to shut down and take [a] deep breath and give a room and balance yourself to be ready for [the] next." Mary incorporated specific actions to decrease her stress, "I did

meditation, exercise, I slept, I balanced my life." Mary self-nurtured in becoming resilient through her past life experiences in college, raising a family, and as a school teacher in Ukraine. Omolo accepted his peers and nursing faculty as having him in the nursing program was a cultural shock for them as well as him.

Resiliency is typically preceded by "adversity and stress" (Stephens 2013, p. 128). Stephens (2013) developed an operational definition of the resiliency phenomenon in nursing students:

> Nursing student resilience is an individualized process of development that occurs through the use of personal protective factors to successfully navigate perceived stress and adversities. Cumulative successes lead to enhanced coping/adaptive abilities and well-being (p. 130).

Stephens (2013) concluded that people who have a repertoire of positive coping mechanisms were best prepared to support others in their quest to pilot through life's trials and tribulations.

Nursing students of all ethnicities and cultures experience external stress necessitating inner strength for controlling stress (Pines et al., 2014). Pines et al. (2014) also deduced that students in their study attempted to avoid or conform to educator or peer requirements to decrease conflict a priori. For the participants in my study, more stress occurred than their peers throughout their nursing program and into their post-graduation employment because they were different in the eyes of their peers, nursing faculty, and healthcare facility nurses. Due to language difficulties, the participants had difficulty completing exams on time. Tim said that when he would be taking an exam that his anxiety level would raise as each student who was not an ELL would turn in their

exam and leave the room. Tim also experienced a patient who did not want him placing an intravenous line by reiterating what the patient told him, "No, no. Tim I don't trust you." So, Tim called the resource nurse who attempted this procedure "many times and did not get one in." Tim experienced rejection due to his race, ethnicity, and dreadlocks. In the interview, Tim stated, "And I was like, well that is what you get. Payback."

The participants, against extraordinary odds became assertive and developed ways to manage stress and anxiety. When Mary studied for her NCLEX-RN exam she "went to the lake and I did canoeing and kayaking and pedal boarding and spend [*sic*] time with friends to balance my life and I took the test and I passed the first try." Earvolino-Ramirez (2007) stated that the predominant and only antecedent for resiliency is adversity. Without adversity, "change, challenge, and disruption" would be eliminated from all life (Earvolino-Ramirez, 2007, p. 78). Adversity leads individuals toward learning strategies to cope and self-nurture that eventually assimilates into resilience to integrate resilience into his or her life.

Jackson, Firtko, and Edenborough (2007) suggested that resilience is developed by nursing students and this may contribute to being successful in the nursing program. This could explain also why nurses become burned out and leave the profession. Without individual resiliency skills, students have difficulty handling adversity in nursing school and as a nurse in employment (Jackson et al., 2007). Each participant demonstrated resiliency through inner self-awareness and making changes or challenging his or herself to reevaluate current coping strategies. While Suzhen had low self-esteem because she thought she was not as intellectually prepared as her peers, she discovered actions to overcome these thoughts and was successful in her program. Suzhen developed a sense

of owning the problem by stating, “I’m a person that accepted more than complaining, because like you [are] complaining, you don’t get anything done, you must accept it and move on.”

Angelou’s (1978/2012) poem, *Still I Rise*, emphasized defiance and resilience among the diverse people as expressed through a stanza:

> You may shoot me with your words,
> You may cut me with your eyes,
> You may kill me with your hatefulness,
> But still, like air, I’ll rise (p. 23).

The poem distributes an essence of pride and assertiveness aiming to support the black race in their charge towards resilience, assertiveness, and social justice. For students to be successful, resilience is a necessary characteristic that is innate and developed. Each participant demonstrated resilience. Through this resilience, participants reflected on how nursing educators could support nursing students’ learning.

Propagation. This section describes how participants demonstrated propagation or dissemination of their learning by sharing strategies for nurse educators to consider when planning a lesson and contributing their knowledge with new nursing graduates through mentoring or orienting to the nursing unit. Student feedback on teaching is important for nurse educators in reflection to make decisions towards improving student-centered learning. This is especially imperative for EDISNs to complete feedback after each course in determining quality the student perceives in their learning and of the nurse educator’s teaching (Cleary, Happell, Lau, & Mackey, 2013). These authors (2013) feel that useful feedback from students presented in an organized fashion adds significance to nurse educators’ teaching styles, practices, and development. The participants provided accurate and appropriate feedback during the interview since they were graduates and

practicing nurses. When asked what nurse educators could have done to improve their education they delivered a few strategies.

When conducting a literature search for how nursing students gave back to the community or nursing profession post-graduation, published research was non-existent. Using CINAHL a trial of several word and words were typed into the search engine such as, "nursing students giving back," 'nursing students volunteering after nursing school," "nursing volunteers," "nursing students turn volunteers upon graduation," "new nurses AND volunteer within the community," and 21 more combinations. Two of the participants revealed that they mentored and precepted nursing students on the units they worked on. Suzhen stated, "I even if just [in] my first year, I precepted some student from other school…I can set a role-model for my student."

Omolo oriented and mentored new nursing graduates to the cardiovascular unit he worked on. Omolo demonstrates empathy for new nursing graduates:

> I can identify with the new graduates, as I don't consider myself an expert yet. But I can identify with them and help them along cause [*sic*] I am also still learning. It is scary when you are left to fly alone.

Summary

Gadamer (1980) projected that "philosophical knowing is identification of something as what it is and has the recognition or 'knowing again'" (p. 127). Gadamer (2001b) suggested that to comprehend meaning and locate the trail towards solidarity, we must find the trajectory on our own. Through dialogue I came to understand and fuse my worldview with the participants' worldview in accepting those different from me. I learned the truth that frees me from biases, authority, and tradition.

The recently graduated EDIRN elucidated stories of their learning experiences that included strategies they used to be successful. From the obtained and analyzed data from the participants, nurse educators are able to read the study and identify areas for instructional changes while focused on enhanced student-centered learning for all. Understanding the EDIRN's learning experiences led to discovery of implications and further research upon completion.

Imagine having left a country, the only country known for many years to enter a new one with unfamiliar laws, customs, traditions, holidays, educational opportunities, and a complex healthcare system. There is no certainty that life will be as they have known it. Empathizing with students through recognition of the difficulties they encounter helps me to understand and better assist them in their learning. The students look to me to guide their learning while I look to them for guidance in "seeing" their culture, language, and traditions.

> Pierre Abelard said, "The beginning of wisdom is found in doubting; by doubting we come to the question, and by seeking we may come upon the truth" (The Freeman Institute, 2006).

Chapter 5: Conclusions

Conclusions

This adventure began with doubting and asking why there are so few graduating and practicing EDIRNs. What contributed to successful completion of an ELBNP for immigrants? I entered into this study to understand the learning experiences of EDIRNs who successfully completed an entry-level baccalaureate nursing program in Minnesota.

Being a nurse educator, I knew they had stories to tell and thought they would be more than happy to tell me. Five participants, four of whom I knew, contributed to the study. They were sincere and adamant when telling their stories. The participants prominently displayed relief when telling their stories as if they had held their silence for too long. Each EDNS may be from a different culture, ethnicity, race, or considered underrepresented; but they ultimately experienced barriers to learning in a nursing program that affected their psychosocial and physical well-being.

There are distinct conclusions that are drawn from the data. The following conclusions were elicited from the study's analysis, philosophy, and published literature. Three prominent areas were presented under conclusions address the participants' difficult experiences and resilience leading to successful completion. They included: acclimating to language and culture within nursing, the existence of oppression within nursing, and solidarity versus solitary within nursing.

Acclimating to language and culture within nursing. Most of the participants experienced difficulty with English through reading, writing, and taking exams. To the participants, medical terminology was like learning another language alongside English and the larger the words the more difficult to pronounce. Mary struggled with

completing assignments because of being an ELL. Tim complained that he developed increasing anxiety every time he saw his peers leave the testing room well before the exam was due to be completed. Suzhen developed low self-esteem and felt like she did not belong as peers ignored her and her exam scores were always passing, but low. Omolo provided a suggestion to improve acclimation to language and culture by pairing EDISNs with student nurses born and educated in the U.S.

Vandenberg (2010) recommended that nursing scholars and educators continue to examine assumptions and conceptualizations about culture that are multifaceted and dynamic. She cautioned that theorizing provides knowledge of specific differences between cultures and ethnic groups could be disastrous by producing "stereotypes, misconceptions," and could compromise "relationship building" (2010, p. 246). Tim stated, "Some people like have never seen or gone to school with a black student, black/African, from Africa – they have never even gone to school with an African American, a colored person from here." Omolo felt "like there was a general perception [among students] that I cannot contribute enough or equal to [my peers]." Mary confirmed that "it's challenging for somebody who has [a] different background to be part of the group because they just don't want you to be there." Ashley sensed that she was being treated like previous or past Somali students, "Oh, she [is] like one of my past students." Past experiences with cultures other than Euro-American may shade nurse educators' perceptions of culturally and ethnically diverse nursing students.

Oppression exists within nursing. Oppression is abundant within the nursing profession as Cleland first identified in 1971 and continues to be explored in this decade (Bickel, 2014; McDonagh et al., 2014; Roberts et al., 2009). Nursing students experience

oppression by peers, nursing educators, nursing staff, patients and their families, physicians, and others in the clinical setting (Jackson et al., 2011). The concept of exclusionary othering is described as people who are invisible to others, ostracized for being different, and given less opportunities for learning (Canales, 2000). Canales' (2000) definition of "*exclusionary othering* often uses the power within relationships for domination and subordination" (p. 19). The consequences of exclusionary othering are low self-esteem, *being on the outside*, and increased attrition rates from nursing programs. Canales (2000) distinguished *inclusionary othering* as transformative relationships among people who "share power and a sense of community" (p. 20). The inclusionary and exclusionary othering concepts are easily related to insider or outsider, oppressor or oppressed, and solitary or solidarity.

Each of the participants experienced exclusionary othering, being an outsider, and oppressed. Omolo, Mary, and Suzhen felt alienated from their peers at the beginning of their nursing program. Mary explained, "We really felt excluded from [the] mainstream. Doesn't matter what you do, doesn't matter how much you want people to be part of the group, no, no, you are not part of the group." Omolo talked about his peers saying, "At the start of the program, it was difficult to get into a clique or different cliques because…of the difference in culture and language." Exclusionary othering or oppression exists not just with relationships with peers, but also through interactions with nursing faculty and nursing staff at healthcare institutions.

Nursing educators are not exempt from displaying exclusionary othering. The participants gave examples of faculty incivility. Ashley met with the department chair at the beginning of the nursing program and was told to drop from the baccalaureate nursing

program and enter the associate degree nursing program. The department chair assumed that Ashley was an ELL, when Ashley actually has been fluent in English since 3-years-old and was educated in U.S. public schools. This assumption probably was made because Ashley looked and dressed like a Somali or Muslim. The department chair may have had previous negative experiences with students similar in culture or ethnicity to Ashley. Omolo had an instructor who claimed he had cheated on a quiz by looking over at his neighbor's paper. The participants experienced exclusionary othering and oppression by nursing educators.

Clinical experiences told as stories were relayed by the participants. Oppression affects nurses in the clinical settings and they share this negative behavior with students. Suzhen relayed that in her advanced medical-surgical clinical, her primary care nurse for the patient ignored her assessments and did not call her to administer medication to the patient. Ashley depicted a time when she perceived the nursing staff felt she was a burden.

> I have had situations where some nurses already kinda [sic] just are on edge because …before we say anything, the professor would come and say, 'Oh, um, she's going to be the nurse that's working with you, she's going to be with this.' And they are already like, 'Oh, okay.' They already think it's going to be a burden on them because they have to do so much more. And that's just a function that they're going [to have to] hold my hand.

College or university administrators are also not exempt from offering exclusionary othering or oppression. Ashley indicated that although the college or university she graduated from is marketed as "multi-culturally diverse and [an] inclusive

community," there are very few ethnically diverse students admitted to the nursing program. And when the EDNS enters the nursing program, they "fail." She further questioned, "Well, our school is 60% Hmong, shouldn't our program be 60% Hmong? Over a hundred Hmong girls are on the waiting list, they meet all the criteria" to be admitted to the program.

Patients are included in offering exclusionary othering or oppression to nursing staff who are different. Tim was told by a patient that he did not want him in the room; not even to double check insulin. Another patient told Tim that he did not want him to restart an intravenous line because he refused to trust Tim. These are adversities that the participants endured during their nursing program. These adversities came from peers, nursing educators, healthcare staff, patients, and others.

Solidarity versus solitary within nursing. Nurses have a high priority need to form a firm foundation with each other and establish nursing as a caring and compassionate profession (ANA, 2015). Epstein & Turner (2015) emphasized that the new code of ethics "forms a central foundation for our profession to guide nurses in their decisions and conduct" (para. 21). Why are nurses unable to project this same caring to others in the nursing profession? Nursing requires solidarity within the profession by denouncing oppression and banding together through "becoming aware of what unites us" (Gadamer, 1992, p. 192). What joins all nurses are the values demonstrated when caring for patients; "altruism, autonomy, human dignity, integrity, and social justice" as stated in *The Essentials of Baccalaureate Education for Professional Practice* (AACN, 2008, pp. 26-28). Another factor that may play a role in oppression within nursing education and nurses at healthcare institutions is burnout.

Several factors cause disruption within nursing; burnout of teachers in educational and nurses in healthcare settings, hopelessness to feel respected or appreciated by others, inability to demonstrate a caring attitude, student incivility, and powerlessness (Luparell, 2011; Matheson & Bobay, 2007; Shirey, 2006; Tinsley & France, 2004). Burkhardt and Nathaniel (2002) wrote, "Nursing today is at a crossroads, free of many of the restrictions of the past, yet not fully franchised as a profession with power and authority" (p. 17). Nurse educators experience similar powerlessness and incivility as staff nurses. When the provost manages the dean of the college without transformational leadership, the dean can become isolated from nursing by the job description he or she is given (Roberts, 1997). In an attempt to conform to upper management the dean is often "marginalized" (Roberts et al., 2009, p. 289) as they promote the agenda of the powerful, provost and president, rather than empowering the departments they supervise. The dean may be unable to empower the department chair or nursing faculty as their time is consumed with endorsing the program of the provost and president. This powerlessness can be passed from the dean to the nursing faculty and finally to nursing students. Powerlessness results as incivility in academia and is recognized by the nursing faculty and students (Clark & Springer, 2007a).

This exodus of nurses from the profession is due to leadership marginalization which also occurs in nursing education (Matheson & Bobay, 2007). Nursing student marginalization, alienation, amalgamation, and conformation are role-modeled by nursing educators to students. Again, a dean supervising nursing faculty may be overshadowed by higher administrators. Basically the dean is middle management; however, can be marginalized by decision-making he or she is not allowed to implement

for the good of the nursing department. The nurse educators whom the dean supervises feel this same frustration and marginalization and potentially reflect this in their teaching practices with students. This was observed by Murphy, Jones, Edwards, James, and Mayer (2008) in a study conducted on how caring by nursing students changed from the beginning of the nursing program to the middle of the program. Caring is a value nurses desire to demonstrate. As nurse educators, caring is modeled; however, if the nurse educator is attenuated with workplace incivility or he or she is burned out, then patience towards students dwindles (Laschinger, Grau, Finegan, & Wilk, 2010). Murphy et al. (2008) found that the younger the student, the more caring was plentiful. When Murphy et al. (2008) completed the same questionnaire with third year students; they discovered that caring was significantly reduced. This study demonstrated that nursing faculty influence not only learning, but values nurses hold dear to the profession. Because of this, nurse educators should reflect on their teaching practices and professional attitudes in demonstrating the core values to nursing students.

Shirey (2006) explained that stress and burnout of nursing faculty are becoming common-place. She described this as, "Organizations that fail to address the phenomenon of burnout wind up retaining within their workforces 'passion extinct' individuals who act like 'deadwood' collecting paychecks, in essence, harming the organizations by tarnishing others and impeding progress" (p. 95). The adverse effects of nursing educators who are stressed or burned-out can transfer to the nursing student. Suplee, Lachman, Siebert, & Anselmi (2008) discussed incivility by students as role-modeled by uncivil action demonstrated by nursing educators. Oppression surrounds all

of the nursing profession causing some nurses to remain solitary, silent, and with a destructive attitude.

Heinrich's (2007) informal study through writings of 261 nurse educators at the 2005 National League for Nursing Summit identified 10 subthemes under the overarching theme of "10 Joy-Stealing Games" (p. 35). "Joy stealing described the impact on faculty targets" that she referred to as "joy-stealing games" (Heinrich, 2007, p. 35). The 10 subthemes include: "the set-up game," "the devalue and distort game," "the misrepresent and lie game," "the shame game," "the betrayal game," " the broken boundaries game," "the splitting game," "the mandate game," "the blame game," and "the exclusion game" (Heinrich, 2007, pp. 35-37). The detachment of relationships by nursing educators' characterizes a dysfunctional nursing education for nursing students (Heinrich, 2007). They observe these games between and within nursing faculty and act on them by producing their own types of incivility; hence, the "cattiness" as described by Tim and Ashley. Heinrich (2007) suggested that the rules of the games need to change "from competition to cooperation and tipping the culture from joy stealing to zestful collaborations" can refocus nursing educators in relating to each other respectfully (Heinrich, 2007, p. 38). I suggest that each faculty member maintain a dialogue with his or her peers to relinquish the games played within the nursing department. This also models to the nursing students that accepting each other for our uniqueness is respectful and appreciated.

Luparell (2011) believed that the answer to incivility is to join the clinical with the academic setting. Staff nurses work intermittently with nursing students in the clinical setting under the direction of the nursing faculty. Nurse educators and staff

nurses suffer student disrespect, yelling, eye-rolling, threats both verbal and physical, tardiness, and unpreparedness (Luparell, 2011). Luparell (2011) produced examples of nursing faculty reactions to unfriendly exchanges with students. These included; "physical and emotional distress, a loss of self-esteem, and a decreased desire to maintain high educational standards" (Luparell, 2011, p. 93). In fact, some altercations are so severe that faculty decided to completely separate from nursing education altogether (Luparell, 2011). She also identified how unprepared hospital nursing staff are when participating in the education of students in the clinical setting (2011). Luparell (2011) suggested that nursing faculty provide empowerment to staff nurses and encourage feedback given to the student related to psychomotor skills and other abstract skills.

One of the roles of a nurse in working with students is that of a preceptor. Through an integrative literature review, Omansky (2010) identified three themes the nurse preceptor experiences; "role ambiguity, role conflict, and role overload" (p. 701). Precepting or mentoring nursing students by nursing staff remains a multifaceted and forceful stimulus to change that contains internal and external strains (Omansky, 2010). Positive aspects of being a preceptor were recognized as growing capabilities and obtaining educational methods (Omansky, 2010). However, other staff nurses and administration pay little recognition and respect for the extra work and time involved in precepting (Omansky, 2010). Some healthcare facilities overload the staff nurse believing that because they have a student with them they are actually one and a half nurse (Omansky, 2010). Ashley stated that working with a staff nurse she perceived that she was "going to be a burden on them because they have to do so much more." Omolo experienced a preceptor in the final program clinical, capstone, that he perceived "was

setting me up for failure each moment." Also, not knowing or understanding what expectations the nurse educator has of the preceptor leads to lack of empowerment within the role.

Without empowerment through transformational leadership in all nursing areas, nursing is observed by others as a stand-alone profession without structure and nurses as a group remain oppressed (Clark, 2008; Randle, 2003; Roberts, 1997). Tinsley and France (2004) documented that nurses left their positions due to "long hours, mandatory overtime, and being called in to work on their day off" (p. 10). Being oppressed, unheard, and with increased work-loads accounts for increased burnout rates and leaving the nursing profession (Tinsley & France, 2004).

Ulrich et al. (2006) conducted an online study of nursing work environments among 4,034 critical care nurses throughout the U.S. Areas assessed included; "communication and collaboration, respect, physical and mental safety and abuse, nursing leadership, support for professional development, recognition, quality and outcomes of patients' care, satisfaction with nursing and with current position, and retention" (Ulrich et al., 2006, pp. 47-52). These nurses reported administrative respect was lower than recognition by patients, patient families, and other RNs (Ulrich et al., 2006). Verbal and physical abuse by anyone in the healthcare setting such as patient, family, physicians, other RNs, and administrative personnel to the working RN was reported 64.4% and 22.2% respectively (Ulrich et al., 2006, p. 49). Mary experienced as a new graduate, a nurse manager who was relentless in enacting incivility towards her. "It was worse because [my nurse] manager was the type of [sic] bully against me personally and another woman and against another woman who know [sic] what is going

on…You have to resign because [the] manager was the head of this campaign." How do novice or new graduate nurses deal with workplace incivility then?

Berry, Gillespie, Gates, and Schafer (2012) addressed this question in a study about incivility in the workplace that asked 197 novice nurses who had graduated 2-years or earlier. Within the study, the authors identified "a negative and significant relationship for white novice nurse to workplace productivity" (Berry et al., 2012, p. 84). Those from other ethnicities and cultures did not experience oppression in the workplace upon graduation. Berry et al. (2012) felt this phenomenon was related to being oppressed and learning adaptation techniques or coping mechanisms that worked when those from other ethnicities and cultures were students in a nursing program. Mary became resilient and found employment after resignation from her first job. She now feels successful and welcome in her new employment as a nurse which she attributed to, "I was successful because I have [a] very strong working ethic." Ashley has observed in her employment as a novice nurse that there is "no sense of community or working together, you just feel like you are an island of your own." When Ashley asked for assistance from fellow colleagues, she stated, "because every time I do [ask for assistance], you're flippant with me."

Summary. *Being on the outside* is a consistent and major theme that flowed through each of the interviews. Being on the outside for the participants is symbolized by the lone maple tree in a field. Treatment by their peers, nursing faculty, and staff nurses was expressed positively and negatively. Gadamer (1992) condoned solitary and promoted solidarity among people; in this instance, among nurses as a group. Roberts

(1983) identified this solitary status among nurses as oppression as described by Freire (1970/2011).

For the participants, this solitariness from being on the outside occurred because of differences in language, culture, and other's perceptions. These aspects are described by the participants as "challenges." Omolo stated "the learning of the language, one is a translation from my language to the English language and then to the nursing language." Mary requested, "You move like everybody else, but you really need a little bit more time because you are processing information a little slower than everybody else." She also commented on bias questions found in exams and suggested that hiring faculty "from a different country would be helpful." Suzhen experienced invisibility by being ignored by her nurse mentor. No matter how much she spoke to the nurse and advocated for the patient, the nurse did not involve her in decisions made and care provided for the patient she was assigned to. Ashley was "lumped" or stereotyped from previous Somali students who required extra help. Ashley stated:

> I have to do two times as more as you would have to do because there is already these assumptions, and you know, all these prejudices, ideas, and yeah…It's going to be tough to work with me because maybe you won't understand me, but you haven't even heard me speak.

A patient assigned to Tim refused to have him as a nurse. "Then I've had where a patient chased me out of the room…They said, 'Nope, no. Nope, no way." Each participant identified being on the outside through language, culture, avoidance, incivility, and appearance.

Through these experiences, each participant remained resilient and incorporated positive coping mechanisms and learning strategies to be successful in their nursing program. The participants, through their nursing programs, unknowingly were preparing themselves for further incivility within the nursing workforce. Berry et al. (2012) assumed that nursing students different from Euro-American nursing students had developed skills to overcome incivility and oppression within nursing.

After further literature reviews and analysis of the data, the overarching theme, *being on the outside,* is influenced by oppression (Freire, 1970/2011), exclusionary othering (Canales, 2010), and solitariness (Gadamer, 1992). Nurse educators are affected by oppression through higher management that is then inadvertently observed by nursing students where adversity without resilience continues the oppressive cycle. Finally, as nurses in a healthcare facility, they carry on the tradition of oppression by ignoring nursing students or maintaining the students' subordination (Clark & Springer, 2007a). These actions perpetuate the cycle of oppression in nursing. Dong and Temple (2011) suggested that nurses liberating patients from oppression will start freeing themselves as well. Since nursing is a caring and compassionate profession, Dong and Temple (2011) felt that nursing can and should be the voice for people who do not acknowledge or comprehend their oppression.

Implications for Nursing Education

The following sections describe implications for nursing educators to identify and empathize with EDISNs in retaining and graduating competent nurses. These actions will offer an increase of EDIRNs practicing to improve culturally competent care for those specific cultures. Immigrants arriving to the U.S. will have more chances of being

cared for by an EDIRN and potentially improving health outcomes. Sections include; interventional development for the EDISN to be successful in nursing school, promotion of solidarity by recognizing and ceasing oppression among all nurses, and incorporating an inclusive nursing education; therefore, uniting the nursing profession as an exact and prevailing profession.

Results of my integrative literature review also have implications for this study. Upon completion of analysis and synthesis of all published literature, I made changes to Yoder's (1993/1996) substantive theory portion of barriers. These modifications also have implications for this study. For example, language in Yoder's (1993/1996) was changed to communication because language consumes all communication be it verbal or non-verbal, written or spoken, and textual or multimedia. The category of academic changed to educational since education offers more possibilities than academia. Academia means learning in an educational setting. Everyone learns inside or outside an educational setting throughout life. So the new category, educational, becomes a broader term that includes learning in everyday life. The fifth category, discrimination or incivility, was added after reviewing the literature.

Yoder's substantive theory of "Instructional Responses to Ethnically Diverse Nursing Students" (1993/1996) continues to be an important model for nursing educators to follow. While Yoder (1993/1996) provided examples that are worthy of being called discrimination, again, more examples became prominent after her research was completed. Canales (2010) called this exclusionary othering. Walker (1997) titled this insider-outsider. If a person is different than others, then they are not respected or recognized for who they are independent of language and appearance and what they

offer. Euro-American nurses and nurse educators continue to recognize barriers to an EDNS's education. However, with literature published by nurses on inclusionary or exclusionary othering (Canale, 2010), incivility within nursing (Clark, 2008; Clark & Springer 2007a; Clark & Springer, 2007b), and nursing as an oppressed profession (Roberts, 1983), positive movement of the nursing profession towards civility and acquiring a respectful nature towards each other remains elusive. With these updated changes made to Yoder's substantive theory, more than 20 years later, maybe staff nurses and nurse educators will heed this substantive model through self-reflection. Nurse educators can self-reflect, dialogue with each other, and make slow yet, progressive changes to their own attitude towards others different than themselves.

Interventional development for the EDISN. The literature review identified barriers for the EDNS and interventions trialed, yet a discrepancy continues to exist between practicing ethnically diverse registered nurses and the ethnically diverse U.S. population. The participants understood that learning English is paramount because Mary explained, "we have to learn how to think in English…because we live in this society and we have to function in this society." However, as the participants learn English and implement nursing language they requested more time to take exams, an understanding from educators that British and American English are dissimilar, and patience from nurse educators as they ask questions or clarification. Nursing educators can be supportive of the ELL while the EDISN acclimates to the language and culture of the U.S. Omolo stated:

> Just be open to them [immigrant students]…Both the instructors and the students tend to put everybody in the same box…They are from this culture so they ought

> to behave in certain ways…when actually it is not the case – it is an individual judgment…And it is not that they're stupid, they can get it, it is just that a [*sic*] your way of thinking so in a way it does not mean that one is wrong and the other one is right.

Omolo suggested that nursing educators teach with an open mind; meaning there is more than one correct way to complete nursing skills and critical thinking. All participants want to be respected, recognized and heard for their thoughts and ideas by nursing educators.

Interventions to assist the ELL education begin with the nurse educator reflecting and examining his or her practices, values, beliefs, ideals, and recognizing his or her own culture (Ball et al., 2015). Nurse educators should "begin by acknowledging and overcoming our individual biases and cultural stereotypes" (Ball et al., 2015, p. 23). Also, nurse educators cannot presume that because someone speaks English he or she does not experience a cultural barrier (Ball et al., 2015). In order to better understand and appreciate each student, the nursing educator should "come to know" him or herself first and dialogue with each EDNS or EDISN to begin an understanding of other ethnicities and cultures. Gadamer (2001a) gave an example of this with the education a doctoral student experiences.

> If we consider the scientific works that are submitted for the title of Doctor (PhD) they have, to a surprising degree, become confined to specialist accumulations. This can, under certain circumstances yield fruitful research contributions, but the key experiences that it provides for one's professional judgement and education are inadequate for the task of survival and becoming at home in the world. Today

> it is much more the case of conforming to what is in fashion, so that one cannot readily go against the trend if one cannot substantiate it with a citation (p. 537).

I suggest that besides coming to know ourselves that we begin to develop a means to overcome the traditional sense of teaching by opening our minds to what other cultures have to offer to health care through their health beliefs. Through recognition of and respect for different cultures represented by EDNSs, solidarity within the nursing profession is encouraged beginning with nursing education.

Promoting solidarity through decreasing oppression among all nurses. Oppression has always been previously experienced by nurses in the educational and healthcare settings (Roberts, 1983). I propose that a significant increase in EDIRNs continues to be hindered related to incivility and oppression that lingers within nursing and with the nurse (Clark, 2008; Roberts, 1983; Roberts et al., 2009). Clark (2008) introduced an analogy to a culture of civility by writing, "Like dancing, creating a culture of civility requires communication, interaction, and an appreciation for the interests each person brings to the relationship" (p. E37). Clark (2008) incorporated "The Incivility in Nursing Education" survey that integrated a qualitative portion consisting of open-ended written answers (p. E39). Nursing educators identified uncivil behavior exhibited by peers that included; "intimidating and bullying students, using inept teaching skills and poor classroom management techniques; making demeaning, belittling comments or gestures toward students, labeling and gossiping about students, and showing favoritism, inconsistency, and bias toward students" (Clark, 2008, pp. E45-46). Clark (2008) suggested that nurse educators and nursing students join together in generating a climate or environment of dialogue, mutual respect, development of a positive commitment to

learning by the educator and student, and caring for each other. By decreasing incivility by faculty and students, solidarity within nursing education should begin to appear.

The participants suggested that the incivility sensed should be eliminated to improve student learning. Omolo gave an example of poor teaching skills, "Besides that [*sic*] is a [*sic*] some instructors didn't care whether you did things like homeworks [*sic*] or not and some of them did care that you did it." He also suggested that nursing educators "try and encourage or facilitate aggregation, to help the immigrant to get immersed into one [*sic*] the culture and the class." Ashley felt that to discuss concerns or questions with a nurse educator was unproductive as the educator is always correct or told her to read the assignment. She gave an example of an EDISN that was in her cohort.

> She failed it [medication math exam] because of that dumb little thing like that….Now you ask her to draw up a medication, she will draw up 10 mls. She is still going to draw up the same 10 mls. She wrote 10.00 and I wrote 10. She's wrong and I'm right. How is that fair? We would have given the exact same dose, the exact same everything."

Ashley likened these verbal exchanges with nursing faculty as "like someone preparing themselves for battle." Incivility and oppression begins early on by the EDISN in their nursing program where each participant learned coping skills and adaptive techniques to be successful (Berry et al., 2012).

Liberating nursing educators and nursing students from incivility and oppression has several positive outcomes such as increasing practicing nurses, teaching fulfillment, patient satisfaction, and nurses united and committed to treating each other respectfully

and with appreciation (Roberts, 2000). I propose that nurses aim to eliminate oppression from within, beginning with the realization that all nurses are equal and the hierarchy that maintains oppressiveness be expelled from the profession. Roberts (2000) expounded on five steps towards "positive identity development" (p. 73) that originally were developed by Freire (1970/2011) and included; "pre-encounter, encounter, immersion-emersion, internalization, and commitment" (Roberts, 2000, p. 73). To begin the liberation process, the individual must recognize and understand the cycle of oppression. In this instance, nursing educators should reflect on his or her prejudices, biases, and stereotypes. Roberts (2000) also suggested that to begin the emancipation process, all nurses should reflect and acknowledge through dialogue the forces that continue the cycle of oppression. The metaphor of the lone maple tree demonstrates how the participants liberated themselves from adversity and oppression to become a resilient nurse mentoring and precepting other nurses. Mary integrated exercise, a nutritious diet, and time for relaxation. Omolo privately cried and then returned with a positive attitude. Suzhen relayed comments made by peers or staff nurses like water on leaves that rolls off. Meaning that comments made initially and personally hurt; however, with time hurtful remarks are ignored.

Dubrosky (2013) recommended that nurses begin to seriously examine oppression in nursing. She presented Young's "Five Faces of Oppression" (1990) as a framework that every nurse can implement in identifying nurse oppression. Young (1990) recognized that oppression involves relationships with groups of people that may be conscious or unconscious, intentional or unintentional. Within the framework Young (1990) proposed types of oppression, "exploitation," "marginalization," "powerlessness," "cultural imperialism," and "violence" (pp. 48-63). Each of these categories within

oppression identifies a type of oppression. Young defined each of these categories or types so people could begin to recognize oppressed people and the perpetuated cycle of oppression. Nurses also need to band together outside of the oppressor's group because the uncivil person prefers that nurses continue the status quo of oppression.

Once the participants found relief through understanding his or her *Dasein's* Being in the world, they were able to make changes to their lives from the incivility they felt. This is the resilience spoken about in the metaphor of the tree. The participants did what they needed to do independent of what others thought of them or acted against them. Ashley told me "that I'm going to bite my tongue while I'm in the program." She learned that when she asked a question or countered a faculty member, "I really feel like a target, but I don't want to make it worse."

Inclusive nursing education. Gadamer (1992) suggested that our social circles or communities are so controlled and focused that the community concentrates on identifying those different and outside their community. He related this to cultivating and producing people from birth through adulthood who are extremely aware of their differences from others and perceptions of themselves by others. Nurses should embrace solidarity rather than suppress it. Through embracing solidarity, nurses demonstrate to others transcendence out of oppression and towards a sense of community. Omolo expressed that as he progressed into the final two semesters; his peers began to accept him and became good friends.

Thus, rather than simply place emphasis on accommodating the EDISN, through single or multiple interventions, the nurse educator maintains an all-inclusive learning environment and recognizes the need to assist the EDISN in connecting the student with

their peers, nursing faculty, and healthcare staff. Omolo suggested to me that nursing faculty and students "tend to put everybody in the same box. They are from this culture so they ought to behave in certain ways." An inclusive environment where differentness is appreciated and respected encourages the beginning of solidarity by identifying biases prior to interacting with others (National League for Nursing, 2016).

An inclusive education embraces "opportunity, thoughtful language, informed dialogue, notions of belonging, communities of caring, ethical pedagogy, advocacy, reflective teaching, and social justice" by the educator (White & Jones, 2011, p. 216). Freier (1970/2011) felt that inclusion is "where the oppressed are found, the act of love is commitment to their cause—the cause of liberation" (p. 89). Ashley attempted to find a solution to conflict with nurse educators and peers. "I will always look for every other solution, every other excuse for why something was done other than race. I don't really like to pull the race card. I think people expect me to." Understanding each student's concerns, problems, issues, and troubles through dialogue and observation skills could have improved the participants' learning experiences.

Inclusive learning by educators begins with active listening and learning from the student. One way to listen is to journal with the students and hold cohort or class meetings to discuss. Ironside (2015) explains that language is essential because it forms cognizance. The nurse educator who dialogues with nursing students utilizes a transformational style of teaching that changes relationships and learning (Ironside, 2015).

Freire (1970/2011) identified characteristics of belonging, respect, humbleness, and belief in dialogue with others becomes a connection of reciprocal trust. Students'

hearts become lighter as they are given individual attention with demonstration of sincere interest using real dialogue in learning about them personally. Through this dialogue, the students and educator develop purposeful learning together where both are "Subjects….of unveiling reality" (Freire, 1970/2011, p. 69).

One way for nurse educators to accomplish this is to model professional behavior to students. Gadamer (1981/1996) expressed:

> The more what is desirable is displayed for all in a way that is convincing to all, the more those involved discover themselves in this common reality; and to that extent human beings possess freedom in the positive sense, they have their true identity in the common reality (p. 77).

Gadamer (1981/1996) also followed Plato in that before 'I can befriend another person, I have to be a friend to myself' (p. 80). Thus, the more nurse educators accept themselves for who they are, they are able to embrace and welcome the EDISN, demonstrate this behavior to other students and peers, and begin the solidarity process. When nurse educators and nurses in general actively and positively connect with EDISNs, value their differences, and acknowledge their beliefs, the EDISN and EDIRN can begin to feel appreciated. Nurses share a common solidarity in values such as caring, compassion, and concern for others so, why not share these same values with nursing colleagues?

The development of empathy and compassion within nursing education is essential to lessen the gap between the EDISN and the nurse educator. A Native American Cheyenne Proverb comes to mind, "Do not judge your neighbor until you have walked two moons in his moccasins" (Olson, 2015, para. 18). This proverb explains acquiring the essentials necessary to understand and comprehend the other's life comes

through living their exact same life, witnessing the same events, overcoming the same obstacles. Technically, all people within the U.S. are immigrants, so immigrants are all people living in the U.S. with the exception of the Native Americans who were here prior to anyone else. For everyone, "it is not a matter of merely tolerating differences, but of truly understanding and honoring the fact that it literally cannot be any other way" (Carlson, 1997, p. 113).

Incorporate evidence-based teaching practices. Patterson and Klein (2012) claimed that educational research studies have increased, yet ask, are nursing educators teaching using the evidence-based information provided in the studies? These authors emphasized that the National League for Nursing (NLN) began publishing *Review of Research in Nursing Education* in 1986 (Patterson & Klein, 2012, p. 240). Since then, many other authors have contributed to nursing education research through literature published as books or in journals. Nurse educators are required by "Core Competency VII: Engage in Scholarship" to conduct research in their designated area of expertise (NLN, 2013, para. 9). According to this core competency, "Nursing educators' acknowledge that scholarship is an integral component of the faculty role, and that teaching itself is a scholarly activity" (NLN, 2013, para. 9). Patterson and Klein (2012) suggested that there be a paradigm shift from creating evidence-based teaching strategies or practices to instituting the evidence into nursing instruction to provide excellence in education. To do this, nursing educators should incorporate pertinent evidence-based teaching practices from the published literature. The nursing department faculty could meet and discuss one evidence-based teaching strategy each week from peer –reviewed

journals. Through integration of best teaching practices the nurse educator supports all nursing students in a proactive manner.

The participants emphatically stated they were tired of having lectures and requested that nurse educators present information in different ways. Suzhen stated she would have appreciated more case studies. Omolo appreciated the nurse educator incorporating a mnemonic as a way to remember fluid and electrolyte balance and another educator taught him a song on how blood travels through the heart. Mary requested more presentations by students and less lecture by the nurse educator.

Understanding culture within nursing education. Allen (2006) pointed out that without realizing, nurse educators associate students with "products" (p. 71). In years past, nurses were a uniform group of Euro-American women who were "white, heterosexual, Christian, lower middle-class, and younger than 21-years-old" (Allen, 2006, p. 71). Allen (2006) suggested that due to this phenomenon, curriculum was developed and arranged accordingly. Allen (2006) continued by announcing that nursing education is "supported by an authoritarian, banking model of education" (p. 73). When considering the average age of nursing faculty being 51-61 (AACN, 2015), nurse educators learned how to teach using this authoritarian educational model (Allen, 2006). Thayer (2014, para 1) referenced a quote Dewey supposedly made that is relevant for nursing educators; "If we teach today's students as we taught yesterday's, we rob them of tomorrow." While nurse educators "talk the talk" about implementing evidence-based teaching methods and developing new teaching strategies to improve learning, do nurse educators actually "walk the walk"? Allen suggested that nurses educated in the

authoritarian style enter the workforce with preconceived values, beliefs, and understandings that interfered with caring for patients who were different (Allen, 2006).

Campinha-Bacote (2010) incorporated her "theoretical model of cultural competence in healthcare delivery" into a process for nurse educators to create a culturally competent mentoring program (p. 130). Phase one consists of educating the faculty on the many facets of mentoring (Campinha-Bacote, 2010). The second phase focuses on "becoming a culturally competent faculty mentor" (Campinha-Bacote, 2010, p. 132). Campinha-Bacote, (2010) identified a definition and significant difference between "becoming" and "being" culturally competent. She distinguished "becomes" from "being" culturally competent by the nurse entering a process that incorporates five components of her model of cultural competence for nurses which included; "cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters" (p. 131). Human beings are incapable of knowing and understanding every aspect of every culture, ethnicity, or race; thus, Campinha-Bacote (2002) suggested that nurses and nursing educators are always learning through integration of her model, "The Process of Cultural Competence in the Delivery of Healthcare Services." A nurse stating that he or she is being culturally competent is incorrect since all people cannot know, be aware, desire, incorporate previous learning of a culture, or want to engage with those different from them.

Nursing educators can incorporate Campinha-Bacote's (2010) five step cultural competence model in beginning to understand the immigrant student's culture. This entails continuously asking questions, clarifying statements, and summarizing what they hear using the five components of Campinha-Bacote's, "desire, awareness, knowledge,

skill, and encounters" (p. 132). Omolo pleaded that nurse educators should "just be open to them [EDISNs]" and relayed an example of "they know what they are talking about, it is just articulating. It is just the same way you can go to Mexico and you try and ask for water in Spanish and you would mix it up."

The participants stated that medical terminology was like learning another language besides English. A specific medical terminology course could be developed for the ELL that would simplify learning the different parts of words, prefixes, roots, and suffixes. This course could be taken as an elective and assist with pronunciation as well as spelling of medical terminologies. This could also improve ELL language skills.

Nursing textbooks are also written at a higher grade level related to medical terminology. One suggestion is to simplify nursing textbooks by rewriting textbooks for easier reading and understanding. Currently, the textbooks are written at a grade level of 17 and above as previously noted in the discussion. For the ELL, Jackson's (2002) dissertation suggested that alternate textbooks be implemented for the ELL who lacks English proficiency. The participants suggested that reading the textbooks required extra time as they had to translate many times to understand what they were reading. Omolo thought that an English speaking mentor would be helpful in understanding larger English words. Tim gave an example of a word on the NCLEX-RN that he did not know its definition.

Another impact that this study has is how multi-syllable words on the NCLEX-RN are confusing for the new graduate who is an ELL. For example, Tim stated that when he read the word "conspicuously" he was lost. This word has five syllables and for an ELL understanding and knowing the meaning is elusive. Bosher and Bowles (2008)

suggested “linguistic modification” to eliminate difficulties understanding English words that do not include medical terminology. While the new graduate is given 6-hours to complete the NCLEX-RN (National Council of State Boards of Nursing [NCSBN], 2016), questions with multi-syllabic words may cause increased anxiety related to unknown definition of that word. Bosher and Bowles (2008) suggested that integrating “shorter, simpler sentences, information stated directly instead of hidden in the sentence, use of question format rather than completion format, highlighting key words, and use of more common words” (p. 170). O’Neill, Marks, & Liu (2006) conducted a study that examined first time NCLEX-RN candidates and graduates of a U.S. based nursing program. Participants self-identified as having English as their primary language or as an ELL and these two groups were compared (O’Neill et al., 2006). The assumption they drew was that English proficiency is necessary for entry-level nursing practice. They recognized that the test items are examined for bias and readability and concluded that with these actions taken, “there are probably barriers that ESL candidates bring with them to the examination for which there are no reasonable remedies” (O’Neill et al., 2006, p. 18). I would suggest that the NCSBN remain aware of the language issues EDISNs who graduate and take the NCLEX-RN face. A continued review of each question in the text-bank with EDIRNs who are an ELL should occur and rewrite accordingly so questions become more comprehensible for ELL nursing graduates.

Dissemination of Information

Dissemination of the information to nursing educators is the primary method to share the findings and analysis of this study. Distribution of my findings, analysis, interpretations, and implications are essential to begin a change within nursing. There are

several ways to spread this information to begin the discourse within nurses and nursing educators. Presenting the information at a regional and national level for nursing educators would be places to start the process of dissemination. The Midwest Nurse Research Society's Annual Conference, a regional venue, and the American Association of Colleges of Nursing, a national organization, would begin the manner of information distribution. Writing for publication is another setting to be exploited for distribution of the information. While these are usual avenues for dissemination of information from research, there are other means to encourage nurses and nursing educators to consider incorporating this information into practice.

Utilizing the "Stages of Change" also known as the "Trans-theoretical Model" can promote self-reflection and an increased awareness for individual change and change within an organization such as a nursing education department (Rimer & Glanz, 2005). As individuals or groups of people move through the five stage process, "precontemplation, contemplation, preparation, action, and maintenance," in a circular fashion, some people remain in the "precontemplation" stage, (Rimer & Glanz, 2005, p. 15). The stages are fluid, meaning that individuals move freely from one stage to another and can return to previous stages. For example, questions an individual or group might ask for each stage might include:

Stage 1: Precontemplation, Are you interested in becoming sensitive to EDISNs?

Stage 2: Contemplation, Are you thinking about how to improve education for EDISNs?

Stage 3: Preparation, Are you ready to join a nursing committee of peers and EDISNs to strategize ways to develop a nursing program that focuses on cultural awareness and sensitivity for all nursing students and faculty?

Stage 4: Action, Are you implementing the strategies approved by the committee?

Sage 5: Maintenance, Are you consistently using the strategies approved and encouraged?

Open uninhibited discussion among each nursing faculty within each nursing program is required for change to begin. A change agent or innovator begins the slow process of change by introducing a small difference from the expected and moves forward gradually. Wright (2010a) defined change "as an attempt to alter or replace existing knowledge, skills, attitudes, norms, and styles of individuals and groups" (p. 20). Wright (2010b) also explained that understanding one and actively listening to others are actions that are supportive to change. Change is an evolutionary process that requires flexibility, prioritization, attention, patience, and documentation (Wright, 2010b). To begin change, discourse between nursing faculty members allows for expression of individual viewpoints. Once attitudes or norms have changed, maintenance is required. Without this stage, individuals or groups tend to return to their previous attitudes and norms. Raymond, a neurobiology professor at Stanton University, is quoted as stating, "We can overrule our mental habits and gut reactions. It's not inevitable these biases have to control our behavior" (Pedersen, 2015, para. 19).

Limitations

In chapter three, I recognized through journaling prior prejudices and biases. I am a Euro-American Caucasian woman who actively listened to post ELBNP graduates who were different from me in race, ethnicity, culture, language, beliefs, values, and dress. Knowing four of the five participants prior to interviewing was a major advantage in practicing unstructured interviewing as I had never conducted unstructured interviewing

with other nurses and this built my confidence with each successive interview. However, these interviews also were a limitation in that those participants may have not been forthright or truthful with me as I was their instructor.

For this reason, I attempted to get more participants that were unknown to me. Some potential participants assumed inclusion into the study comprised RN to baccalaureate programs as well. The “Letter of Invitation” contained the inclusion criteria with the first one that read, “You completed a 4-year entry-level baccalaureate nursing program within one of the 18 nursing programs within Minnesota (private or public school)." Upon calling these potential participants, I reiterated what the requirements were. Two didn't realize the study was for immigrants into the U.S. Four potential participants were from RN to baccalaureate nursing programs. Another was not due to graduate until this summer. One potential participant graduated in 2011. Two possibilities could be the cause for the confusion; 1) I was not clear in writing indicating the inclusion criteria; 2) the potential participants did not accurately or thoroughly read the "Letter of Invitation"; and 3) words or terms used were unknown.

Eleven responses were received via electronic mail with two participants enrolled in the study, one of which was known to me. One participant was recruited that was unknown for an interview and another unknown EDIRN became a member checker. No other participants responded to the invitation through their employment or as an alumnus through their college or university. Snowballing occurred; however, most participants did not meet the inclusion criteria. Thus, the number of participants interviewed in this study is small; however saturation was achieved.

Upon completion of the pilot study of three participants, saturation was met. Each of those participants provided richness within their stories. I believe that replication of this study could happen with other EDIRNs. Also, in hermeneutical phenomenology, the research is never-ending. The process always continues and in replication could be unique as each study completed depends on the participants, the context, and the researcher.

Three of the five participants were older than 27-years-of age. These participants could have a more worldly view and having experienced life longer could have provided more insight than the two younger participants. Also, immigrants from another state or nursing program might have had something different to say. Thus, this study cannot be generalized to the entire population of EDIRNs.

Finally, the monetary incentive for participating could have swayed answers given during the interview, answers they thought I wanted to hear. Each participant seemed forthright and adamant about their stories. The member checker provided validation to what the participants spoke of in the interpretation of their interviews.

Recommendations for Further Research

Hermeneutic phenomenology is the beginning of all research (Heidegger, 1927/1962). This research study opens up many avenues or opportunities for further research. The directions that this research could enter include grounded theory in development of a substantive theory. Or, maybe a mixed-methods study by incorporating a qualitative methodology to discover EDISNs' strategies to remain resilient in the nursing program with development of an instrument to determine this quantitatively. How do EDISNs "transform a disastrous day into a growth experience and them move

forward in practice?" (Hodges, Keeley, & Grier, 2005, p. 550). Another area to explore would be to determine what the self-concept is of EDISNs while in a nursing program.

I suggest conducting a descriptive qualitative, grounded theory, or quantitative study with nursing educators in an ELBNP, Associate Degree Nursing Program, and a Practical Nursing Program related to published literature including: Campinha-Bacote's (2002) model, "The Process of Cultural competence in the Delivery of Healthcare Services, Yoder's (1993/1996) substantive theory on "Instructional Responses to Ethnically Diverse Nursing Students," Canales (2010) inclusionary and exclusionary othering, and Clark's (2008) comments on incivility between nurses, nursing educators and students. Have nursing educators read literature on oppression within the nursing profession? Have they witnessed incivility between or among nurses, nursing educators, or nursing students? What have they done to decrease the frequency of these actions? What suggestions might they have to decrease or substantially eliminate the negative or superior attitudes within the nursing profession?

The NLN (2013) has broadly written eight core competencies for nursing educators. A research study in understanding how nurse educators integrate these competencies with EDISNs might be helpful in addressing this aspect in future NLN core competency revisions. Another hermeneutic phenomenological study on the perceptions of nursing educators who teach EDISNs could be conducted.

How does oppression in nursing education affect nursing students and nursing educators? How can nurse educators eliminate adversity and oppression for themselves and their students? I suggest conducting a Rogers' Evolutionary Concept Analysis of how each of the following concepts; exclusionary versus inclusionary othering, solitary

versus solidarity, insider versus outsider, and oppressed versus oppressor are used throughout the years. Further research could compare and contrast these same concepts. How is each concept different or similar from the others? For example, what is the difference between insider versus outsider and oppressed versus oppressor? Are these different or similar concepts? How do people use or perceive these concepts?

Finally, identification of textbook grade levels to better understand how or what improvements could be made to simplify reading for nursing students. This research could use qualitative, quantitative, or mixed methodologies. Continued research is essential to providing appropriate and comprehensive student-centered learning.

Final Words

As a Euro-American Caucasian female nurse educator, this dissertation impressed upon me the need to be sensitive and aware of how I conduct myself as a teacher. Nursing as a caring and compassionate profession is a value I hold dearly. So, reflecting on my values, beliefs, and experiences as a nurse and nurse educator held prior to the interviews, cleared my mind that signaled an awareness of differences, yet similarities. As each participant's stories became fused with my horizons, I found myself personally relating to those stories. Although my nursing education began over 36-years-ago, I still recall similar experiences to these participants. I was viewed as "different" by my peers and nursing faculty. The director of the nursing program kept asking me if this was the right education for me. I really only had two nurse educators in my entire four years of undergraduate education that "knew" me and told me that I was an excellent nursing student. While other nursing faculty continued to find fault with my actions and ways of thinking in an attempt to fail me out of the program. Like the participants, I tried to

remain out of sight and mind of those instructors and promised myself that one day I would become a nurse educator and care about all nursing students. I am not am immigrant, but I certainly have felt oppressed and with uncivil behavior shown to me by my peers. My hope is that one day we will all be accepted for the unique individuals we are.

> As Mahatma Ghandi once said, "We must become the change you wish to see in the world" (Sources of Insight, 2011, p. 1).

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Appendix A

Figure 2.1: Yoder's Conceptual Model

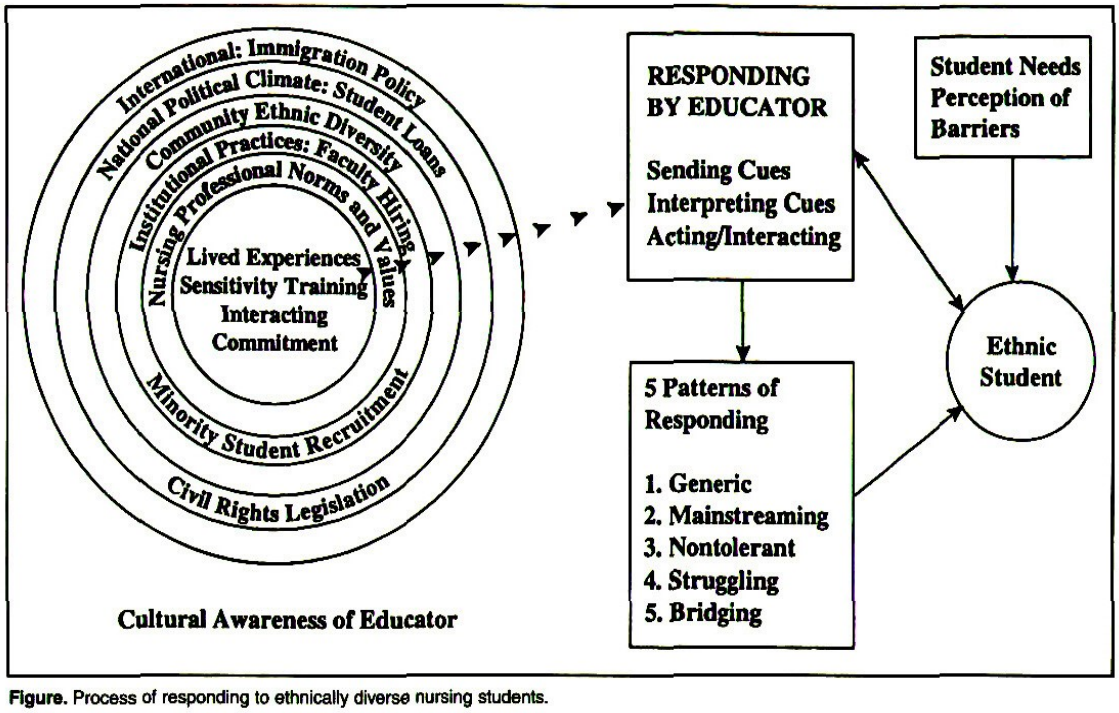


Figure 2.1. Yoder's conceptual model based from the development of a substantive theory after interviewing nursing faculty and ethnically diverse students. Taken from "Instructional Responses to Ethnically Diverse Nursing Students," by M. K. Yoder, 1996, *Journal of Nursing Education, 35,* p. 318. Copyright 1996 by SLACK, Inc.

Appendix B

Table 2.1 Research Related to Interventions Integrated for Retention of EDNSs

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Anders et al., 2007	disproportion-ate representation of Hispanics in nursing	Financial, decreased aware-ness, pre-requisite course competit-iveness, support family	Quantit-ative and Qualit-ative (reflection exercise) and Quantit-ative (number of EDNS graduates who passed NCLEX-RN)	"economically disadvantaged Hispanic student" (p. 128)	Multiple approach: Provide academic tutors, social events, scholarships/ stipends, outreach manager to schools, summer orientation, RN mentors, faculty becomes more culturally competent through use of cultural consultant	HRSA grant.	Increased Hispanic and minority support by 25% with 29 Hispanic graduated in 2007 (p. 134)	Cultural competency of faculty should be driven by the ethnic group being taught. Cultural consultant an asset.

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Bagnardi & Perkel, 2005	High attrition rates of minority students from 16% to 33% (p. 17)	English as a second language (ELL), inadequate academic preparation, financial, personal (family responsib-ilities)	Quantit-ative	"minority and disadvantaged students"	The Learning Achievement Program (LAP): Program has an administrator and advisor, 4 week orientation prior to start of program, nursing socialization sessions, learning center help, review sessions, cultural consultant working with nursing faculty	HRSA grant.	20 students entered LAP and 14 graduated in 2002 (p. 20) 20 students entered LAP and 19 students continued the program in 2003 (p. 20).	Not specific. Diverse faculty

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Banister, Bowen et al., 2014	Attrition rates high.	Financial, linguistic, isolation, racism	Quantit-ative, Rating of mentees by mentors	Minority nursing students	The Clinical Leadership Collaborative for Diversity in Nursing: mentoring with practicing minority nurse.	Not identi-fied	Zero attrition. Low job turnover rate.	Encourage more practicing minority EDNs to become mentors (shortage).

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Bosher & Bowles, 2008	Linguistically challenged EDNSs have difficulty taking multiple-choice tests. Low pass rates on National Counsel of Licensure Exam (NCLEX-RN) by diverse nurse graduates.	Language, English translation linguistic bias.	Qualit-ative compari-son.	5 ELL volunteer students in first year of ELBNP at the College of Saint Catherine in St. Paul, Minnesota	"To determine the effects of linguistic modification on English-as-a-second-language students' comprehen-sion on nursing course test items" (p. 167).	Not identi-fied	Fleisch-Kincaid scale showed less complex test questions making them easier to read. Average number of words per sentences decreased along with passive sentences decreased. Reading ease increased from 47.6 to 51.8. Grade level for questions dropped from grade to.4 to 8.7. Participants identified modified test questions	Linguistic Modification: Reviewed incorrect exam questions with ELL students. Questions considered to be difficult to understand were revised or modified and evaluated for comprehensibility by these students.

							more comprehen-sible 77% of the time while original test questions were more comprehen-sible 23% of the time (p. 170). Student positive comments regarding modified test questions.	

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Brown, 2008 and Brown & Marshall, 2008	Disparities exist on National Council Licensure Examination for Registered Nurses (NCLEX-RN), native born 95% pass while foreign-born 47% pass (p. 184)	Language barrier: basic and academic Social isolation, discrimin-ation	Quantit-ative	"foreign-born ELL students" (p. 184)	BEST RN program (looks at internal and external "facilitators or barriers" (p. 23). A multi-strategy approach evolved to include student support in language, academic and social areas. Faculty support for cultural awareness and student engagement.	Not identi-fied.	67% pass rate. 0% passed NCLEX-RN in first cohort, 50% passed in second cohort (p. 189)	Incorporate Learning Styles Inventory for EDNSs. Conduct periodic reviews of teaching materials. Monthly student meetings. Special orientation to nursing education. Establish community partnerships. Hire a student recruiter/advisor that is an alumnus of the program.

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Cantu & Rogers, 2007	Hispanic population growing along with their health disparities. Need to decrease health disparities by increasing number of Hispanic nurses.	Lack of academic support. Nursing programs lack caring for minority nursing students.	Qualit-ative, Comments from EDNS to their mentors.	"educationally and/or economically disadvan-taged" students: ELL or financially strapped (p. 126)	Mentoring of students by students who have passed all nursing courses, culturally aware, desiring to grow, and approved by faculty Partnership with community agencies	"feder-ally funded" (p. 125)	Student's positive comments.	Partner with technical and community nursing programs.
Carr & DeKemel-Ichikawa, 2012	Lack of ethnically diverse nurses (EDNs).	Accents/ dialects lead to unsafe practice, misunder-standings	Quantit-ative	Pilot program. ELL students with thick accents.	Nursing Success Program (NSP): To test an accent modification program with ELL students.	Not identi-fied.	13 of 13 ELL nursing students demonstrated through pre- and post-test the ability to correctly produce phonemes (p. 82).	Clinicians from Communication and Sciences Disorders Department worked with ELL nursing students.

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Condon et al., 2013	Increasing minority nurses will improve cultural competency and decrease health disparities.	Lower retention in nursing programs and lower NCLEX-RN pass rates.	Quantit-ative	80 disadvantaged or underrepresented minority nursing students (over 3 years)	Success in Nursing: Individuals Pathways Program (SLIPP): a prep course prior to beginning nursing program (offering "critical thinking, study skills, math, medical terminology, professionalism, reading and writing"). When in the program had "minority nursing faculty advisors, RN mentors,	HRSA grant	87% retention rate and 83% passed NCLEX-RN (p. 281).	Consider various interventions or strategies. Create a faculty development program focusing on recruitment, retention, and advisement of EDNSs. Consider non-cognitive characteristics rather than grade point average when considering students for the nursing program.

					study groups, and financial aid" (p. 281).			

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
DeLapp et al., 2008 Rearden, 2012	Alaska Native and American Indian continue to be disproportion-ately represented in nursing programs.	Nursing programs do not provide caring for or connect-ions to the Alaska Native/ American Indian.	Quantit-ative with Qualit-ative from student comment.	"66 Alaska Native/Ameri-can Indian" nursing students and graduates between 1998-2005 (p. 296)	Program: Recruitment and Retention of Alaska Natives into Nursing (RRANN) Program included peer tutoring, Student Success Facilitator for student counseling, peer mentoring, are in dorm devoted only to nursing students with Resident Advisor a nursing student, newsletter, stipends, partnerships	Bureau of Health Profess-ions HRSA, Employ-ment and Train-ing Admin-istra-tion U.S. Dept. of Labor, Office of Rural Health Policy, Dept. of Ed., Cost-Co Corp.	46 graduated and 20 still in program at time of article publication. Of those graduated, all but one passed NCLEX-RN the first time (p. 296). Students provided positive testimonials.	Consider a trimester approach to education to spread out coursework from 9 months to 12 months. Offer a graduate program so EDNSs are empowered to continue their education.

					with community schools.			

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Edwards et al., 2009	White population is minority in Oklahoma. Health disparities exist.	Did not identify barriers.	Quantit-ative	"minority and educationally disadvantaged students admitted to baccalaureate program" (p. 65)	Recruitment Enhancement Cultural Affirmation Program (RECAP): mentoring by faculty, orientation, software programs, mind mapping. Financial aid, learning style assessment, and individual academic planning Cultural Advisory Committee for faculty to improve cultural awareness to teach outside textbook	HRSA, DHHS Divi-sion of Nursing Bureau of Health Profes-sions	Numbers of minority students graduate each successive year (45 to 70). 96% passed NCLEX first time with 4% passing the second time (p. 66)	Evaluate all nursing content and clinical courses for cultural competency. Create a center for consultation for cultural competency and healthcare excellence for faculty. Annual conference for faculty to continue honing cultural competency knowledge and skills.

					generali- zations.			

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Escallier & Fullerton, 2009	School of nursing committed to increasing diversity in nursing.	Conducted a survey of barriers from students enrolled in school of nursing (SON). Results not disclosed.	Quantit-ative,	Disadvant-aged undergraduate nursing students in New York	3 retention strategies: Self-assessment of cultural awareness, sharing of successful teaching and learning approaches by faculty to faculty, mentoring by volunteer mentors, technical (computer) support for students.	HRSA grant	100% retention rate. Mentor/ mentee relationship unsuccessful.	Make visible the cultural competency woven through each nursing course (in objectives and written materials, assignments). Mentorship is important for EDNSs.

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Evans, 2007	Need to increase EDNs in the U.S.	EDNSs face disparities in nursing school.	Quantit-ative	Hispanic/ Latino and American Indian	Nursing Workforce Diversity Grant (ALCANCE) recruitment and retention. Retention included financial assistance, academic counseling, community nurse mentors, and tutoring.	DHHS, HRSA, Divi-sion of Nursing	12 students received services of ALCANCE. 3 had graduated at time of article publication. Two-thirds felt less isolated. Students requested more interaction with diverse students.	Improve services for American Indian.

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Fletcher et al., 2003	Underrepre-sented ethnic minority nursing students.	Ethnically diverse nursing students have few role models and there are few minority nursing faculty.	Unknown. Discus-sion of strategies with a few comments at the end by students	African American students	Minority Recruitment and Retention Initiative (MRRI): Forums for diverse students and faculty in all university programs, partnerships with other colleges and universities, encourage participation in Minority Student Health Care Association, mentoring by ethnically diverse nursing faculty.	Not identi-fied	"9 full-time and one part-time ethnically diverse nursing faculty" (p. 131). 21% of nursing students are ethnic (p. 131).	Establish a welcoming environment for EDNSs. Begin and maintain collaborative partnerships with healthcare agencies outside of academia and other healthcare professions within the academic world.

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Gardner, 2005b	Underrepre-sentation of ethnic minorities in nursing.	Previous article addressed barriers (Gardner 2005a)	Quantitati ve using number of students who remained in the program.	Ethnically diverse nursing students from 2003-2004	Minority Retention Project: Retention coordinator reviewed tests, taught study and test-taking classes, established a mentoring network with RNs from the community, ELL students paired with students who are primary English speakers, organized family nights, health care seminars related to specific cultures, and minority	The Pro-mise of Nursing for North-ern Cali-fornia Faculty Devel-opment Grant Pro-gram	100% retention (p. 568)	Institute a Retention Coordinator in developing a supportive atmosphere for pre-nursing and EDNSs.

					support groups.			

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Georges, 2012	Hispanic population continues to grow exponentially in the Bronx, New York. Only 8% enroll in nursing.	Not specifi-cally identified.	Quantit-ative by addressing numbers who passed NCLEX-RN Satisfact-ion Survey	12 ELL students	family day, tutoring, exam reviews, summer externships, monthly group meetings, one-to-one mentoring/coaching, financial aid, review session for NCLEX, study skill review, preceptor workshops for hospital staff, and workshops on cultural competence for nursing faculty and hospital staff (pp. 65-66).	Jonas Center for Nursing Excel-lence.	15 Hispanic pre-nursing student and 12 Hispanic nursing students participated (p. 23) 31 passed NCLEX first time, one failed. Students were positive with statements on satisfaction survey.	Seek funds to assist students.

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Guhde, 2003	ELL nursing students enrolling in nursing programs.	ELL is a barrier to passing NCLEX-RN	Quantit-ative, Pre- & post-test given for listening and taking notes with ELL students.	One ELL nursing student from China	Nursing tutor used to improve understand-ing, writing skills, and pronunci-ation. Students listen to a taped report to write the report down and compose a nursing note. Medical terminology is given verbally and written as a list for the student to pronounce.	HRSA grant	Tutoring helped student learn English. Increased communi-cation in groups. Increased student's socialization with English speaking peers.	Collaborate with ELL, English, or language departments.

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Hesser et al., 1996	Few studies on retention of minority or disadvantaged students and fewer documenting outcomes of the program.	Personal, academic, social, financial, vocational and other concerns addressed as barriers.	Quantit-ative quasi-experi-mental compar-ison between 2 groups: African American and non-black minority and majority (white)	Students pre-program (MAAP) from 1978-1982. Students in program (MAAP) from 1984-1988. All students were junior nursing students.	Minority Academic Advising Program (MAAP): All-encompas-sing counseling, consultation with study skills expert, advising training for faculty, quarterly advising meetings, newsletter, presentations by black role models, summer orientation to program.	Not identi-fied	Statistically significant with students' first time NCLEX-RN pass rates, 49% to 64% respectively (p. 307). Grade point averages increased with the program, 2.91 to 3.13 (p. 307). Retention rates increased from 92.1% to 97.4% (p. 307).	A campus-wide commitment not only by faculty, but administration to support EDNS success.

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Igbo et al., 2011	Attrition rates (56% graduation of EDNSs)	Inade-quate prepar-ation for nursing school.	Qualit-ative – student feedback Some quant. as demon-strated through program progress-sion.	Nursing students from disadvantaged backgrounds.	Consortium to Advance Nursing Diversity & Opportunity (CANDO): orientation to program, activities such as study skills, critical thinking, coaching, and socialization (p. 376).	Nursing Work-force Diver-sity Grants, DHHS, HRSA, BHPRr, Divi-sion of Nursing	Increased collegial interactions between students. "This program will impact my life forever!" (p. 378). Retention rates increased from 56% to 77% (pp. 375 & 379).	Use interactive online modules, involve social work for personal issues, play proactive educator role to student needs, and collaborate between disciplines.

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Klisch, 2000	Need for a more diverse nursing workforce	Attrition rates of ELL nursing students are high.	Quantit-ative Satisfac-tion survey with strategies implement-ed.	ELL nursing students.	ELL assigned a specific advisor, enhancing faculty and student cultural competence. ELL students took a language proficiency test, language tutoring, language partnerships, offered Assertive-ness training, extended test time with quiet area, social support offered, and transcultural nursing	No funding	31 students enrolled with 23 graduated and 21 passing NCLEX-RN	Need faculty and institutional support. Share creative ideas among all schools of nursing.

					placed in nursing courses.			

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Nugent et al., 2004	Diversity of nurses must reflect population being cared for.	Identifi-cation of barriers supports the model: inadequate education-al prepara-tion, financial, poor social adjust-ment to education	Quantit-ative, African American students	Recruitment retention of African American nursing students at Medical College of Georgia SON	Mentorship Model for Retention of Minority Students (MMRMS): mentoring is the overarching theme that consists of support components: academic, financial, self-development, professional and leadership, and faculty/insti-tutional awareness.	HRSA – Nursing Work-force Diver-sity Grant	18% entering program in 2001 were African American, 100% retention rate and 81.3% graduation rate. 3 students repeated a failed course to progress (p. 93).	Need faculty and administrative commitment & support (mentally, financially, & intellectually) from the academic institution. Collaborate with healthcare agencies. Conduct qualitative research to determine the EDNS's experience at the academic institution. Maintain statistics in number of EDNSs admitted, graduation rates, NCLEX-RN pass rates.

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Ormeaus & Redding, 1990	Reflect health care needs of increasing ethnically diverse population	Low enrollment of disadvan-taged students in nursing program (financial or academic issues)	Quantit-ative	Academic and financially underprivil-eged pre and enrolled nursing students.	Getting Assistance in Nursing (GAIN): stipends offered, enroll students in reading and writing courses if low score on standardized testing. Curriculum taught from simple to complex.	DHHS Divi-sion of Nursing	Educationally and financially disadvantaged enrollment increased (27%-54%). NCLEX-RN board scores improved (began at 88% at program beginning and was 98%, 100%, and 95% for each successive year.	Program worked with much information from this program to share by those that implemented the program. Otherwise, no recommendations given.
Peter, 2005	Minority nursing students have a high attrition rate.	Increased attrition rates due to inadequate prepar-ation.	Quantit-ative	Minority nursing students	Learning for Success (LFS): faculty coaching, study skill workshops, peer tutors, study groups, and early identification	DHHS	GPA mean increased t0 3.18. 93% of at-risk students had grade of C or better. 10% pass in 1st semester, failed in second	Funding helps with faculty coaching.

					of at-risk students.		semester.	

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Stewart, 2005	Need for minority nurses and nursing faculty	Attrition rates at 26% and NCLEX-RN pass rate down to 70% (p. 9)	Quantit-ative	Minority nursing students	Modules developed on success strategies, stress management, study & test-taking skills, assertiveness, self-esteem to assist students. Stipend and academic monitoring implemented. Nurse consultant for faculty workshops to increase cultural sensitivity and include cultural awareness in curriculum and test revisions.	HRSA	Retention increased to 95%, NCLEX-RN pass rates improved to 90% over 2 years (p. 10).	Offer workshops to nursing faculty on teaching to the EDNS. Recognize students do not learn similarly; use a variety of teaching methods. Integrate mentoring after offering a mentor workshop.

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Stokes, 2003	Retention of minority nursing students.	Loneliness isolation, & anxiety reported by minority nursing students.	Qualit-ative, Minority and inter-national students	Minority and international students.	"Gatherings" Peers supporting each other for 1-1.5 hours during designated times with food offered	No men-tion of funding	"As minority & international students, we need each other's strengths and abilities to draw upon" (p. 82). Several other positive remarks were shared with faculty.	Continue gatherings.

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Suther-land et al., 2007	Diverse population inadequately represented by nurses.	Absence of social support groups, lack faculty contact and commit-ment	Quantit-ative using a Likert survey and descriptiv e statistics Compared ARMS students with non-ARMS students.	Minority nursing students, first-generation college, rural community students, and students earning a C or failing a course were invited to participate in ARMS.	Affirming At-Risk Minorities for Success (ARMS): faculty-student advising and mentoring, expert tutoring, provided a laptop computer with software, workshops on how to be successful.	DHHS – Basic Nurse Educa-tion and Practice Pro-gram grant	ARMS students did not perform better than non-ARMS students. ARMS students did pass all classes. ARMS students passed NCLEX-RN similarly to non-ARMS students (p. 353).	Mentoring and tutoring is essential for the success of the EDNS.

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Swinney & Dobal, 2008	Recruit and retain students from outside college/ university community so they return to their home community to practice.	Not readily identified. Concen-trate on specific barriers. (SAFER Model)	Quantit-ative Relayed numbers of EDNS who completed the nursing program and passed NCLEX.	Two medically underserved communities with high populations of African American and Hispanic. Project targeted middle and high school students.	Embrace the Challenge (ETC): begin nursing clubs, field trips, tutoring in math, science, and language, stipends to become certified as a nursing assistant, offers a NCLEX-RN review, full-time minority student advisor, offers cultural competency workshops for faculty.	Private donor	More than 450 participated as middle and high school students. From this 9 were accepted into nursing programs. 22 minority or disadvantaged students completed nursing programs and passed NCLEX (p. 202).	Implement cultural competency workshops specifically for nursing faculty. Establish a minority advisor who is a minority.

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Symes et al., 2002	Health disparities increase in minority population due to low EDN numbers.	Immi-grants may have limited English skills. EDNSs attrition rate 35%, possibly due to difficulty speaking and compre-hending English.	Quantit-ative with some qualitative from faculty comments	All students with a Nurse Entrance Test result of less than 55%.	Student Success Program (SSP): Students participate in oral, reading, and writing with a speech and language pathologist. Students also explore learning styles and faculty integrates classes on stress and time management.	Not identi-fied.	89% of those enrolled in the program remained. SSP students "are the best students I have had" (p. 230).	Offer program to non-eligible students.

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Trossman, 2009	Underrep-resented nursing students can improve nursing care.	Attrition rates of underrep-resented popul-ations.	Quantit-ative	Accepted into nursing program and from an underrepre-sented population	Bringing the Best to Nursing (BBN) precursor to Nursing Scholars Program (NSP): peer group meetings, tutoring, seminars on stress, management, and study techniques, community nurses as mentors, English as Second Language courses, computers with skill help, financial assistance,	Anony mous grant of 10,000 dollars and HRSA 3 year grant.	90% of BBN students graduated from 133.	None noted.

					and faculty advisors.			

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Valencia-Go, 2005	Need diverse nurses who relate to increasing diverse population by being "caring, competent, humanistic, and sensitive" (p. 19).	Limited academic prepar-ation, low self-esteem, and previous discrim-ination experi-ences	Quantit-ative	All nursing students participated; however, only 65 minority students were followed.	Growth and Access Increase for Nursing Students Project (GAINS): Formation of an Advisory Committee to consult with the project team. Offered advising using a learning contract, peer tutoring, group tutoring with an education specialist, pre-nursing course workshops, mentoring (upperclassm an peers,	DHHS	Program completion rates for each year's cohort were 82.6%, 86.9%, and 94%. Weak mentor program – practicing nurses had difficulty finding time and students failed to meet. Only one graduate had to retake the NCLEX-RN.	EDNS support should be ongoing throughout the entire pre-nursing and nursing programs. Offer financial assistance to EDNSs so they do not have to work and can spend more time with a tutor. Decrease nursing faculty workload and commitments to become involved in helping EDNSs to success.

					faculty, practicing registered nurses, and alumni), and faculty development.			

Citation	Acknowledge Issue	Identify Barrier/s	Study Type	Participant Focus	Intervention	Funds	Findings-Results	Recommendation
Wilson et al., 2010	Little change in racial and ethnic composition of practicing nurses while diversity of population increases.	Increasing attrition rates, falling test grades and decreased NCLEX scores.	Qualit-ative, EDNS mentee and Faculty mentor	10 Faculty mentors (trained) and 30 mentees from junior and senior level nursing students who were ethnically a minority or educationally or financially disadvantaged (p. 146).	Preparing the Next Generation of Nurses Mentoring Program (NGN): Faculty preparation for mentoring (cultural competency training, mentoring workshops)	HRSA/ DHHS – Bureau of Health Profes-sion Divi-sion of Nursing	Themes: Faculty – caring, academic success, role modeling Students – support system, improved awareness of nursing, enriched academically (p. 147). Recommends SON to prepare faculty to mentor students.	Incorporate nursing faculty as mentors after investing time and money to properly prepare them through workshops and cultural competence training.

Appendix C

Figure 2.2: Conceptual Model of Confounding Barriers, Barriers, and Interventions

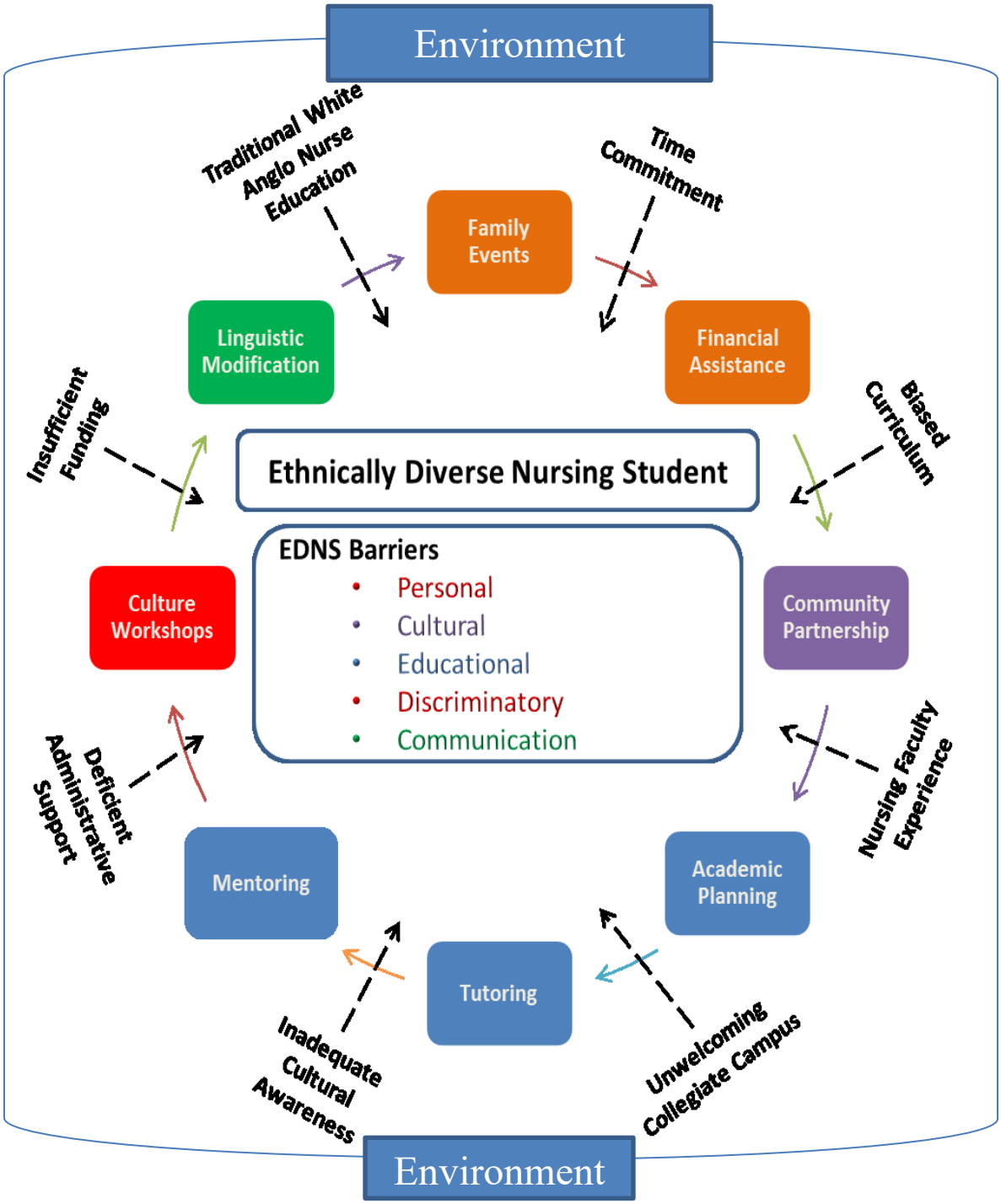


Figure 2.2. A model was created from the integrated literature review to explaining the relationships of barriers and interventions, while suggesting potential interferences (confounding barriers) as indicated by the broken arrows. The colors of interventional rectangles correspond and center around the colored barriers listed in the center box.

Appendix D

Figure 3.1 Illustration of the Hermeneutic Circle in Gathering Data and Interpretation

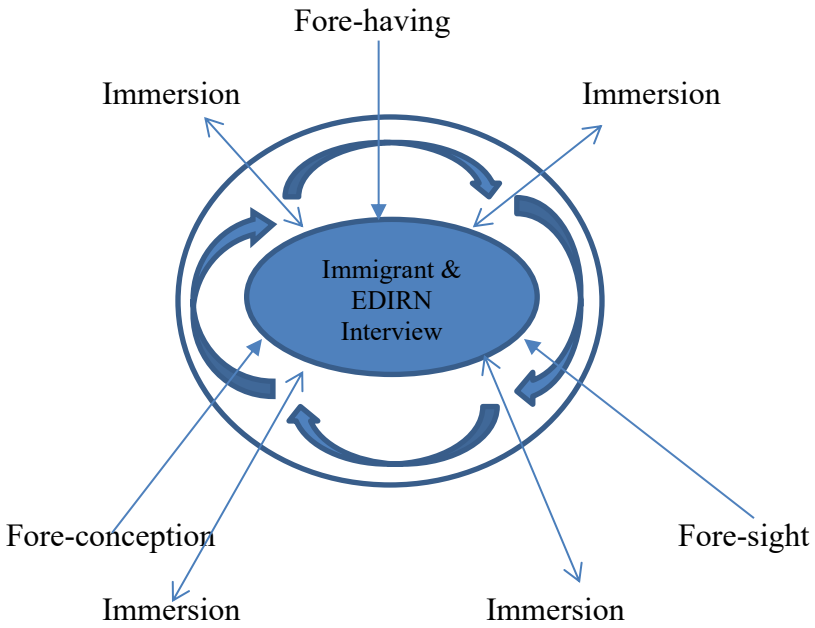


Figure 3.1. Represents perceptions of the world brought to the interview by the participant and me. Together the participant and I became immersed in their stories, bringing clarity and understanding to their lived experience. The Hermeneutic Circle was also implemented when Dr. Isaacson, the hermeneutic expert for SDSU and I discussed the transcripts and interpretations.

Appendix E

Letter of Invitation

1525 32nd Ave. N.
Saint Cloud, MN 56303

January 21, 2016

Recent Graduate of an Entry-Level Baccalaureate Nursing Program and
Working in Minnesota as a Registered Nurse

Dear Ms. or Mr. _____:

You are reading this letter of invitation because you have either recently graduated from an entry-level baccalaureate nursing program within the state of Minnesota (graduated within the years of 2013, 2014, and 2015) and live and work as a registered nurse in the State of Minnesota.

My name is Marcia Scherer and I am a Doctor of Philosophy Nursing Candidate at South Dakota State University. I am conducting a research study of ethnically diverse immigrant registered nurses (EDIRNs) who have recently graduated from an entry-level (4-year program) baccalaureate nursing program in Minnesota. The research is qualitative and consists of a demographic survey and a 1-2 hour interview with myself at a date, time, and location of your choosing. Upon completion of the interview you will be given a $40.00 Amazon gift card.

This study addresses a critical issue facing nursing educators in the U.S. Health disparities among immigrants and refugees continue to increase as the discrepancy between the numbers of practicing ethnically or racially diverse nurses lags significantly behind the growing influx of foreign-born people. The solution to this crisis is to understand the learning experiences of ethnically or racially diverse immigrant registered nurses so nurse educators can create or tailor current learning interventions and strategies within their curriculum to increase the number of successful and graduating ethnically or racially diverse immigrant students.

To be eligible to participate in this research study, you need to meet all of the follow requirements:

1. You completed a 4-year entry-level baccalaureate nursing program within one of the 18 nursing programs within Minnesota (private or public school).
2. You graduated from this college or university during the years of 2013, 2014, or 2015.
3. You were born in a foreign country and completed your nursing education in the United States on an educational visa or an immigrant, refugee, naturalized citizen, or becoming a naturalized citizen.

4. You passed the National Council Licensure Examination for the Registered Nurse (NCLEX-RN).
5. You reside in the state of Minnesota.
6. You currently work as a registered nurse in the state of Minnesota.

If you said "yes" to all six statements, you are eligible to participate in this study. Please contact the primary investigator, Marcia Scherer, at: marcia.scherer@jacks.sdstate.edu or call: 612-859-2801. This study has institutional review board approval from South Dakota State University and St. Cloud State University.

Sincerely,
Marcia Scherer
Marcia Scherer, MS, RN, CNE, PHN, LSN
PhD nursing candidate at South Dakota State University

Appendix F

Letter to Deans and Department Chairs

1525 32nd Ave. N.
Saint Cloud, MN 56303

January 21, 2016

Dr., Ms., or Mr. _____
Nursing Department Chair
College or University
Address
City, MN Zip

Dear Dr., Ms., or Mr._____:

My name is Marcia Scherer and I am a Doctor of Philosophy Nursing Candidate at South Dakota State University. My doctoral dissertation centers on a qualitative research study using Hermeneutic Phenomenology to understand ethnically diverse immigrant registered nurses' (EDIRNs) meaning of their learning experiences when they were in an entry-level baccalaureate program (ELBNP) in Minnesota. The purpose of this study is to understand learning experiences of EDIRNs and their strategies to successfully complete an ELBNP, while introducing a new perspective and information from EDIRNs to nursing science. The EDIRN for this study is referred to as a foreign-born person who enters the United States (US) legally on a visa, through employment or a nursing program of study, or as a relative of someone and can become a naturalized citizen after living and working in the US for 5-years. Registered nurse corresponds with a healthcare provider who has completed their nursing education in Minnesota and has successfully passed the National Council Licensure Examination-Registered Nurse.

As part of this study, I require participants who have graduated from an ELBNP within the last 3-years. According to the Family Educational Rights and Privacy Act, I understand you are unable to give the name and address of these graduates to a researcher. Thus, I am requesting that you distribute the attached "Letter of Invitation" to all of your nursing alumni who have graduated within the years of 2013, 2014, and 2015 through e-mail. I am hoping that some of them will meet the criteria and contact me.

This study addresses a critical issue facing nursing educators in the U.S. Health disparities among immigrants and refugees continue to increase as the discrepancy between the numbers of practicing ethnically or racially diverse nurses lags sufficiently behind the growing influx of foreign-born people. The solution to this crisis is to understand the learning experiences of EDIRNs so nurse educators can create or tailor learning interventions or strategies within their curriculum to increase

the number of graduating ethnically or racially diverse immigrant students to enter nursing practice.

Institutional Review Board Approval has been granted by South Dakota State University (Approval #IRB-1510008-EXM) and St. Cloud State University (Approval #00001841).

Thank you for your assistance in alerting potential participants.

Sincerely,

Marcia Scherer, MS, RN, CNE, PHN, LSN
PhD nursing candidate at South Dakota State University

Appendix G

Table 3.1 *List of Entry-Level Baccalaureate Nursing Programs Contacted*

University or College Name	Contact Name	E-mail	Private/ Public	Response?
Bemidji State University	Dr. Nancy Hall	nhall@bemidjistate.edu	public	no
Bethel University	Dr. Beth Peterson	e-peterson@bethel.edu	private	no
College of St. Benedict/St. John's University	Dr. Rachelle Larsen	rlarsen@csbsju.edu	private	no
College of St. Scholastica	Ms. Paula Byrne	pbuyrne@css.edu	private	no
Concordia College of Nursing	Dr. Polly Kloster	Kloster@cord.edu	private	yes, no alumni fit inclusion criteria
Crown College	Dr. Teresa B. Newby	newbyt@crown.edu	private	no
Globe University	Ms. Kendra Saal	Ksaal@msbcollege.edu	private	no
Gustavus Adolphus College	Dr. Barbara Zust	bzust@gustavus.edu	private	yes, letter sent out
Herzing University	Ms. Kathy Smith	Katsmith@hersing.edu	private	no
Minnesota State University, Mankato	Dr. Julia Hebenstreit	Julia.hebenstreit@mnmsu.edu	public	no
National American University	Dr. Lisa Hawthorne	Lhawthorne@national.edu	private	no
Presentation College	Dr. Sandra Welling	Sandra.Welling@presentation.edu	private	yes, letter sent out
Saint Catherine University	Dr. Margaret Pharris	mdpharris@stkate.edu	private	no
St. Cloud State University	Dr. Joyce Simones	jmsimones@stcloudstate.edu	public	yes, I contacted for pilot study

St. Olaf College	Dr. Diane Neal	neal@stolaf.edu	private	no
University or College Name	Contact Name	E-mail	Private/ Public	Response?
University of Minnesota	Dr. Connie Delaney	Delaney@umn.edu	public	unable to participate
University of Northwestern	Dr. Ginger Wolgemuth	gfwolgemuth@unswp.edu	private	no
Winona State University	Dr. Martha Scheckel	MScheckel@winona.edu	public	yes, letter sent out

Note. This list included private and public schools that according to the Minnesota Board of Nursing are approved to provide an ELBNP. There are 18 total schools of nursing in Minnesota that offer an ELBNP. I received six responses from the 18 schools. Of the six responses three were unable to participate in the formal study related to alumni not meeting criteria, the inability to participate, or I knew the participants.

Appendix H

Letter to Chief Nursing Officers and Nurse Managers

1525 32nd Ave. N.
Saint Cloud, MN 56303

January 22, 2016

Vice President, Hospital Operations, Chief Nursing Officer
Saint Cloud Hospital
Saint Cloud, MN

Dear Ms. or Mr._____:

My name is Marcia Scherer and I am a Doctor of Philosophy Nursing Candidate at South Dakota State University. My doctoral dissertation centers on a qualitative research study using Hermeneutic Phenomenology to understand ethnically diverse immigrant registered nurses' meaning of their learning experiences when they were in an entry-level baccalaureate program in Minnesota. The purpose of this study is to understand learning experiences of ethnically diverse immigrant registered nurses and their strategies to successfully complete an entry-level baccalaureate nursing program, while introducing a new perspective from ethnically diverse immigrant registered nurses to nursing science. The ethnically diverse immigrant registered nurse for this study is referred to as a foreign-born person who enters the United States (US) legally on a visa, through employment or a nursing program of study, or as a relative of someone and can become a naturalized citizen after living and working in the US for 5 years. Registered nurse corresponds with a healthcare provider who has completed their nursing education in Minnesota and has successfully passed the National Council Licensure Examination-Registered Nurse.

As part of this study, I require participants who have graduated from an entry-level baccalaureate nursing program within the last 3 years. While I understand the need for confidentiality of the nursing staff and the inability to give the name and address of ethnically or racially diverse immigrant registered nurses, I am requesting that you distribute the attached "Letter of Invitation 1" to all of the nursing staff or nurse managers to give to their nursing staff. I am hopeful that some of the nursing staff will fit the inclusion criteria and contact me to participate.

This study addresses a critical issue facing nursing educators in the U.S. Health disparities among immigrants and refugees continue to increase as the discrepancy between the numbers of practicing ethnically or racially diverse nurses lags sufficiently behind the growing influx of foreign-born people. The

solution to this crisis is to understand the learning experiences of ethnically diverse immigrant registered nurses so nurse educators can create or tailor current learning interventions and strategies within their curriculum to increase the number of graduating ethnically or racially diverse immigrant students to enter nursing practice.

Institutional Review Board Approval has been granted by South Dakota State University (Approval #IRB-1510008-EXM) and St. Cloud State University (Approval #00001841).

Sincerely,

Marcia Scherer
Marcia Scherer, MS, RN, CNE, PHN, LSN
PhD nursing candidate at South Dakota State University

Appendix I

Table 3.2 *List of Hospitals Contacted*

Hospital Name	Contact Name	Title	E-mail	Response?
Abbott Northwestern Hospital	Dr. Susan Sendelbach	Director of Nursing Research	sue.sendelbach@allina.com	yes, completed IRB, sent out letter
Children's Hospitals and Clinics of MN	Roxanne Fernandes	Chief Nursing Officer (CNO)	Roxanne.fernandes@childrensmn.org	yes – sent out letter
Essential Health St. Mary's Medical Center	Dr. Sandra McCarthy	Vice President of Hospital Operations	Sandra.mccarthy@essentialhealth.org	no
Hennepin County Medical Center	Karen Wilde	CNO	Karen.wilde@hcmed.org	yes – sent out letter
Mayo Clinic Rochester	Pam O. Johnson	CNO	Johnson.pamela2@mayo.edu	no
Park Nicollet Methodist Hospital	Dr. Roxanna Gapstur	CNO	Roxanna.gapstur@parknicollet.com	no
Regions Hospital	Catherine McCallister	Director of Nursing	Catherine.g.mccallister@healthpartners.com	no
St. Cloud Hospital	Roberta Basol	Care Center Director	basolr@centracare.com	yes, completed NRRB, sent out letter
St. Luke's Hospital	Sue Hamel	CNO	shamel@slhduluth.com	no
University of Minnesota Medical Center, Fairview	Laura Reed	CNO	lreed1@fairview.org	no

Note. Ten hospitals were contacted via electronic mail with a 60% response rate. Two hospitals required their institutional board review be completed. These were completed and returned. Saint Cloud Hospital required that I meet in front of the board to present my research prior to approval to send the "Letter of Invitation" out.

Appendix J

Table 3.3 *Participant Demographics*

Pseudonym Chosen	Age	Gender	Country Of Origin	Number of Languages Spoken (Includes English)	Private or Public Nursing Education	Number of Years in U.S.	Number of immi-grants in nursing class (Includes partici-pant)
Omolo	37	male	Kenya	3	Public	20	1
Mary	54	female	Ukraine	3	Public	15	4
Suzhen	26	female	Vietnam	2	Public	7	4
Tim	34	male	Kenya	4	Public	14	2
Ashley	25	female	Somalia	2	Private	21	5

Note. The participants for the pilot and formal study were combined for the entire study. The member checker was not included in this table.

Appendix K

Demographic Tool

Please complete the demographic survey to the best of your ability. This survey along with the taped interviews will be kept confidential and in a locked safe in the home of the investigator. Please assign yourself a pseudonym, as this allows the researcher to identify pieces of the interview and text, without any personal identifiers (real name) in the paper's analysis and final results.

1. Chosen pseudonym for self: _____

2. Gender: _____Female _____Male _____ Other

3. Age: _____ years

4. The country I was born in is _____.

5. I have been in the United States for _____ years.
(provide a number)

6. My first language is _____.

7. What other languages do you speak? _____

8. What term do you use to describe your ethnicity? _____.

9. I graduated from _____in_____.
(name of college or university) *(provide month & year)*

10. I obtained my registered nurse license _____.
(provide month & year)

11. _____ethnically diverse students (non-white) were in my nursing co-hort.
(provide a number)

12. I have been practicing as a registered nurse for _____.
(*provide number of years and months)*

Appendix L

Questions for the Interviewee to Ponder 1 Week Prior to the Interview

Dear Participant:

As part of the research study, sometime during the week prior to our meeting face-to-face, there is an exercise I would like you to spend no more than 2 hours completing. If it has been some time since you were in nursing school there may be some experiences you won't readily remember related to learning. This exercise is meant to restore some memories of learning while you were in nursing school. Physically you can go to the nursing school and sit in a classroom, visit with faculty, or just walk the halls. You could also return to clinical settings to help you remember what learning for you was like. As you remember both the positive and negative experiences of learning, you can write them down or journal about them and bring this journal or comments written down to the interview. You do not have to answer any or all of the following questions. They are provided to you to help with reflection and memory restoration.

Some questions you might ask yourself:

- How was learning different for me than for my peers?
- What experiences stand out from learning through group activities?
- How did your teachers support your learning? What was helpful; what was not?
- What did I enjoy most about learning in the nursing program I graduated from?
- What did I find most disturbing about learning in the program I graduated from?
- What was my approach to learning in the nursing school environment?
- How did I approach learning in the clinical setting? Was it different than my peers?

Appendix M

Human Subjects Approval Request

South Dakota State University

_____Exempt ___X__Expedited Review _____Committee Review

1. Principal investigator/researcher _Marcia Scherer_____ Phone No. _612-859-2801_____

E-mail address of researcher _marcia.scherer@jacks.sdstate.edu

____Faculty__X__Graduate Student____Undergraduate Student____Not SDSU Researcher

If student, faculty advisors Dr. Linda Herrick (SDSU) and Dr. Lynnette Leeseberg Stamler (UNMC)

College/School _South Dakota State University Graduate School_ Department _Nursing (PhD)

(Please use an additional sheet to list names and contact information for others involved with the project.)

2. Project title The Learning Experiences of Immigrants Who Are Graduates of an Entry-Level Baccalaureate Nursing Program in Minnesota

3. Sponsoring agency: currently none

4. Project period (contact with participants): From _10_/1_/2015_ To _9_/30_/2016_

5. Location(s) of study: Minnesota in close proximity to the participants' location

6. Number of human participants to be selected _10-15 total between pilot and formal study together

7. Types of participants to be selected (check all that apply):

X__ Normal Adults ___ Pregnant Women ___ Prisoners

___ Minors ___ Fetuses ___ Mentally Disabled or Delayed

8. Exemption requested? _____ Yes __X___ No

If "yes", indicate basis for exemption. For complete descriptions of the exempt categories of research, see: http://www.sdstate.edu/research/compliance/humansubjects/index.cfm

___Educational Research ___Educational Tests ___Study of Existing Data

___Survey/Interview Research ___Observational Research ___ Food Tasting

(The above do not automatically make a project exempt; it may require expedited or full committee review.)

9. Will any drugs, chemical or biological agents be administered to human subjects?

____ Yes __X__ No *If Yes, include documentation regarding safety from a source other than the manufacturer in METHODS.*

10. Will specimens or samples of tissues, body fluids, or other substances be collected from participants?

____ Yes __X__ No *If Yes, include details of collection, storage, labeling, use, and disposal in METHODS.*

11. Has each investigator involved in the study completed CITI on-line training and filed a copy of

the certificate in the Office of Research and Sponsored Programs? __X__ Yes ____ No

12. ***Research Protocol:*** Complete a description of the proposed study following instructions.

13. ***Informed Consent:*** Attach copies of all forms which will be used to obtain the legally effective informed consent of human subjects or their legal representatives, or justification why informed consent should be altered or waived.

14. ***Additional Materials:*** Attach a copy of all surveys, recruitment materials, and any other relevant documents.

Authorized Signatures:

Principal Investigator __*Marcia Scherer* Date 10/1/2015 I ____ do __X__ do not wish to appear before the committee

Advisor (if student project)_____ Date _____

Department Head or Dean _____ Date _____

Research Protocol

A. **Objectives:**

The profession of nursing recognizes the increasing health disparities that immigrants and refugees settling in the United States (U.S.) experience. One solution to this problem is to grow the number of health care professionals within each distinct cultural population (Fleming, Berkowitz, & Cheadle, 2005; The Sullivan Commission). Numbers of ethnically diverse nurses have not kept pace with the rapid growth within the U.S. of increasing diversity. The U.S. Department of Commerce (2014) revealed that 39% of the U.S. population represents ethnic and racial minorities, while the American Association of Colleges of Nursing (2014) revealed that only 19% of the registered nurses within the U.S. are ethnically diverse. This indicates a 20% discrepancy between number of ethnic and racial minorities populating the U.S. and the number of ethnically diverse registered nurses practicing. Researchers have studied this phenomenon identifying barriers to nursing education and trialing interventions to decrease attrition rates for ethnically diverse nursing students (EDNSs).

Several articles in the nursing literature have addressed barriers that potentially influenced attrition rates of EDNSs. Barriers to EDNSs' learning were identified and extensively published by a variety of authors and include: (a) financial, (b) loneliness, (c) feeling unwelcome, (d) difficulty with English language, (e) pressure to assimilate to white society, (f) overwhelming nursing workload, and (g) lack of support by nurse educators. Once barriers were identified, researchers created and implemented interventions hoping to retain EDNSs in nursing programs.

These interventions were linked with identified barriers, implemented with EDNSs, and studied within programs of nursing that attempted to increase EDNSs graduation rates, passage of the National Council of Licensure Exam for the Registered Nurse (NCLEX-RN), and entrance into the nursing profession. Interventions noted in the literature included: (a) mentoring, (b) community awareness and partnerships, (c) peer or nursing tutors, (d) module development and counseling on success strategies and stress management, (e) cultural competency training for faculty, and (f) linguistic modifications. However, research is remiss in asking the ethnically diverse immigrant who was born in a foreign country, completed an entry-level baccalaureate nursing program (ELBNP) located in Minnesota, and passed the NCLEX-RN what their learning experiences were and successful and unsuccessful strategies employed. The research studies examined in depth did not include nursing students in an ELBNP who were foreign-born. For example, Central Minnesota has a large population of resident Somali immigrants and refugees, yet only one Somali has graduated from Saint Cloud State University's (SCSU) ELBNP since the first cohort completed the program in 2004. To understand why with barriers identified and interventions and strategies trialed, this investigator will ask questions of participants that have not been asked of them before.

Thus, the research questions for this qualitative hermeneutic phenomenological research study are:

1. What are the overall learning experiences of ethnically diverse immigrant registered nurses (EDIRNs) who have graduated from a private or public ELBNP in Minnesota within 3 years?

2. What were the strategies employed by the EDIRN to complete the nursing program?
3. What helped or hindered the EDIRN in completing their nursing program?

The purpose of this qualitative hermeneutic phenomenological study is to understand the learning experiences of EDIRNs and their strategies to successfully complete an ELBNP in Minnesota, while introducing a new perspective and information from EDIRNs to the state of nursing science.

B**. Participants:**

A purposive sample of participants who are EDIRNs and have graduated within the last 3 years from an ELBNP in Minnesota will be sought. Interviewing recently graduated EDIRNs offers the participant the opportunity to readily recollect their experiences in their nursing program. Minnesota has 12 private and six public schools offering an ELBNP. One to five consenting EDIRNs who have graduated within the last 3 years from SCSU will be asked to participate in a "pilot" study and will participate in an unstructured interview. This will allow the principal investigator to trial the interview questions and interpret transcripts. Graduates of SCSU completed in the pilot study may be included in the formal study if the interview produces stories similar to stories as told by interviews completed within the formal study.

According to Langdridge (2007), hermeneutic phenomenology is conducted with specific individuals who meet certain homogenous characteristics which are outlined in the inclusion and exclusion criteria. Criteria for inclusion into the study are crucial in attempting a correct sampling of EDIRNs. For this study, the EDIRN refers to a foreign-born person who enters the U.S. legally and has completed a bachelor's program in nursing and has been licensed as a registered nurse. The EDIRN must self-identify as entering the U.S. as a child or adult. Registered nurse corresponds with a healthcare provider who has completed their nursing education in the U.S., specifically Minnesota within the last 3 years for this study, passed the NCLEX-RN as verified by the Minnesota Board of Nursing, and currently works as a registered nurse. The EDIRN must reside in Minnesota to participate in this study.

The pilot study will consist minimally of 1-5 participants graduated within the last 3 years from the SCSU nursing program. Every effort will be made in the formal study to singularly dialogue with a minimum of six participants who are not graduates of SCSU. By selective sampling, the investigator hopes to identify the learning struggles and successful strategies that EDIRNs' experienced in their ELBNP.

C. **Time Required for Individual Participants:**

The time required for the participant has several components including recruitment, preparation for the interview, and the interview. The phone calls or e-mail responses to eligibility requirements and setting up a time to meet is anticipated to take about 5 minutes of time. The participant will be asked to complete a 2-hour maximum preparation time the week prior to the scheduled meeting by reminiscing about learning experiences when in their nursing program and writing notes in preparation for the interview. Lastly, a 1 to 2 hour in person meeting will consist of reviewing and

signing of the consent form, completion of the demographic survey, and the interview about their learning experiences.

D. **Compensation to Participants:**

Upon completion of the entire study process, the participant will receive a $40.00 Amazon gift card. The participate will need to respond to eligibility questions through phone calls or e-mails, agree on a time and place for the face-to-face meeting with the investigator, come to the agreed upon meeting, sign the consent form, complete the demographic survey, and finish the 1-2 hour interview.

E. **Benefits to Participants:**

Benefits include the opportunity to tell their story and know that this information could benefit future EDINSs and EDNSs by creating, trialing, and instituting improved teaching strategies.

F. **Methods:**

Hermeneutic phenomenology is a philosophy and methodology further developed by Heidegger and Gadamer's philosophical views. Using this methodology will introduce new information and an understanding about immigrants' learning experiences in an ELBNP in Minnesota into nursing science. This study will clarify the barriers and successful and unsuccessful interventions to learning that EDIRNs' have identified and used in their ELBNP. This method was chosen because all current literature reviewed from 1990-2015 does not specify the populations studied as immigrants, but rather use terms like "ethnically diverse," ethnic minorities," and "minorities."

The hermeneutic phenomenologists, Heidegger and Gadamer, argue that to begin any scientific research study, the investigator needs to first understand the phenomenon before contemplating further research. This is done by being attentive or "being present" through immersion in dialogue. Heidegger wrote, "*Language*, whether spoken or held in silence is the primary and broadest humanization of beings….and thereby the grounding of *Dasein*" or being there (1989/1999, p. 359). Gadamer agreed with Heidegger that thought from the mind and spirit encompasses true Being only in conversation with others (Gadamer, 1960/2004; Heidegger, 1989/1999). Through language, the "world" is revealed to all human beings who dialogue with each other. "For language is by nature the language of conversation; it fully realizes itself only in the process of coming to an understanding" (Gadamer, 1960/2004, p. 443). Heidegger (1927/1962) wrote that a conversational interpretation is not understanding, but "rather the working-out of possibilities projected in understanding" (p. 189). Gadamer expounded further by the addition of interpretation of the dialogue post-interview, "Understanding occurs in interpreting" (1960/2004, p. 390).

This hermeneutic phenomenological study will utilize a sample of EDIRNs and in-depth interviews to identify educational strategies that were helpful or hindered their ability to learn. Information will be collected through the demographic survey and individual interviews.

The investigator will contact potential participants who respond to the invitation sent out from the deans or department chairs in the universities and chief nursing officer or nurse managers at large teaching hospitals, or who are referred by another person who participated or received an invitation.

Through an e-mail or a phone call to the potential participant the investigator will review the eligibility criteria and seek their willingness to participate.

During the second e-mail or phone call contact, the participant will be asked to complete a contemplation exercise during the week prior to the interview reflecting on their positive and negative learning experiences in their nursing program. Since the study asks for a recall over a possible 3-year period, this exercise is recommended to enhance the recall process for the participant. The investigator will suggest to the participant to flip through textbooks used, notes taken, reminisce with alumni classmates, return to a clinical setting, and may even want to return to the nursing rooms on campus to serve as memory triggers.

How the investigator represents herself as a researcher and someone U.S.-born can greatly impact the participant responses and demeanor (Fontana & Frey, 2005). Participant responses can also be influenced by the way the investigator dresses and the attitude displayed. The investigator will wear business casual clothing and appear calm and relaxed.

After consent is obtained in the face-to-face meeting, the participant will be asked to complete the demographic form prior to the interview. This interview will take approximately 1 to 2 hours. The interview will be recorded using Soniclear as the primary digital recorder and transcription software with a tape recorder as a backup. Each participant unstructured interview will begin with this lead-in statement, "Understanding your learning experiences in nursing school is important to me. Please tell me about your learning experiences in nursing school." Another statement that may elicit more stories include: "What was the learning experience like being a nursing student?" From this beginning point, questions and statements to encourage more in-depth discussion about their experience include (Munhall, 2012):

1. Please give me an example of that.
2. Tell me about your main concerns when learning.
3. Describe your strong learning experiences.
4. What did that do for you?
5. Please elaborate more on that.

By using these types of qu estions and statements, the investigator eliminates interjections or pre-conceived notions into the participant's experience (Munhall, 2012). The interviews will be transcribed by the investigator as soon as possible after completion, while the interview prominently resounds in the investigator's mind.

The investigator will keep a journal for field notes of the experience by recording reflections and observations of the participant in documenting the participant's appearance and attitude. A journal offers congruency between verbal language and body language. A written journal also allows the investigator to explore and write thoughts and self-observations before and after each of the interviews to increase awareness of self "biases, prejudice, preconceptions, stereotypes, and assumptions" (Munhall, 2012, p. 138).

The journal for the investigator becomes a mainstay in conducting a process known as reflexivity (Clancy, 2013). Reflexivity allows the investigator to reflect on perceived ideas, assumptions, thoughts, and reactions to become aware of the investigator's values and beliefs (2013). Coming to understand self is necessary to eliminate thoughts of prejudice and disbelief to truly understand the participant's experience.

Following this dialogue, the interview will be transcribed, and the texts will be interpreted by the investigator incorporating the hermeneutic circle and the journaling, an understanding of self and biases, and ultimately understanding Being through the EDIRN's experiences. Analysis of the text through interpretation will be completed using the three steps of Benner (1985) and Leonard (1994), common themes, exemplars, and paradigm cases. See Appendices A through E for the following: diagram of method/procedure, letter to dean or nursing department chairs, letter to chief nursing officer or director of nursing, letter of invitation to participants, and demographic survey.

Typed transcripts of the interviews and the interpretive analysis will be shared with two other hermeneutic phenomenologists, Dr. Mary Isaason and Dr. Audrey Poorbear, who are not affiliated with any Minnesota schools of nursing or healthcare facilities and have completed at least one hermeneutic phenomenological study based in Gadamer's philosophy. They will assist in interpretation of the pilot data to assure accurate interpretation of study data.

G. **Risks to Participants:**

Risks to participating in this qualitative study will be presented to each participant verbally and in the consent. A potential risk for participants' is reliving unpleasant memories they had in nursing school, which may include situations of discrimination or misunderstandings between themselves, peers, nursing educators, tutors, preceptors, and administrative personnel. If, after reading the information, the participant agrees to engage in the study, then, the information sheet and consent will be verbally reviewed and signed by the participant immediately before the participant completes the demographic survey and interview.

H. **Risk Reduction:**

If reliving a painful experience results in emotional distress such as crying, the investigator will respond by allowing time for composure and ask if the participant would like to continue or end the interview. The participant will be assured that they can withdraw from the study at any time without penalty or retaliation. The participant will be directed to their employee assistance program if they would like to meet with a counselor.

I. **Confidentialit**y:

The typed transcripts of the interviews and the interpretive analysis will be shared with two other hermeneutic phenomenologists, Dr. Mary Isaacson and Dr. Audrey Auer, who are not affiliated with any Minnesota schools of nursing or healthcare facilities and have completed at least one hermeneutic phenomenological study based in Gadamer's philosophy. The typed transcripts will be discussed, specifically those interviews from the pilot study to assure accurate interpretation. The demographic

information, consent forms, and digital and audiotapes will not be shared.

The information from the demographic survey, consent forms, interviews using digital and audiotapes, typed transcripts, and interpreted analysis will not be shared with any other faculty member, staff, or administration within SCSU, with deans or department chairs at the EDIRN's place of graduation, or with nurse managers, director of nursing, or chief nursing officers where they are employed. All information received such as consent forms, demographic surveys, the Soniclear digital recordings, audiotapes from the back-up recorded interviews, typed transcripts, and written analyses will be kept stored in a safe in the investigator's home office. Transcribed interviews and written analyses will be saved on a jump-drive and a read-only CD-ROM that will also be kept in the investigator's home office safe.

Conversations with the dissertation chairs, the hermeneutic phenomenological group, dissertation committee, and all written reports will only use the pseudonym names chosen by the participants. The personal data stored in the home office locked safe will be destroyed 3 years after conclusion of the dissertation. The potential date for completion of the dissertation defense is September, 2016; thus, destruction of all data will be conducted September, 2019.

J. **Recruitment:**

Due to the provisions of the Family Education Rights and Privacy Act, department chairs or deans of any post-secondary educational institution are unable to provide the names of graduated EDIRNs (U.S. Department of Education, 2015). An e-mail and a formal letter will be sent to the ELBNPs' department chair or dean in the 18 schools with a request to send the invitation to all graduates of their baccalaureate nursing program who have graduated within 3 years (e.g., the graduating classes of 2013, 2014, 2015). Saint Cloud State University will be excluded as the investigator is a faculty member there. The invitation will have the eligibility criteria listed with directions explaining how to contact the researcher if they would desire to be a part of the research study. The investigator will have no names unless and until potential participants contact her.

A second form of recruitment is to network with the chief nursing officers and nurse managers in large healthcare institutions, such as Saint Cloud Hospital, Hennepin County Medical Center, and the University of Minnesota Medical Center Fairview asking them to distribute letters of invitation to all registered nurses in their employ. Again, the investigator will have no names unless and until they contact her. The third recruitment will be achieved through "network sampling," or "snowballing," the researcher recruits more participants through their friends and acquaintances, or by word of mouth (Burns & Grove, 2009, p. 356).

Through an e-mail or a phone call to the potential participant, the investigator will review the eligibility criteria and seek their willingness to participate. During a second e-mail or phone call contact, the participant will be asked to complete a contemplation exercise during the week prior to the interview reflecting on their positive and negative learning experiences in their nursing program. When meeting face-to-face with each participant, the consent form will be read aloud and the

information sheet will be reviewed again. The investigator will answer any questions the participants may have to the participant's satisfaction. Confidentiality will be stressed. When the participant has no more questions, the consent form will be signed, and the participant will receive a copy of the consent form.

Information Sheet

Participation in a Research Project
South Dakota State University
Brookings, SD 57007

Department of _Graduate Nursing Science_

Project Director _Marcia Scherer_____ Phone No. _612-859-2801_____

E-mail marcia.scherer@jacks.sdstate.edu_____ Date _____

Please read (listen to) the following information:

1. This is an invitation for you, a recent graduate from an entry-level baccalaureate nursing program in Minnesota, a registered nurse, and an immigrant, to participate in a research project under the direction of Marcia Scherer. The ethnically diverse immigrant registered nurse for this study is defined as a foreign-born person who enters the U.S. legally on a visa, through employment or a nursing program of study, or as a relative of someone and can become a naturalized citizen after living and working in the U.S. for 5 years (Martin & Midgley, 2006). For this study, registered nurse corresponds with a healthcare provider who has completed their nursing education in Minnesota, has successfully passed the National Council of Licensure Exam for the Registered Nurse, and currently works as a registered nurse in Minnesota.

2. The project is entitled "The Learning Experiences of Immigrants Who Are Graduates of an Entry-Level Baccalaureate Nursing Program in Minnesota."

3. The purpose of the project is to understand the learning experiences of and success strategies used by ethnically diverse immigrant registered nurses who have graduated within the last 3 years from an entry-level baccalaureate nursing program in Minnesota.

4. If you consent to participate, you will be involved in the following process, which will take about 2-4 hours of your time:

Once you have responded to the initial call for participants, the researcher, Marcia, will call or send you an e-mail asking specific questions to evaluate if you meet the criteria set for the interview. Marcia will then send you an e-mail inviting you to participate, along with an information sheet, a copy of the consent form, and questions to think about 1 week prior to the scheduled interview. Together, through phone calls and/or e-mails, a discrete, calm, and quiet place, will be identified which could be your home where a private conversation can occur, read and sign the consent form, and answer any further questions you may about the research study have without distractions. One week prior to the scheduled meeting, you will reflect on your experiences while in nursing school over a maximum timeframe of 1-2 hours. Please write notes down to prepare for the interview. At the interview time, you will complete a verbal and written consent form and a short demographic survey at the single face-to-face interview. The 1-2 hour interview will be recorded using a digital computer recorder and an audiotape recorder.

5. Participation in this project is voluntary. You have the right to withdraw at any time without penalty. This will not affect your current employment or future employment. If you have any questions, you may contact the project director at the number listed above.
6. The research has no physical risks to you. This study has the same amount of emotional risk you might experience when you share in a conversation or information with another person. The possible risk to you in completing this research study is the possibility that you will relive unpleasant memories you experienced in nursing school that were sad, frustrating, and anxiety producing. Other areas that may be potentially emotionally tasking may be situations of discrimination and misunderstandings between you, your peers, and nurse educators. If you find yourself or Marcia observes you becoming overwrought with emotions, Marcia will stop the interview and allow you to continue if you desire when you are able or the interview can conclude. If you desire counseling, you will be directed to the Employee Assistance Program where you work.
7. Benefits to you include the opportunity to tell your story and know that this information could benefit future ethnically diverse immigrant nursing students and racially and ethnically diverse nursing students leading to creating, trialing, and instituting improved teaching strategies.
8. You will receive a $40.00 Amazon gift card as compensation for your complete participation in this study. However, there will be no reimbursement for travel or parking to attend the interview.
9. Your responses are strictly confidential. When the data and analysis are presented, you will not be linked to the data by your name, title, or any other identifying item. The pseudonym you choose for yourself will be used in the data and analyses. Two hermeneutic phenomenological specialists will be reading the typed interview transcripts to help the researcher, Marcia, understand the meaning you are conveying. The analysis conducted by the researcher on the interview data will also be shared with the two specialists.
10. As a research participant, I have read the above and have had any questions answered. I will receive a copy of this information sheet to keep.

If you have any questions regarding this study you may contact the Project Director. If you have questions regarding your rights as a participant, you can contact the SDSU Research Compliance Coordinator at (605) 688-6975 or SDSU.IRB@sdstate.edu.

This project has been approved by the SDSU Institutional Review Board, Approval No.:

Participant Consent Form

Participation in a Research Project
South Dakota State University
Brookings, SD 57007

Department of _Nursing Graduate Program (PhD student)

Project Director Marcia Scherer_____ Phone No. 612-859-2801_____

E-mail marcia.scherer@jacks.sdstate.edu and mlscherer@stcloudstate.edu Date _8/3/2015__

Please read (listen to) the following information:

1. This is an invitation for you, a recent graduate from an entry-level baccalaureate nursing program in Minnesota, a registered nurse, and an immigrant to participate in a research project under the direction of Marcia Scherer.
2. The project is titled, "The Learning Experiences of Immigrants Who Are Graduates of an Entry-Level Baccalaureate Nursing Program in Minnesota."
3. The purpose of the project is to understand the learning experiences of and success strategies used by ethnically diverse immigrant registered nurses who have graduated within the last 3 years from an entry-level baccalaureate nursing program in Minnesota.
4. If you consent to participate, you will be involved in the following process, which will take about 2-4 hours of your time:

Once you have responded to the initial call for participants, the researcher, Marcia, will call or send you an e-mail asking specific questions to evaluate if you meet the criteria set for the interview. Marcia will then send you an e-mail inviting you to participate, along with an information sheet, a copy of the consent form, and questions to think about 1 week prior to the scheduled interview. Together, through phone calls and/or e-mails, a discrete, calm, and quiet place will be identified where a private conversation can occur, read and sign the consent form, and answer any further questions you may about the research study have without distractions. One week prior to the scheduled meeting, you will reflect on your experiences while in nursing school over a maximum timeframe of 1-2 hours. Please write notes down or journal to prepare for the interview. Then, you will fill out a short demographic survey upon completion of the verbal and written consent which will be accomplished at the single face-to-face interview. The 1-2 hour interview will then commence using a digital computer recorder and an audiotape.

5. Participation in this project is voluntary. You have the right to withdraw at any time without penalty. This will not affect your current employment or future employment. If you are a nursing student participating in the pilot study, your course grades will not be affected. If you have any questions, you may contact the project director at the number listed above.
6. The research has no physical risks to you. This study has the same amount of emotional risk you might experience when you share in a conversation or information with another person. The possible risk to you in completing this research study is the possibility that you will relive unpleasant memories you experienced in nursing school that were sad, frustrating, and anxiety producing. Other

areas that may be potentially emotionally tasking may be situations of discrimination and misunderstandings between you, your peers, and nurse educators. If you find yourself or Marcia observes you becoming overwrought with emotions, Marcia will stop the interview and allow you to continue if you desire when you are able or the interview can conclude. If you desire counseling, you will be directed to the Employee Assistance Program where you work.

7. Benefits to you include the opportunity to tell your story and know that this information could benefit future ethnically diverse immigrant nursing students and racially and ethnically diverse nursing students leading to creating, trialing, and instituting improved teaching strategies.

8. You will receive a $40.00 Amazon gift card as compensation for your complete participation in this study. However, there will be no reimbursement for travel or parking to attend the interview.

9. Your responses are strictly confidential. When the data and analysis are presented, you will not be linked to the data by your name, title, or any other identifying item. The pseudonym you choose for yourself will be used in the data and analyses. Two hermeneutic phenomenological specialists will be reading the typed interview transcripts to help the researcher, Marcia, understand the meaning you are conveying. The analyses conducted by the researcher on the interview data will also be shared with the two specialists. The nursing school faculty, staff, and administration and anyone from your employer will not have access to your interview, working interpretations, and ongoing analyses at any point during the research project. You will also be referred to by your pseudonym in the research process and the final documents.

As a research participant, I have read the above, have had any questions answered, and agree to participate in the research project. I will receive a copy of this consent form for my information.

Participant's Signature _____ Date _____

Project Director's Signature _____ Date _____

If you have any questions regarding this study you may contact the Project Director. If you have questions regarding your rights as a participant, you can contact the SDSU Research Compliance Coordinator at (605) 688-6975 or SDSU.IRB@sdstate.edu.

This project has been approved by the SDSU Institutional Review Board, Approval No.: IRB-1510008-EXM

Human Subjects Committee - Checklist

South Dakota State University

COMPLETE by checking all appropriate items and INCLUDE THIS SHEET IN ALL SUBMISSIONS

Project Director: ___Marcia Scherer___

Project Title: The Learning Experiences of Immigrants Who Have Graduated from an Entry-Level Baccalaureate Nursing Program In Minnesota

1. _x_ Does the title of the study appear and match the title used throughout the proposal?

INVITATION TO PARTICIPATE

2. _x_ Does the consent form begin with a clear invitation to participate?
3. _x_ Is there a description of who participants will be; how they were selected?

PURPOSE

4. _x_ Is there a clear statement of the purpose of the research?
5. _x_ Does it state who is conducting the research?
6. _x_ Does the consent form state that participation is voluntary?
7. _x_ Is it stated that the participant may withdraw without penalty?

PROCEDURES

8. _x_ Is the explanation of procedures adequate?
9. _x_ Are copies of the instruments attached?
10. _x_ Has permission to use instruments been obtained, if was developed by someone else?
11. _x_ Does it state amount of time the participant will be involved?

BENEFITS

12_x_ Is the statement of potential benefits complete?

COMPENSATION

13. x__ Is the availability of compensation stated?
14. _x_ Is there any cost to the participants?
15. _x_ Is there compensation in case of injury?
16. _x_ Is there alternative treatment available?
17. _x_ Is there a statement on emergency medical treatment (for more than minimal risk studies)?

RISKS

18. _x_ Is the description of the potential risks and discomforts complete?
19. _x_ Are methods of risk reduction in place? (i.e., referral in case of upset due to questions asked)
20. _x_ Does it state that the investigator may remove a participant from the study if it is in their best interest?

CONFIDENTIALITY

21. _x_ Is the assurance of confidentiality, when applicable clear and complete?
22. _x_ Is the FDA access (or other access) to research records statement included, if applicable?
23. x__ Has the participant had an opportunity to ask questions and they have been provided with contact information should they questions in the future?
24. _x_ Does it state that participants will receive a copy of the consent form?

SIGNATURES

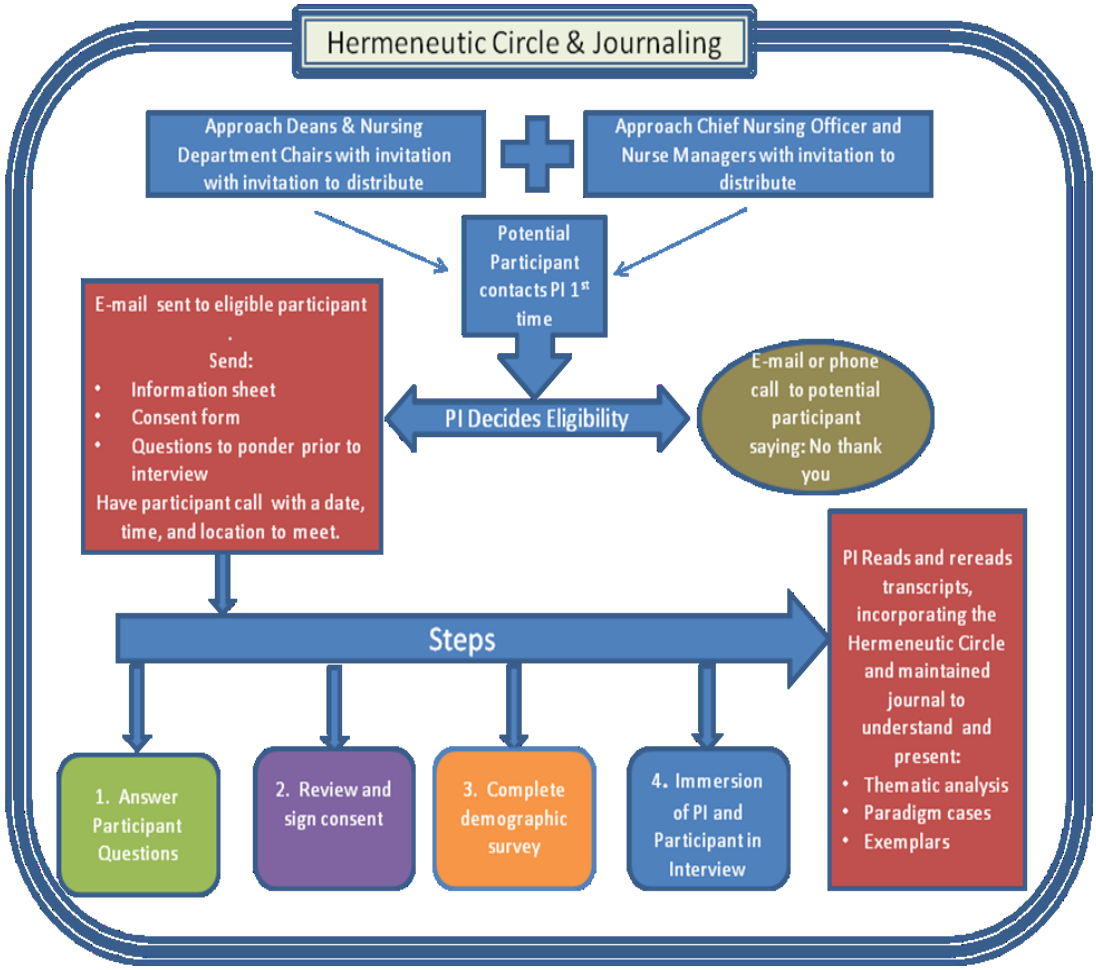
25. _x_ Are there dated subject and investigator blanks?

GENERAL QUESTIONS

26. _x_ Is the investigator's name and phone number on the form (i.e., signature block)
27. _x_ Is the consent form written in "lay language"?
28. _x_ Is the consent form free of any exculpatory language? (That is, no PI can claim that they are not responsible for anything that happens to a participant do to their participation in

their study).
29. _NA_ If children are included as subjects, is provision made for securing the assent of the child and the consent of the parent/guardian?
30. __ Has permission been obtained from schools, agencies involved?
31. _x_ What is the overall risk classification? Minimal? Greater than minimal?

PROTOCOL QUESTIONS
32. __ Do you have any major questions pertaining to the protocol (indicate on back with page # and section referenced)?


Hermeneutic Circle & Journaling
Approach Deans & Nursing Department Chairs with invitation with invitation to distribute
Approach Chief Nursing Officer and Nurse Managers with invitation to distribute
Potential Participant contacts PI 1st time
E-mail sent to eligible participant .
Send:
• Information sheet
• Consent form
• Questions to ponder prior to interview
Have participant call with a date, time, and location to meet.
PI Decides Eligibility
E-mail or phone call to potential participant saying: No thank you
Steps
1. Answer Participant Questions
2. Review and sign consent
3. Complete demographic survey
4. Immersion of PI and Participant in Interview
PI Reads and rereads transcripts, incorporating the Hermeneutic Circle and maintained journal to understand and present:
• Thematic analysis
• Paradigm cases
• Exemplars

Appendix N

Approval Letter from South Dakota State University IRB

South Dakota State University

Office of Research/Human Subjects Committee
SAD Room 200
Box 2201 SDSU
Brookings, SD 57007

To: Marcia Scherer, College of Nursing

Date: October 20, 2015

Project Title: The Learning Experiences of Immigrants Who are Graduates of an Entry-Level Baccalaureate Nursing Program in Minnesota

Approval #: IRB-1510008-EXM

Thank you for taking such care in completion of the request and research protocol. This activity is approved as exempt human subjects' research. The basis for your exempt status from 45 CFR 46.101 (b) is:

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

If there are any unanticipated problems involving risks to subjects or others, or changes in the procedures during the study, contact the SDSU Research Compliance Coordinator. At the end of the project please inform the committee that your project is complete.

If I can be of any further assistance, don't hesitate to let me know.

Sincerely,

Norm

Norman O. Braaten
SDSU Research Compliance Coordinator

Appendix O

Agreement Authorization with Saint Cloud State University

Institutional Review Board (IRB) Authorization Agreement

Use when SCSU relying on IRB review of another institution

Institution Providing IRB Review (Institution A): South Dakota State University

IRB Registration#: 00001132 Federalwide Assurance (FWA) #: 00000663

Institution Relying on the Designated IRB (Institution B : St. Cloud State University

IRB Registration #: 00001841 Federalwide Assurance (FW A) #: 00002648

The Officials signing below agree that St. Cloud State University may rely on the designated IRB for review and continuing oversight of its human subjects research described below: *(check one)*

- ☐ This agreement applies to all human subjects research covered by Institution B's FWA.
- ☐ This agreement is limited to the following specific protocol(s):

Research Project Title: The Learning Experiences of Immigrants who are Graduates of an Entry-Level Baccalaureate Nursing Program in Minnesota
Principal Investigator(s): Marcia Scherer
Sponsor/Funding Agency: n/a Award#: _____
- ☐ Other (describe): __

The review performed by the designated IRB will meet the human subject protection requirements of Institution B's OHRP-approved FWA. The IRB at Institution A will follow written procedures for reporting its findings and actions to appropriate officials at Institution B. Relevant minutes of IRB meetings will be made available to Institution B upon request. Institution B remains responsible for ensuring compliance with the IRB's determinations and with the Terms of its OHRP-approved FWA. This document must be kept on file by both parties and provided to OHRP upon request.

Signature of Signatory Official - Institution A:

_____ Date: 10-30-2015

Kevin D. Kephart, PhD.
Vice President for Research and Economic Development
South Dakota State University

Signature of Signatory Official - Institution B:

_____ Date: 11/5/15

Dr. Marilyn Hart
Interim Associate Provost for Research
St. Cloud State University
720 4th Avenue South AS210
St. Cloud, MN 56301

Appendix P

Study Information Sheet

Information Sheet

Participation in a Research Project
South Dakota State University
Brookings, SD 57007

Department of _Graduate Nursing Science_

Project Director _Marcia Scherer_____ Phone No. _612-859-2801_____

E-mail marcia.scherer@jacks.sdstate.edu_____ Date 2/1/2016

Please read (listen to) the following information:

1. This is an invitation for you, a recent graduate from an entry-level baccalaureate nursing program in Minnesota, a registered nurse, and an immigrant, to participate in a research project under the direction of Marcia Scherer. The ethnically diverse immigrant registered nurse for this study is defined as a foreign-born person who enters the U.S. legally on a visa, through employment or a nursing program of study, or as a relative of someone and can become a naturalized citizen after living and working in the U.S. for 5 years (Martin & Midgley, 2006). For this study, registered nurse corresponds with a healthcare provider who has completed their nursing education in Minnesota, has successfully passed the National Council of Licensure Exam for the Registered Nurse, and currently works as a registered nurse in Minnesota.
2. The project is entitled "The Learning Experiences of Immigrants Who Are Graduates of an Entry-Level Baccalaureate Nursing Program in Minnesota."
3. The purpose of the project is to understand the learning experiences of and success strategies used by ethnically diverse immigrant registered nurses who have graduated within the last 3 years from an entry-level baccalaureate nursing program in Minnesota.
4. If you consent to participate, you will be involved in the following process, which will take about 2-4 hours of your time:

   Once you have responded to the initial call for participants, the researcher, Marcia, will call or send you an e-mail asking specific questions to evaluate if you meet the criteria set for the interview. Marcia will then send you an e-mail inviting you to participate, along with an information sheet, a copy of the consent form, and questions to think about 1 week prior to the scheduled interview. Together, through phone calls and/or e-mails, a discrete, calm, and quiet place, will be identified which could be your home where a private conversation can occur, read and sign the consent form, and answer any further questions you may about the research study have without distractions. One week prior to the scheduled meeting, you will reflect on your experiences while in nursing school over a maximum timeframe of 1-2 hours. Please write notes down to prepare for the interview. At the interview time, you will complete a verbal and written consent form and a short demographic survey at the single face-to-face interview.

The 1-2 hour interview will be recorded using a digital computer recorder and an audiotape recorder.

5. Participation in this project is voluntary. You have the right to withdraw at any time without penalty. This will not affect your current employment or future employment. If you have any questions, you may contact the project director at the number listed above.
6. The research has no physical risks to you. This study has the same amount of emotional risk you might experience when you share in a conversation or information with another person. The possible risk to you in completing this research study is the possibility that you will relive unpleasant memories you experienced in nursing school that were sad, frustrating, and anxiety producing. Other areas that may be potentially emotionally tasking may be situations of discrimination and misunderstandings between you, your peers, and nurse educators. If you find yourself or Marcia observes you becoming overwrought with emotions, Marcia will stop the interview and allow you to continue if you desire when you are able or the interview can conclude. If you desire counseling, you will be directed to the Employee Assistance Program where you work.
7. Benefits to you include the opportunity to tell your story and know that this information could benefit future ethnically diverse immigrant nursing students and racially and ethnically diverse nursing students leading to creating, trialing, and instituting improved teaching strategies.
8. You will receive a $40.00 Amazon gift card as compensation for your complete participation in this study. However, there will be no reimbursement for travel or parking to attend the interview.
9. Your responses are strictly confidential. When the data and analysis are presented, you will not be linked to the data by your name, title, or any other identifying item. The pseudonym you choose for yourself will be used in the data and analyses. Two hermeneutic phenomenological specialists will be reading the typed interview transcripts to help the researcher, Marcia, understand the meaning you are conveying. The analysis conducted by the researcher on the interview data will also be shared with the two specialists.
10. As a research participant, I have read the above and have had any questions answered. I will receive a copy of this information sheet to keep.

If you have any questions regarding this study you may contact the Project Director. If you have questions regarding your rights as a participant, you can contact the SDSU Research Compliance Coordinator at (605) 688-6975 or SDSU.IRB@sdstate.edu.

This project has been approved by the SDSU Institutional Review Board, Approval No.: 1510008-EXM

Appendix Q

Consent Form

Participation in a Research Project
South Dakota State University
Brookings, SD 57007

Department of _Nursing Graduate Program (PhD student)

Project Director Marcia Scherer_____ Phone No. 612-859-2801_____

E-mail marcia.scherer@jacks.sdstate.edu and mlscherer@stcloudstate.edu_____Date _8/3/2015__

Please read (listen to) the following information:

1. This is an invitation for you, a recent graduate from an entry-level baccalaureate nursing program in Minnesota, a registered nurse, and an immigrant to participate in a research project under the direction of Marcia Scherer.
2. The project is titled, "The Learning Experiences of Immigrants Who Are Graduates of an Entry-Level Baccalaureate Nursing Program in Minnesota."
3. The purpose of the project is to understand the learning experiences of and success strategies used by ethnically diverse immigrant registered nurses who have graduated within the last 3 years from an entry-level baccalaureate nursing program in Minnesota.
4. If you consent to participate, you will be involved in the following process, which will take about 2-4 hours of your time:

   Once you have responded to the initial call for participants, the researcher, Marcia, will call or send you an e-mail asking specific questions to evaluate if you meet the criteria set for the interview. Marcia will then send you an e-mail inviting you to participate, along with an information sheet, a copy of the consent form, and questions to think about 1 week prior to the scheduled interview. Together, through phone calls and/or e-mails, a discrete, calm, and quiet place will be identified where a private conversation can occur, read and sign the consent form, and answer any further questions you may about the research study have without distractions. One week prior to the scheduled meeting, you will reflect on your experiences while in nursing school over a maximum timeframe of 1-2 hours. Please write notes down or journal to prepare for the interview. Then, you will fill out a short demographic survey upon completion of the verbal and written consent which will be accomplished at the single face-to-face interview. The 1-2 hour interview will then commence using a digital computer recorder and an audiotape.
5. Participation in this project is voluntary. You have the right to withdraw at any time without penalty. This will not affect your current employment or future employment. If you are a nursing student participating in the pilot study, your course grades will not be affected. If you have any questions, you may contact the project director at the number listed above.
6. The research has no physical risks to you. This study has the same amount of emotional risk you might

experience when you share in a conversation or information with another person. The possible risk to you in completing this research study is the possibility that you will relive unpleasant memories you experienced in nursing school that were sad, frustrating, and anxiety producing. Other areas that may be potentially emotionally tasking may be situations of discrimination and misunderstandings between you, your peers, and nurse educators. If you find yourself or Marcia observes you becoming overwrought with emotions, Marcia will stop the interview and allow you to continue if you desire when you are able or the interview can conclude. If you desire counseling, you will be directed to the Employee Assistance Program where you work.

7. Benefits to you include the opportunity to tell your story and know that this information could benefit future ethnically diverse immigrant nursing students and racially and ethnically diverse nursing students leading to creating, trialing, and instituting improved teaching strategies.
8. You will receive a $40.00 Amazon gift card as compensation for your complete participation in this study. However, there will be no reimbursement for travel or parking to attend the interview.
9. Your responses are strictly confidential. When the data and analysis are presented, you will not be linked to the data by your name, title, or any other identifying item. The pseudonym you choose for yourself will be used in the data and analyses. Two hermeneutic phenomenological specialists will be reading the typed interview transcripts to help the researcher, Marcia, understand the meaning you are conveying. The analyses conducted by the researcher on the interview data will also be shared with the two specialists. The nursing school faculty, staff, and administration and anyone from your employer will not have access to your interview, working interpretations, and ongoing analyses at any point during the research project. You will also be referred to by your pseudonym in the research process and the final documents.

As a research participant, I have read the above, have had any questions answered, and agree to participate in the research project. I will receive a copy of this consent form for my information.

Participant's Signature _____ Date _____

Project Director's Signature _____ Date _____

If you have any questions regarding this study you may contact the Project Director. If you have questions regarding your rights as a participant, you can contact the SDSU Research Compliance Coordinator at (605) 688-6975 or SDSU.IRB@sdstate.edu.

This project has been approved by the SDSU Institutional Review Board, Approval No.: IRB-1510008-EXM