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## Physicians Among Us: The Lived Experience of Unlicensed Foreign Born and Educated Physicians Present in the US as they Retrain for Non-Physician Primary Care Roles.

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FLORIDA INTERNATIONAL UNIVERSITY

Miami, Florida

PHYSICIANS AMONG US: THE LIVED EXPERIENCE OF UNLICENSED  
FOREIGN BORN AND EDUCATED PHYSICIANS PRESENT IN THE UNITED  
STATES AS THEY  
RETRAIN FOR NON-PHYSICIAN PRIMARY CARE ROLES

A dissertation submitted in partial fulfillment of

the requirements for the Degree of

DOCTOR OF EDUCATION

in

ADULT EDUCATION AND HUMAN RESOURCE DEVELOPMENT

by

Dwight N. Nimblett

2022

To: Dean Michael Heithaus  
College of Arts, Science and Education

This dissertation, written by Dwight Nimblett, and entitled Physicians Among Us: The Lived Experience of Unlicensed Foreign Born and Educated Physicians Present in the US as They Retrain for Non-Physician Primary Care Roles, having been approved in respect to style and intellectual content, is referred to you for judgment.

We have read this dissertation and recommend that it be approved.

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Date of Defense: March 30, 2022

This dissertation of Dwight Nimblett is approved

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Dean Michael Heithaus  
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Andrés G. Gil  
Vice President for Research and Economic Development  
and Dean of the University Graduate School

Florida International University, 2022

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ABSTRACT OF THE DISSERTATION

PHYSICIANS AMONG US: THE LIVED EXPERIENCE OF UNLICENSED  
FOREIGN BORN AND EDUCATED PHYSICIANS PRESENT IN THE US AS THEY  
RETRAIN FOR NON-PHYSICIAN PRIMARY CARE ROLES

by

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Florida International University, 2022

Miami, Florida

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There are as many as 65,000 unlicensed foreign born and trained doctors across the United States who are credentialed in their home countries but unable to practice in the U.S. The primary goal of this study was to describe and understand an understudied human experience: the lived experience of unlicensed foreign educated physicians who are present in the U.S. as they retrain for non-physician primary care roles. The theoretical framework undergirding the study is Jack Mezirow's Transformative Learning Theory (TL), also referred to as Perspective Transformation. Otherness and Liminality Theories offer peripheral perspectives to the study.

Seven FEPs were purposively sampled and chosen. A ten-questionnaire instrument was developed. While site selection was an important consideration during the initial iteration of the methodology, due to disruption by the COVID-19 pandemic, interviews were conducted using ZOOM video conferencing technology. Participants were interviewed once using the semi-structured interview protocol.

Data were collected via 45-70 minute one-on-one interviews. A coding table was designed for use in this study. The column headings included the participants' pseudonym, direct quotes, units of meaning, deductive quotes, and notes. A separate table was used for each participant. As units of meaning emerged from the direct quotes, they were coded and organized by topic.

From the topics, three main themes were generated (a) Migratory Patterns of FEPs (b) Beliefs about Obstacles and Challenges, and (c) Beliefs about Reclaiming the Self. The data were inductively and deductively thematically analyzed. Validity and Reliability were promoted by use of Member Checking, use of Rich, Thick Description, Theoretical Triangulation, and Clarifying Bias (bracketing & reflectivity).

Results revealed that FEPs all experienced, though to varying degrees, all ten phases of Transformative Learning. Participants also, without exception experienced feelings of ambiguity, translocal identity, and self-doubt, particularly during the BSN phase of the BSN to MSN program. These feelings were all characteristic of Transformative, Othered and Liminal experiences.

Findings also revealed that participants experienced a reclamation of the self, having endured the threshold, liminal, and othered encounters. Both Theory and Practice may be enriched through this research, as TL, Otherness and Liminality theories have not been extended to undergirding research around unlicensed FEPs. Future research is warranted as there are significant gaps in the formulation of a comprehensive body of knowledge around the phenomenon.

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# **CHAPTER I**

## **INTRODUCTION**

The migratory-patterns of health-professionals is a widely encountered phenomenon. In its simplest terms, migratory patterns of highly skilled individuals are a combination of their aspirations to migrate and their ability to do so (Carling & Schewel, 2018). Young et al. (2012) proffer a more complex view of migratory decision making that involves macro, meso, and micro-level factors. The macro-level factors include national economic and sociopolitical concerns; meso-level factors include profession-specific issues such as education/job environment; and micro-level factors point to individual circumstances such as family-ties, language skills, recruitment, and opportunity windows.

Migrants who are more highly educated, in principle, tend to enjoy faster integration into the host labor market and assimilate into the society without magnifying existing tensions among native populations (Brucker et al., 2012). International migration as a concept is made more meaningful as highly skilled individuals encounter territorial, organizational, and conceptual borders of destination states (Geddes & Scholten, 2016).

The United States has always played an important and historical role in the health worker migration story. U.S. physicians travelled to Europe, particularly to Germany and to France, as early as the 1800s, to pursue cutting-edge knowledge and training in the medical arts of the time (Tankwanchi et al., 2019). Consequently, medical practice in the United States was positively impacted when physicians returned with profoundly enhanced knowledge and skills (Rowland, 2010).

Some two centuries later, the phenomenon of physicians arriving to the United States with useful knowledge and skill sets endures, but with exceptions. A great many of the arriving physicians are (a) foreign born, (b) have entered the United States for the first time, and (c) have been medically trained and educated abroad with a foreign conferred medical degree in hand (Tankwanchi et al., 2019). The term most commonly used to describe this category of medical practitioners who hail from diverse countries of origin is *Foreign Educated Physician* (FEP), also known as *Foreign International Medical Graduate* (F-IMG). For the purposes of this study, the term FEP refers to one who was born outside of the United States or its territories and who has also received medical training and his or her degree outside of the United States. FEP is used here separately and distinctly from a United States citizen who travels abroad to be medically trained and educated.

International migration includes flows of refugees, including the highly skilled, spawned by wars and territorial instability; the movement of individuals across borders in search of improved employment opportunities; and the comings and goings of entire families who seek refuge from food insecurity, drought, and other environmental hardships (Boyle, Halfacree, & Robinson, 2014). Geddes and Scholten (2016) distill international migration into four key motives... “to work, to join family, to seek refuge, and to study” (p. 2). A great number of migrants, however, are neither elites, nor are they low-skilled living waged individuals, but rather occupy a middling status position in their countries of origin (Landolt & Thieme, 2018).

The movement of the highly skilled worker also results from the influences of market-based migrant intermediaries (Walton-Roberts, 2020); as a result of the global

growth of free trade; expansion of transnational corporations; as well as concentrated and deliberate recruitment efforts of organizations, institutions and governments (Salt, 1997).

Highly skilled practitioners run the gamut of professions and include architects, engineers, computer scientists, educators, researchers, and healthcare professionals, among others. The term *skilled* may refer to the tacit knowledge (Peroune, 2007) that is encapsulated within the individual, or it may refer to what is needed for a category of employment or to perform a specific task (Kofman, 2014). Skilled immigrants, particularly in regulated professions such as the health industry, are often confronted by duplicitous and complex certification and credentialing systems in destination states (Walton-Roberts, 2020). According to a report from World Education Services, IMPRINT, and George Mason University Immigrants who earned a degree only abroad were less likely to achieve professional success, at a rate of 15%. Alternatively, those who pursued higher education both abroad and in the United States attained success at a rate of 28%. In Boston, a whole 42% of respondents seeking to enter the workforce said employers did not recognize their foreign credentials. (Laucharoen 2020, p.1)

Attitudes toward immigrants, including the highly skilled, vary along the continuum from acceptance and tolerance to resentment and xenophobia (Hainmueller & Hiscox, 2014). These attitudes belie two important concerns—material economic concerns and noneconomic concerns. Material economic concerns center around natives' fears about labor market competition and the fiscal drain on public amenities. On the other hand, noneconomic concerns center on cultural and ethnic tensions between native and immigrant populations (Hainmueller & Hiscox, 2014). Both concerns, material

economic and noneconomic, are at the core of why even highly skilled professionals encounter significant barriers to the practice of their professions in the United States labor market. Furthermore, regardless of country of origin or recipient country, highly skilled migrant workers are not immune to nationalistic concerns.

The regulation, credentialing, acculturation, and accreditation of immigrant labor continues to be critical to public policy in many high-income countries (Ruhs & Anderson, 2013). Europe and North America in particular have seen rapid shifts in labor immigration spawning both controversy and conviction to already highly charged conversations. Policy makers, natives, and politicians all debate the impact that rising migrant populations have on economies and citizenry (Tridafiloplos, 2012).

One such immigrant debate in the United States which has come to characterize concerns about cultural and ethnic tensions, labor market competition, and the drag on public services, centers around the presence of foreign born and educated physicians who reside in the United States. Foreign-trained professionals residing in the United States, often encounter systemic and policy hurdles that stunt their ability and full potential to leverage their skills and training in the U.S. workforce (Laucharoen, 2020). Laucharoen highlights the plight of one foreign-trained professional:

For immigrants like Abubakar Jumah Buteera, who came to Boston from Uganda in October of 2019, confronting the job market has been incredibly challenging. Buteera had earned a law degree from Islamic University in Uganda, before doing postgraduate work in taxation and revenue administration and later earning a diploma from the Law Development Center. He was working as an attorney covering LGBTQ and human rights issues in Uganda when he ran into trouble

with the police due to doing this work. Buteera fled to the United States but had difficulty integrating into the workforce, despite his educational background and qualifications, because his schooling did not transfer. He took jobs that were not a part of his career path, such as working in a wood warehouse, handling a pallet jack at Market Basket, and driving for Amazon. This experience was very discouraging, he said. (p.1)

The 2019 American Community Survey (ACS) estimated the number of foreign born in the United States to be nearly 45.7 million, or roughly 13.5 percent of the total United States population (ACS, 2019). Of the 3.1 million professional degrees recorded in 2019, FEPs and other highly skilled migrants such as architects, engineers and others holding professional degrees account for 3 percent of the overall professional degree labor force (ACS, 2019). According to ACS, from a total of 36.6 million educational and health service jobs, naturalized U.S. citizens combined with non-U.S. citizens accounted for 14 percent of the educational and health service jobs. As a whole, these highly skilled professions are an important subset and contributors to the wider migratory community.

Foreign born and educated physicians who successfully navigate the three stages of the United States Medical Licensing Exam (USMLE) and are matched with a hospital residency program, are able to become credentialed to practice in the United States. However the number who are successful in doing so is relatively low. According to the Educational Commission for Foreign Medical Graduates (ECFMG 2019), of a total of 6,869 non-US citizen FEPs who progressed to the National Resident Matching Program, 4,028 or 59% were matched with a hospital. By extension, this ECFMG data also reveals the more troubling statistic that for year 2019, 41% or 2,816 FEPs remained unlicensed to



practice medicine in the United States at a time when the physician shortage there is projected well into 2030 (Zhang et al., 2020).

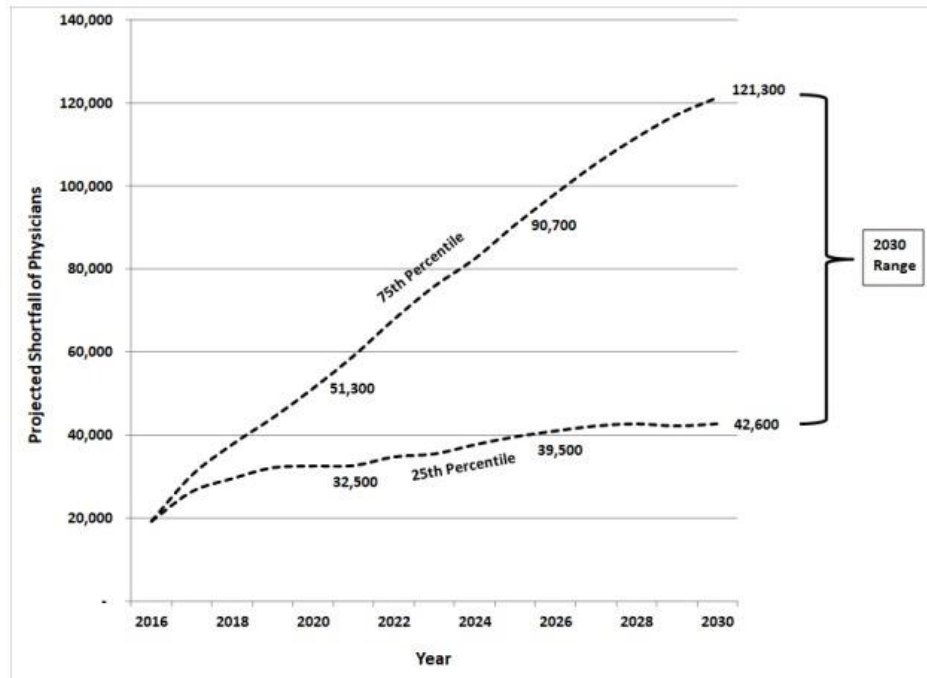
### **Background to the Problem**

As world populations grow and healthcare needs expand, many countries continue to be challenged by the demand for trained physicians and nurses. These alarming statistics of physician supply and demand are further compounded by the confluence of healthcare reform, physician retirements, and specialty choice. Thirty-two million individuals have already been added to the health insurance rolls because of the Patient Protection and Affordable Care Act (Flowers & Olenick, 2014). Aging Baby Boomers, the introduction of the Affordable Care Act (ACA), and retiring physicians have all contributed to the demand for physician services outpacing supply in the United States (Zhang et al., 2020).

While the COVID-19 pandemic's deleterious effects on the overall health of the health-care workforce are yet to be quantified, it is likely that due to professional burnout, the pandemic will have a significant impact on the industry's already tenuous workforce projections. According to Sultana et al. (2020), burnout is characterized by emotional exhaustion, depersonalization, and a decreased sense of self-worth. "The frontline health workforce is experiencing a high workload and multiple psychological stressors which may affect their mental and emotional health leading to burnout symptoms" (p.1). Demand for physicians and their attendant services will continue to outpace supply well beyond 2030 (Zhang et al., 2020).

**Figure 1**

*Total Projected Physician Shortfall Range, 2016-2030*



*Note.* Source: Association of American Medical Colleges, (2018)

### **Statement of the Problem**

At odds with the dire healthcare projections for physician shortage is the fact that there are thousands of unlicensed, yet highly skilled FEPs residing in the United States, who are unable to practice medicine (Rampell, 2013). Peters (2018) states that according to the Massachusetts Immigrant and Refugee Advocacy (MIRA) Coalition, “there as many as 65,000 unlicensed foreign-trained doctors across the United States... who have medical training in their home countries but can’t practice in the US.” (para. 6) These medical practitioners get caught up in “credentialing limbo” and are uncertain of their prospects to ever use their lifesaving skills again. Credentialing limbo is a term often used to refer to professionals who are caught up in the process of obtaining required

credentials in the form of licenses and certifications in order to practice in their given professions (Gonzales, 2017). The journey for a great number of healthcare professionals is prolonged, expensive, and complex, and in the United States in particular, training occurs mostly at the postgraduate level. Although the exact number is not known, a substantial number of foreign-trained healthcare professionals never manage to re-qualify in the United States (Rabben, 2013).

The Educational Commission for Foreign Medical Graduates (ECFMG) was created by the medical profession to make certain that FEPs meet acceptable professional practice standards to work in the United States. The Commission demands that FEPs: (a) pass various examinations designed to determine professional capability; (b) receive an ECFMG certificate which reflects professional knowledge, demonstrates English language proficiency, and cultural adaptability; and (c) maintain J-1 immigrant status (Duvivier, 2019).

Other means used to ensure high professional standards for FEPs, include the Accreditation Council of Graduate Medical Education (ACGME) and the certification demands of several American Boards of Medical Specialties (ABMS), designed to judge the abilities of both primary and specialty care physicians (Duvivier, 2019). During this arguably onerous and rigorous credentialing process, FEPs who are yet to be credentialed are often resigned to working in low profile jobs, settling for any job they can land — stocking warehouses, cleaning houses, driving taxis, waiting tables and performing other menial tasks (Dowling & Bohlat, 2012); (Dellorto, 2013).

When these highly skilled workers arrive to the United States, it can take several years to earn medical licensure, leaving them underemployed or unemployed for

extended periods of time. Involuntary part-time work and involuntary temporary work, including underpayment, are at the core of underemployment (Maynard & Feldman, 2011). The underemployed numbers of unlicensed FEPs who reside in the United States represent an untapped bounty of healthcare professionals with sound clinical knowledge and experience (Grossman & Jorda, 2006).

To be sure, some safeguards that delay FEPs as well as other highly skilled workers' journey to licensure are essential, like verification of foreign credentials and proof of English language proficiency. However, there are other safeguards that involve burdensome testing processes and duplicative training that threaten the persistence and successful transition of FEPs into their former roles (Flowers & Olenick, 2014). What happens all-too-often, then, is that FEPs transition into nurses and non-physician primary care roles such as nurse practitioners (Ramira et al., 2018).

Accreditation safeguards aside, a number of barriers, seen and unforeseen, often present themselves to the newly landed FEPs and their soon-to-be intercultural encounters. Intercultural encounters involve the exchange of cultural identities and ideas as persons from different origins interact with each other (Guttormsen, 2018).

Laucharoen (2020) writes:

Immigrants seeking to enter the workforce may experience subtler barriers, such as language and cultural differences. They may encounter biases on the part of prospective employers or subconscious racism, according to AACA COO and head of workforce development programs Edward Hsieh. Unfortunately, hearing an individual's accent may lead to that person not being hired, said Hsieh.

Students are taught to communicate within American work culture in classes at

AACA, learning about body language, hand gestures, and eye contact. Stephens also works with students to develop an awareness of pitch, tonality, and how one modulates their voice to not speak in a monotone. (p. 1)

Faced with these seemingly insurmountable odds, many FEPs make the difficult choice to suspend or altogether give up the pursuit of practicing medicine in the United States at a time when their expertise is most needed. Alternatively, several FEPs choose novel pathways to retrain for careers in nursing, clearly a far cry from being a practicing physician, but at least they have found a means to remain in the health profession.

Olenick (2014) describes the physician-to-nurse practitioner opportunity at one U.S. University in the following manner:

...[it] offers FEPs an opportunity to become primary-care providers through their Accelerated Combined BSN/MSN Program for Foreign-Educated Physicians (FEP to BSN [Bachelor of Science in nursing]/MSN [Master of Science in nursing]) program. The accelerated curriculum allows students to obtain their MSN degree and become nurse practitioners (NPs) in eight semesters (3 years). (p. 51)

In a review of the scholarly literature, Rabben, (2013), Simon (2010), Villagomez (2009), Flowers & Olenick (2014) and others revealed that academic research around the phenomenon of unlicensed FEPs, present in many countries, and particularly in the United States, is limited. Rabben (2013) reveals the root of the challenge in conducting a study around the FEP population and summarizes it in the following manner:

The U.S. government does not publish data on the number of physicians, engineers, or other professionals who enter the United States each year as refugees, asylum seekers, or immigrants. The State Department and the Department of Homeland Security do collect statistics on refugees' self-reported educational levels. Such data do not reveal whether a refugee who identified himself or herself as a physician or an engineer with a bachelor's or advanced degree has qualified to practice or has practiced his or her profession. It seems plausible that thousands of immigrant and refugee physicians may have entered the United States in recent years. (p.3)

More research is required to address this research gap because more needs to be known about how and why FEPs make the decision to transition from physician to non-physician primary care providers, rather than trying to gain licensure to practice in the United States. In particular, barriers or facilitators that arise in the process of their retraining and what might be done to ensure optimal professional outcomes need to be understood.

### **Purpose of the Study**

The purpose of this study is to describe the lived experience of foreign-born and educated physicians who are unlicensed to practice medicine in the United States as they attempt to retrain for non-physician primary care roles.

### **Research Question**

Rubin & Rubin (2011) suggest that the research question should get at the heart of the puzzle that the researcher is attempting to figure out. Likewise, Ravitch & Riggan (2016) proffer the following narrative regarding research questions:

The process of developing your research questions is primarily one of excavation. You disembark onto a vast swath of intellectual terrain, formed by an amalgam of what you care about and are interested in, the field(s) you have been exposed to and are working within, and what is already known about the problems or questions that pique your interest. Somewhere buried within that mass of interests, concerns, and exposures are your research questions. (p. 58)

This study seeks to answer the following primary question:

What is the lived experience of unlicensed foreign born and educated physicians who reside in the United States as they retrain for non-physician primary care roles?

### **Conceptual/Theoretical Framework**

Ravitch and Riggan (2016) suggest that a conceptual framework clarifies why the topic of study is relevant and presents the argument about why the means proposed to study the topic are appropriate. The introductory sections of this chapter attempt to uncover the plight of the unlicensed and underemployed FEPs even at a time when there is a global shortage of physicians generally and a projected U.S. shortage of physicians well into 2030 in particular (Zhang et al., 2020). The construction of the conceptual framework also serves to reveal the relationships and linkages among the researcher's topical research/empirical evidence, exploration of the research questions, and the uncovering of the researcher's interests (curiosities). Reio et al. (2020) describe two distinct forms of curiosity—cognitive and sensory. “Cognitive curiosity is the desire for information and knowledge, while sensory curiosity entails desiring new thrills and experiences” (p. 19).

The conceptual/theoretical constructs, to this study are (a) Transformative Learning Theory (TL), also referred to as Perspective Transformation (Mezirow, 1991), (b) Otherness/Othering (c) Liminality. Transformative Learning Theory emerges as the lens best suited to the deeper understanding of the phenomenon of unlicensed FEPs in the United States as they retrain for non-physician primary care roles. In addition, the existing literature regarding both complimentary concepts Otherness/Othering and Liminality will be scrutinized for the ways in which their essence might add credibility (Tracy, 2010) to the overall theoretical framework and the analysis of the data.

### **Transformative Learning Theory**

The ten phases of Mezirow's (1991) seminal theory will help to contextualize the stages of the FEP experiences. Key elements of the transformational learning process are cited frequently in the literature. Initially, a disorienting dilemma, or "an activating event that typically exposes a discrepancy between what a person has always assumed to be true and what has just been experienced, heard or read" (Cranton, 2002, p. 66) and may contribute to a readiness for change. (Taylor, 2000 p. 1)

Beginning with the first phase, "their disorienting dilemma," through to the final phase that represents "reintegration into their lives," the phases enumerated below, will add greater context to the stages of their journey to career satisfaction.

1. A disorienting dilemma
2. A self-examination with feelings of guilt or shame
3. A critical assessment of epistemic, sociocultural, or psychic assumptions
4. Recognition that one's discontent and the process of transformation are shared and that others have negotiated a similar change



5. Exploration of options for new roles, relationships, and actions
6. Planning a course of action
7. Acquisition of knowledge and skills for implementing one's plan
8. Provisional trying on of new roles
9. Building of competence and self-confidence in new roles and relationships
10. A reintegration into one's life on the basis of conditions dictated by one's perspective.

Arguably, FEPs as well as other foreign educated professionals who enter the United States with the hopes of seamlessly and in a timely manner continuing their former professions, too often find themselves confronted by seemingly insurmountable barriers, so much so that FEPs frequently decide to train as nurses and nurse practitioners, rather than physicians. The discrepancy between what was always assumed to be true in terms of ability and promise, *and* what is being experienced or perceived constitute the FEP's disorienting dilemma (Taylor, 2000). To the highly skilled immigrant professional, the ability to persist in one's former vocation after migrating to a new society is a significant indicator of overall adjustment and well-being (Bernstein, 2000).

### **Otherness/Othering**

*Otherness* and *Othering* have been popularized by feminist theory and studies devoted to post-colonial power relationships (Brons, 2015). De Beauvoir's mid-twentieth century work introduced the notion of *the Other* as the grounds on which the idea of the self is simultaneously constructed. De Beauvoir's theorizing consequently led to concepts of the Other, *Otherness*, and *Othering* popularly found in areas such as cultural geography and nursing science (Brons, 2015). Brons distinguishes two forms of othering

described as crude and sophisticated othering. At its core, crude othering involves the process of distantiation defined as the emotional or spatial pulling back/distancing of the observer from the observed (Harvey, 2020). Sophisticated othering is typically more consequential and often ascribes deviance, inferiority and radical alienness to the other (Brons, 2015).

As experienced by so many foreign born and trained professionals who have migrated to the US, Crang (1998) describes Othering as a process in which identities exist in unequal relationships. Crang further suggests that when a mental model of an Other is constructed, often that model is formed in response to what is alien or different about the other—a look, a custom, a tradition, or language. Immigrants in pursuit of careers are sometimes met with subtle barriers brought on by their language and cultural differences (Laucharoen, 2020).

For unlicensed FEPs who are present in the United States, the dynamics of otherness and othering present unique adjustment and career persistence challenges upon arrival to the United States from their countries of origin. Exploration of Otherness, therefore, as it pertains to the lived experience of the category of FEPs under scrutiny, in addition to providing a complimentary lens to analyze and interpret the data, can provide an important window into the hurdles and systemic biases encountered during their intercultural encounters (Guttorsmen, 2018).

### **Liminality**

The foreign nature of unlicensed FEPs affirms both their otherness as well as their inherent transitional uncertainty (liminal state) as they navigate novel realms, praxis and social contexts. Malksoo (2018) describes liminality as:

...a central phase in all social and cultural transitions as it marks the passage of the subject through 'a cultural realm that has few or none of the attributes of the past or coming state'. It is thus a realm of great ambiguity, since the 'liminal entities are neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention, and ceremonial'. Yet, as a threshold situation, liminality is also a vital moment of creativity, a potential platform for renewing the societal make-up. (p. 1)

Van Gennep's (1960) theorizing regarding rites of passage provided a common lens through which occupational journeys and transitions from one occupational identity to another are viewed.

### **Significance of the Study**

It is the sincere hope of this researcher that an in-depth phenomenological study of the lived experience of unlicensed FEPs present in the United States as they retrain for non-physician primary care roles, will engender a deeper understanding of the plight of foreign educated professionals in general and unlicensed FEPs in particular. The phenomenological approach which allows for the in-depth questioning of the meaning of life as it is lived, it is hoped, will serve to uncover the practical utility of understanding the unlicensed FEP's lived experience and the essence of their journeys, responsibility of personal actions and decisions (Van Manen, 2017).

It is hoped that the study will describe and further the dialogue about the challenges that immigrants encounter despite levels of education or former station in life. The story is best told through the perspectives of the people involved:

“I went back to zero,” said Buteera. “I am a person who would wake up, wear my tie and shoes and shirt, get my briefcase, go to work, have my cases, and have my office. I ended up being a pallet driver.” He added, “It’s kind of demeaning. But I have to work. I have to get the money for bills and all that. It’s been so challenging, integrating into manual labor, when you’re used to something else.” (Laucharoen, 2020 p.1)

From a practical standpoint, given that the projected shortage of healthcare practitioners in the United States will persist well into the 21<sup>st</sup> century (Zhang et al., 2020), the leveraging of the underutilized skill sets of unlicensed foreign educated physicians can be critical in moderating the projected healthcare worker shortfall. The rationale for the study is further bolstered by the fact that unlicensed FEPs in the United States continue to represent an underutilized and untapped source of healthcare professionals with sound clinical knowledge and capabilities (Grossman & Jorda, 2006; Zhang et al., 2020).

This study around this highly skilled migrant worker population is also timely, given the COVID-19 pandemic’s ongoing negative impact on the health-care workforce and the subsequent need to recenter a wary and disoriented industry. This investigation will provoke conversations important not merely to FEPs, but to policy making around foreign-trained professionals. The deeper understanding of issues important to unlicensed FEPs including, credentialing, acculturation, and their subjective wellbeing might serve as proxies to the better understanding of the plights of foreign trained engineers, scientists, researchers, architects, dentists and others who confront their own

disorienting dilemmas, otherness, and liminality on their own journeys toward fruitful careers in the United States

Because there is limited research that explores the issues around unlicensed FEPs present in the United States, this research may contribute something new to the conceptual, practical and theoretical literature. Theory may be enriched through this research, as TL, Otherness and Liminality theories have not been extended to undergirding research concerning FEPs. Second, once possible barriers are identified that are involved in the transition process from FEP to nurse practitioner, more research could be designed to get at the degree each barrier is associated with career decisions to become nurse practitioners and their eventual outcomes. Thirdly, this research may be of practical importance as it may advance conversations regarding quality-healthcare, medical education, access and healthcare consumption, and medical regulatory communities. To Human Resource Development (HRD) professionals, this study may provide practical information about the barriers FEPS encounter and what might be done to mitigate their effects and inform aspects of medical education and health-care workforce planning.

### **Delimitations of Study**

Although it would be ideal to investigate all FEPs, this study will focus on the lived experience of unlicensed foreign born and educated physicians as they retrain for non-physician primary-care roles in the context of south Florida, United States.

### **Definition of Terms**

*Acculturation:* A multidimensional process consisting of the confluence among heritage-cultural and receiving-cultural practices, values and identifications (Schwartz et.al. 2010).

*Alterity:* A term used to traditionally point towards obvious differences of cultural practices like rituals or institutional procedures... (Horatschek, 2010).

*Baby Boomers:* A cohort in the United States born in the years 1946 to 1962 (Whitbourne & Willis, 2014).

*Constructivism:* A theory that describes knowledge as emergent, developmental, ... constructed explanations by humans engaged in meaning-making in cultural and social communities of discourse (Fosnot, 2013).

*Culture:* “Culture consists of systems of ideas rather than behavior or material artifacts. Culture is a system that has structure, has an identity, and maintains boundaries” (Namenwirth & Weber, 2016).

*Distantiation:* A process that signals the emotional or spatial pulling back/distancing of the observer from the observed (Harvey, 2020).

*Deductive Analysis:* A form of analysis which analyses the data through a theoretical lens with the theoretical concepts informing the coding and theme generation (Braun & Clarke, 2015)

*Essentialism:* “...the concept that groups can be categorized based upon apparent differences and, to the extent that differences are identifiable, that those differences are characteristic of the defined groups.” Jauregui et al. (2020)

*Foreign Born:* The U.S. Census Bureau indicates that the term foreign-born is used to refer to any person who is not a U.S. citizen at the moment of birth (Colby & Ortman, 2015). Foreign-born runs the gamut of non-natives who reside in the United States including undocumented migrants, foreign students (temporary migrants), legal permanent residents, humanitarian refugees and naturalized citizens.

*Immigrant*: one that immigrates: such as a person who comes to a country to take up permanent residence (Merriam-Webster, 2017)

*Inductive Thematic Analysis*: A form of analysis that is largely grounded in the data as opposed to concepts and theories (Braun & Clarke, 2015).

*Liminality*: The liminal state is a central phase in all social and cultural transitions as it marks the passage of the subject through a cultural realm that has few or none of the attributes of the past or coming state (Malksoo, 2012).

*Migrant*: a person who moves regularly in order to find work especially in harvesting crops (Merriam-Webster, 2017).

*Migration*: the act, process, or an instance of migrating (Merriam-Webster, 2017).

*Othering*: “Othering concerns the consequences of racism, sexism, class (or a combination hereof) in terms of symbolic degradation as well as the processes of identity formation related to this degradation” (Jensen, 2011, p.65).

*Nom de plume*: The phrase nom de plume is used to refer to a pen name (Merriam Dictionary, 2016).

*Selfing*: A process by which those in the in-group construct their own identities in relation to others (Johnson et al. 2004)

*Transformative Learning Theory*: A ten step process, first developed by Jack Mezirow in 1978 that begins with a disorienting dilemma, or "an activating event that typically reveals a divergence between what an individual has always assumed to be true and what is being experienced.

*Underemployment*: A term used to describe involuntary part-time work and involuntary temporary work (which together comprise time-related underemployment),

underpayment, and over-qualification (also called skills-related underemployment) that form the core dimensions of underemployment (Maynard & Feldman, 2011).

*Zoom:* Zoom is a web conferencing platform that is used for audio and/or video conferencing

### **Organization of the Study**

This study in the phenomenological tradition will examine and describe the lived experience of unlicensed FEPs as they retrain for non-physician primary care roles. Mezirow's (1991) Transformative Learning Theory is the primary theoretical framework that will undergird the study. Secondly, Otherness/Othering and Liminal Theory (in-between and in-betweenness) further support the conceptual model. Chapter 1 introduces the background to the problem, statement of the problem, purpose of the study, research questions, conceptual framework, significance of the study, delimitations, definition of terms, and organization of the study. Chapter 2 presents a review of the literature that pertains to unlicensed foreign educated physicians and what role, if any, the theories of Otherness/Othering, Liminality (in between and betweenness), and Perspective transformation play in both their challenge and opportunity. Chapter 3 present the methodology, Chapter 4 presents the findings, and Chapter 5 summarizes the study.



## **CHAPTER II**

### **LITERATURE REVIEW**

The previous chapter presented the context of the study and an overview of the underlying assumptions on which the study is based. It also affirmed that little scholarly research has been conducted about the population of foreign educated physicians (FEP) who are unlicensed to practice medicine in the United States. A PubMed and ProQuest peer reviewed search using the term "*Unlicensed Foreign Educated Physicians*" returned 168 titles most of which identified with only a part of the search term, only 21 titles however, included all of the search term "Unlicensed Foreign Educated Physicians."

Scrutiny of these matching titles revealed that while many of these articles reflected a shared interest in aspects of the unlicensed foreign educated physician experience, on aggregate, there was not sufficient academic literature to formulate a comprehensive body of knowledge (Villagomez, 2009) around the studied phenomenon.

While scholarly literature is replete with information detailing the migratory patterns and participation of internationally educated professionals in various fields (Chassels, 2010), much less is known of FEPs and the perspective transformations (Mezirow, 2012) required to reunite with their vocation of healing and saving lives. The examination of scholarly literature reveals significant gaps in the formulation of a comprehensive body of knowledge around the phenomenon of the lived experience of unlicensed foreign born and educated physicians, retrained as non-physician primary care providers in the United States, which is the focus of this research.

This chapter is organized into four sections each of which describes an important aspect of the research as revealed in the literature review. The first section explores the

literature focused on the migratory patterns of healthcare professionals globally and centers on reasons for physician migration; push and pull factors; brain drain/waste; recruitment practices, and policy formation important to donor and recipient countries. FEPs emigrate from their countries of origin for various reasons including the lure of higher wages, to escape conflict and wars, to seek professional enhancement, and to seek freedom, safety, and economic stability (Villagomez, 2009). Push factors are the circumstances within a country or region that foster the movement of health professionals away from a region or country of origin. Pull factors, on the other hand, are the circumstances and systems which attract health professionals away from the country of origin toward the destination country. These push and pull factors have emerged as the primary lenses through which health care worker migratory patterns are studied internationally (Schumann, 2019).

The second section is devoted to the principle of “otherness and othering” made popular by feminist theory and studies devoted to post-colonial power relationships (Brons, 2015). For unlicensed foreign born and educated physicians who are present in the United States, the dynamics of otherness and othering complicate their career path forward and make less certain the successful transition from country of origin to the United States. Exploration of otherness, therefore, as it pertains to the lived experience of the category of FEPs under scrutiny can provide an important window into the hurdles and systemic biases encountered during their intercultural encounters (Guttorsmen, 2018).

The third section focuses on the concept of *liminality*, defined as a critical phase in all social and cultural transitions where the subject navigates a new cultural realm that

bears little resemblance to his/her past. Unlicensed FEPs who are present in the United States, despite their timely and formerly validated life-saving credentials, must learn to successfully navigate formidable and novel intercultural and professional realms. Turner (1969) suggests that the liminal state is one of persistent ambiguity where individuals are neither here nor there. Unlicensed FEPs confronted with the liminal state are neither physician nor healthcare provider. Faced with the disorienting dilemma (Mezirow, 2012) they are “betwixt and between” the experiences of the old and their new lives.

The final section relates transformative learning theory and perspective transformation from Jack Mezirow’s seminal work, *Transformative Dimensions of Adult Learning* (1991) to the plight and dilemma of the unlicensed FEP in the United States who is attempting to be retrained as a non-physician primary care provider. Foreign born and trained physicians having migrated to the US, animated by the possibility of beginning or resuming a fruitful vocation are often surprised by and confronted with “exceptional licensing requirements, glass ceilings, suspect application rejections, unwarranted disciplinary actions or other slights.” (Mahon, p.27) Scholars have frequently summarized TL’s ten steps into three phases. Anand, et al (2020) describe the three phases of TL as a) the Transformation of the World View b) The Learning Process of the Individual Navigating the Transformative Experience and c) the Behaviors that Support Perspective Transformation.

U.S. Census Bureau data for the period 2009-13 reveals that there were 45.6 million college graduates in the U.S. labor force; of which 7.6 million were foreign born. Further analysis revealed that skills were underutilized in one out of every four, or roughly 1.9 million of the college educated immigrants who were working in low-skilled

jobs or all together unemployed (Batalova, Fix, & Bachmeier, 2016). For the individual this disorienting dilemma is the activating event that reveals a mismatch between what the individual has deemed to be true - career persistence, and what is being experienced - underemployment (Cranton, 2002). In Mezirow's theory opaque and ambiguous disorienting dilemma is followed by nine other phases of transformative learning,, each of which arguably, is pertinent to both the plight, and potential success of the unlicensed FEP in the United States (Eschenbacher & Fleming, 2020).

The primary goal of this chapter is to analyze and synthesize these four key concepts, share the latest writings and similar research undertakings, and then relate them to the broader picture, and ongoing conversation (Creswell, 2016) around the lived experience of unlicensed FEPs present in the United States, as they retrain for non-physician primary care provider roles.

### **Health Professionals on the Move: A Global Phenomenon**

For centuries, highly skilled health professionals have travelled the globe to both share and search for new knowledge. In addition to their search for knowledge, human beings have always identified with important issues related to physical health, well-being, and vulnerability to disease (Rowland, 2010). While health professionals on the move have always been characterized by their dynamic and fluid nature, in times of major economic or geopolitical change, understanding their mobility takes on even greater significance (Vasishtha & Maier, 2013).

The equitable distribution of health professionals in health care systems remains a challenge to policy makers as they attempt to craft solutions to meet the health demands of their populations (Buchan et al., 2014). More recently the COVID-19 pandemic's

deleterious effects on the health-care industry have magnified the need to examine the potential contributions of qualified immigrant workers in various spheres of the health-care industry.

Pre COVID-19, upward of 2.6 million immigrants were employed in the U.S. health industry, 1.5 million of which included the highly skilled such as physicians, registered nurses, and pharmacists (Batalova, Fix, & Pierce, 2020). See Figure 2.

**Figure 2**

*Foreign Born Medical Practitioners by Specialty and Citizenship Status*

SPECIALTY, 2016	PERCENT WHO ARE FOREIGN BORN	PERCENT WHO ARE NOT CITIZENS
Physicians	29.1	6.9
Dentists	23.7	3.9
Nursing, Psychiatric and Home Health Aides	23.1	8.7
Pharmacists	20.3	3.7
Dieticians and Nutritionists	17.4	7.7
Medical Assistants	17.3	5.6
Dental Assistants	16.5	5.5
Optometrists	16.2	1.9
Registered Nurses	16.0	3.3
Licensed Practical and Licensed Vocational Nurses	15.0	4.0

*Note.* Source: JAMA analysis of American Community Survey data, Dec. 4, 2018

The opportunity for unlicensed foreign educated physicians, who are present in the United States, to be able to continue to pursue their vocation and calling, provides motivation and explains much of the willingness of FEPs to persist through the academic and career progression challenges they encounter. According to Clayton-Wright (2019), persistence which is motivation led, involves a way of thinking that successfully guides individual behaviors through major challenges or obstacles identified in the environment. Yoon et al. (2015) point out that:

The notion of a calling shares the same Latin root as the word vocation (voco, vocare, vocatus), meaning “to summon, to call, to name, to call upon, to invite, to challenge...the concept of calling has evolved into a broader reference to any strong sense of purpose that sustains motivation; nourishes a proper sense of self-fulfillment; and enables one to work with a vision. The impact of one’s work extends beyond individual pursuits to benefit others, society, or a transcendent figure. (p. 2)

Menninger (1957), in his seminal work, contends that work is a measure of one’s maturity... a foundation of mental healthiness and the degree to which one maintains internal and external wholeness. Roe (2015) on the other hand argues that for many, the notion of internal and external wholeness, in the pursuit of a career, is an elusive luxury that many can ill afford and is strongly influenced by global, educational, social, traditional, and economic realities. Decisions made in the agricultural, environmental, legal, and trade sectors, for example, often have a direct impact on what takes place within the healthcare workforce at the local, national, and international levels. Such factors have led to changes in how healthcare services are provided, how healthcare

workers are educated and in the migratory patterns of healthcare workers (Ergin & Akin, 2017). As such, healthcare workers in countries with lower incomes, limited access to professional development and training, and over-extended systems, often choose to move to countries with the promise of greater access and opportunity, either by choice or invitation. These push and pull factors are significant determinants in the decision of FEPs to emigrate. Macro-level factors include national economic and sociopolitical concerns, meso-level factors include profession-specific issues such as education/job environment, and micro-level factors point to individual circumstances such as family-ties, language skills, recruitment, and opportunity windows (Young et al., 2012). Figure 3 shows examples of the macro, meso, and micro-level factors that influence healthcare professionals to migrate to the United Kingdom. Another study that looked at factors which motivated physicians to migrate from developing to developed countries revealed their yearning for better wages; the practical need to travel to where jobs exist; and the desire to enhance professional identities (Villagomez, 2009).

**Figure 3**

*Factors Attracting Health Professionals to The United Kingdom*

Drivers	Factors
<p><b>Macro-Level</b></p> <ul style="list-style-type: none"> <li>Economic</li> <li>Health System</li> <li>Political</li> </ul>	<p>National economic and sociopolitical factors that exert influence across all international labour markets and also affect the health system dynamics relevant to health professionals.</p> <p>Prospect of Improved standard of living for self/family, means to remit income to country of origin</p> <p>Un/underemployment amongst health professionals in home country, poor salaries and working conditions in health sector in home country</p> <p>Political instability in home country versus stability in United Kingdom</p>
<p><b>Meso-Level</b></p> <ul style="list-style-type: none"> <li>Progression opportunities</li> <li>Additional skills</li> <li>Career development</li> </ul>	<p>Profession-specific factors (e.g. education/training, job conditions) that frame perceived opportunities in a given occupational sector</p> <p>Shortage of postgraduate training opportunities and/or posts in particular specialty/profession in home country</p> <p>Experience working in different system rather than learning from theory, learn to use state-of-the-art equipment, broaden knowledge</p> <p>Professional challenge associated with different ways of working, reputation and status of United Kingdom system, organization or clinical field, opportunities for involvement in research and/or general networking</p>
<p><b>Micro-Level</b></p> <ul style="list-style-type: none"> <li>Family/Social Network</li> <li>Personal fulfilment</li> <li>Language skills</li> <li>Opportunity window</li> <li>United Kingdom policy</li> <li>Recruitment incentives</li> <li>Migration stepping-stone</li> </ul>	<p>Individual circumstances and attitudes through which macro-and meso level drivers are viewed but which also influence migration decision making in their own right</p> <p>Perceived better quality of life for family, desire to give children quality education and cultural experience, partner decision to work in the United Kingdom, choices possible within context of social/migrant networks in the United Kingdom</p> <p>Desire for a life change/excitement, stage in career or life cycle (opportunities at a particular point), experience a different culture, accessing a gateway to Europe</p> <p>Desire to improve own/family's English language proficiency, opportunity for children to learn/practice English, English first language, so United Kingdom easier country to work in</p> <p>One-off opportunity provided by the United Kingdom's former policy of active international recruitment</p> <p>Responsive to positive recruitment strategy from United Kingdom Government</p> <p>United Kingdom market position relative to other countries: barriers to/ease of entry, nature of support provided at recruitment stage</p> <p>Work in United Kingdom attractive as potential stage in onward migration, primary to the United States</p>

*Note.* Source: Young (2011)

Wismar et al. (2011), sought to uncover the extent to which the mobility phenomenon impacted health systems in the European Union (EU) and how it impacted important policy strategies. The researchers looked at the motivations and lived experiences of health professionals on the move by examining the characteristics, impact and potential of policies aimed at managing issues important to health worker mobility.



The need for a sustained ethical approach to international recruitment aimed at mitigating the downside of skill loss and brain drain in developing and labor-challenged regions, saw the creation in 2010 of the World Health Organization's WHO Global Code of Practice on the International Recruitment of Health Personnel. The WHO Global Code of Practice engages in effective workforce planning; reduction of overreliance on internationally recruited health-care workers; and encourages the ethical treatment of health workers on the move (Wismar et al., 2011). "An important aspect of the Code is its emphasis on improving data gathering and research on health worker migration and its impact on health systems" (Williams et al., 2020, p.5).

Buchan et al.'s (2013) detailed analysis of the mobility of health professionals within the EU primarily assessed its impact on health system performance and reviewed important policy strategies that address mobility. The authors provide a rigorous and systematic analysis of the mobility patterns in Europe as well as evidence-based and policy-focused lessons relevant to the policy debate in the EU. Among the key findings was that the monitoring of health professional mobility remains a challenge particularly where short-term moves and return patterns are concerned. Political challenges and priorities also limit continual and updated monitoring of FEPs at the local level (Vasishtha & Maier, 2013). Countries and regions impacted by financial, economic, and geopolitical crises focus on priorities other than the call to finesse their workforce intelligence systems (Buchan et al., 2013).

The COVID-19 crisis has further highlighted the importance of maintaining updated workforce intelligence systems. Accurate data are critical to understanding the

influence health-care mobility has on the workforce and its long-term impacts on the wellness of the population. Vasishtha & Maier, concluded that

Monitoring would need to be embedded in an overall health workforce intelligence system with clear accountability lines, and to be transparent through making the data publicly available. Monitoring and good-quality statistics on the practicing workforce will improve workforce planning and forecasting and act as an early warning system on shortages of certain professions or specializations or on regional imbalances that would enable policymakers to take informed action. (2013, p. 121)

Glinos and Buchan (2013) identified six types of mobile health professionals, each representing an archetype of workers animated by motivations, purpose, country of origin circumstances, destination country conditions, personal profile, and anticipated length of stay abroad. Although they suggest that more than six types of mobile health professionals are possible and that some elements of overlap are likely, identify the six types as:

- The Livelihood Migrant—moves to earn a better living
- The Career-Oriented Migrant—travels to develop his/her career
- The Backpacker—sees mobility as an opportunity to experience other countries
- The Commuter—commutes back and forth across borders to work
- The Undocumented—is motivated by the chance of a better livelihood but works unofficially
- The Returner—migrates in reverse

Buchan and Gilnos et al. (2014) present factors necessary for evaluating the phenomenon of health professional migration including, a) the ways mobile health workers are othered, b) the freedom of persons to move, c) interprofessional migration (Villagomez, 2010) as a solution to underemployment, d) advantages of financial remittance to the source country, and e) the benefits of the highly skilled to the destination country. Villagomez defines interprofessional migration as the movement of individuals across geographical as well as professional boundaries and contends that

Some FEPs are no longer just migrating across geographical boundaries. Some of them are migrating across professional borders: from the profession of medicine to the profession of nursing. Depending upon their unique personal and past professional circumstances, interprofessional migration may have happened because of their geographical migration, or it perhaps happened to facilitate their migration to the US or to other developed countries of the world. (p. 12)

The Global Code of Practice on the International Recruitment of Health Personnel is a global framework that includes the adoption of ethical norms and organizational legal arrangements to steer international cooperation on issues around health worker migration (Taylor & Dhillon, 2011). One Canadian study considered adherence to the Code's principles regarding international recruitment of health workers. Data collected between 2010 and 2018, determined trends in intra-and inter-regional mobility of foreign-trained doctors and nurses working in case study destination countries in Europe. In 2018, FEPs and nurses made up over a quarter of the physician workforce and 5% of the nursing workforce in five of eight countries (Austria, Belgium, France, Germany, Ireland, Norway, Switzerland, and the United Kingdom) and four of five case study countries

(Belgium, France, Norway, Switzerland, and the United Kingdom), respectively (Williams et al., 2020).

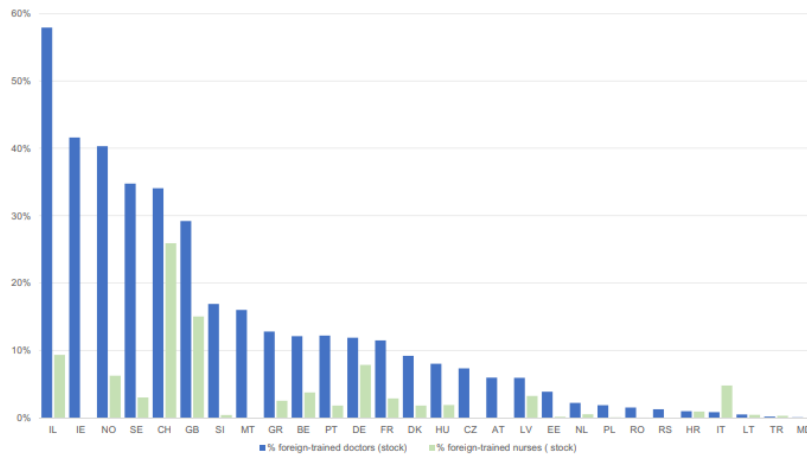
According to Bourgeault et al., (2016), earlier studies in Canada and similar destination countries, involving interviews with 189 stakeholders, revealed a lack of knowledge of the goals of the Code of Practice among health worker recruiters, local employers, and regional health authorities, that is physicians, nurses, and midwives fall below the WHO's critical threshold guidelines of 2.28 per 1000" (Bourbeault et al., 2016, p.1). While the respondents revealed a keen sense of the section of the Code meant to mitigate unscrupulous recruitment practices, the study also showed that the Code had little impact on patterns of health worker migration and potential policy decisions internationally. The need was evident for greater shared responsibility and stakeholder cooperation regarding migration policy and development, including bilateral trade agreements (Bourbeault et al., 2016). According to Buchan et al. (2014), at the global level, there are no substantive monitoring tools or policy initiatives meant to moderate the movement of physicians and health care professionals globally.

Migratory patterns of physicians are shaped by both attractants as well as barriers to mobility which include immigration and visa procedures, credentialing and licensure regulations, and cleverly crafted recruitment strategies by destination countries. The more commonly reported push and pull factors fall into three specific categories:(a) salary and financial incentives, (b) working/training conditions and facilities, and (c) sociopolitical conditions such as regional safety, and political climate (Schumann, 2019). Ibrahim et al., (2019) agree that

global access and improved mobility offer medical practitioners new opportunities to leverage their skills and specialties in an interconnected international employment market, with migratory patterns and flows recorded mostly from low- and middle-income countries to high-income countries in North America, Western Europe, and increasingly from the Middle East.

**Figure 4**

*An Overview of the Country of Training of Doctors in Eight Case Study Countries*



**Figure 1** Foreign-trained doctors and nurses as a share of total stock of doctors and nurses, 2018 (or latest available year\*). IL, Israel; IE, Ireland; NO, Norway; SE, Sweden; CH, Switzerland; GB, United Kingdom; SI, Slovenia; MT, Malta; GR, Greece; BE, Belgium; PT, Portugal; DE, Germany; FR, France; DK, Denmark; HU, Hungary; CZ, Czech Republic; AT, Austria; LV, Latvia; EE, Estonia; NL, Netherlands; PL, Poland; RO, Romania; RS, Serbia; HR, Croatia; IT, Italy; LT, Lithuania; TR, Turkey; MD, Moldova. Note: \*Latest available year for foreign-trained doctors if no data for 2018: Turkey, 2015; Croatia, Denmark, Netherlands, Sweden, 2016; Germany, Greece, Hungary, Latvia, Lithuania, Malta, Moldova, Poland, Portugal, Romania, Switzerland, 2017. Latest available year for foreign-trained nurses if no data for 2018: Portugal, 2014; Greece, Turkey, 2015; Denmark, Netherlands, Sweden, 2016; Croatia, Germany, Hungary, Latvia, Moldova, Poland, Romania, Slovenia, Switzerland, 2017. Countries reporting data on foreign-trained physicians but not nurses: Austria, Bulgaria, Czech Republic, Ireland, Malta,

*Note.* Source: European Observatory on Health Systems and Policies, (2018)

While section one presented literature around the migratory patterns, motivations, and policies affecting FEPs, the following section examines the literature regarding unlicensed FEPs and their “Otherness” as landed immigrants to the United States.

### **Otherness: *Problematizing Difference***

I understand now that nothing, but “otherness” killed Jews, and it began with naming them, by reducing them to the other. Then everything became possible. Even the worst atrocities like concentration camps or the slaughtering of civilians in Croatia or Bosnia. Drakulić (as cited in Brons, 2015)

De Beauvoir’s seminal mid-twentieth century introduction of the idea of *the Other* as a basis on which the notion of the self is also constructed, led to the concepts of the *Other*, *Othering*, and *Otherness*, terms which have gained popularity in areas such as cultural geography and nursing science (Brons, 2015). For health professionals who contemplate migration, areas of thought around nursing science and cultural geography are of particular relevance.

Crang (1998) refers to othering as a process in which identities exist in unequal relationships. When a mental model of an Other is formed, it is often in response to what is unfamiliar about the Other: a look, a tradition, a custom, or language. With respect to foreign born and educated physicians transplanted into the United States, it can be argued that as they begin to interact within the host country, all these constructed mental models about them may apply, (*their* look, *their* tradition, *their* custom or language). The degree to which the mental model is accurately formulated often depends on the levels of interaction which takes place between the subject of modeling and the object othered. The less interactions that occur, the more likely it is that the social and cultural assumptions made are erroneous and ill-formed (Dodge, 2020).

Liu and Kramer (2018) have drawn upon postmodern, hermeneutic, and postcolonial approaches to conceptualize three types of Other identities. Lui and Kramer

rely on social categorization processes that use both cultural and phenotypic markers as the main categorization criteria. Viewed through the lens of *difference-as-problem*, Other-identities are often seen as opportunities to be managed, marginalized, or muted. The Other is often referred to as defiant, deviant, and dangerous. Critical studies, according to Lui and Kramer, have shown that the persistent sense of being the Other is a preoccupation of sojourners and immigrants. Yet, sojourners and immigrants are often able to formulate an improved sense of self as they embrace inter-cultural encounters and consequently positively fuse their out-group or othered ascribed identity with their self-identity.

While Liu and Kramer proffer three types of Other-identities; Brons (2015), on the other hand, conceptualizes two kinds of othering, which he termed “crude” and “sophisticated.” Brons argues that crude othering merely involves keeping someone or something at an emotional or intellectual distance. Sophisticated othering, as reflected in Hegel’s dialectic, points to self-other identification (Brons, 2015). Hegelian dialectic refers to an interpretive method in which the contradiction between a proposition (thesis) and its antithesis is resolved at a higher level of truth (synthesis) (Collins English Dictionary, 2021). Sophisticated othering often ascribes inferiority, deviance, and radical alienness to the other.

According to Dodge (2020), the symbolism for otherizing is no more evident than in the construction of wall structures meant to separate one in-group from the threatening out-group Other. The physical manifestation of the phenomenon can be found in various regions of the world including The Great Wall of China, the Berlin Wall, the Belfast Peace Walls, and the West Bank Wall. The U.S. Mexico border wall has come into both

prominence and heightened symbolism as the otherizing politics of “build that wall” has come into international attention (Dodge, 2020). Horvath et al., (2019) suggest that the idea of wall-construction is a most basic yet enduring architectural artifact that signals spatial liminality and is associated throughout human culture with the pain of marginalization, otherness, and loss of agency on one side, and feelings of protection, community, and security on the other. Researchers have looked at the ways dominant health care systems marginalize and build walls around particularly ethnic and other cultural groups. Johnson et al. (2004) critique othering and being othered in the nursing context.

The researchers opine that in existing literature, there is a dearth of examples of othering in the interaction between health care providers and patients. They therefore employ ethnographic methods, including interviews and focus group discussions, to explore the interactions between Canadian health care providers and South Asian immigrant women. In the process, three (3) forms of othering which shape how health care providers view their South East Asian patients come to light: *essentializing explanations*, *culturalist explanations*, and *racializing explanations*. The analysis also revealed how individual actions are influenced by the social and institutional contexts that create the conditions for othering practices (Johnson et al., 2004).

Essentializing involves offering overgeneralizations regarding culture, race, location, social background, and health care practices. The researchers point to Allen (1999) who contemplates the ahistorical nature of overgeneralizations that are abstracted from the broader social, economic, and political issues influencing culture, health, health



practices, and ways of life. Culturalist explanations, on the other hand, draw on culture and culture differences to explain away behavior.

At no time therefore is the system itself considered to be a contributing factor; all responsibility is placed on the othered individual for “nonconformist” behavior.

Racializing explanations are a form of racial discrimination, used to reinforce otherness and seemingly deficient qualities. In the analysis of provider/patient interaction, for example, the researchers found that “...health care providers often conflated issues of race (e.g., “visible minorities”) with issues of language” and communication, such that while “...language barriers are an important concern, what lies unspoken is the assumption that certain “races” have language problems” (Johnson et al., p. 264). Finally, the analysis reveals the process of othering and how language is used to parse *they* from *us* and White from Brown thereby employing cultural nuances to generalize about and to legitimize responses to the other, in this case, South Asian women.

Botorff et al. (2004) lead us to consider the concept of essentialism. Jauregui et al. (2020) introduce the concept as they review the efficacy of teaching practices informed by generation theory applied specifically to the Millennial cohort. The researchers submit that generational learners, particularly the Millennial learner, is a socially constructed myth, which perpetuation reinforces both power differentials and stereotypes, thereby delegitimizing and minimizing the unique qualities and beliefs of individuals.

Jauregui et al. (2020) conclude that generationalism can be viewed and clarified through the concept of othering. Citing Purhonen (2016), othering among the generations is described as the process whereby:

The dominant agent group creates a representation of the other target group characterized by the latter's differences from the agent group's normative standard, to reflect different positions in social space and to reinforce political and power differentials between representative members of the agent and target groups. (p.41)

Jauregui et al. (2020) take the analysis a step further and submit that othering and essentialism interact and inform each other. They define essentialism as "...the concept that groups can be categorized based upon apparent differences and, to the extent that differences are identifiable, that those differences are characteristic of the defined groups." The researchers provide the example of essentialism in medicine where categorization with respect to disease is appropriate, but it is then extended to inappropriate areas, "...such as in creating different categories of persons based on appearance or geographic origin, as in the social construct of race" (p. 63).

Othering not only labels those who appear to be different, but also reveals a process by which those in the in-group construct their own identities in relation to others (Johnson et al. 2004); the process of Selfing. Turning to the world of politics, Holslag (2015) considers the influence Othering together with Selfing influence behavior in times of conflict, using the Armenian genocide as the backdrop. Suny (2017) writes of the Armenian genocide:

Neither religiously motivated nor a struggle between two contending nationalisms, one of which destroyed the other, the genocide was the product of a pathological response of desperate leaders who sought security against a people

they had both construed as enemies and driven into radical opposition to the regime under which they had lived for centuries. (p. 11)

Holslag contends that in a political and social crisis, the dominant group begins to establish a new sense of Self and does so looking inwardly and by creating dichotomies and images until eventually the Other is no longer recognizable and has no further linkage with the dominant culture. Holslag argues that Othering and Selfing occur where the in-group begins to feel threatened as inferiorities within their own self-identity become apparent. The oversubscribed sense of self-superiority is then conveyed to the chastised group and that group only, which is viewed as a threat to the status quo and to the existence of the newly constructed self, such that the only course of action becomes the annihilation of the out-group.

Holslag suggests that the emerging identity and the internal threat are culturally and socially created myths stood up by the interplay among a complex network of ideas, imagery, values, and symbols. Identity is therefore created in the process of Selfing, and begins not merely in terms of action, but much more succinctly in thoughts and ideas. Arguably, for the unlicensed FEP present in the United States to be able to persist in their chosen vocation, they must first come to terms with the *Other-identities* ascribed to them; to navigate both crude and sophisticated othering (Brons, 2015); to bridge the emotional and intellectual distancing experienced. The notion of 'other,' offered as a threshold concept by Meyer (2006), is likely experienced as both an intellectual and emotional transformation. These sojourners must be able to delegitimize the notion of difference-as-problem (Liu & Kramer 2019), and to resist the overgeneralizations made about their culture, race, location, social background, and health care practices.

## **Liminality – In Betwixt and Between**

Turner (1969) states that:

The liminal state is a central phase in all social and cultural transitions as it marks the passage of the subject through ‘a cultural realm that has few or none of the attributes of the past or coming state’. It is thus a realm of great ambiguity, since the ‘liminal entities are neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention, and ceremonial’. Yet, as a threshold situation, liminality is also a vital moment of creativity, a potential platform for renewing the societal make-up. (p. 359)

Horvath et al. (2019) argues that because of liminality’s reach, versatility, and range of possible applications, the concept may rival and surpass conventional concepts such as ‘system, structure, or institution’, emerging as a master concept with the promise to foster a renewal in social thought.

While much of the theoretical perspectives around rites of passage and threshold concepts focus on the impermanence of liminality, Bamber et al. (2017) explored whether liminality can be cast as a permanent state (Ellis & Ybema, 2010; Ybema et al., 2011) that is where the vagaries of life create uncertainty and that uncertainty and temporality become institutionalized. Bamber et al., propose a thesis of occupational limbo different from transitional and permanent liminality.

Johnsen and Sørensen (2015) suggest that there is a state that can be referred to as permanent liminality where a regular work situation is suspended – “possibly indefinitely – in a social limbo”. (p. 326) Remote work arrangements brought on as a response to the 2020 COVID-19 pandemic, is a current example of the permanence of liminality,

underscored by the social limbo resulting from the suspension of regular work arrangements coupled with the uncertainty of the duration of the suspension. Turner (1985) argued:

The rites of margin or limen are performed in limbo space and time for those undergoing transition . . . having lost their previous status and cultural location and not yet having passed through to their new place (or returned to their old place) in the sociocultural order. (p. 209)

Aspects of Van Gennep's (1909) seminal French work, *Rites of Passage*, translated into English in 1960 is a commonly used lens through which to view occupational journeys and the passage from one occupational identity to another. Van Gennep (1960) and Beech (2011) refer to pre-liminal, liminal, and post-liminal phases, inferring a 'before' and 'after' state as the individual moves from one state to another. Arguably, FEPs' occupational journeys from physician to non-physician primary care provider might be characterized by the *before and after* state as they navigate from one occupational identity to another.

Bamber et al. (2017) further argue that there is a utility to the challenges, uncertainties and inbetweenness of the liminal state as it fosters new ways of thinking, creativity, productivity, and relationship building. Cunha et al. (2010), Shortt, (2015), Tempest et al. (2004), and Thomson and Hassenkamp (2008) describe encounters with liminal challenges as provisionally liberating from structural and social responsibility, giving way to a new and more meaningful identity on the other side of the threshold. CBS News Reporter Christopher Brito (2021) recounts one conversation with aerospace

engineer, Diana Trujillo, which underscores how liminal encounters can recast a new and more meaningful identity:

She came to the US with only \$300 and worked housekeeping jobs to pay for school. Now she's a flight director for Mars Perseverance. "I saw everything coming my way as an opportunity, she said. "I didn't see it as, "I can't believe that I'm cleaning. I can't believe that I'm cleaning a bathroom right now." It was just more like, I'm glad that I have a job and I can buy food and have a house to sleep... every instant I need to be present because every instant matters." (Brito, 2021, para. 1)

Bamber et al. (2017) provide an illustrative example of the relationship between limbo and liminality. According to the researchers, the data suggests that unlike liminality which fosters creativity, productivity, and relationship building, the limbo state, according to respondents, offered little value, hope, or meaningfulness. From a human resource perspective, the ability to identify individuals who are navigating the less productive limbo state, provides an opportunity for policy makers to purposefully problem solve and to advocate on behalf of those individuals seemingly trapped in limbo. The researchers looked at the system of higher education in the United Kingdom and the emergence of a work arrangement described as Teaching Only contracts (TO).

As an academic career pathway, some argued that the proliferation of the little-governed, non-research academic positions would create an inevitable rift between research and teaching. By 2005, one in five U.K. academics was hired on a teaching-only contract. By 2013, of the research-intensive institutions, 25% of academic staff fell into the category of TO. By 2015, across all sectors, 60.7% of non-full-time academic staff

were found to be on TO while 9.7% of full-time staff were recorded as TO (Bamber et al., 2017).

Given the persistence of teaching-only arrangements, the statistics contextualize the discussion as to the distinction between the state of limbo vs. the transitional liminal state. TO academics, who must surrender to heavy teaching only roles, find themselves in professional limbo, excluded from the high-quality research which affords recognition, reward, and relevance among their peers (Bamber et al., 2017). In the United Kingdom, as in the United States, and most research-intensive universities globally, research priorities—quantity and quality of output—are the cornerstone of career success, prestige, and rankings in domestic and international league tables.

Several bodies of work purport a more permanent liminal state (Beech, 2011; Cullen, 2009; Czarniawska & Mazza, 2003; Shortt, 2015; Sturdy et al., 2006; Swan et al., 2016). This notion of permanent liminality is not without challenge. Thomson and Hassenkamp (2008), for example, argue:

Liminality cannot be permanent unless the therapist [in this case] shuns social structure altogether and accepts its lack of stability'. Reflecting on Garsten's (1999) description of temporary workers as substitutable, dispensable and inhabiting prolonged liminality, Beech (2011: 288) notes: 'However, they do not reach the aggregation phase . . . [and therefore] they would not conform to the anthropological use of the term. (p. 6)

Other researchers Ybema et al. (2011) refute any notions of permanence associated with liminality and argue that while there can be a liminal state that is drawn out and persistently uncertain, it is still distinct from a permanent liminality. Ybema et al.

offer two clear identity positions where transitional liminality induces in the individual a feeling of being not-X-anymore-and-not-Y-yet, permanent liminality creates a more permanent sense of being neither-X-nor-Y or both-X-and-Y.

In the study of liminal experiences of teaching-only staff at U.K. universities Bamber et al., (2017) employed a semi-structured interview protocol. The research-intensive Russell Group universities were sampled based on the nature of the tri-pathway teaching contract arrangements including institutions that are research only, research and teaching, and teaching-only (Bamber et al., 2017).

Participants were first identified based on job titles on institution websites. Initial samples were drawn from business schools and engineering ( $n = 399$ ) and ( $n = 192$ ) respectively. Twenty of the United Kingdom's 24 research-intensive, Russell Group universities were included. Of the total invitations distributed, a final 51 interviews provided data. Table 1 summarizes the demographic information as well as basic interviewee details of the study.



**Table 1***Basic Interviewee Details*

Respondent	Age	TO experience	Professional experience	Respondent	Age	TO experience	Professional experience
TO1	60 +	11+ years	0–3 years	TO27	40–49	4–7 years	11+ years
TO2	30–39	4–7 years	4–7 years	TO28	50–59	7–10 years	11+ years
TO3	40–49	4–7 years	7–10 years	TO29	21–29	0–3 years	0–3 years
TO4	50–59	7–10 years	11+ years	TO30	30–39	4–7 years	4–7 years
TO5	50–59	11+ years	11+ years	TO31	50–59	11+ years	11+ years
TO6	50–59	11+ years	11+ years	TO32	21–29	0–3 years	4–7 years
TO7	50–59	4–7 years	4–7 years	TO33	40–49	0–3 years	0–3 years
TO8	50–59	11+ years	4–7 years	TO34	50–59	7–10 years	11+ years
TO9	30–39	0–3 years	11+ years	TO35	30–39	0–3 years	4–7 years
TO10	50–59	4–7 years	4–7 years	TO36	50–59	4–7 years	11+ years
TO11	40–49	4–7 years	11+ years	TO37	40–49	7–10 years	11+ years
TO12	40–49	0–3 years	11+ years	TO38	50–59	4–7 years	11+ years
TO13	60 +	11+ years	4–7 years	TO39	40–49	4–7 years	11+ years
TO14	60 +	4–7 years	11+ years	TO40	50–59	7–10 years	11+ years
TO15	30–39	11+ years	0–3 years	TO41	50–59	11+ years	0–3 years
TO16	40–49	7–10 years	11+ years	TO42	30–39	11+ years	4–7 years
TO17	60 +	11+ years	0–3 years	TO43	30–39	0–3 years	0–3 years
TO18	40–49	4–7 years	11+ years	TO44	60 +	4–7 years	11+ years
TO19	30–39	0–3 years	4–7 years	TO45	30–39	0–3 years	4–7 years
TO20	40–49	7–10 years	11+ years	TO46	40–49	7–10 years	11+ years
TO21	40–49	4–7 years	4–7 years	TO47	50–59	7–10 years	7–10 years
TO22	60 +	7–10 years	11+ years	TO48	40–49	4–7 years	11+ years
TO23	50–59	4–7 years	11+ years	TO49	30–39	0–3 years	0–3 years
TO24	60 +	7–10 years	4–7 years	TO50	40–49	0–3 years	11+ years
TO25	40–49	0–3 years	4–7 years	TO51	30–39	4–7 years	0–3 years
TO26	50–59	11+ years	0–3 years				

*Note.* Source: SAGE, June 12, 2017

Once the questions were refined, the researchers conducted semi-structured interviews to tease out participants’ lived experiences around four focused themes including: a) motivations for entering academia and, if relevant, pursuing the TOC pathway; b) everyday work-lives and tasks; c) individuals’ perceptions of the evolution of their career; and d) the status of TO academics more generally (p. 9). For this study, the

researchers used the computer-assisted qualitative data analysis software, NVivo 10, to code the data. A summary of this data is shown in Table 2

**Table 2**

*Coding Summary*

	# of respondents	# of comments
<i>Limbo (held-back/held-down/locked-in/locked-out)</i>		
Marginalized to second-class citizen status	47	60
Teaching pathway perceived to be 'non-academic'	16	26
<i>Career</i>		
Lack of career structure for TO academics	46	57
Research = career	39	55
Lack of incentives (vis-à-vis research colleagues)	31	39
Lack of reward, including promotion/ progression opportunities	41	65
Lack of recognition	41	56
Lack of a TO-specific performance measurement system	33	43
TO assigned (excessive, unfair, relatively large) administrative duties	48	79
<i>Job title: 'Teaching'</i>		
Is an issue	37	46
Is not an issue	10	11
<i>Identity work</i>		
Administrative and pastoral work/visibility	25	32
Undertaking research	31	29
If you want teachers to research, support it	20	25
Investing more into core pursuits (i.e. teaching/ student experience)	44	51
Internally motivated/self-recognition	30	33

TO = teaching-only.

Source: SAGE, June 12, 2017

The work of Bamber et al. (2017) contributes to the literature's alternative theoretical and conceptual perspectives on the notion of liminality within occupational realms. The researchers report that there is both nuance and clear distinction between

occupational limbo and liminality. Teaching-only staff reported a frustrating *stuckness* perceiving a less than realistic chance of going beyond the threshold and out.

Individuals who cross over social and cultural thresholds often experience a shift in the way they see the world and in the way they understand the nature of being.

Threshold work is associated with affective and cognitive changes in the individual (Land et al., 2016). The world is viewed and experienced differently both intellectually and in the way it is felt and experienced. Encounters with threshold concepts are routinely described as frightening or difficult and as experiences which must be approached with caution. The anxiety that comes with threshold work is associated with the fear of entering the liminal space, of letting go of the familiar and learned ways of viewing the world (Land et al., 2016).

Individuals experience threshold concepts differently, and the extent of their difficulties as they navigate threshold realms varies. The depth of engagement with the threshold concept for the unlicensed foreign born and educated physician manifests itself at various stages of their journeys. Arguably the costly financial and emotional burden of licensing and recredentialing is among the earliest encounters. While in the Bachelor of Science in Nursing (BSN) program in particular, the tensions between the scope of nursing practice and the scope of medical practice present another troubling liminal encounter. Success is dependent on his/her willingness to endure the uncertainties associated with that liminal space (Rattray, 2016). Some learners despite their challenges, boldly embrace the uncertainty of liminal encounters with the expectation that meaningful transformation is likely on the other side of the work. Others approach the

liminal space reluctantly, seemingly unable to let go of the clarity of a familiar past and ontology (Meyer, 2006).

### **Transformative Learning Theory & Perspective Transformation**

The previous section of this chapter discussed the concept of liminality and its potential, in spite of its unnerving characteristics, for individuals who navigate threshold realms to undergo moments of critical reflection, creativity, and eventual transformation (Bamber et al., 2017). Like in all threshold work, however, there are moments of ‘not-knowingness’ (Eschenbacher & Fleming, 2020) that are characterized by disorientation, the questioning of previously held assumptions, and vulnerability. This final section of Chapter 2 examines the literature associated with Mezirow’s (1997) ten phases of Transformative Learning (TL), also referred to as Perspective Transformation, and how this framework, steeped in its constructivist’ assumptions, is suitable to examine the lived experience of unlicensed FEPs in the United States as they attempt to retrain as non-physician primary care providers.

Key elements of the transformational learning process are cited frequently in the literature. Initially, a disorienting dilemma, or "an activating event that typically exposes a discrepancy between what a person has always assumed to be true and what has just been experienced, heard or read" (Cranton, 2002, p. 66) and may contribute to a readiness for change. (Taylor, 2000, p.1)

When these changes take place and our meaning perspectives are challenged, previously held beliefs are not as readily interpreted (Mälkki, 2019). (Mezirow 1997) contends that whether individuals willingly engage in threshold work or are unwittingly

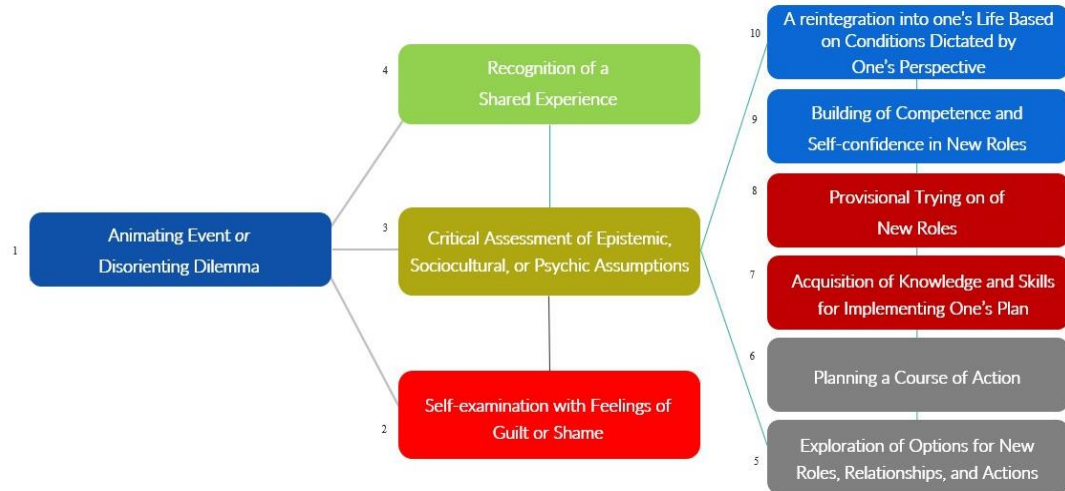
thrust beyond familiar borders by the vicissitudes of life, perspective transformation first begins with exposure to a disorienting dilemma.

Mezirow distills ten phases of TL enumerated below beginning with a disorienting dilemma, followed by each phase, relevant to TL's core principle, revealing the ability to cope and to recast meaning perspectives amid overwhelming ambiguity and opaqueness (Eschenbacher & Fleming, 2020). These phases are:

1. A disorienting dilemma
2. A self-examination with feelings of guilt or shame
3. A critical assessment of epistemic, sociocultural, or psychic assumptions
4. Recognition that one's discontent and the process of transformation are shared and that others have negotiated a similar change
5. Exploration of options for new roles, relationships, and actions
6. Planning a course of action
7. Acquisition of knowledge and skills for implementing one's plan
8. Provisional trying on of new roles
9. Building of competence and self-confidence in new roles and relationships
10. A reintegration into one's life based on conditions dictated by one's perspective

**Figure 5**

*Ten Steps of Transformative Learning Theory*



Source: Mezirow, (1991)

Anand et al., (2020) go even further stating that the concept of transformative learning in scholarly literature is often presented in three ways: the transformation of an individual's world view; the phases of the individual navigating a transformative experience, and the behaviors that support eventual transformation. The experiences of unlicensed FEPs in the United States attempting to be retrained as non-physician primary care providers is a population not unlike the population of women, engaged in re-entry work, who Mezirow first studied in 1978 as he formulated TL Theory. These adult women were attempting to re-enter programs in community college. As a grounded theory of adult education, TL described “how adult women in higher education underwent fundamental change in how they made meaning of what they knew—their life experiences to guide their future action... .” (Anand et al., 2020, p. 733)

Mezirow (1991) contended that his TL theory is based on constructivist assumptions and that humanism and critical social theory are at the root of the theory. Mezirow believed that the locus of sense-making was inside us as opposed to external media and that sense-making of our experiences are largely brought about through human interactions and experience (Taylor & Cranton, 2012). In addition to constructivist assumptions that root TL theory, humanist assumptions also play an important role in grounding TL. Humanism stresses freedom and autonomy where personal choices are bridled by heredity, personal history, and environment (Cranton & Taylor, 2012). Some of the leading assumptions which underpin humanism are that:

- Human nature is inherently good
- Individuals are free and autonomous and can therefore make important personal choices
- Human potential is boundless
- Self-concept is germane to human development
- Human beings tend toward self-actualization
- Reality is through the eyes of the beholder
- Human beings have an inherent responsibility both to themselves and the other

(Elias & Merriam, 2004)

Despite the linearity of the assumptions, an enduring criticism levied against humanism's association with TL theory is that they are grounded in Western thought and therefore theorists find difficulty in translating them into non-Western situations and perspectives (Wang & King, 2006). Still, TL theory cannot be realized without humanist assumptions as it requires the belief that individuals are able to make important choices,

grow and develop, perceive their own reality, and ultimately transform (Cranton & Taylor, 2012).

The third of the rooting principles around TL is Critical Social Theory which is concerned with critiquing and transforming society as opposed to explaining and describing it (Cranton & Taylor, 2012). Brookfield (2005) advances three core assumptions around critical theory:

1. Seemingly open, Western democracies are in fact predominantly unequal societies ripe with economic inequity, racism, and classism
2. The states' inequities, and isms are normalized by the repetition and dissemination of the dominant ideology
3. Critical theory recognizes the states inequities and isms as the precursor to its ability to transform them (Cranton & Taylor, 2012).

### **Summary**

Chapter 2 presented a review of the literature which synthesizes four perspectives important to the lived experience of unlicensed foreign educated physicians present in the United States as they retrain for non-physician primary care roles. The first section explored the literature focused on the migratory patterns of healthcare professionals globally. Concerns center around reasons for physician migration; push and pull factors; brain drain/waste; and policies developed to mitigate troublesome recruitment practices particularly aimed at underserved and underrepresented countries and regions.

This is followed by three sections which examined three theoretical research. The second section was devoted to the concept of Othering/Otherness. Researchers have examined the ways dominant health care systems marginalize and build walls around



particularly ethnic and other cultural groups. This form of Othering not only labels those who appear to be different, but also reveals a process by which those in the in-group construct their own identities in relation to others (Johnson et al. 2004). For the unlicensed FEP present in the U.S, to be able to succeed in their chosen non-physician career, they must first come to terms with the Other-identities ascribed to them; and reconcile the emotional and intellectual distancing encountered (Brons, 2015).

The third section explored the theory of Liminality. There are arguments made for and against liminality as a place of creativity, reflection, and transformation as well as arguments made for the existence of a less productive and less meaningful state-of-being, defined as limbo. Through a human resources and social justice lens, the ability to construct and identify target populations (Anderson & Grace, 2018) that might be navigating the less productive occupational limbo state, presents both challenge and opportunity for policy makers to purposefully craft policy language that advocates on behalf of those individuals seemingly suspended in limbo. Liminality is regarded as an important phase in all social and cultural transitions where the individual navigates a new cultural realm that is dissimilar to their familiar past (Turner, 1969).

The final section of Chapter 2 presents Transformative Learning Theory. The ten phases of TL begin with a disorienting dilemma with each phase bearing relevance to TL's core principle - the ability to cope amidst ambiguity and opaqueness (Eschenbacher & Fleming, 2020). The transformation of an individual's world view; the phases of the individual navigating a transformative experience, and the behaviors that support eventual transformation are three recurring themes found in scholarly literature regarding Mezirow's Perspective Transformation (Anand et al., 2020).

Combined, these three theoretical perspectives form useful lenses to not only undergird this research, but also to interpret the data. This research is significant in that it examined FEPs through these novel theoretical lenses, revealing new insights into the utility of these theories for social science research. Still, many consumers of health care in the United States will attest to having been treated at one point or another by a foreign educated physician. In some instances, the foreign educated physician might be a U.S. citizen who has merely travelled abroad to pursue their medical education, and upon completion, returned home to practice within United States shores. In other instances, however, the foreign educated physician encountered might be one who was both born and educated outside of the United States and who has migrated to U.S. shores to pursue their vocation.

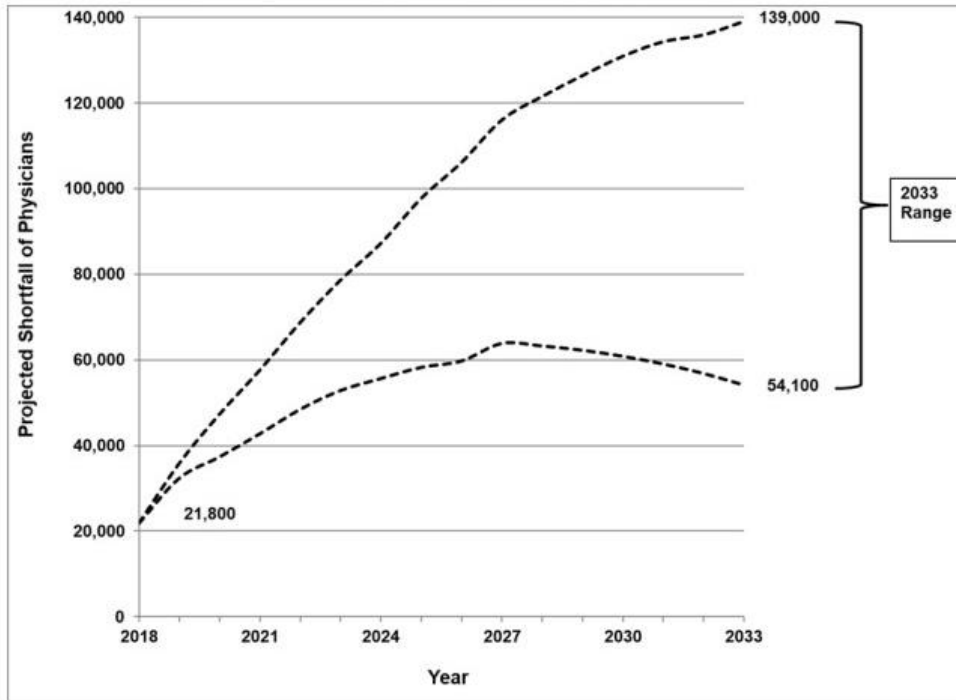
The geography and migratory patterns of the latter are often given away by that unique indicator of “otherness” ... a not-so-subtle accent, an unmistakably resonant “*twang*,” defined as “the characteristic speech of a region, locality, or group of people” (Merriam-Webster.com, 2022). A persistent conceptual ambiguity remains around the lived experience of unlicensed foreign educated physicians who are present in the United States, particularly at a time when due to the COVID-19 pandemic, FEPs’ contributions to sustaining the health of the U.S. medical workforce are in dire need.

The Association of American Medical Colleges (AAMC) projects that by year 2033, there will be a shortage of primary care physicians between 21,400 at the low end, and 51,200 on the high end. In terms of non-primary care specialties, the number balloons to between 33,700 and 86,700 physicians (AAMC, 2020). Demand for physicians continues to outpace supply, particularly while still challenged by the scourge

of COVID-19. Unlicensed FEPs in the United States are an untapped source of potential primary care providers who are rich in high levels of medical training, and cultural and ethnic diversity (Flowers & Olenick, 2014).

**Figure 6**

*Total Projected Physician Shortfall Range, 2018-2033*



*Note.* Source: Association of American Medical Colleges, (2021)

Despite the considerable job loss experienced in the early half of 2020 because of COVID-19, immigrants with health-focused degrees, previously underemployed or unemployed due to credentialing or licensing hurdles, continue to represent a bounty of professionals who can offset the labor crisis brought on by the effects of the virus. Batalova, Fix, and Pierce (2020) suggest that immigrant professionals' abilities to communicate across various languages, as well as their cultural diversity, are useful

assets when, as is being experienced, there is the need to communicate sensitive information around disease and wellbeing to immigrant populations.

Triscott et al. (2016) contend:

the diversity of cultural backgrounds of IMGs was considered to be a valuable asset, particularly in multi-cultural Canada. Many IMGs speak multiple languages which facilitates communication with culturally diverse patients. Sharing a common language and a common culture with patients was seen to provide a level of comfort and assist physicians in establishing trust, and rapport with patients.

(para.25)

## **CHAPTER III**

### **METHODOLOGY**

In this chapter the rationale for the methodological approach is presented, the methods of investigation are outlined, and explanations for the design decisions are provided. The overarching design elements in this study are offered in detail, including the research tradition that guides the study; the role of the researcher; participant and site selection; ways in which data was collected, stored, managed, inductively and deductively analyzed; and finally, choices made to ensure credibility—validity and reliability.

The primary goal of this study was to describe and understand an understudied human experience: the lived experience of unlicensed foreign educated physicians who are present in the United States as they retrain for non-physician primary care roles. Secondly, the researcher aims to contribute to knowledge regarding obstacles and challenges that may hinder vocation progression of unlicensed foreign-educated physicians present in the United States. A vocation is regarded as a calling which sometimes requires the walking away from and recasting of traditional extrinsic career satisfiers, such as money and status (Lees, 2014).

The question which framed this research was:

What is the lived experience of unlicensed foreign born and educated physicians who are present in the United States as they retrain for non-physician primary care roles?

#### **Qualitative Research**

In terms of rationalizing the approach to this study, the aim was not to confirm hypotheses about the given phenomenon or to predict causal relationships among

variables. Further, the researcher's interest was not to arrive at a numerical understanding of the FEP phenomenon under scrutiny. The goal was to pursue the social construction of meaning around the unlicensed FEP phenomena. To best do so, the qualitative approach and traditions that allow for such constructions of meaning were utilized. This type of inquiry is characterized by researcher-participant interaction that takes place within the natural realm (Denzin & Lincoln, 2011).

Qualitative research is an approach for uncovering and giving meaning to what individuals or groups ascribe to a social or human problem (Creswell, 2016). This process of research involves the use of evolving questions, data typically collected in the participant's natural setting, and inductive data analysis that depends on the researcher's interpretations of the themes and meanings of the data (Creswell, 2016). Qualitative research can offer dynamic textual descriptions of FEPs' lived experience, behaviors, emotions, relationships and dilemmas.

Creswell (2016) likens qualitative research to a quilt made up of various colors, shapes, threads, and materials, bonded by general frameworks. As Klein (2011) wrote:

The qualitative research tradition allows for a process to take place that will enable the researcher to uncover peoples' perceptions and reactions and thus gain a clearer understanding of how they feel about themselves, about others, and about their experiences and surroundings. (p.57)

As noted in Chapter 1, there is little literature to be found regarding the lived experience of FEPs who are unlicensed in the United States and unable to practice medicine. Qualitative research offers then, an opportunity to tease out and describe the

lived experience and authentic interpretations of complex life stories of FEPs, from the participants' narratives, feelings and emotions. Dilthey (as cited in Peroune, 2004) states:

Only from his actions, his mixed utterances, his effects upon others, can man learn about himself; thus, he learns to know himself by the round-about way of understanding. What we once were, how we developed and became what we are, we learn from the way in which we acted, the plans which we adopted, the way in which we ourselves felt in our vocation, from old dead letters, from judgments on which were spoken long ago.... We understand ourselves only when we transfer our own lived experience into every kind of expression of our own and other peoples' lives. (p.38)

### **Phenomenology as a Qualitative Method**

Phenomenology is the qualitative method used in this research study. Creswell (2016) describes phenomenology as the study of individuals or groups of individuals for the purpose of describing the essence of their lived experience around a specific phenomenon. Phenomenological research attempts to discover what is real to participants based on the narratives of their experiences and feelings and offers detailed descriptions of the phenomenon (Yüksel & Yıldırım, 2015). Brinkmann and Kvale (2016) suggest that in phenomenological traditions, objectivity is an expression of one's loyalty to the phenomena investigated.

As a research paradigm, phenomenology can be traced as far back as Kant and Hegel, (Groenwald, 2004), although there have been many individuals who have since shaped its thought. The term paradigm is derived from its Greek *paradeigma* and Latin origins, *paradeigma* and means pattern, model or example. Thus, "a paradigm is the

patterning of the thinking of a person; it is a principal example among examples, an exemplar or model to follow according to which design actions are taken” (Groenwald, 2004, p. 5).

Frantz Brentano is regarded as providing a basis for phenomenology with his emphasis on the intentional nature of consciousness (Groenwald, 2004). Martin Heidegger (1889-1976) likewise talked about the notion of “Dasein or Being there” (Groenwald, 2004 p. 4). In the twentieth century, Husserl stood out as. Vandenberg Husserl (1997), the leading proponent of phenomenology, proposed that to arrive at certainty, anything outside immediate experience must be ignored. In the current study, the researcher’s aim was to describe, authentically, the phenomenon of unlicensed FEPs in transition, abstaining from pre-conceived notions and frameworks while honoring the illumined facts (Groenwald, 2004). Max Van Manen (2016) wrote:

Phenomenology, in its multiple contemporary manifestations and historical orientations, continues to make us mindful to be critically and philosophically aware of how our lives (and our cognitive, emotional, embodied and tacit understanding) are socially, culturally, politically and existentially fashioned. But phenomenology also reminds us that these constructions themselves are always in danger of becoming imperatives, rationalities, epistemologies, and ontologies that need to be bracketed, deconstructed, and substituted with more reflective portrayals. (p.7)

Phenomenological research therefore emerged as the most appropriate “model to follow” and was therefore used to examine the immediate experience of FEPs and thereby address the research question(s) posed.



## **Role of the Researcher**

One important distinguishing feature between qualitative and quantitative inquiry is the role played by the researcher. With qualitative research, unlike that of quantitative research, the researcher is the primary instrument for data collection (Klein, 2011). The basic set of beliefs that provoked my curiosity concerning unlicensed FEPs transitioning to non-physician primary care roles, stemmed from the performance of my professional role within the division of Academic and Career Success (ACS) at one south Florida University. Thus, as is common for researchers, curiosity first brought me to wonder about the phenomenon in question; that is, FEPs transitioning from one professional role to another. Reio (2013) posited that “curiosity and its related exploratory behaviors (e.g., experimenting, consulting, reflecting, observing) have an important role in healthy functioning ... the desire to experience and know for the sake of learning and adaptation ... is an important part of daily life ...” (p. 1). Thus, curiosity has brought me to this study.

Maxwell argues, as cited by Ravitch and Riggan (2016), personal interests color the role of the researcher and are what lure researchers to do the work in the first place. They are the motivators for asking questions and seeking knowledge. Personal interests mirror our curiosities, preoccupations, and notions about the nature of knowledge. The role of the researcher is also important to the relationship between the researcher and the participants of interest, in this case the FEPs.

My duties within the Department of Academic and Career Success, at the time, required frequent interactions with FEPs, all of whom were adult learners at various stages along their educational journeys. FEPs at the pre-admission stage to the institution

frequented my office in search of general information about academic support provided to students enrolled in the FEP-to-Nursing program. Although at this pre-formed stage of their academic journeys our encounters were merely incidental, I was always struck by how eager many of these students were to share their personal stories.

At the pre-enrollment stage, I often interacted with FEPs who were required to pass various nursing admission exams such as the Health Education Services Inc. (HESI), and Test of Essential Academic Skills (TEAS) before being fully admitted to the Physician-to-Nursing program. The University's Testing Center is charged with the responsibility to facilitate some of the assessments of the FEPs. Even during this important assessment stage with the looming prospect of critically important exams ahead, many of the FEPs with whom I interacted seemed eager to use their time to reveal glimpses into their personal lives.

Those FEPs who successfully matriculated to the institution, also depended on tutorial services offered through the Center for Academic Success. These services were often accessed by FEPs in search of help to navigate the academic, cultural and language challenges that so often present themselves to foreign-born adult learners. As adult learners, interacting with the institution's tutorial services for the first time, FEPs showed considerable readiness to learn. These initial encounters that would later stoke my curiosity and harden my topic-choice, showed FEPs to be problem-centered, task centered, and motivated to learn, all qualities of adult learners (Knowles, 2020).

Yet, even at this nascent stage of their academic journeys, FEPs often showed a willingness to share their feelings about various disorienting dilemmas (Mezirow, 1991) in their lives. The betwixt and betweenness (liminal state) of their emerging student

identities became the subject of many recurring casual conversations. FEPs hinted at their disorientation from being neither medical doctors nor nurse. The appreciation for their stories of their disorienting dilemmas (Mezirow, 1991) would eventually loom large in the building of the conceptual framework used in this study. This study is underpinned largely by Jack Mezirow's seminal Transformative Learning Theory and further complimented by the perspectives from Otherness and Liminality Theories.

After years of being exposed to similar conversations with FEPs, I confess to becoming overly curious about FEP phenomena as they preliminarily appeared, showed, and revealed themselves (Manen, 2016). My interest in their lived experience; in their mystery of meaning; in their unexamined stories; was sufficiently provoked to challenge me to embark on the chosen topic of study (Manen, 2016).

In the role of researcher also, I am compelled to moderate bias by accounting for what Creswell (2016) describes as *reflectivity*—the conscious coming to terms with the fact that the researcher's social identity, background, and decisions all play a role in the meaning and context of the experience under investigation (Klein, 2011). As researcher, determined to moderate researcher-bias, I am compelled to examine beforehand, similarities between myself and the FEP participant population.

This critical introspection revealed the following: I am an immigrant to the United States who at one time occupied a liminal space—that notion of being “betwixt and between”—defined extensively in Chapter 2. My earliest work authorization and *non-immigrant* visa in the United States was characterized by constant reminders of my own translocality. Translocality is defined as being identified with more than one location (Oakes & Schein, 2006). I am both a naturalized citizen of the United States where I

have lived for well over half of my life, and I am a citizen of my country of birth, Trinidad and Tobago. As Harward (2017) stated “Citizens can possess both local and global identities that motivate them to advance the interconnected common good of their own communities and other communities worldwide.” (as cited in Landorf & Doscher 2018) As such, I am particularly sensitive to discourses around immigrant lived experiences.

Not unlike the would-be participants for this study regarding adjustment to a new form of education, as a student I have had to transition from a British educational system and experience to an American system of education. The tensions between the pedagogical and andragogical educational approaches created peculiar adjustment challenges and disorientation in the early stages of my own adult learner development.

In the British system of education, for example, pedagogical assumptions of (1) learner dependence, (2) subject-centered curricula, (3) the use of carrots and sticks, and (4) the irrelevance of prior learning experiences, *tabula rasa* (Knowles et al. 1998), formed the foundation of my student identity. Upon migrating to the United States, I was confronted with a system of education that in part embraces a more andragogical approach to adult learning where (1) the need to know is stoked, (2) self-direction and autonomy are encouraged, (3) prior learning is assessed and honored, (4) readiness to learn is recognized, (5) problem-centered and task-centered orientations to learning are normalized, and (6) motivation is inward-leaning as opposed to outward (Ozuah, 2016).

Earliest unrehearsed encounters with FEPs revealed their own concerns about similar tensions between pedagogical vs. andragogical learner upbringings. The pursuit of this doctoral education also is being experienced as a non-traditional student—well

into adulthood with its attendant challenges of family, and work-life balance—not unlike the casual stories shared by would-be participants to this study.

Yet even though there are obvious advantages for having had these previous, unsolicited encounters with FEPs, in the conduct of this study, however, those advantages must be deliberately reflected upon, contextualized, and bracketed. Bracketing is a qualitative research practice used to mitigate the potentially harmful effects when preconceived notions of a topic are introduced into the research process, (Tufford & Newman, 2012). The researcher's proximity to participant, if too close, can be fraught with dangers that potentially can become limitations to the study, particularly for the inexperienced researcher (Klein, 2011). Novice researchers should pursue issues to which they are not directly connected, and instead choose a study that is fresh and novel (Bogdan & Biklen, 2016).

Despite the obvious affinity of this researcher to the would-be participants, the sound advice of the scholars Bogdan and Biklen has been considered. Subjectivity and bias must be moderated. Brinkmann and Kvale (2015) advocate a process of phenomenological reduction that also demands a bracketing of judgement as to the existence or nonexistence of the artifacts of an experience. Dörfler, and Stierand, (2020) address the issue of researchers' preconceived notions in the following manner:

... we do not see the use of intuition and the insider view as a limitation; to the contrary, we believe that these were indispensable and key for achieving significant and game-changing findings. Thus, the notion of bracketing, as we describe it here and as we have applied it, is not about getting rid of subjective

components and removing pre-understandings but raising awareness of them and explicitly incorporating them. (p.2)

Subjectivity, as noted by Darawsheh, (2014), is a natural part of any researcher's thought process. Incorporating the qualitative research practices of reflectivity, and bracketing, however, allowed this researcher to moderate subjectivity by continually engaging in self-reflection. Self-reflection, in turn, built awareness about this researcher's leanings, feelings, assumptions, and perceptions and allowed for the intentional and transparent admission that even with the best of intentions, some of the context, sense-making, interpretations and understanding of the data collected, was shaped, in part, by a priori assumptions.

## **Participant and Site Selection**

### **Participants**

Ravitch and Riggan (2016) suggested that the chosen phenomenon determines the method of finding participants and not the other way around. Because the traits of the individuals who have had experiences relating to the phenomenon of interest are already known, the participants were identified with some degree of accuracy. Purposive sampling best describes that process of participant selection when sufficient information is known to identify the primary participants. This nonrandom sampling technique, also known as judgment sampling, is the intentional choice of a participant based on known traits that the participant possesses. Purposive sampling techniques do not demand foundational theories or a set number of participants (Etikan et al., 2017). Snowball sampling was also used, albeit unsuccessfully, in an attempt to increase the participant pool.

For the study, a total of seven FEPs who were either currently or formerly associated with a Physician-to-Nursing program were chosen. The overarching goal in deciding on the chosen seven was to authentically describe the essence of the phenomenon of interest (Etikan et al., 2017). Gentles et al. (2015) suggests that anywhere between two and 10 participants is sufficient to reach *saturation*—the point at which interviewee responses yield no additional perspectives on the topic. Had there been no indication that sufficient richness was attained after the seven participants were interviewed, the researcher was prepared to solicit other participants to reach the point where saturation, or informational redundancy was reached (Gentles et al. 2015). This solicitation was not necessary as the seven participants without exception allowed for thick description. This qualitative technique goes beyond merely recording or describing an event, but rather seeks to give background and context needed to make sense of the meanings, intentions and interpretations (Drew, 2021).

The researcher had developed a working relationship with one administrator within a Physician-to-Nursing program who has agreed, in principle, to be a key actor in rendering assistance to this study. “Site entry and participant access generally require more than a simple negotiation process ... success in the field frequently means the development of long-term relationships and sustained efforts to manage work with gatekeepers, sponsors, and informants on site” (Durdella, 2017, p. 176).

The administrator played the role of gatekeeper, a term commonly used to describe one through whom access is facilitated into an organization (Creswell, 2016). Given the appropriate permissions, the individual distilled enrolled participants based on,

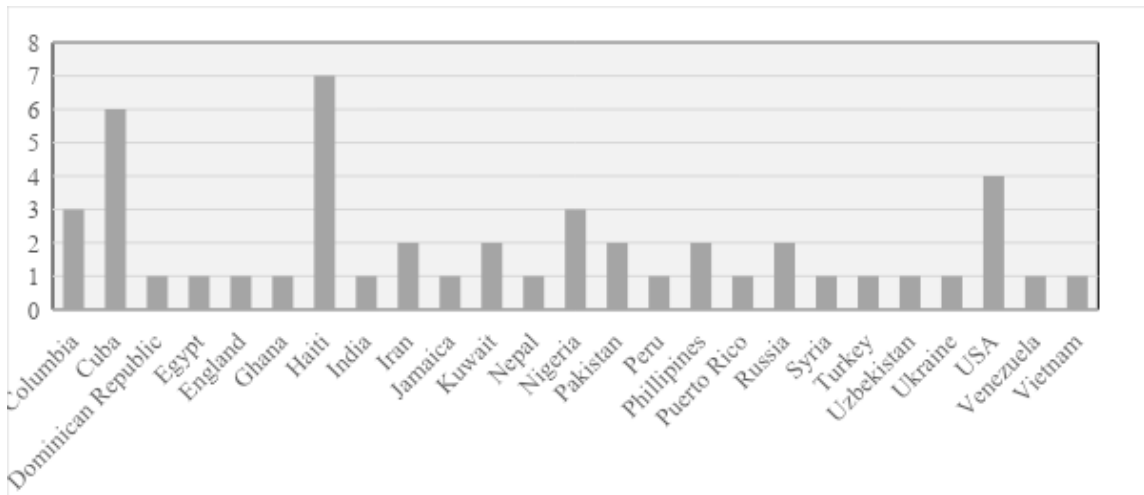
among others, gender, ethnicity, country of origin, U.S. state of residency, languages spoken, year of cohort admission, and former medical training.

Once these individuals and their demographics were identified, and given the relatively small sample size, the process of recruiting participants included a personalized recruitment letter that introduced and identified the nature of the study; explained how the researcher obtained the contact information of the prospective participant; commented on the potential for follow up emails, phone calls, or in-person contact; and a statement of opt-out from being contacted procedure (See Appendix II).

The Figures 5 and 6 shown below depict the tapestry and demographic diversity among FEP students admitted to the Physician-to-Nursing program for year 2016—also referred to as Cohort 10.

**Figure 7**

*Country of Origin of FEP Admits into a Physician-to-Nursing Program, 2016.*

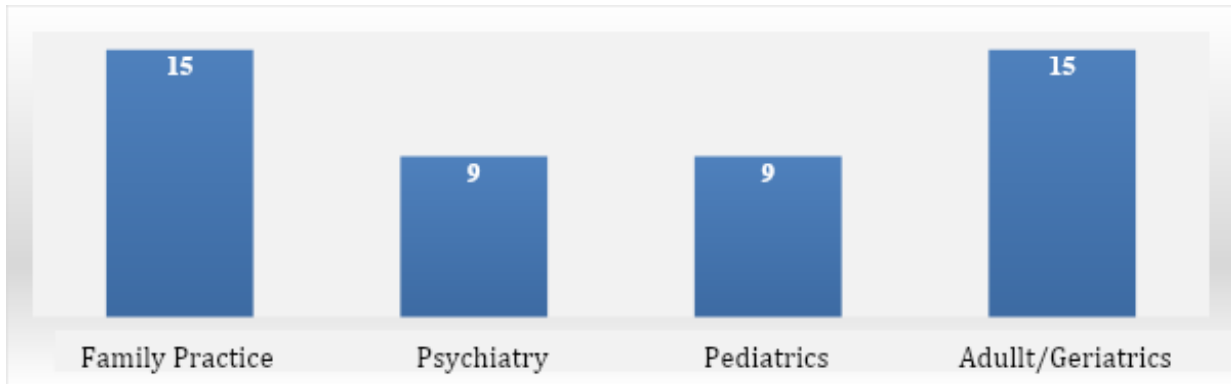


Source: Nicole Wertheim College of Nursing & Health Sciences



**Figure 8**

*Prior Medical Specializations of FEP Admits to a Physician-to-Nursing Program, 2016.*



Source: Nicole Wertheim College of Nursing & Health Sciences

A brief outline with the following points was presented to the gatekeeper for review (Creswell, 2016). These were:

- Explanation of the rationale behind choice of site
- The nature of the goings-on at the site during the study
- How disruptiveness to the site will be moderated
- The process of reporting results
- Benefits to the gatekeeper from the study

### **Site Selection**

A good site should be accessible, diverse enough to deliver sufficient research participants, and appropriate for fostering trustworthy relationships (Marshall & Rossman, 2014). The primary setting for this study, was a well-established FEP program at a large southern U.S. university.

The College ... created the nation's first Foreign-Educated Physician (FEP) nursing track in 2000. This pioneering track offers doctors from other countries,

who are not practicing medicine in the United States, the unique opportunity to reemerge in the healthcare industry—as nurse practitioners. (NWCNHS Brochure, 2018)

Because the FEPs traverse both campuses of the university during their course of study, it was intended for interviews to be conducted at both campus sites. Note: as a result, COVID-19 restrictions however, interviews were conducted using ZOOM video-conferencing technology.

### **Data Collection**

The interview is a tried-and-true pathway to the understanding of peoples' perspectives and experiences (Brinkman & Kvale, 2015). Brinkman and Kvale further suggest that a semistructured life world interview is suitable to uncover themes of the lived, everyday world from the participants' own perspectives. Because this semi-structured interview type is well aligned with the phenomenological perspective which seeks to thoroughly describe as opposed to explain, it was used as the instrument of choice. With the semi-structured interview, the goal is to gain descriptions of the interviewee's lived experience particularly around his/her interpretation of the meaning of the phenomena under scrutiny.

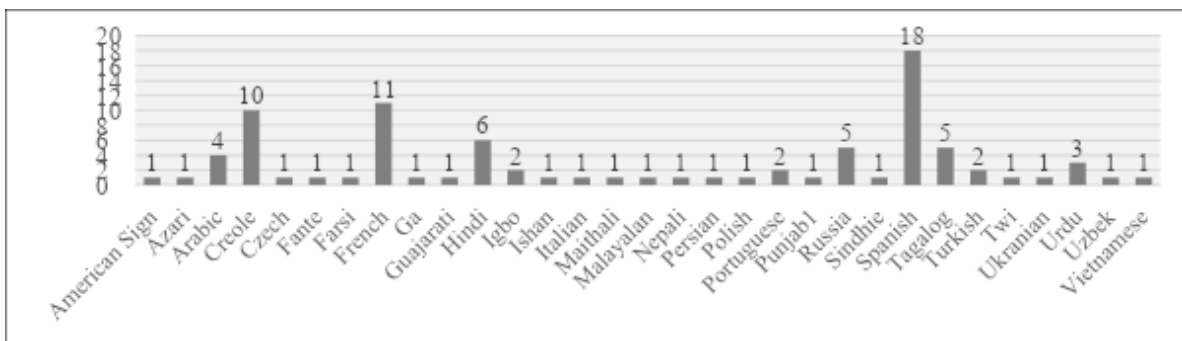
The semi-structured interview was conversational enough to tease out candid participant perspectives, yet it is rigorous enough to have specific purpose in its approach and technique (Brinkman & Kvale, 2015). The process was constrained neither by too-open everyday conversations nor the rigidity of closed questionnaires. An interview guide was used throughout the interview process that focused on the thematic concerns of the FEPs (Brinkman, 2014). Distinct from the interview questions, and to orient the

participants to the study, the overarching research question was shared with the participants. The video conferencing technology allowed, with participant permission, the electronic recording of each interview.

Brinkman and Kvale (2015) suggest that in cases of language diversity, careful consideration must be given when confronted with the need for cross-cultural interviewing. Figure 9 depicts the language diversity of FEPs admitted to the program in year 2016. As the Figure shows, upward of 30 distinct languages were reported to have been spoken by the 2016 cohort.

**Figure 9**

*Languages Spoken by FEP Admits into the Physician-to-Nursing Program, 2016*



*Note.* Source: Nicole Wertheim College of Nursing & Health Sciences

Factors important to cross-cultural interviewing, according to Brinkman and Kvale, include use of information probing questions, “making direct rather than circuitous replies, referring directly to matters that are taboo, looking into a person’s eyes when speaking, and sending a man to interview a woman or vice versa” (Brinkman & Kvale, 2015, pp. 168-169). Because it may be challenging to be fully aware of the myriad of cultural factors that might color the relationship between interviewer and interviewee,

cultural habits, practices, narrative resources, and positions were carefully taken into consideration during the interview process.

The following sample questions were used in the interview schedule.

1. Tell me about the factors that played an important role in your decision to leave your country of origin to migrate to the US.
2. When you arrived to the US what were your career plans?
3. Once admitted to the Nicole Wertheim College of Nursing & Health Sciences Physician-to-Nurse program, tell me how you experienced the transition from medical doctor to student-nurse.
4. Describe your experience as student-nurse in the Physician-to-Nursing program.
5. As an immigrant who is a student, do you believe that you were treated or perceived to be any different from native born students?
6. Describe your feelings toward your cultural differences such as language, lifestyle, and accent and how they may or may not have been a stumbling block or a stepping stone to your student-experience.
7. Describe how your prior medical knowledge and training in your country of origin may have facilitated your persistence as a student in the US
8. As a researcher, I am thinking about a concept called liminality which is defined as the passage of a subject through a realm which bears little or no resemblance to the past. Given the basic definition, describe your feelings, if any, of being in-between and between as you moved from one stage of your professional identity to another.

9. Tell me about your perceptions regarding the vocation of medical practice vs. the scope of practice associated with nursing.

10. Is there anything that you would like to share that I have not asked?

### **Data Storage**

ZOOM technology includes both audio and video recording capabilities, so those functions were used to record the interview sessions. Collected data was stored both on the physical hard drives of the equipment as well as in *One Drive* which is a cloud-based technology. A 5x8 double-margined notepad was used for notetaking and memoing. The consent form protocol as well as the practice of verbally asking participants as to their comfort of being recorded was adhered to (Groenewald, 2004; Murray et al., 2018). Care was taken to ensure that participants were not negatively impacted, financially, or otherwise by their agreeing to be interviewed using the video communication technology.

The data were collected via 45 to 70-minute one-on-one interviews. The recording features within ZOOM were activated only after permission to record was sought from each participant. None declined. Once the recordings were completed, they were downloaded into the secure ZOOM folder. A coding table consisting of five columns was designed for use in this study. The column headings included the participants' pseudonym, direct quotes, units of meaning, deductive quotes, and notes. A separate table was used for each participant.

### **Data Analysis**

Groenewald (2004) uses the term explication to describe the process of scrutinizing elements of a phenomenon while maintaining the context of the whole. Data analysis is the process of preparing and contextualizing the data into themes and interpreting the

results (Creswell, 2016). Braun and Clarke (2015) describe two common forms of thematic analysis—inductive analysis and deductive analysis—both employed in this study. Inductive Thematic Analysis is analysis that is largely grounded in the data as opposed to concepts and theories, therefore, participants' utterances regarding their lived experience were scrutinized and interpreted. Deductive Analysis on the other hand, analyses the data through a theoretical lens. In this study, predetermined theoretical frameworks informed the coding and theme generation. In scholarly literature, the ten-step theory of transformative learning is frequently concentrated and presented in three phases: a) the transformation of an individual's world view, b) the learning process associated with navigating the transformative experience, and c) the behaviors that lead to eventual transformation. Participant interview data were analyzed to reveal the extent to which, if at all, any of the participant experiences aligned with any of the aforementioned summarized phases of TL. See Figure 11.

To guard against researcher bias, rightly regarded in this study as an important limitation, bracketing was used. Bracketing is a qualitative research practice used to mitigate the potentially harmful effects when preconceived notions of a topic are introduced into the research process, (Tufford & Newman, 2012). Also, delineating units of meaning; clustering units into topics and themes; interview summations, validation, and development of an overall summary were employed (Greonwald, 2004).

Data was transcribed using the transcription features embedded in Microsoft Word. Each line of the transcripts was time-stamped and the participant's pseudonym displayed. A coding table was generated for each participant. Codes, themes and sub themes were generated from the scrutiny of the information yielded in the 5 columned

table. Coding involves the thorough reading of the transcript followed by categorization of the interview statements (Brinkman & Kvale, 2015).

### **Validity & Reliability**

The extent to which findings are deemed to be accurate from the viewpoint of the research participants, researcher, and the reader, is dependent upon the degree to which validity and reliability are applied to the research process. To ensure validity and reliability in this study, this researcher relied on four strategies frequently used in qualitative research, including member checking, use of thick description, theoretical triangulation, and clarifying bias. Creswell, (2016) implies that validity and reliability are critical to qualitative research.

Member checking, which is an informal validation strategy, was achieved by sharing aspects of the findings with the research participants to substantiate that what this researcher understood was in fact was meant by the participant. In addition to member checking, this researcher relied on the use of thick description which is a validation strategy that goes beyond just recording or description of an event, but rather adds background and context to further promote meaning. To further promote validity and reliability this researcher looked at the data through multiple theoretical lenses (Noble & Heale,2019). Theoretical triangulation specifically was employed for this study. Creswell (2016) describes the clarifying of bias as a form of critical reflection that allows for the bracketing of judgements and preconceived notions of the phenomenon. Clarifying of bias can be useful when, as in this researcher's case, there is proximity between the research participants and the researcher.

## Summary

In Chapter 3, the overarching design elements in this study have been offered in detail. The phenomenological research traditions that guide the study have been presented. The role of the researcher and the importance of employing strategies such as member checking, thick description, theoretical triangulation, and clarifying bias to mitigate subjectivity and researcher-bias were offered. The deliberative process such as purposive sampling involved in participant and site selection was shared. Data collection strategies and processes involving semi-structured interviews were discussed. The use of video communication technologies to remotely conduct the interviews because of COVID-19 safety guidelines was introduced.

Given the FEP program data which showed upward of 30 languages spoken by the 2016 cohort, the importance of carefully considering cross-cultural interview protocols were presented. The usefulness of data storage devices and technologies such as ZOOM's recording function and cloud-based technologies were also considered then chosen. Microsoft Word, was used for transcribing the data. A coding table consisting of five columns was designed for use in this study. The column headings included the participants' pseudonym, direct quotes, units of meaning, deductive quotes, and notes. A separate table was used for each participant. To promote and ensure the credibility and trustworthiness of the data, this researcher used a combination of validity and reliability strategies including member checking, triangulation, use of rich, thick description, and self-reflection regarding researcher bias, bracketing, and reflectivity. Creswell, (2016) suggests that validity is one of the hallmarks of qualitative inquiry and determines



whether the findings are accurate from the view of the researcher, participant, or the readers of the interpreted data.

## **CHAPTER IV**

### **FINDINGS**

This chapter presents the findings about how foreign born and educated physicians (FEPs) who are present in the United States and unlicensed to practice medicine, come to terms with the pursuit of non-physician primary care provider roles. To Human Resource Development (HRD) professionals and medical communities, these findings provide practical and useful information about the barriers and opportunities FEPs encounter, and the choices that they make as a result.

#### **Participants**

A total of seven foreign-born and foreign-educated physicians were interviewed for this study using the semi-structured interview protocol. A semi-structured interview allows the interviewer to listen to the interviewee as they discuss their lived experience. The interviewer plans the questions in advance that serve to trigger and encourage the interviewee to talk. The interviewer by their probing and questioning steers the interview to get at the relevant data. Willig (2008) as cited in Henriksen et al. (2021).

The phenomenological qualitative method is used in this research study as this researcher sought to discover what is real to the FEPs based on their narratives of their experiences. Creswell (2016) describes phenomenology as the study of individuals or groups of individuals for the purpose of describing the essence of their lived experience around a specific phenomenon. (Yüksel & Yıldırım, 2015). Brinkmann and Kvale (2016) suggest that in phenomenological traditions, objectivity is an expression of one's loyalty to the phenomena investigated.

All participants, in keeping with the criteria established for participation, were foreign born and had completed and received their physician credentials and licensure outside of the US and her territories. There were five females and two males making up the group of foreign educated physicians. Two of the participants are married to each other and had travelled similar, yet not identical paths to non-physician primary care careers. In terms of countries of origin, there were four who hailed from Haiti including the aforementioned married couple, one unmarried male (credentialed in Belgium), one married female from Guyana (credentialed in Cuba), and one married female from Columbia (credentialed in Columbia). The seventh, an unwed female, hailed from the Bahamas (credentialed in the Bahamas). All seven of the participants matriculated, though at different stages, into the Physician-to-Nursing program at one public, South Florida tertiary institution.

Table 3 contains demographic and other information for the participants, all of whom are given pseudonyms to protect their identities.

**Table 3**

*Participants' Demographic Data*

Name	Gender	Birthplace	Country of Licensure	Practiced Medicine Abroad	Marital Status	Languages Spoken	Projected/ date of Graduation
Nancy	Female	Columbia	Columbia	Yes	Married	Spn/Eng	2021
Susan	Female	Haiti	Haiti	Yes	Married	Creole/Fr/Eng	2017
Victor	Male	Haiti	Haiti	Yes	Married	Creole/Fr/Eng	2016
Winston	Male	Haiti	Belgium	Yes	Single	Creole/Fr/Spn/Eng	2016
Mandy	Female	Bahamas	Bahamas	Yes	Single	Eng	2015
Jessica	Female	Haiti	France	Yes	Single	Creole/Fr/Eng	2013
Stacey	Female	Guyana	Cuba	Yes	Married	Spn/Eng	2021

The data were collected via 45 to 70-minute one-on-one interviews. The participants were interviewed once. Due to the Covid-19 pandemic, interviews were conducted using ZOOM video conferencing technology. The recording features within ZOOM were activated only after permission to record was sought from each participant. None declined. Once the recordings were completed, they were downloaded into the secure ZOOM folder. A coding table consisting of five columns was designed for use in this study. The column headings included the participants' pseudonym, direct quotes, units of meaning, deductive quotes, and notes.

The following steps were guided by the scholarly work of Braun and Clarke (2015). First, the transcripts were read through while listening to the audio. Secondly, the transcripts were read through to generate inductive units of meaning. Thirdly, transcripts were re-read and deductive codes noted as they related to TL, the theoretical framework

that undergirds this study. The units of meaning were then scrutinized for the numbers of times a particular topic reappeared and for the relationship each had with the other. . Creswell (2016) stated that sound qualitative research goes beyond description and the categorization of themes to make multifaceted theme connections. A separate coding table was used for each participant. A snapshot of the working coding table for one of the participants can be found in Appendix III.. This coding process for the seven participants generated 16 topics shown in Table 4.

**Table 4**

*List of Emerging Topics/Units of Meaning*

Topics/ Units of Meaning
Push & Pull Factors of Migration
Safety / Security
Credentialing Limbo
Starting Over
Opportunity
Credential/Certification
Disorientation
Language Barriers
Livelihood
Underemployment
Family Reunification
Scope of Practice
Loss of Symbols/Identity
Problematizing Difference
Acceptance
Peace

**Validity & Reliability**

Validity is defined as the preciseness or correctness of a thing described, interpretation of it, or conclusion about it, Maxwell (as cited in Coleman, 2022), and reliability is associated with the suitability of the methods undertaken and the integrity of

the final conclusions, Noble & Smith (as cited in Coleman, 2022). Creswell, (2016) suggests that validity and reliability are the strong suits of qualitative research and are determinant on whether the findings are accurate from the view of the researcher, participant, or the readers of the interpreted data.

This researcher demonstrated that the process used for promoting credibility and accuracy was a good-fit for the research purpose by relying primarily on four validity and reliability strategies commonly used in qualitative inquiry including a) Member Checking, b) use of Rich, Thick Description, c) Theoretical Triangulation, and d) Clarifying Bias (bracketing & reflectivity).

### **Member Checking:**

Throughout the interview, this researcher casually echoed, paraphrased, and requested clarification regarding participants' utterances to ensure that what this researcher understood is what in fact was meant by the participant. This type of informal validation strategy, referred to as member checking helped to substantiate the accuracy of the exchanges during the data collection stage. Gray (2018); Rutakumwa et al. (2020) suggest that the researcher also be sensitive to and continually aware of the degree to which verbal and non-verbal responses are congruent further confirming a genuine response. This researcher felt that the use of ZOOM video conferencing, with its tiled, up-close windows helped to capture some of those verbal and non-verbal cues. The close-up recordings provided by Zoom, allowed this researcher to capture nuanced behaviors such as breathing patterns, or eye movements, or pauses that may not have been readily observed in a face-to-face interview setting. Post interview, this researcher also shared with the participants, pertinent sections of their responses and merely asked them to

provide feedback regarding the accuracy of both the report and its interpretation. This researcher found this form of member checking both desirable and useful to promote the accuracy and credibility of the process.

### **Thick Description**

The second validation strategy used to ensure the credibility of the interpretation of the data was the use of thick description. Drew (2021) defines thick description as a qualitative strategy that goes beyond the mere recording or description of an event, but rather seeks to give background and context needed to make sense of the meanings, intentions, and interpretations. Clifford Geertz (1973), one of the pioneering theorists around thick description, contends that thick description brings us into proximity with the lives of strangers.

For example, Jessica, an FEP who hails from Haiti, used thick description to convey her sense of loss due to the 2010 earthquake that by some accounts claimed over 300,000 Haitian souls including her closest loved ones. Mitigating the losses was the pull factor that led Jessica away from her country of origin, and it contextualized her intentions and decision making.

In some instances, thick description involved voluminous, page long, detailed accounts from the participants with each sentence building intentionally on the other to provide context and to make sense of the meanings. In Jessica's case, however, it is in the simplicity of her utterances, expressed in just a few sentences that provided thick description which as Clifford Geertz (1973) suggests, brings us into proximity with the life of the stranger. For example, in her interview Jessica reveals that

... after the earthquake in January 2010, I lost my husband. He passed away. Yeah, I lost my clinic. I lost, so you know almost all activities I had in my country. So, I lost the clinic. I lost my husband. I lost the school. There was nowhere for the kids to go to...everything collapsed. It's like I lost almost everything. I decided it's better to start over in the US instead of staying.

**Theoretical Triangulation:**

Triangulation involves looking at data from more than one perspective to promote the credibility and validity of research (Noble & Heale, 2019). Denzin and Lincoln, (2011) described four distinct forms of triangulation as Data Triangulation, Methodological Triangulation, Researcher Triangulation, and Theoretical Triangulation. Regardless of the form employed, each has the same overarching goal, and that is to aid the researcher in developing a more comprehensive understanding of the phenomenon. As described in the previous chapters, this study is built upon multiple theoretical frameworks (TL, Otherness, and Liminality), each critical to the construction of meaning and to the interpretation of the FEP participants' data. Working at times in concert, each perspective was used in the triangulation process to promote the credibility and validity of the study. In terms of theoretical triangulation for example, the confusion and disorientation expressed by participants as they encountered the initial activating event and dilemma in TL, are not unlike the Liminal feelings of ambiguity and unknowingness expressed by the participants as they began the threshold work during the BSN phase of the program. Furthermore, the feelings of Otherness spawned by the realization that the scope of medicine and the scope of nursing practice were chasms apart, based on the participants' reports also created feelings of disorientation, ambiguity, and self-doubt.



The three theories, triangulate seamlessly to validate the accuracy of this researcher's interpretations and the integrity of the final conclusions drawn.

### **Clarifying Bias**

The fourth strategy used to promote validity and reliability was the clarifying of bias which Creswell (2016) described as a form of critical reflection which produces a frank narrative that echoes with the reader. In the section of this study entitled Role of the Researcher, this researcher clearly expresses similarities between the researcher and the participants, particularly as they pertained to the immigrant experience. As interpreter of participant data and meanings, this researcher was transparent about the potential for bias to be injected into the study. This admission and reflection allowed for the bracketing of judgement, and of the preconceived notions around immigrants in transition. In fact, the crafting of the first interview question intentionally introduced the immigrant experience both for the participant and as a reflective reminder to the researcher that some of this interpretation and meaning making is bound to be shaped by similarities in background and immigrant experience of both the researcher and the participant. The first question to the participants follows: *Tell me about the factors that played an important role in your decision to leave your country of origin to immigrate to the United States* (Interview Question no. 1.).

### **Thematic Analysis**

The findings from the study are presented by employing the process of thematic analysis which is a recursive process that involves familiarization with the data, code generation, theme generation, theme review, naming the theme, and preparing the report.

Howitt and Cramer 2010) state that thematic analysis provides an “accessible, systematic, and rigorous approach to coding and theme development.” (p.223)

Braun and Clarke (2015) describe two common forms of thematic analysis—inductive analysis and deductive analysis—both employed in this study. Inductive Thematic Analysis is analysis that is largely grounded in the data as opposed to concepts and theories. Deductive analysis on the other hand, analyses the data through a theoretical lens with the theoretical concepts informing the coding and theme generation.

### **Inductive Analysis**

The topics generated out of the body of the data as shown in Table 4 were further scrutinized, inductively analyzed, and arranged into three primary themes which were all evident through the narratives of each interviewee. These were (a) Migratory Patterns (b) Beliefs about Obstacles and Challenges and (c) Beliefs about Reclaiming the Self. Each primary theme contained secondary themes and sometimes sub themes. The themes are shown in Table 5.

**Table 5.***Summary of Themes Generated from Interviews*

Summary Theme	Primary Themes	Secondary Themes	Subthemes
1. Migratory Patterns Push and Pull factors	Safety, security, insecurity	Mobility	
	Opportunity for a better life	Livelihood	Financial stability
	Curiosity	Ddifferent culture	
	Loss	Natural disasters	Survival
	Starting over		
2. Beliefs about Obstacles and Challenges Encountered	Credential limbo	Underemployment	Loss
	Being othered	Discrimination	Building walls
	Difference as a problem	Language barriers	The next best thing
	Scope of practice	Nurse vs physician	Letting go
	Liminality	Betwixt and between	Stuckness Incivility
3. Beliefs about Reclaiming the Self	Acceptance of new roles	Coming to terms	
	I am me again	Mental wholeness	
	Regaining confidence	Perspective Transformation	

Using these themes as a framework this researcher then sought to accurately capture clear representations of their experiences by teasing out and documenting thick description and meaning around the unlicensed FEP phenomenon. Clifford Geertz, (1973) in his seminal work, *Thick Description: Toward an Interpretive Theory of*

*Culture*, opines: “It is not against a body of uninterpreted data, radically thinned descriptions, that we must measure the cogency of our explications, but against the power of the scientific imagination to bring us into touch with the lives of strangers” (p.8). A description and examples of the primary themes, with secondary and sub themes follows..

### **1. Participants’ Migratory Patterns – Push and Pull Factors**

A common thread which runs through all the participants’ experiences is that they are representative of health-care workers on-the-move. During the interviews, each participant described, in some detail, his/her mobility, and the activating events that led to the decision to leave his/her country of origin. Interviewees recounted their desire to earn a better living, to develop their career, to experience other countries, to live a more safe and secure life, to reunite the family, and to mitigate loss. Each of the participants, in addition to earning their medical licensure outside of the United States, were already practicing medicine in one capacity or another prior to migrating to the United States

Stacey was born and raised in Guyana, South America -n English-speaking country that culturally resembles the Caribbean region. After growing up in Guyana, Stacey moved to Cuba to pursue her medical training in Camaguey Cuba. She described her experience:

Alright, so, uh, my I’ll give you a little background. I studied in Cuba, medicine. When I was in my fifth year, which is the year before you start internship, I met my husband to be. We met, fell in love... the whole nine yards, then we, then I came back to, I went back to Guyana to do my internship and then, he came over, we got married in Guyana, I’m talking about 10 years ago. It’s been 10 years since we’ve been married, so I’m talking about 2010, 2011.

### *Safety and Security*

Stacey describes in some detail, the events which led to her leaving her medical practice and vocation in Guyana. For her, safety and security was a primary theme as she confirmed:

Uhm, there wasn't that many light skinned Cubans or light skinned people in Guyana. You can see a few and people would you know, lock eyes on you and decide that you are definitely not Guyanese. This is a foreigner, so that's the context I'm talking about. Now my husband is a huge soccer fan, and he loves the Brazilian national team. This meant that he often wore his Brazilian soccer T shirt. And why is this Bad? Dwight, that's bad because in Guyana, the Brazilians are the ones with the money. They come to Georgetown, which is the Capital, and they open businesses. They do a lot of gold mining, so when you think of a Brazilian you think of money alright, and my husband was assaulted. He was, before we had a car. He was just leaving work dressed in a shirt and dress pants going to catch the bus and guys were on bicycles with knives behind him. You know, so many occasions people tried to kidnap him. Things like that... there was so much violence and corruption. We were actually planning to buy a House. We were planning to start our family and everything, and then that was one of the reasons... one of the main reasons why we left because we couldn't have a safe future.

Stacey further describes the animating events that influenced her decision to leave her country of origin, to walk away from the practice of medicine and the symbols of her

years of scholarship and sacrifice. The most basic of human needs to feel safe animated Stacey's decision making. She recalled:

When we would stop at the stop lights, you lock your car. When you go to the ATM, you're always looking behind you. When you go to the ATM you look over your shoulder. Right? it's dangerous. For people of our skin tone, we fit in, but for him, my husband, it was a constant stress, constant struggle, and tension. And that's the main reason why.

Victor is a male who hails from Haiti. Prior to migrating to the United States, Victor served for many years as a physician in Haiti. He worked for the well-known and noble organization, Doctors Without Borders. Like Stacey, it was the prospect of safety and insecurity, magnified by an unstable political climate that pushed Victor away from his country of origin. Concern for his personal safety played an important role in his decision-making as kidnappings of professionals were common throughout the Island. He talked about his concerns:

The first thing that came to my mind is you know security because at the time I was working pretty well over there. You know I've got a decent life. I mean, you know I was doing good, but there were so many insecurities... and they start with the kidnapping. I had friends who were kidnapped. So as you know, yes, actually I said to myself you know what? I think it's time for me to go somewhere else. Actually, I was fortunate because I had a green card. I was a resident in New York, so it's not like I came here with nothin'. I've been a U.S. resident for the past ten years before I decided to move back here. Even though I really wanted to stay

in my country to help the people who needed the help, it was too dangerous for me the way the country was at the time.

Victor, like other participants in the study, expressed the deep concern he has for the wellbeing of his country, and agonized with the decision as to whether to stay or to go. He stated:

I used to work in an NGO called Doctors Without Borders. We usually work in underserved communities, so they were kind of familiar with my face. I knew them, and what they were doing because we were providing help to either them or their families. So those gang members knew me, and I knew them well. But those people now they know my face. They know I am a physician, and they are going to say, you know what? These are the kinds of people who make a lot of money, and we on the other hand are suffering. Maybe one day they will get to me. I have a friend whose wife was kidnapped. When that happened, I decided that I do not want to go through all of that.

Victor, like so many others, was faced with the real threat of harm to himself and his family members. The theme of safety and security persisted as push factors throughout his and other participants' decision making.

### ***Mitigating Loss***

Jessica was born and raised in Haiti. Jessica enjoyed the prestige of owning and operating a successful medical practice in Haiti that included clinics and even a medical school. Jessica's husband was also a practicing physician. In fact, Jessica reports that other close relatives in Haiti were also practicing physicians. Jessica also practiced medicine in several countries including French speaking Guadelupe. It is no

understatement to say that the life-saving vocation of medicine played an important role in Jessica's identity.

Unlike Stacey, who migrated to the United States from Guyana because of security and safety concerns, Jessica's migration out of Haiti, on the other hand, is a story about mitigating unimaginable loss. She explained:

I used to come to the US where I would live for short periods of time, but in 2010, after the earthquake in January 2010, I lost my husband. He passed away. Yeah, I lost my clinic. I lost, so you know almost all activities I had in my country, so I decided to relocate in the United States and stay here to manage that. I had one child already living in the US. Also, it was a disaster for the country... kids were unable to go to school, and you know everything was shut down. Everything was closed. So, I decided you know, to recover my family members. Also, my mum decided tha' it's better for all the family and the kids to be relocated in the United States. I took my mom's advice.

Jessica further describes the animating events of loss, spurred on by the disastrous 2010 earthquake that was responsible for the deaths of over 200,000 of her fellow Haitians. The injured topped well over 300,000 according to government estimates. Jessica described how loss further influenced her decision to leave Haiti for the United States.

So, I lost the clinic. I lost my husband. I lost the school. There was nowhere for the kids to go to...everything collapsed? It's like I lost almost everything. I decided it's better to start over in the US instead of staying.



### *Opportunity for a Better Life*

Nancy, a female who hails from Bogota Columbia is married with a young son. She received her medical training in Columbia and graduated from medical school in 2000. She was a general practitioner and also worked in primary care and pediatrics. Unlike Stacey who cited safety concerns as the animating event for deciding to leave Guyana, and Jessica who cited mitigating loss as her activating event, Nancy instead reports that opportunity for a better life and livelihood for her and her family was the main reason for migrating to the US.

Windows of opportunity are cited frequently in the literature as important pull factors for migrants. They occur at the meso-level and tend to relate to individual circumstances such as family reunification, cultural profile of the host country, language skills, recruitment, and opportunities for a better life for self and loved ones (Young et al., 2012).

Nancy recalled her motivation:

... and when my son was born, we decided that we wanted to offer him like a different kind of life, like more opportunities. That was like the main reason that we decided to move here to this country because we know that he is going to have more opportunities because in Colombia things there are not going well since, like a couple of years ago. The opportunities for study are there and the level of the education is very good, but after that everything is very complicated. When you are a new graduate and when you want to, like, uh, have a job and like organize your life' it's very complicated and also because Colombia is a very traditional country and maybe if our son wanted to like I'don't know, study or do something

like not so traditional with his life, it would not be the best scenario for him. For example, if he wanted to be a scientist or to be an artist, like there is not much space for that there. There is space, but it is very difficult and very hard to like, have an education in that. After that, to work and organize your life is hard. That was the main reason that we decided to come here to this country.

### *Curiosity*

Not all migratory patterns of health workers are born out of security concerns, or the pursuit of livelihood opportunities, or to mitigate painful loss. In some instances, FEPs give up the familiar, and the comforts of their countries of origin to exercise a deep curiosity about the professional world around them - a yearning for exploration.

Mandy is one such FEP whose self-imposed uprooting was born out of curiosity. Reio and Sanders-Reio (2020) describe two distinct forms of curiosity—cognitive and sensory. “Cognitive curiosity is the desire for information and knowledge, while sensory curiosity entails desiring new thrills and experiences” (p. 19). Mandy showed both these types of curiosity.

Mandy hails from the Bahamas which is geographically at its closest point a mere 50 miles off the coast of Florida. This proximity between the two countries has long accounted for deeply rooted historical, cultural, and human capital exchanges between the two. In some parts of South Florida such as Coconut Grove, and Coral Gables, Bahamian DNA flows through its architecture, cuisine, and seasonal festivals. Not surprisingly, Mandy, despite her comfortable life in the Bahamas, was prepared to walk away from all the pomp, prestige, and stability that come with the title of “physician” in the tiny archipelago nation.

Despite her comfortable life, Mandy was lured by the prospect of new experiences and the thrills that accompany them. As she says:

I felt like my country was a little bit too small for me. I really wanted to live in a country where I would have more freedom and to be exposed to more. Um, not only medical freedom, but life, right? I had a hunger for more... to experience more in terms of medical exposure and learning more in the medical field. I felt that I should give it a try. You know, to get into a residency and such... you know I wanted a blend of both worlds.

## **2. Participants' Beliefs about Obstacles and Challenges Encountered**

Participant interviews showed that each participant was at a different point of acceptance of their fate upon arrival in the United States. Some were already aware of the steep challenges and obstacles that lay ahead. For others it was upon arrival that they first realized the enormity and even existence of these challenges. For all participants, they were faced with a level of personal sacrifice in gambling with their original career and vocation.

### ***Acceptance of New Roles***

A consistent theme is that ultimately, the decision to enroll in the Physician to Nursing Program, was one born of practicality, and not due to a sudden change of heart in a vocation or career path. Generally, economic factors, anticipation of a long and grueling study period similar to their original journey through Medical School, and the prospect of time spent away from family, were sacrifices not deemed worthy of hazarding when the possibility of successful completion of the USMLE program and gaining a medical residency, was a tenuous expectation at best and unachievable at worst.

Susan is the wife of Victor the FEP previously highlighted in the section entitled “Participants’ Migratory Patterns”. He had fled Haiti and his job as a physician with “Doctors Without Borders”, due to his security concerns and fears of being kidnapped. His wife Susan, also a physician, later joined him, and though her hope was to continue in the medical field, she ultimately decided to avoid the medical recertification challenges to instead become a nurse practitioner. Walter-Roberts (2020) contends that talented immigrants, particularly in regulated professions such as the health industry, often face duplicitous and complex certification and credentialing systems in destination states. Susan talks about her realization of the obstacles she faces:

OK, so I had the choice to do the USMLE to pass the board to be a physician. But I wanted to have something really fast, and I mean, that is more practical. That I am sure that I'm gonna have a job after three years and a half. That there's no doubt, because for the USMLE, you have to study more. You have to pass two exams and at the end, you don't even know if you're gonna get into a residency. So I wanted to have a simple and safe option.

And additionally, she also had to consider her family situation:

... so basically I have two factors that I wanted to (come to the US). To rejoin my family and have everybody together. By then, I already had my daughter, my first daughter. Yeah, so that we reunite the family, and the second reason is that I knew that program (FEP to Nurse Practitioner), was what I want because... I mean, it was sure for me, certain... I wanted to come back to the clinic pathway and do similar things as a physician like I was doing in Haiti... seeing patients from eight to five. I didn't want to have any night shift. Because when you are nurse, not

nurse practitioner, you have night shifts too. Yeah, so I wanted to have an 8 to 5 schedule and have a stable job and then to have everything like a house and to be able to do what I need to take care of my family and all my needs.

Susan's decision to put family before self, is echoed by Nancy, the FEP from Columbia, who had made the journey to the US to give her 1 year-old son at the time a better future. Nancy explained:

Since the beginning, since we decided to move here, I had in mind to like work in the healthcare field. But I was sure that I didn't want to become like a physician here. Because of my son, because he was little when we moved here, he was just 1 year old, and I wanted to be with him. I didn't want to miss all those years, and I knew that if I started to study and try to validate my title here it will take like a lot of time, a lot of energy and after doing all that I still need to pass residency. And obviously I will not be able to spend time with him..., I will not have the opportunity to like, see him all the time and like that was my main plan..., when we moved here, I didn't want to like take the USMLE steps and all that. I didn't want to do that, but I wanted to do something in the healthcare field...

Both Susan and Nancy had a desire to remain in the medical field, and had the opportunity presented itself, would have maintained their prior career paths as physicians. The choice to become a nurse practitioner was rather "the next best" choice, a sentiment shared by Susan's fellow FEP husband Victor, who says of joining the Physician to Nursing Program: In his own words Victor confirmed:

At first I didn't want to. I have to tell you. At first I didn't want to do it, and that's one of the reasons why my wife went before me, 'cause she said, you know what?

I'm not gonna go through all those steps, of USMLE program, and everything. (I'll) go, it's the next best thing. Let me do it, but I'll be the first one. But the more I was waiting, you know, I was studying for my steps of USMLE program, and...I have other friends who are flowing through that program, Physician to Nursing and they've been telling me, "oh, it's good, it's good, come on man, come on, it's good... you still will be able to practice and to see the patients the same way as you used to in the past.

### ***Credentialing Limbo***

For all participants, the Physician to Nursing program provided the best opportunity to do a job most closely approximating their former physician roles and to accomplish the transition within a time period that made most practical sense, taking into account family and livelihood. Nevertheless, some participants were taken aback by the scant regard the Medical Association held for their prior academic and professional training. This credentialing limbo triggered the disorienting dilemma for these FEPS upon realizing that these long years of intensive study and professional practice apparently now counted for naught. Nancy described her particular experience of this disorientation:

At the beginning I was thinking about maybe like becoming a physician assistant or a nurse practitioner, and I thought because I already have the knowledge it will be like, easier. I'm sorry, I don't know why, but I thought it will be like easier to follow that path. You know, to become one of those. But since I graduated, like I told you before in 2007 like... all the places that I visited schools...asking for information, I was considered old. And even though I was in practice for many

years after I graduated, they didn't count any of that experience... When I first moved here, I felt like my medical license and my medical studies were not enough for the people here. Then it was harder to try to enter to one of those programs, and in... looking for the programs and looking like what to do, I found the program here in Florida. And that's why I'm lucky. I could... enter to the program, because like you know, life works in a perfect way because I just enter to the program and then the program closed.

***Scope of Practice: The Nurse Versus Physician Dilemma***

Participants, with varying degrees of willingness, chose to enter the Physician to Nursing program, with the hopes that they may be able to simulate their previous healthcare careers by becoming nurse practitioners. All participants indicated that they believed the program would be well within their realm of knowledge and, based on their previous rigorous study to become doctors, likely easier than their past study, thus giving them an advantage over individuals without their medical knowledge. Nevertheless, participants were uniformly taken aback by the difficulty the Foreign Physician to Nursing program presented to them, and the feelings of uncertainty and insecurity which accompanied it, particularly at the BSN phase of the program.

Each participant without exception highlighted the issue of coming to terms with the nursing scope of practice as being one of the most challenging, if not the most challenging, of the entire Physician to Nursing experience. The nurse versus physician way of thinking was often an early signal that an identity crisis was not too far behind. Participants described this phase as a need to “change my mentality”, “change my brain” and reflected on an experience akin to a changing world view, with the familiar world

being their vocation - the practice of medicine. In more than one instance, participants physically twisted their heads around as far as their necks would allow when describing the scope of practice dilemma. Susan observed:

I had to twist my brain the other way because you're trying to think one way and you literally are forced to think like a nurse... I would say, I had to train my brain I think 4 steps or three steps before what I would normally do. As a doctor you go in and you examine and diagnose and you treat. But the nurse knows what pathology it is, and they know how to position the bed the right way for that patient. It's the little things that you overlook in medicine, that I had to learn and to take into consideration as a student nurse. It was tough. It was tough, let me tell you. Just like, the fundamentals of nursing, you think, "oh you're a doctor. This is easy." Nursing is not medicine. At least the first part of it, the BSN part of it, 'cause ... the MSN, it's all medicine. But the first part of it, that was not medicine. It was nursing and it's beautiful.

Nancy's comments on her early nursing experience mirror those of Susan and go even further:

That was very like difficult because of like first of all, because of the type of education like I told you before, like the way that I was trying to think, it's the way that a doctor, a medical doctor thinks. Things... physicians do, you think about the illness and the symptoms. It is very different. Everything is very different and organized... following a certain kind of steps. And when you enter to the nursing world, it is about being with the patient. It's not only what their symptoms are, but how the patient is feeling and how to really advocate for the



patient and all that. That's really amazing..., and that's something that you don't learn in medical school.

She used the example of the “number in the room” to explain her increased patient empathy:

In Med school, I felt like you learn about empathy with the patient, but it's not at the same level of a nurse. You know all the nursing theories that I learned during this time, in the couple of years in these two programs? They make me think about really that relationship that you can have with the patient, and like I told before, like in Med school that was not there all the time. Like sometimes in many, many situations the patient becomes like a number. The number of (their) room, the number of a bed or like the result of a laboratory; or an image.

Something like that, but you don't think about how really the patient is feeling because you are not with the patient.

Jessica, the FEP from Haiti who left her home after losing her husband, and Mandy from the Bahamas also mention the frustrations of having to learn to think like a nurse and no longer being allowed to perform functions that were previously expected of them as a physician. Nancy and Mandy go even further in detailing the disorientation experienced when having to stifle impulses of practice that were previously second nature to them, as a physician. The discrepancy between the assumptions that Nancy and Mandy made regarding their impulses to perform tasks like physicians and the reality of having to instead think like nurses is characteristic of a disorienting dilemma, the initial phase of Mezirow's Transformative Learning Theory.

For Jessica, and some of the other participants, returning to school so many years later in life also presented a challenge with changes in technology and methods of learning. They bemoaned the loss of agency even with seemingly simple things like having to wear scrubs, sneakers, and different colored clothing as being similarly galling. They bemoaned the loss of their physician symbols. She stated

First of all, yeah it is a different type of learning experience because the teaching strategies are different. We used to have with the teachers like explaining in detail, but now it's completely different with the technology... so you don't feel that same connection. So being a student like almost more than 15 years after, it's difficult to adjust to the new technology... So every day it's a learning process...and then you have to learn in a different way because you have to understand that as a nurse you cannot prescribe. You cannot order, so you have to have a different mindset when you go to each class. It's like you know you have the knowledge, but you have to learn a different way. Because it's the different scope of practice and the teacher told you, "now you have to be careful"...And being a nursing student, it's very difficult because you feel like that what they're teaching you, you know already. This is, uh, you know already what they're talking about. For instance, talking about like anatomy, talking about physical assessment... you know how to do an assessment, but you have to do it and then do it again.

## *Liminality*

Jessica goes on to explain the feelings of being in betwixt and between “... neither physician nor nurse” a liminal phase as described in Chapter 2. Malksoo (2018) describes liminality as:

The liminal state is a central phase in all social and cultural transitions as it marks the passage of the subject through ‘a cultural realm that has few or none of the attributes of the past or coming state’. It is thus a realm of great ambiguity, since the ‘liminal entities are neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention, and ceremonial’. Yet, as a threshold situation, liminality is also a vital moment of creativity, a potential platform for renewing the societal make-up. (p.1)

The theory of liminality is one of the constructs used in this study to interpret the participant data regarding their feelings of ambiguity, uncertainty, and stuckness.

Jessica’s liminal experience is characterized by her feelings of ambiguity as she experiences new situations that bear little resemblance to her past. She observed:

You don't really like it at the beginning. They tell you they're gonna teach you. To be honest, you don't see yourself working as a nurse. You don't understand how you're gonna do it, and you have to wear the scrubs that you don't like. You do simulation in nursing classes where you have to do all the stuff that most of the time, you used to order people to do. Before you told them to take the vitals, but now they tell you, you're gonna take the vitals. So, yeah, I need to take the vitals. It's really...difficult.

### *Scope of Practice*

And continuing on the theme of agency and performing undesirable tasks, Jessica pointed out a specific example:

Also, you have to make the bed well. I remember ... they tell you, you're gonna do the bed and I've never been able to do the bed correctly because you know, I never really had to as a doctor. I would just arrive, and... the patient is already in the bed... So now you have to learn how to do the bed, how to, you know, prepare the bed for the patient, give a bath, so those type of stuff, you feel a little bit diminished. You say, "Oh my God, what am I doing?" It was some classes. I remember those classes on a Saturday. You come, you know, really, just as a nurse with your scrubs, with your sneakers that you never like to wear, before, as a doctor, you used to have your heels, your lab coats, and now you have to do the bed.

While Mandy also presents evidence of the same struggles of the other participants in coming to terms with her new "scope of practice", her attitude of early acceptance of these changes, went a long way toward making the physician to nurse transition, more palatable. She explained:

... I mean honestly, it's two totally different disciplines. So, to me I was kind of confused... and this, it drove me nuts. I said to myself, I said, if this is what I need to do to get to the next step, I'm just gonna do it, and for me I liked it, because what it did was it fine-tuned my medical information, my medical knowledge and so for me, I feel like it was fruitful. And I can tell you from a nursing perspective, they look at the body holistically. I don't want my words to come back and bite

me because a doctor, a doctor may come and listen to this and be offended.

Honestly, uhm, nurses to nurse practitioners spend way more time with patients. They get to understand more. They ask more questions, and they help the patients understand more of what their diagnosis is. There's more patience, and, um, I don't know whether or not we do it because nursing is, kind of a nurturing type of discipline and medicine is a little different... From how I practice now, I'm still a physician. You then realize that I'm not ever gonna lose that name because I've already been crowned.

While all participants struggled with the shift from physician to nurse, for some these issues were exacerbated by language barriers; for many FEPs English is a second, third or even fourth language as seen in Figure 9. Therefore, they were forced to manage what is already a difficult transition, with the added pressure of doing so in a language that is not naturally their own. Such was the challenge for Winston, a Haitian national, who studied medicine in Mexico City and Belgium, but faced constant obstacles accepting his new role as a nursing student in the Physician to Nursing program. His frustrations with his loss of his status as a physician are palpable as he recalls:

To switch my career of physician to go to the nursing, I feel, I feel bad. But also I accept these reality, this is the reality of the USA. This is political, because before, in past years when you come here as a physician. They give you position as an AB, a physician assistant. And after, and now in current times, they don't give,... you any more physician assistant position. Uh, sometimes I feel bad because, uh, the nursing body is different from a physician,... but when you are in nursing, you have to receive order... as a physician you give order... As a

physician, my custom is to give order, not to receive order. Sometimes, when I took the exam, it was very, very difficult for me with the pharmacology ... because sometimes I felt that I (did)...enough. Then I answered bad the question always in pharmacology....When they give me some pharmacology question, sometimes I answer as a physician because I forgot. So... this is a... difficult ...for every person as a physician right now to switch...This, this is a difficult thing.

Winston goes on to share the anguish he experienced “taking orders” in his clinicals class, sometimes from physicians, as a former physician himself. He repeatedly, throughout the prior quote and in the one below, refers to himself as a physician, revealing his conflicted emotions about being a nurse, the title he now carries.

And also the physician give you order when the physician know you are also a physician. Sometimes, it depends on who the physician is how he treat you. To switch from a physician, to only a nurse is very painful. The keyword is painful, but you don't have no choice. To switch from a physician to only being a nurse is very painful. For me, for example my country right now is very bad always. I want to come back to my country to practice as a physician, but also if I have what is here NP license, this can also help me. This can be like a supplement if I come back to my country, I have a NP nurse practitioner license, then I have more... licenses. Uh, it could work very well in my country, but unfortunately, my country right now... is very bad politically and economically.... I have to wait, but also I have a dream to go back to my country at the end.

Winston highlights his struggle to assimilate here, and the frustration he feels having to “take orders” from someone who, at another time of his career would have been his peer. But even more challenging for most of the former-physician participants, was having to take orders from nurses, who in their previous physician lives would have been their subordinates but were now their teachers and instructors. Coupled with this role reversal, was the additional factor that some of these nurses were themselves unsure how to regard the FEPs and sometimes treated them as interlopers, imposters capable of taking away jobs that should be going to “real nurses”.

Nancy explains this in more detail:

...the other part that was difficult was, I remember when we started going to clinicals, like many, many of the nurses were like, not so gentle, not so nice with us, because yeah, many of the nurses are thinking ok, you are a physician, and you are from other parts of the world. You are not from here. Why are you coming here? Why are you studying this? And why are you gonna take away the job of a nurse? It was like, many of them thought that there were not enough space for everyone. You know, it's like you are coming here to take something that is not for you.... And the other part was, some of the nurses also in the clinical practices...you know, were like, OK, you think you know your stuff because you're a doctor, but that's different stuff. You can forget that, and you need to learn what I do, because I'm a real nurse. And that wasn't fair. You know, that's not the way that you should approach anyone. OK,... even if you say you have some kind of different knowledge, maybe you can teach me something, I can teach you something, and we can learn like both parts. That obviously can help

both parts even more, than that attitude of, I don't know, like you don't belong here or something like that. That part was very difficult too. And I remember that when we were going in our groups, we were going to the clinical place, sometimes we were like, we are not going to say that we are FEPs. Like no, nobody is going to say that, because if someone says that, the nurses are going to be mad with us and we are not going to receive the same treatment as other students.

This unfamiliar role of the FEPs as being subordinate to their nurse instructors, as well as facing being “Othered” where the difference was clearly viewed as a problem by some of their handlers was also a source of great discomfort for Jessica. She observed:

...the clinical part at the hospital was difficult. First of all, at the beginning you arrive and then, (the impression from the nurses is), OK. So, what are you? You are nice, you want to practice with us, yes, but you are a doctor. So, when you identify yourself, “OK, I'm an IMG international medical graduate, I am a foreign medical doctor, and I'm in the (BSN) program to become a nurse. So, first of all, sometimes you have to be trained by an LPN. So that thing is freaking me out because, I'm a doctor, and then I want to become a nurse, so they don't know exactly what to do with you, what to teach you, what you know, what to do. So, some of them were a little mean. Some of them they don't know what to what to tell you exactly. So..., depending on the location, of the clinicals, we had a lot of,...frustration, because it's not exactly the practice and the setting that we expected or the end result that we expected... And also for us it was very difficult, (because) sometimes you don't feel that you want to go and dress like a nurse and



to be trained by an LPN. Sometimes..., and this part was very difficult, now you have to explain also all the time why you want to do that become a nurse. Why? Because the question that they always ask you is, “why you don't... try to get your USMLE? This is the key point. If you are a doctor, why you don't get your USMLE? So now, you have to explain that you needed something a livelihood quickly and you consider this nursing program as a solution...OK, so and then they tell you, but you don't fit for this. You're not gonna be a nurse...Do you want this? Do you want to be at the patient's bedside, because you don't have good bedside manner. It's difficult... You have to explain and try to help them understand that. So, you look like a loser. You look like a loser or something, because the correct way should be to get your USMLE. So, if you don't get the USMLE, or you're trying to get it, some of us try to get the USMLE but they fail, or you got the first part and the second part, but you failed the third part and you're not admitted to residency. So, they consider us losers compared to others. Then yeah, this is a problem....so, you have to face that challenge....So they nurse instructors, don't know how to treat you. Sometimes they try to explain things that you know already. So, then they say, “OK, because you know this already, you should do perform, better. So, the clinicals were very, very difficult. At the beginning, for the first year, because the first...you're trying to become a nurse. The second year is different, because you're more in the master program MSN, so it's... more or less different...The first year it was a challenge; you look like a loser and also you are a stranger to them...But when they see the way you interact with patients, you know, they finally, they accept you.

Nancy's observation and feelings about her situations, as do all of the responses thus far, reveal complex emotions, as well as deep and often conflicting feelings, as the FEPs chart a path toward their goal of becoming nurse practitioners. They wrestle not only with their own feelings of doubt and insecurity, that is characteristic of the liminal phase, but also those pressures brought to bear on them by teachers and instructors who often made them feel like the other, when they should be the very individuals who should be facilitating their transition. This pushback was not just limited to instructors but also at times displayed by friends and family, their most vital support systems, Thus the conflict about their decisions to enter the nursing program extends beyond themselves. Susan aptly described the dilemma:

... so there was this one guy in my class. He started with us and during the BSN he matched and he left, so he's doing residency. He matched 'cause he met somebody and the person helped him. And so every time I meet with my best friend, (because she and the person they are very good friends), she's always like, "Susan, you're so young, you should do it still (USMLE), and try to match... So, one thing I would say, is that sometimes,... you do lose that peace when you have certain conversations with people.... So when I meet with my friend and this other friend I have, he's like, "Sarah do it, you're so smart, you're so young..." He's like, "do it, do it", and you know, they play with my brain so much... They came by my house and they met my husband for the first time, and we were at the table, right? We were eating and they were like, you know, they're telling my husband, "you know, Sergio", (my husband's name is Sergio), " You need to convince Susan to go into the USMLE." You know, and then he was... like

“yeah, why?” Oh, because there's this (USMLE), and she knows everything, she just needs to study and then she's gonna meet people who are gonna help her”. And then they left. But they created a fire in my house. Yeah, now my husband would be like Susan, “You want me to buy the books for you (to study for USMLE), Susan?” ... And I would be like, “no, you know, we don't have children. It's gonna be 10 years now. We married to start our family. I don't wanna do this again.” You know I'm at peace with it. We are at peace, but my husband is such a high achiever, you know, and he wants me to be fulfilled. You know, I don't blame him...You want your spouse to be the best person they can be. And I don't know if he thinks that I'm not being genuine, or maybe I'm convincing myself that I am at peace and what-not. But I believe that I am at peace. I don't know if he's telling me this because he doesn't really know the nitty gritty of the USMLE and everything.

### **3. Reclaiming the Self**

Thus far the research has shown the difficulties FEPs face with reconciling themselves to their new career paths because of their own doubts, the questions, attitudes, and uncertainties of teachers and instructors, and additionally, the misgivings of family and friends. These internal and external pressures lead to marked insecurities, and in almost all cases, feelings of diminishment; a shrinking of the self until that self is almost unrecognizable.

Nevertheless, there was a utility to the challenges, uncertainties, and feelings of inbetweenness faced by FEPs as it fostered new ways of thinking, creativity, productivity, and relationship building. In all instances, participants successfully advanced through the

most difficult phase of the program, the BSN phase, and embarked on the MSN phase which offered the prospect of reuniting them with a scope of nursing practice that closely resembled their former selves. Their ingrained habits of striving for excellence that brought them success in their first iterations of their careers, did not allow them to accept anything less of themselves in this second iteration. They went on to come to terms, in varying degrees with their change of career course, and what this new career was representative of in their defining themselves.

### *I Am Me Again*

Nancy reflected on her journey and shares that though her “struggle” to accept her new self is on-going, the decision to transition from physician to nurse practitioner was the best option for her and her family given the circumstances, and this acknowledgement of that has helped her to re-build her psyche and regain her confidence.

Well, uh, yes, I believe that there is a struggle of feeling this way. Still every day... Obviously I think about my education as a physician like all the time in my location, because that's what I was; that's Nancy. That's what I... really, that's my identity. Like many people say, like maybe... “I know I'm a lawyer, but I always wanted to be a musician”. Something like that never happen(ed) to me. Since I was young, I knew that I wanted to be a physician... like if I'm born again, if I have another life, I'm going to be a physician...that's a huge part of my identity, then uhm. Of course, there's like all the time, I'm between that and that new Nancy that I have been creating these last couple of years. You know it's not so different, but yes it is different and I like to think that now I have more tools to work (with), you know. Now I have more resources now, I have like more to

offer, you know, because before, I was only Nancy the physician who spoke Spanish... now I'm Nancy, the physician *and* the nurse practitioner, and I can help you in Spanish, (and) I can help you in English. You know... I can bring more to the table... I can give more to the patients, you know. And as an immigrant, I can give them even more... I can connect with (them) in like so many new ways... and I like that part. But still, there's a part of me, when things become like very difficult, very horribly rough, uh, I still think like, "what am I doing? Why? Why I did this? Why did I do this to me? Why do I like to have this kind of pressure?" I was in my country, I was OK. It wasn't the best but I was good. Then I remember my son and I see my son and I see how wonderful he is and all the opportunities that he has and I like to see the way that he's growing up, with a different vision of the world than that I had when I was his age, you know. And I like that... the other part is obviously I still am in contact with many of my friends and... my most beloved friends are physicians in my country... and many of them they went to study outside, like outside from Colombia to other places in the world, and then they return to Colombia...and they are working there. Like they are still like doctors, physicians and with like some high medical degree and sometimes, (even though) I'm like, I'm happy because of their achievements, but that makes me think, maybe I could have that, you know. Maybe I could be at that level and then I remember, no, but I'm not in an inferior level. I'm in a very different situation. But like for me to understand what I'm telling (you now)...that has been the work of many years since we moved here...and just like these last couple of months maybe... and it's because...now I feel much more confident in the clinical

practice. You know, now I feel like that's me and that is what has been like guiding me to thinking that way. But now I have more to offer...if you talk with Nancy, like maybe one year ago, a year and a half ago, this speech (would be) totally different. Like if you compare like the Nancy of one year ago and the Nancy that you are talking (to) today, very very different because it has been like a huge change in everything.

Nancy's evolution has been a work in progress, and apparently continues to be so, but she offered that though having been a physician will always be her identity, she believes this journey has enriched her experience so that she is no longer "only Nancy the physician" but is in a position where she "can bring more to the table" as "Nancy, the physician, and the nurse practitioner". And when doubts creep in as they invariably do, the initial catalyst of her activating impulse, her son, is all the reminder that she needs to know that she made the right decision, and her doubts are assuaged.

Jessica's acknowledgment, on the other hand, offers a different perspective as she ultimately reconciled herself to the choices she made that have brought her to her current career track as a nurse practitioner. One can posit that the loss of her former career has been made more profound by all the other losses that she had suffered prior to her loss of identity as a physician including the loss of her husband, her clinic and school and finally, having to leave her country behind. Having forged ahead and taken the path best-suited to her circumstances, she was unprepared for how much this theme of "loss" would repeat in her life, but like Nancy, Jessica was ultimately able to strike a balance that returned her to not her old self, but something closely approximating it, and one now

enriched by her experiences in the Physician to Nursing program: She recounted her experiences surrounding loss in the program:

...the program had a lot of success but being the first cohort was challenging. Because, you know...at the beginning... we had our own challenges because we have to re-adjust our mindset and we still had that sensation that we are losing our prescriptive privilege, we are losing our symbols... we no longer... have lab coats, we were no longer being called Doctor, so...it was difficult for us. So, I think the first year was difficult, but by the 2nd year... we really enjoyed the master program, we regained this privilege, this prescriptive privilege again, we ...have lab coats again, so then it becomes a little bit easier for us. When I was a physician, of course you have heels, you're well dressed, especially if you work in clinic and uh, and you have your title also; they call you doctor. So you have to lose everything when entering the MSN program... Because when you don't have the ability to prescribe, it's a problem, but when we realize that when you complete the master's program MSN and we pass the board we can regain the prescriptive authority, then we become a little bit more cheerful, or relax(ed), because we see that being a nurse practitioner when we complete the master and pass the board, we will gain the prescriptive authority. Although we need(ed) at that time to have a physician to cosign for you. Now you no longer need (that) all the time, but because you will be regaining your prescriptive authority you feel already more comfortable.

This is that ability that we had before. We feel comfortable writing a prescription for it because we know that part already. It's like in this program physician to

nursing, the 1<sup>st</sup> year, you go by something you don't know, and then the second year (you go by something) you do know... You feel like yourself again. OK, once you get in the program, you feel that you're no longer a physician, 'cause you know, nobody calls you Doctor. ...and then you have to retake the classes or we take some stuff that you feel you already know... during the first semester we had that emptiness a little bit because we're completely lost. You're not a nurse, you're not a nurse practitioner. You would like to be a nurse, but you don't have really that mindset, the scope of practice. It's worse for you than for a student to get into the regular nursing program because you have to change your mindset and remember all the stuff that you can no longer do... This is what holds the emptiness... you remind yourself that no, your work is to collect the sample, but you cannot make orders. We can achieve the data, interpret the data, but you cannot prescribe... you have to realize that... so this emptiness, it make you be a little bit irritated not aggressive, but not comfortable with the teachers and you try to blame everyone, "it's the program"... I bought my first aid USMLE, so I'm starting the (nursing) program with my USMLE Book Open. Can you imagine, because we feel emptiness and we refuse to accept that we really have to move on to that (nursing).

So first, it's like a denial you don't want to tell people... it takes time to adjust, so maybe at that time counseling would have been helpful... It was a very, very interesting program and... what I realize later, and I need to say that at the beginning, this is the problem. At the beginning you think that, oh, I know everything, right? You know a lot, regarding the practice of medicine, but



regarding the laws within the culture in this country with... you know the disease in this country, the management. There's a lot that you have to learn. And so at the beginning you think that there's nothing to learn. But after all, you realize, there's still something to learn every day, because it's not the same country, it's the same people, yeah, but not the same country. So, you will still have to adjust. And if you keep your open mind, you realize that overall it (the physician to nursing program), was very good. At the beginning I started the journey and not knowing how I'm gonna understand nursing and at the end I work as a teacher... You know it's like you experience all the change as well and look for the good. So... I have my niece who became a nurse and I (helped) to prepare her for her nursing review for the class. And I work as a teacher in the college for nursing students...

For Jessica, her tumultuous journey of loss brought unexpected benefits, and as most of the participants in this study, she ultimately saw her movement from physician to nurse practitioner as having benefitted and enriched her life, her future, her immigrant community, and that of her family.

The storied journeys for all of the participants - pushed and pulled from their countries of origin to these United States is ultimately one of risks, hopes, and overcoming obstacles and challenges.. This section and analysis reveal how the participants' experiences align with the TL, Otherness, and Liminality - the theoretical constructs that underpin this study.

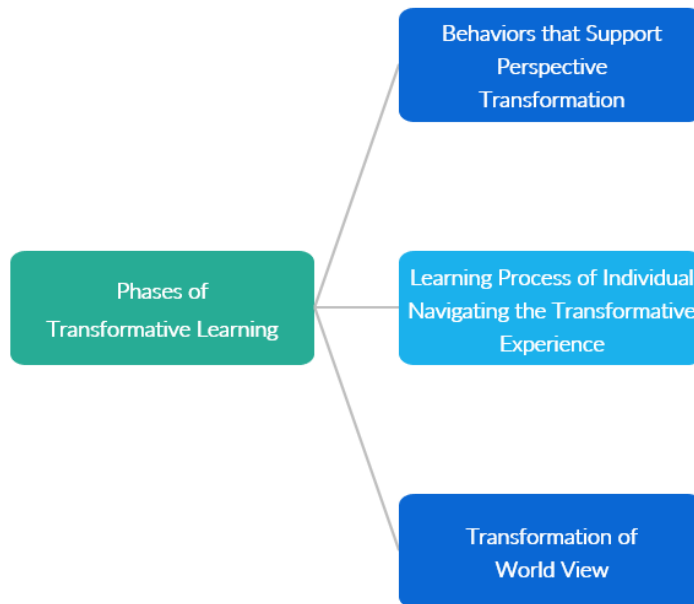
### **Deductive Analysis**

The concept of transformative learning in scholarly literature is often distilled and presented in three phases: the transformation of an individual's world view, the learning

process of navigating the transformative experience, and the behaviors that support eventual transformation (Anand et al., 2020). Participant interview data were analyzed to uncover the extent to which, if at all, participant experiences matched the 3 phased framework: transformation of the individual's world view, the learning process of navigating the transformative experience, and the behaviors which support transformation.

**Figure 10**

*Three Phases of Perspective Transformation*



*Note.* Source: Anand, (2020)

These three summary phases of TL were used as the framework for examining and interpreting the interview data.

**Phase One: Transformation of an Individual's World View**

Characteristic of phase one is the transformation of an individual's world view. The things we know, our meaning structures, which Mezirow (1978) described as our

frame of reference and how they are influenced by one's cultural upbringing and beliefs are assimilated over time. FEPs in this study freely shared how they made meaning from the sum of their life experiences. Many of the participants highlighted the head spinning issue of coming to terms with the nursing scope of practice as being one of the most challenging, (if not the most challenging) of the entire Physician to Nursing experience. The "nurse" versus "physician" way of thinking was often an early signal that a "crisis of the soul" was not too far behind. For most, this was their disorienting dilemma...that event that made them realize that the thing they once held to be true, the inherent power in their physician titles, in fact was an albatross around their necks, particularly during the BSN (Bachelor of Science Nursing) phase of their journey. Nancy describes her thoughts this way:

And I remember that when we were going in our groups, we were going to the clinical place, sometimes we were like, we are not going to say that we are FEPs. Like no, nobody is going to say that, because if someone says that, the nurses are going to be mad with us, and we are not going to receive the same treatment as other students.

Participants described this phase as a time when they needed to "change my mentality", "change my brain" and reflected on it as an experience akin to changing or shifting from their world view from that of a previous familiar world being their former vocation of the practice, pride, and prestige of medicine. In more than one instance, participants physically twisted their heads around as far as their necks would allow when attempting to describe the transformation of their world view. Susan recalled:

I had to twist my brain the other way because you're trying to think one way and you literally are forced to think like a nurse... I would say, I had to train my brain I think 4 steps or three steps before what I would normally do. As a doctor you go in and you examine and diagnose, and you treat. But the nurse knows what pathology it is, and they know how to position the bed the right way for that patient. It's the little things that you overlook in medicine, that I had to learn and to take into consideration as a nurse. It was tough. It was tough, let me tell you.. Susan's transforming view is echoed by that of Nancy:

That was very like difficult because of like first of all, because of the type of education like I told you before, like the way that I was trying to think, it's the way that a doctor, a medical doctor thinks. Things... physicians do, you think about the illness and the symptoms. It is very different. Everything is very different and organized... following a certain kind of steps. And when you enter to the nursing world, it is about being with the patient. It's not only what their symptoms are, but how the patient is feeling and how to really advocate for the patient and all that. That's really amazing..., and that's something that you don't learn in Med school.

Jessica's comments of her nursing experience mirror those of Susan and Nancy, but go even further as she details the practical experiences in her new role as nursing student:

I remember for the practice they tell you you're gonna do the bed and I've never been able to do the bed correctly because, you know, I never do the bed as a doctor. I just come, and the patient is already in the bed and you have the nurse to do the bed.

Something like that. So now you have to learn how to do the bed, how to you know, prepare the bed for the patient, you know. Give a bath, so those type of stuff so you feel a little bit diminished. You say, Oh my God, what am I doing? It was difficult. It was some classes, I remember those classes on a Saturday. You come, you know, really just as a nurse with your scrub,s with your sneakers that you never like to have. You used to have your heels, your lab coat, and then you have to do the bed. You have to do all those stuff.

The framework of transformation of world view is further supported when Jessica describes her encounters with her nurse teachers/instructors who are unable to comprehend the motivating factors for her choice to become a nurse:

...it was very difficult. Sometimes you don't feel that you want to go and dress like a nurse and to be trained by an LPN. Now you have to explain also all the time why you want to do that? Because the question that they always ask you, why you will not try to get your USMLE? This is the key point. If you are a doctor, why you don't get your USMLE? So now you have to explain that you need something quick and you consider that program as a bridge. OK so and then they tell you, but you don't fit for this setting.

You're not gonna be a nurse. Do you want to be at the bedside, because you don't have bedside manner... So, you have to explain and try to help them understand that. So you look like a loser...for some people because the correct way should be to get your USMLE. So if you don't get the USMLE or you trying to get it, (some of us try to get the USMLE but they fail), or you got the first part and the second

part but you failed third part and you're not admitted. So, they consider we are losers compared to others.

Participants reported how their meaning, perspectives, and points of view transformed during their transition from physician to nurse.

## **Phase 2: Learning Process in Navigating a Transformative Experience**

Phase two in the transformative experience incorporates the various learning processes required by the individual navigating that transformative experience. Many of the FEP participants identified and described how navigating the clinical phase of the student experience was the most difficult. The clinical experience of the BSN is the phase where they first realized how different the scope of medicine was from the scope of nursing practice and the one that most exposed the FEPs vulnerabilities and insecurities.. It was also in this phase that the tensions between their former physician-selves and their aspiring nurse-selves first appeared, forcing them to have to engage in threshold work, one of the chosen perspectives for this study characterized by fear, doubt, and uncertainty. Winston observed that:

... sometimes I feel bad because, uh, being a nurse, is different from a physician,...but when you are in nursing, you have to receive order... as a physician you give order... As a physician, my custom is to give order, not to receive order. Sometimes, when I took the exam, it was very, very difficult for me with the pharmacology ... because sometimes I felt that I did...enough. Then, I answered bad the question always in pharmacology....When they give me some pharmacology question, sometimes I answer as a physician because I forgot (that I must answer as a nurse). So... this is... difficult ...for every person as a

physician... to switch (to nursing),...This, this is a difficult thing. And also, the physician give(s) you order(s), when the physician know(s) you are also a physician. Sometimes, it depends on who the physician is, how he treats you. To switch from a physician, to only a nurse is very painful. The keyword is painful, but you don't have no choice.

The degree to which FEPs continued to identify as a physician seemed to directly impact the degree to which they were challenged by this disorienting clinical nursing phase. It is in this phase where FEPs began to experience the “chain-of-command in reverse”, as their work behaviors had to be managed by a “lesser in command”. They had to take orders from nurses where previously they were the physician who gave orders to the nurse. Jessica details her frustrations with this deeply conflicting liminal phase in the following manner:

...the clinical part at the hospital was difficult. First of all, at the beginning you arrive and then, (the impression from the nurses is), OK. So, what are you? You are nice, you want to practice with us, yes, but you are a doctor. So, when you identify yourself, “OK, I'm an IMG (international medical graduate), I am a foreign medical doctor and I'm in the (BSN) program to become a nurse. So, first of all, sometimes you have to be trained by an LPN. So that thing is freaking me out because, (I'm) a doctor, and then (I) want to become a nurse, so they don't know exactly what to do (with you), what to teach you, what you know, what to do. So, some of them were a little mean. Some of them they don't know what to what to tell you exactly. So..., depending on the location, (of the clinicals), we

had a lot of,... frustration, because it's not exactly the practice and the setting that we expected or the end result that we expected...

Mandy further bolsters this theory, declaring that she believed her attitude and positive approach to this transformative experience, directly impacted the result:

It's a process that you go through in your mind to step back and do something that you think is less, because as far as I'm concerned, as long as I am doing what I love and servicing humanity, I'm making a difference in someone's life. I don't have a problem with it, but. When we look at names some people they are attracted to names. They're like you know why I'm going to be a nurse, and I was a doctor. Yeah I would. I would be lying if I tell you it didn't bother me a little bit, but it didn't. It didn't last long at all because it's only a name. It's only a name because it doesn't make who you are, and I can tell you if you are smart. If you are knowledgeable, if you are a good person and you're very good with what you do and you're excellent, you'll be a light bulb that was shining any darkness...

Doubtless, the same qualities that drove participants to initially pursue a career in medicine as physicians, persistence, diligence and determination, stood them in good stead as they sought to overcome their challenges and navigate the transformative process. Over 70% of participants reflected that the lessons learned in their previous medical study, as well as their acquired habit of persevering in the face of difficult odds helped propel them forward as well in this instance. Susan's words support these ideas, as she discusses how the toughness of her medical training provided a good dry-run for the FEP to NP program:



And all of the habits I developed for studying back in the days when I was in my early 20s, the same level of rigor and studying and discipline and everything transferred over... and of course...when we got into the MSN, I knew almost everything its just like certain guidelines and certain screening tools and things that we don't have back home or things that we've never heard of, or novel things because science changes every day. Those are the new things that we have to learn. But my prior training just set me up perfectly for this.

Others found inspiration to forge ahead, in the field of nursing itself, and recognized the transformative value of joining their nursing skills to their clinical ones:

I like to think that now I have more tools to work with. You know now I have more resources now, I have like, more to offer, you know because before I was only Natalia the physician, in Spanish... now I'm Natalia, the physician and the nurse practitioner and I can help you in Spanish...I can help you in English. You know there's more ways; then I can bring more to the table... I can give more to the patients you know. And as an immigrant, I can give them even more, you know and... it doesn't matter like from which part of the world is that person, but I can help you in like maybe in any way I like...I can connect with you in like so many new ways... and I like that part.

Jessica cited a positive that was similar to Mandy's, and also saw the value of a new tool to add to her tool-kit. She also highlighted the necessity of accepting her change in status and title as a key point in her learning journey:

...once you get in the program, you feel that you're no longer a physician...'cause you know nobody call you Doctor...during the first semester we had that

emptiness a little bit because...We completely lost. This is the thing you're not a nurse, you're not a nurse practitioner. You would like to be a nurse, but you don't have really...the mindset, the scope of practice. It's worse for you than for a student to get into the regular nursing program because you have to change your mindset and you have to remember all the stuff that you can no longer do. This is what holds the emptiness you used ... to realize and make decision,...now you can comfort the patient and wait for the doctor to place the order. So now you become like you play a second role so and nobody like that. You remind yourself that no, your role is to collect urine your role is to collect the sample, but you cannot make orders. We can achieve the data, interpret the data but you cannot prescribe so you have to realize that OK, you have to start thinking as a nurse. So this emptiness. Sometimes it makes you. Uh, be a little bit irritated. Not aggressive, but not comfortable with the teachers and you try to blame everyone, it's the program. But in fact it's not! The problem is because you're not in the mindset of learning nursing or being a nurse. You refuse because you don't feel that you're built into that setting... The only hope is that OK, when I got the master I can regain certainly to interpret data and place orders. So to understand that you're gonna regain some, you're not gonna have all the privilege. But at the beginning you really feel that you're losing. You're losing every yeah, losing your privilege. So I think the first year was difficult, but by the 2nd year when we really enjoyed the master program, we regain this privilege...It's because when you don't have the ability to prescribe,...it's a problem, but... when we realize that... when you

complete the master, we pass the board we can regain the prescriptive authority,... then we become a little bit more cheerful.

Jessica here through self-examination comes to the realization that moving forward, requires accepting the constraints of the role she has transformed into. The promise of moving on to the next phase and finding herself on more familiar clinical ground, is an added motivation to push ahead.

### **Phase Three: Acquiring Behaviors That Support Transformation**

This phase represents the acquisition of behaviors that support eventual transformation and the formulation of the improved sense of self. This stage is incorporated in the tenth phase of Mezirow's Transformative Learning Theory, "A reintegration into one's life based on conditions dictated by one's perspective". Susan revealed her thoughts on the relationship between attitude and behavior and her ability to persist through the more difficult phase of being a student nurse. She reflected:

For male FPS it's harder for them because of a certain pride or I don't know what's the right word. But for them, it's definitely tougher than for women. I'm the youngest person in my class, but I'm talking about people that were surgeons and that were recognized in their countries as a somebody. When I came here, I had just been working for four years in Guyana as a doctor, but I'm talking about people in my class, that were doctors for 20 years, 15 years and they were all the way up there and now to become a nurse or nurse practitioner, where nobody out of this country knows what the nurse practitioner is. For men and for everybody in general, but for especially the male doctors, it's hard to come to peace with it. It's a challenge. I see it there first. A lot of them are frustrated and they still keep

trying to match (for the USMLE program), and things like that, you know. They don't let go of the dream. And is it once a doctor, always a doctor? But sometimes things change, situations change. Everybody has a different story.

Participants expressed varying degrees of ambivalence of the final transformative phase, but all seemed to have achieved a measure of acceptance, and universally acknowledged genuine value in the skill-sets they had acquired in their transformations to nurse-practitioners. Mandy expressed it this way:

Honestly, uhm, nurses to nurse practitioners spend way more time with patients. They get to understand more. They ask more questions and they help the patients understand more of what their diagnosis is...I don't know whether or not we do it because nursing is kind of a nurturing type of discipline and medicine is a little different, and the doctors really give the nurses you know do this, do that, I don't know from what. From how I practice now, I'm still a physician. You realize that I'm not never gonna lose that name because I'm I've already been crowned. And so I take the nursing aspect with my medicine, and I take advantage of it, and I think that's why I have such a good relationship with most of my patients.

### **Summary**

A thematic analysis was conducted on data collected through semi-structured interviews of seven unlicensed foreign-born and educated physicians. Data were analyzed inductively as well as deductively. From the inductive analysis of the data, three primary themes were generated (a) the migratory patterns of FEPs (b) participants' beliefs about challenges and (c) participants' beliefs about regaining the self. The pre-determined three-phase representation of TL—Transformation of the World View; the Learning

Process of Individuals Navigating the Transformative Experience; and Behaviors that support Perspective Transformation—provided the framework for deductively analyzing the participant data. Based on the deductive analysis of the three summary phases of TL, the data fully supported the essence of the framework Transformation of the World View, the Learning Process of Individuals Navigating the Transformative Experience, and the Behaviors that Support Eventual Transformation. See Figure 11 below.

**Figure 11**

*Summary Phases of Transformative Learning*

Deductive Analysis		
Transformation of the World View	Learning Process of Individuals Navigating the Transformative Experience	Behaviors that Support Perspective Transformation
I still had that mentality. Well, even though I was a student nurse. I will go over there; she's a nurse (instructor) and tried to tell her what to do. And actually, it was supposed to be the other way, because I'm supposed to learning from her - <b>Victor</b>	It's a process that you go through in your mind to step back and do something that you think is less, because as far as I'm concerned, as long as I am doing what I love and servicing humanity, I'm making a difference in someone's life. I don't have a problem with it... I would be lying if I tell you, it didn't bother me a little bit, but it didn't, it didn't last long at all because it's only a name - <b>Mandy</b>	if I'm born again, if I have another life, I'm going to be a physician. Here in this country or wherever in the world; that's a huge part of my identity. All the time, I'm between that, and that new Nancy I have been creating these last couple of years... it's not so different, but yes it is different and I like to think that now I have more tools to work with. You know...more resources now I have like more to offer - <b>Nancy</b>
So, I was I was on the plane, and I remember I was thinking I'm leaving my country as a doctor and what am I gonna be? I'm gonna go and be a nurse? Because I heard all of the nightmare stories about people trying to get matched with the USMLE. Unless you know somebody, or unless you're like a super intelligent Einstein level person, it's really hard to match, it really is - <b>Susan</b>	It wasn't that bad. The reason why because I was surrounded by other physician who made the same, who made the same decision. I know that I wasn't the only physician, so I say you know what? I'm not by myself, so I mean I cannot say, Oh no what I've done, why did I do that - <b>Victor</b>	My mind was clear and made up from the very start to get to that level again; to be able to prescribe. It's good that I did ... the BSN to see things from a different perspective, 'cause you're not taught those things in medical school... and that's why it was a challenge. I came to peace and then everything flowed after that... once a doctor, always a doctor? But sometimes things change, situations change. Everyone has a different story- <b>Susan</b>
So now you have to learn how to do the bed, how to, you know, prepare the bed for the patient, you know. Give a bath, those type of stuff so you feel a little bit diminished. You say Oh my God, what am I doing?... So, you look like a loser- <b>Jessica</b>	it was definitely difficult like to adapt to the program, to adapt to the different way of thinking to the different way to analyze a patient and something that helps me a lot was the people in the program. Because all of the people was in the same place. We were all physicians from different parts of the world, like with different backgrounds and everyone was there doing the same and everyone was there like supporting each other - <b>Nancy</b>	I said... if this is what I need to do to get the next step, I'm just gonna do it and... I liked it because...it fine tuned my medical information, my medical knowledge. From how I practice now, I'm still a physician... I'm not never gonna lose that name because I've already been crowned. So, I take the nursing aspect with my medicine, and I take advantage of it - <b>Mandy</b>
I was (considered) old. I graduated many years ago. Though I was in practice for many years after I graduated, they didn't count any of that experience... I felt like my medical license and my medical studies were not enough for the people here...At the exact moment that I moved to this country. Like with everything that happened... like really all my confidence, all that prouddness that I had...it went to the floor- <b>Nancy</b>	At the beginning you think that, oh, I know everything, right? You know a lot regarding, the practice of medicine, but regarding the laws... the culture in this country, the diseases in this country, the management... And so at the beginning you think that there's nothing to learn. But after all, you realize there's still something to learn every day because it's not the same country - <b>Jessica</b>	... when we realize that when you complete the master, we pass the board we can regain the prescriptive authority... then we become a little bit more cheerful or relax because we see that being a nurse practitioner... we regain the prescriptive authority,... you feel already more comfortable... You feel like yourself again - <b>Jessica</b>

Chapter 5 that follows is a discussion about the summary of results, followed by a review of the responses to the research question; implications for theory and practice; limitations and recommendations for future research; and lastly concluding remarks.

## CHAPTER V

### DISCUSSION

This chapter reflects on the Summary of Results for this study followed by a review of the responses to the research question; implications for theory and practice; limitations and recommendations for future research; followed by concluding remarks.

#### **Summary of Results**

The purpose of this study was to describe the lived experience of foreign born and educated physicians who are unlicensed to practice medicine in the United States as they retrain for non-physician primary care roles. This is an important topic as unlicensed FEPs constitute an untapped bounty of healthcare skills and clinical experience. Their presence and expertise loom large particularly during the time of a global pandemic that has created shortages of skilled healthcare workers in the United States.

An appreciation of the challenges and opportunities that these FEPs encountered can engender a deeper understanding of the plight of foreign-educated professionals in general and unlicensed FEPs, the focus of this study. The phenomenological approach served to uncover the practical utility of understanding the essence of their storied journeys, personal actions and decision-making (Van Manen, 2017).

The study describes and furthers the dialogue about the challenges that this class of immigrants encounters despite their levels of education or former stations in life. One participant explained:

But sometimes you compare yourself to the nurses knowing that you are a doctor. And you think, I am the same as this person. I am making the same money as this person, and I went through all of that struggle in medical school and all of the

struggles back home. And then I'm this. In the end I am the same thing as this person." (Sara)

Seven participants were interviewed using the semi structured interview protocol. They were all foreign born, and hailed from different countries including Columbia, Guyana, Haiti, and the Bahamas. In some cases, their foreign training, region of licensure, and practice extended beyond their countries of origin and included the Bahamas, Belgium, Canada, Columbia, Cuba, France, Guadeloupe, Guyana, and Mexico. A mix of males and females also allowed for the possibility of diverse perspectives.

Due to the COVID 19 pandemic, interviews were conducted using ZOOM technologies with all of the participants giving permission to be visually as well as audio recorded. The ZOOM audio recordings were transcribed by using a feature within Microsoft Word that transcribes and timestamps audio. Because the data sample was small, a five-columned coding table was designed and deemed to be sufficient for the purposes of this study. It included columns for the participant's pseudonym; direct quotes; units of meaning; deductive codes; and notes. A separate table was used for each participant.

A thematic analysis that involved familiarization with the data by reading and re-reading the transcripts, code generation, theme generation, theme review, theme nomenclature, and preparing the report was conducted. Braun and Clarke (2015) describe two common forms of thematic analysis—inductive analysis and deductive analysis—both employed in this study.

Consequently, this researcher generated three primary themes as well as 16 secondary and sub themes. The primary themes generated by this researcher were (a)

Migratory Patterns (b) Beliefs about Obstacles and Challenges and (c) Beliefs about Reclaiming the Self. The distilled 3 phases of TL commonly found in scholarly research, were used as the theoretical lens to deductively analyze the participant data. The data

### **Responses to Research Questions**

This section is dedicated to the participants' responses to the primary research question which was: What is the lived experience of foreign born and educated physicians who are unlicensed to practice medicine in the United States as they retrain for non-physician primary care roles?

The semi-structured interview of the participants who were all representative of health-care workers whose career paths deviated from the vocation of the practice of medicine. From the interviews, participants described the activating events, commonly referred to as push and pull factors, that led to the decision to leave his/her country of origin. Push and pull factors have emerged as the primary lenses through which health care worker migratory patterns are studied internationally (Schumann, 2019).

Flowers and Olenick (2014) contend that FEPs migrate to the USA largely for personal, social, political, and financial stability, a common denominator among developing nations. Some FEPS exhaustively attempt physician recertification, while others, as borne out in this researcher's study, embark upon a surer path in pursuing non-physician primary care roles.

This study also revealed FEPs' desire to earn a better living, to develop his/her career, to experience other countries, to live a more safe and secure life, to reunite the family, and to mitigate loss. Each of the participants, in addition to earning their medical



licensure outside of the US, was already practicing medicine in one capacity or another prior to migrating to the US.

The participants freely shared one or another aspect of their lived experience that animated their decision to migrate. As indicated by the interview extracts below, the discussion began with a question about what factors led to the FEPs leaving their countries of origin. This researcher felt that this opening question situated the participants, relative to the essence of the research question, *their lived experience*, at a beginning point... meant to get to the heart of why they left. Stacey stated:

You know, so many occasions people tried to kidnap him. Things like that... there was so much violence and corruption. We were actually planning to buy a House. We were planning to start our family and everything and then that was one of the reasons, the one of the main reasons why we left because we couldn't have a safe future.

Victor stated:

I was doing good, but there were so many insecurities... and they start with the kidnapping. I had friends who were kidnapped. So as you know, yes, actually I said to myself you know what? I think it's time for me to go somewhere else.

Mandy stated:

I really wanted to live in a country where I would have more freedom and be exposed to more not only in the medical field, but life, right? And I felt like my country was a little bit too small for me, and so I had a hunger for more in terms of medical exposure and learning more in the medical field. I felt like I should

have given it a try. You know, to get into a residency and so you know it would be a blend of both worlds for me.

Jessica offered another perspective:

So, we had a drug store, and the practice, the clinical as well. So I lost the clinic also in the earthquake. I lost my husband. I lost the school where the kids used to go also collapsed. It's like I lost almost everything, so I decided it's better to start over in the US instead of staying.

### **Findings related to existing literature**

Three theoretical concepts were used to undergird this study. The theoretical frameworks included Mezirow's 10 Phases of Transformative Learning Theory also referred to as Perspective Transformation, Otherness theory; and Liminality theory. TL, distilled into three primary phases, Transformation of the World View, the Learning Process of Individuals as they Navigate the Transformative Experience, and Behaviors that Support Perspective Transformation, provided the theoretical lens to deductively analyze the data.

### **Transformative Learning Theory**

The TL framework provides a lens through which to view, classify, and interpret the FEPs' lived experience as they retrained for non-physician primary care roles. The participants in this study represent a population not unlike the population of women, engaged in re-entry work, who Mezirow first studied in 1978 as he formulated TL Theory. The adult women then were attempting to re-enter programs in a community college. Anand et al. (2020) stated that "TL described how adult women in higher

education underwent fundamental change in how they made meaning of what they knew—their life experiences to guide their future action” (p. 733)

This researcher posits that even a cursory view of the FEPs’ reported lived experience reflects close alignment between said experience and the phases of TL. Thus, this framework helped to situate each participant as they made meaning of what they knew. While each participant experienced perspective transformation to varying degrees, each described his/her own activating event that led to the first TL phase... exposure to a *disorienting dilemma*.

Chapter 4 presented participant extracts and responses detailing how they, having been confronted by the disorienting dilemma, entered the second phase, a *self-examination* that was often accompanied by feelings of fear, guilt, anger, and shame. Olenick acknowledged that some students can be disappointed and even angry at the outset. “But most after a semester and a half turn around and say, ‘I didn’t want to do it, but now I love it,” she said. Most are grateful at gaining a second chance at helping others in the health care field and expanding their knowledge into a new field (Stern, 2016; Olenick, 2014).

Their self-examination led the FEPs, without exception, to the third phase of TL which is a critical assessment of assumptions. For individuals to change their meaning perspectives, "they must engage in critical reflection on their experiences, which in turn leads to a perspective transformation" (Mezirow, 1991 p. ??).

The FEPs engaged in this study all discussed the importance of their cohorts and how critical it was for them to foster peer relationships in the program, particularly at the BSN stage. Engagement with their peers led to the recognition that their “discontent”

emerging from the challenges and the process of transformation were shared experiences. With the support of their peers, participants reported a willingness to “explore options for new roles, relationships and actions” (Mezirow 1991).

The sixth TL phase, planning a course of action, is arguably a preoccupation of the FEPs as they navigate the physician to nursing program. Having settled on a course of action, the participants began to take on new knowledge and skills (seventh TL phase) necessary for carrying out their plans. The interview data led this researcher to conclude that this knowledge acquisition phase proved the most difficult for all of the former physicians as they were confronted by their own “Otherness” - a recognition that the scope of practice of medicine is radically different from the scope of practice of nursing.

Jessica stated:

OK, I'm an IMG international medical graduate, I am a foreign medical doctor and I'm in the (BSN) program to become a nurse. So, first of all, sometimes you have to be trained by an LPN. So that thing is freaking me out because, (I'm) a doctor, and then (I) want to become a nurse, so they don't know exactly what to do with you, what to teach you, what you know, what to do. So, some of them were a little mean. Some of them they don't know what to what to tell you exactly.

It is in this seventh phase that the FEPs became acutely aware of their “nakedness” that their difference previously of having been a practicing physician and formerly a point of tremendous pride, instead now exposed vulnerabilities, insecurities, and uncertainties about their knowledge and assigned positions. Stern (2016) contends

that “some foreign trained physicians could have a problem dealing with the “ego issues” of not being a doctor since in foreign countries, they are viewed as gods.” (p. 3)

Furthermore, FEPs have recorded discrimination, poor treatment, challenges with communication related to language barriers, and misunderstood verbal cues from patients and peers (Auerbach, et al., 2013; Chen, et al., 2011; Neiterman, & Bourgeault, (2015).

Nancy recalled:

That part was very difficult too. And I remember that when we were going in our groups, we were going to the clinicals place, sometimes we were like, we are not going to say that we are FEPs. Like no, nobody is going to say that, because if someone says that [they are former physicians] the nurses are going to be mad with us and we are not going to receive the same treatment as other students

The degree to which the FEPs accepted the fact that acquisition of new nursing knowledge and skills was critical to their success, determined their likelihood of persisting through the program. Persistence, which is motivation led, involves a way of thinking that successfully guides individual behaviors through major challenges or obstacles identified in the environment (Wright, 2019).

This researcher compared this seventh stage of perspective transformation to the participants’ liminal encounters. The liminal state is germane to most social and cultural transitions indicated by the passage of the FEPs through a sphere that bears little resemblance to their past. This state was characterized by reports of feelings of ambiguity and feelings of being in betwixt and between; no longer physician but not yet nurse. Unsuccessful navigation of the liminal state may have long lasting effects on the fate of the practitioner.

Vapor & Xu (2011) studied the experiences of Filipino physicians turned nurses and found that the transition involved multi-dimensional challenges captured in three themes in context of cross-national, and transprofessional migration. As a result, the physicians faced a “double whammy” adjustment to a new cultural and work environment common to all foreign nurses (cultural adaptation) and unique identity/role change from physician to nurse (transprofessional adaptation)—that made their transition especially challenging resulting in short-lived nursing careers.

Yet, as a threshold experience for the FEPs, the liminal phase fostered creativity, resilience, resourcefulness, and a rebirth of their will. Individuals who cross over social and cultural thresholds often experience a shift in the way they see the world and in the way they understand the nature of being. Threshold work was found to be associated with affective and cognitive changes in the individual (Land et al., 2016).

With the embrace of the practice of nursing, coupled with the acquisition of new skills, the FEPs reported a readiness to try on their new nursing roles. While they reported to inwardly holding on to the physician moniker, outwardly they reflected a comfort and coming to terms with their new nurse identity. “I’m at peace” (Sandy); “I am me again” (Nancy). With this acceptance came confidence as well as competence in their new roles as per the ninth phase of Mezirow.

The tenth phase of Mezirow’s seminal work involves the individual’s reintegration into his/her life governed by conditions dictated by a new perspective. All the participants reflected this reclaiming of self and new perspective to varying degrees. Despite their reported feelings of wholeness, they candidly shared that they still experienced doubts and a lingering feeling of being the other.

## **Otherness**

Additional findings in this study that bore strong likeness to prior research included the research participants' reported feelings that they were made to feel different—of being othered due to their cultural differences, language barriers/accent, and unfamiliarity with the scope of nursing clinical practice. Prior research conducted by Triscott et al. (2016) examined FEPs as they sought assimilation into Canadian medical family practices. Participants in this Canadian study mirrored significantly the findings in this research as they too reported persistent feelings of being othered due to challenges with their communication and language, clinical practice, learning, and cultural / personal differences.

Similarly, critical studies by Liu and Kramer (2018) found that othered identities, viewed through the lens of difference-as-problem, created interactions that were to be either managed, marginalized, or muted. This was not unlike the feelings expressed by FEPs in this study particularly as they navigated the BSN and clinical phase of their studies. During this phase participants universally reported feelings of otherness, of being managed, voiceless and diminished as a person. Responses to feelings of being managed because of the environmental and programmatic demands, in more than one instance resulted in participants adopting a coping persona, a fake-it-till-you-make-it attitude that masked their true feelings and emotional expressions.

Reio, Opengart, and Ding (2022) argue that there is a utility to this type of emotion management and to taking on a fake persona. FEPs in their earliest clinical classroom encounters reported that they agonized about the rules which stymied their ability to express the fact that they were actually physicians. Entire cohorts agreed that it

would be best to hide the fact that they are physicians. This fake persona they believed, would shield them from the judgement, criticism, and slights, that came from trainers and other handlers in the clinical classroom. Nancy study best described this dilemma:

And I remember that when we were going in our groups, we were going to the clinicals place, sometimes we were like, we are not going to say that we are FEPs. Like no, nobody is going to say that, because if someone says that they are former physicians, the nurses are going to be mad with us and we are not going to receive the same treatment as other students.

For many of the participants though, overcoming such incivility, and the barriers it erects, became a motivating preoccupation. Andersson and Pearson (1999), as cited in Reio et al., (2022), define incivility as “low-intensity deviant behavior that departs from norms of mutual respect, with ambiguous intentions to harm.” (p.1). (Dodge, (2020). Horvath et al., (2019) in one study found that the preoccupation with overcoming barriers is associated throughout human culture with the pain of marginalization, otherness, and loss of agency found on one side, and feelings of protection, community, and security on the other.

### **Liminality**

While not all of the participants suffered being othered due to their accents and cultural differences, they all however reported feelings of uncertainty, ambiguity, lack of confidence, worthlessness and doubt, particularly as they passed through the BSN phase of study, Villagomez and Reyes’ (2009) pioneering work on FEPs reported strikingly similar findings regarding participant feelings of confusion and ambiguity when confronted by the differences between the scope of medicine and the scope of nursing



practice. “Every participant verbalized their observations regarding the differences in nursing practice in the US and nursing practice in their home countries.” (p.197) These feelings were amplified as the participants became aware of how significantly different the scope of practice of medicine was from the scope of practice of nursing. Jessica, one participant in this researcher’s study described her liminal and threshold encounters as::

You don't really like it at the beginning. They tell you they're gonna teach you. To be honest, you don't see yourself working as a nurse. You don't understand how you're gonna do it and you have to wear the scrubs that you don't like. You do simulation in nursing classes where you have to do all the stuff that most of the time, you used to order people to do. Before you told them to take the vitals, but now they tell you, you're gonna take the vitals. So, yeah, I need to take the vitals. It's really...difficult. Also, you have to make the bed well. I remember ... they tell you, you're gonna do the bed and I've never been able to do the bed correctly because you know, I never really had to as a doctor. I would just arrive, and... the patient is already in the bed... So now you have to learn how to do the bed, how to, you know, prepare the bed for the patient, give a bath, so those type of stuff, you feel a little bit diminished. You say, “Oh my God, what am I doing?”

These shared feelings of ambiguity and doubt by the participants strongly support the theoretical construct, liminality, as an appropriate lens for analyzing and interpreting the data.

Despite the findings that this research on FEPs strongly supports TL theory, some theorists have challenged important aspects of the theory. For example, Cranton (2016) questioned one of TL’s fundamental steps, critical reflection, arguing that theorists

should consider that transformation might be possible without critical self-reflection—a step regarded by many theorists to be the cornerstone of TL. Findings from this study also support the perspectives of Otherness and Liminality and enrich what is already known, having been tested in the new context of FEPs transitioning to nurses.

### **Implications and Recommendations**

The research on the lived experience of unlicensed FEPs who are present in the United States as they retrain for non-physician primary care roles remains limited. Therefore, this research contributes an additional perspective to the conceptual, practical and theoretical literature. Theory also may be enriched through this research, as TL, Otherness and Liminality theories have not been extended to undergirding research concerning FEPs.

In terms of implications for practice, additional research needs to be undertaken. Pre-COVID-19 data reveals that a sustained physician shortage is projected well into 2033 (Zhang et al., 2020). Currently, the COVID-19 pandemic's deleterious effects on the overall outlook of the health-care workforce are yet to be quantified. They are made worse by the reality of retiring physicians, a steep increase in the need for primary care, and the prospect of professional burnout. Burnout is characterized by emotional exhaustion, depersonalization, and a decreased sense of self-worth. Sultan et al. 2020 stated "The frontline health workforce is experiencing a high workload and multiple psychological stressors which may affect their mental and emotional health leading to burnout symptoms." (p. 309) Additionally, a similarly designed study that fuses TL, Otherness, and Liminality might be used as a proxy to discover the obstacles and opportunities experienced by foreign educated professionals, FEPs by any other name.

While the demand for physicians and their attendant services continue to outpace supply, nurse practitioners, the subjects of this study, continue to be a valuable source of non-physician primary care. Therefore, it is urgent and imperative that the pathways to success for these “unicorns of medicine” be more fully appreciated and understood. Credentialing limbo, cultural adaptation, starting over, professional identity crises, language barriers, otherness and liminal encounters are all impediments worthy of the attention of policy makers, human resource practitioners, curriculum designers and medical regulatory communities in particular. This researcher believes that with the identification of barriers involved in the transition process from FEP to nurse practitioner, more research could be designed to get at the degree to which each barrier is associated with career progression to become nurse practitioners and their eventual outcomes.

Another implication for practice that emerged from the data is the FEPs expressed a need for counseling and mentorship as they navigated the BSN to MSN program.

In terms of curriculum design, physicians can benefit from being exposed to some aspects of nursing practice. The data revealed a troubling chasm between the scope of practice of medicine and the scope of practice of nursing. The process of becoming a nurse practitioner differs from the training to become a physician. Nurse practitioners “see patients in a holistic way. We take care of every single process and social issues. Physicians are more targeted in how they help people.” (Stern, 2016, p.3) For FEPs, the fusion of scope of practice for physicians with that of scope of practice for nurses produced a noteworthy combination, with nursing knowledge overlaying their medical expertise with a more patient-centric bias. This fusion ultimately produced a more well-rounded patient experience.

Even though scholarly research is limited around the FEP turned nurse phenomenon, there is sufficient alignment among the studies that have been completed that show FEPs endure considerable challenges posed by their professional identity formation, feelings of otherness, feelings of confusion and ambiguity and challenges with cultural assimilation. Since these challenges present as recurring themes in their lived experience, curriculum designers may benefit this population by building into the BSN phase more targeted opportunities for student mentorship, counseling, and cultural assimilation and sensitivity support.

Theory may be enriched through this research, as TL, Otherness and Liminality theories have now been extended to undergirding research for this population. This researcher believes that Transformative Learning Theory as a whole has been significantly enhanced having been complimented by the perspectives of Otherness and Liminal theory.

### **Limitations**

One possible limitation is that while the FEP to nurse transition is a universal phenomenon, this study was confined to South Florida, and to participants from one public minority serving institution. Research extended to other States or even to other regions of the world such as the Caribbean, Latin America and Asia might serve to enrich and enhance both theory and practice around the phenomenon.

Another limitation is that the data set was small despite the fact that it generated thick description across all participants. A study of this nature might benefit from a larger sample size of participants leading to a more diverse set of perspectives. The findings

therefore were relevant to this small population within a specific region and must give pause before generalizing beyond this study. The challenge of locating FEPs remains.

Thirdly, this researcher used the phenomenological research design to probe the lived experience of the participants as it related to the phenomenon but to the exclusion of other potential sources of data. A study of this nature might be enhanced by using a case study research design where the researcher can explore a “bounded system” (Creswell 1998, p.61) where the FEP to Nursing program is administered, using in depth and detailed data collection derived from multiple sources of information.

An enduring concern of this researcher is the inherent potential for bias in qualitative study. An important limitation in this study was the possibility of researcher and participant bias due to this researcher’s proximity to the participants and the chosen topic. This researcher therefore had to frequently bracket prior assumptions and encroaching biases. The researcher also relied on member checking, thick description, theoretical triangulation, and clarifying bias to help moderate bias and to promote trustworthiness, validity and reliability.

### **Recommendations for Future Research**

For FEPs whose attempts at becoming nurse practitioners are unsuccessful and therefore remain as only RN’s, a longitudinal study is needed to measure how their prior, yet underutilized physician training, positively or negatively impacts them and their work environment.

Due to the relatively small number of FEPs who gain residency in the US after successfully completing the stages of the United States Medical Licensure Exam

(USMLE), future research is needed to determine the nature of the barriers to their credentialing and certification.

An expanded study should be conducted regarding the phenomenon of FEPs turned Nurses to encompass not just North America, but the Caribbean, Latin America, and Asia. This expanded study would introduce diverse perspectives with the potential to enrich and enhance both theory and practice around the phenomenon.

Based on the conclusion from this research that the theories of TL, Otherness, and Liminality, are complimentary to the study of FEPs transitioning to Nurses, more in-depth study through the vehicle of a case study design should be employed.

Current research indicates that patients treated by FEP Nurse practitioners report an equally and in many cases more fulfilling primary care experience when compared to being treated by a board certified physician. Future research should be conducted therefore to determine the feasibility of creating an uncomplicated pathway for established FEP NPs to receive the title of primary care physician.

Future research is needed to compare Nurse practitioner FEPs with non-FEP Nurse Practitioners to determine whether there are any significant differences in their delivery of patient care including social/inter-personal interaction; communication, and clinical proficiency.

The COVID-19 pandemic and its effects on the health industry has quickened the need to understand the impact of the virus on the flows of medical workers globally. Given the projected shortage of primary care health professionals in the United States, future research is needed to determine the degree to which COVID-19 has impacted the

flows of FEPs to the United States, given their proven value to the U.S. healthcare system.

Viewed through the lens of TL, and its complimentary perspectives of Otherness and Liminality, all participants in this study reported having come to a state of reclamation of the self, the tenth and final phase of Jack Mezirow's TL theory. Further study is warranted to determine whether these feelings endure and translate into job satisfaction and retention in the Nurse practitioner workspace.

### **Concluding Remarks**

The set of beliefs that provoked my curiosity about unlicensed FEPs transitioning to non-physician primary care roles arose from my interactions with them in my former role at one south Florida University. I have come to appreciate that within these FEPs there is a rich diversity that is an amalgam of their ethnicity, geographical origins, and clinical prowess, indeed, their lived experience. I have come to know these FEPs as they want to be known, and have come to appreciate their overwhelming desire to be a part of the healthcare provider solution. This work will enhance current studies, concepts and theories around the phenomenon. Institutions are fortunate to have FEPs, these unicorns of medicine, within their walls and to have the opportunity to unfurl their tapestry to provide an avenue for them, as this study has done, to tell the story of their stories.

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## **APPENDICES**

## APPENDIX 1

### Sample Interview Questions

1. Tell me about the factors that played an important role in your decision to leave your country of origin to migrate to the US.
2. When you arrived to the U.S. what were your career plans?
3. Once admitted to the Nicole Wertheim College of Nursing & Health Sciences Physician-to-Nurse program, tell me how you experienced the transition from medical doctor to student-nurse.
4. Describe your experience as student-nurse in the Physician-to-Nursing program.
5. As an immigrant who is a student, do you believe that you were treated or perceived to be any different from native born students?
6. Describe your feelings toward your cultural differences such as language, lifestyle, and accent and how they may or may not have been a stumbling block or a stepping stone to your student-experience.
7. Describe how your prior medical knowledge and training in your country of origin may have facilitated your persistence as a student in the U.S.
8. As a researcher, I am thinking about a concept called liminality which is defined as the passage of a subject through a realm which bears little or no resemblance to the past. Given the basic definition, describe your feelings, if any, of being in-between and between as you moved from one stage of your professional identity to another.
9. Tell me about your perceptions regarding the vocation of medical practice vs. the scope of practice associated with nursing.

10. Is there anything that you would like to share that I have not asked?

APPENDIX II

Recruitment letter:

03-05-2021

<<Name of potential participant>>

<<Address>>

<<City, State, Zip>>

Re: Physicians Among US: The Lived Experience of Unlicensed Foreign Born and Educated Physicians as they Retrain for Non-Physician Primary Care Roles

Investigator: Dwight N. Nimblett

Dear <<insert name>>:

I am writing to let you know about an opportunity to participate in a research study about the lived experiences of unlicensed foreign born and educated physicians who are present in the US as they retrain for non-physician primary care roles. This study is being conducted by Dwight Nimblett at Florida International University. This study will explore and describe the experiences of former physicians who were born and medically educated outside of the US but who are unlicensed to practice medicine in the US.

You are enrolled or were previously enrolled in the Physician to Nursing Program at Florida International University and as such have been identified as a potential participant to this study. Your contact information was obtained from xxxx. None of your private information has been accessed or disclosed in this attempt to contact you. In some instances, potential participants such as yourself may have given prior permission to be contacted for the purpose of future study

participation. I believe you may be eligible for or interested in an approved research study as described.

This letter merely gauges your interest in this study as a potential participant and does not mean that you have been enrolled in the study. Agreement to be contacted or a request for more information does not obligate you to participate in this study.

You may contact the researcher at xxx-xxx-xxxx for more information regarding this study.

Thank you for taking the time to consider participation in this study.

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Signed



**ADULT CONSENT TO PARTICIPATE IN A RESEARCH STUDY**

PHYSICIANS AMONG US: THE LIVED EXPERIENCE OF UNLICENSED FOREIGN BORN AND EDUCATED PHYSICIANS AS THEY RETRAIN FOR NON-PHYSICIAN PRIMARY CARE ROLES

**SUMMARY INFORMATION**

Things you should know about this study:

**Purpose:** The purpose of this study is to explore and describe the lived experiences of unlicensed foreign born and educated physicians, as they attempt to reemerge in the U.S. healthcare industry in non-physician primary-care roles.

**Procedures:** If you choose to participate, you will be asked to do the following things:

1. You will be interviewed and with your permission, your responses recorded by a digital audio recorder and smartphone. No video recordings will be necessary. Recordings will be transcribed and coded.
2. Your only requirement will be to be interviewed not exceeding 2.5 hours with a possible .5 hours of review.
  - **Duration:** Your participation will require approximately 3 hours (180 minutes) divided into 2.5 hours of interview and a possible .5 hours of review.
  - **Risks:** There are no known risks associated with your participation in this study.
  - **Benefits:** It is anticipated that your participation in this study may help in the construction of a comprehensive body of knowledge around the phenomenon of unlicensed foreign educated physicians present in the U.S.

- **Alternatives:** There are no known alternatives available to you other than not taking part in this study.
- **Participation:** Taking part in this research project is voluntary.

Please carefully read the entire document before agreeing to participate.

## **PURPOSE OF THE STUDY**

The purpose of this study is to explore and describe the lived experience of unlicensed, foreign born and educated physicians who are present in the US, as they attempt to reemerge in the U.S. healthcare industry in non-physician primary-care roles.

## **NUMBER OF STUDY PARTICIPANTS**

If you decide to be in this study, you will be one of 12 people in this research study.

## **DURATION OF THE STUDY**

Your participation will require 3 hours (180 minutes) divided into 2.5 hours of interview and a possible .5 hours of review.

## **PROCEDURES**

If you agree to be in the study, we will ask you to do the following things:

1. You will be interviewed and with your permission, your responses recorded by a digital audio recorder and smartphone. No video recordings will be necessary. Recordings will be transcribed and coded. The anonymity of your responses will be maintained by assigning pseudonyms and or letters of the alphabet to substitute your name.
2. Your only requirement will be to be interviewed not exceeding 2.5 hours with a possible .5 hours of review. It is not expected to require more than two (2) encounters. None of the process involves experimentation of any kind. There will not be any trick or misleading questions involved in this semi structured interview.

## **RISKS AND/OR DISCOMFORTS**

There are no known risks associated with your participation in this study.

## **BENEFITS**

The study has the following possible benefits to you: It is anticipated that your participation in this study may help in the construction of a comprehensive body of knowledge around the phenomenon of unlicensed foreign educated physicians present in the U.S.

## **ALTERNATIVES**

There are no known alternatives available to you other than not taking part in this study. However, any significant new findings developed during the course of the research which may relate to your willingness to continue participation will be provided to you.

## **CONFIDENTIALITY**

The records of this study will be kept private and will be protected to the fullest extent provided by law. In any sort of report we might publish, we will not include any information that will make it possible to identify a subject. Research records will be stored securely and only the researcher team will have access to the records. However, your records may be reviewed for audit purposes by authorized University or other agents who will be bound by the same provisions of confidentiality.

## **USE OF YOUR INFORMATION**

- Your information collected as part of the research will not be used or distributed for future research studies even if identifiers are removed.

## **COMPENSATION & COSTS**

There are no costs to you for participating in this study.

**MEDICAL TREATMENT**

*N/A*

**RIGHT TO DECLINE OR WITHDRAW**

Your participation in this study is voluntary. You are free to participate in the study or withdraw your consent at any time during the study. Your withdrawal or lack of participation will not affect any benefits to which you are otherwise entitled. The investigator reserves the right to remove you without your consent at such time that they feel it is in the best interest.

**RESEARCHER CONTACT INFORMATION**

If you have any questions about the purpose, procedures, or any other issues relating to this research study you may contact Dr. Thomas Jr. Reio, at 11200 SW 8<sup>th</sup> Street, Miami, FL, 33199

305 348-2093 – email: reiot@fiu.edu

**IRB CONTACT INFORMATION**

If you would like to talk with someone about your rights of being a subject in this research study or about ethical issues with this research study, you may contact the FIU Office of Research Integrity by phone at 305-348-2494 or by email at ori@fiu.edu.

**PARTICIPANT AGREEMENT**

I have read the information in this consent form and agree to participate in this study. I have had a chance to ask any questions I have about this study, and they have been answered for me. I understand that I will be given a copy of this form for my records.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

---

Printed Name of Participant

---

Signature of Person Obtaining Consent

---

Date

### APPENDIX III

#### Coding Table and Units of Meaning

##### A Working Example

The purpose of this study is to **describe the lived experience of foreign-born and educated physicians who are unlicensed to practice medicine in the U.S.** as they attempt to retrain for non-physician primary care roles.

RQ: What is the lived experience of unlicensed foreign born and educated physicians who reside in the United States as they retrain for non-physician primary care roles?

Participant profile: sample

- Where they are from (country of origin)?
- How long they practiced before moving to the U.S.?
- Where did they receive their medical training?
- Where did they receive their medical credentials?

Process: Thematic Analysis:

- First, read through the transcript while listening to the audio and memo in the margins of the transcript
- Second, read through the transcript and create inductive units of meaning
- Third, read through the transcript and create deductive codes using theory
- 

#### SAMPLE CODING TABLE

Participant Pseudonym	Direct Quote	Units of Meaning	Deductive Code	Notes
<b>Nancy</b>	Yeah, then that was that perfect opportunity because I was looking for that. But in the FIU program they were the only ones that took I cannot say like all the credits, but they took a lot of credits from my previous education. They allowed me to continue my education there because if not I had to start again in any other place in any other university. Like I had to start from zero from basic science even though I had the education. I had the experience and all that still that wasn't valid for	Credential transfer  Starting over  Not enough        Earliest	Disorienting dilemma	Opportunity Looking for program Found program that accepted prior learning Starting from zero

	<p>them. Challenging since the beginning because like the way that I was trained to think about medicine about health care, it was different than the way of a nurse.</p> <p>That that was like I told you before, that was very like difficult because of like first of all, because of the type of education like I told you before, like the way that I was trying to think, it's the way that a doctor, a medical doctor thinks. Things like you know, uh, physicians do, you think about the illness and the symptoms. It is very different. Everything is very different and like organized like following like a certain kind of steps. And when you enter to the nursing world it is about being with the patient and like understanding like who the patient is not only what are their symptoms but how the patient is feeling and how to really how to like advocate for the patient and all that? That's really that amazing. First of all really, and that's something that you don't learn in Med school.</p>	<p>Challenge</p> <p>Scope of Practice</p> <p>OR</p> <p>professional identity?</p>		
	<p>You know all the nursing theories that I learned during this, like a couple of years in these i two programs? They put me like they make me think about really that relationship that you can have with the patient. In medical practice, many times the patient becomes a room or bed number. You don't think about how really the patient is feeling because you are not with the patient.</p>	<p>Scope of practice</p>		<p>A Recurring theme about scope of practice and the difference between how physicians view their patients as opposed to how nurses view their patients</p>
	<p>It was difficult and the other part that was difficult was I remember when we started going to clinicals like many of the nurses were like not so gentle and not so nice with us because yeah, many of the nurses are thinking like OK, you are a physician from other parts of the</p>	<p>Incivility in the training room</p>	<p>Activating event</p>	<p>You are not from here. Why are you coming here? Not so gentle</p>

	<p>world. You are not from here. Why are you coming here? Why are you studying these?</p> <p>Speaker 2 And why are you gonna take like the job of a nurse like if there's more like?</p> <p>Speaker 2 It was like many of them thought that there were no enough space for everyone.</p> <p>Speaker 2 You know, it's like you are coming here to take something that is not for you.</p>	Othered... difference as problem		
	<p>I believe that the most important part of that Like to answer that question is talk about like my language. But yeah, and in in that way, like the language was a barrier for me since the beginning, like to enter to the program like I remember that they that you need to have.</p>	Communication challenges/ barriers Otherness	Disorienting then Plan of action	TL connection Immersion in English encounters
	<p>But then in the when we started the program like I, I felt like obviously more prepared, but for reading and for studying and really like reading and like listening and studying in English. 00:28:14 Participant (NR) It hasn't been like so difficult the difficult.</p>	Uncertainty with the language	Liminal state  Otherness	Make connection between uncertainty and motivation to learn
	<p>In the class and with my classmates, there was like maybe there was a group of maybe? 12 people that speak Spanish. The rest of the people was from other places of the world and some speaking, though some many are from India. Then this big Hindi or some other languages and there's say people from Japan and from Nepal. And you know there was a mix.</p>	Cultural Diversity yet sameness (South Florida)		
	<p>Nice, but I decided like no. I need to find people that helps me to improve my English. Then I'm gonna like go with another people. I mean if I want to speak if I want to say something. If I want to</p>		Transformative Learning	Planning a course of action – stage 6



	express how I'm feeling or my needs or whatever that needs to be in.			
	<p>Because you know, at home I speak Spanish all the time. And if if you live here in Florida people start to learn a little bit or people speak Spanish because here and you don't have to speak English. That's rude, and I don't like that idea. I I don't agree with that idea, but you don't need to speak English to live here in Florida.</p>	Language and Identity		Shared experience – stage 4

## VITA

### DWIGHT NIMBLETT

#### EDUCATION ACADEMIC EXPERIENCE

2014-2022	Doctorate in Adult Education/Human Resource Development Florida International University, Miami, Florida
1997-1998	Barry University Master of Science, (Higher Education Administration)
1993-1994	Barry University Bachelor of Liberal Studies (Behavioral Sciences)
1990-1993	Miami Dade College
1986-1989	University of the West-Indies, St Augustine, Trinidad Practitioner's Certificate (Creative Writing/20th Century Theater Arts)
2016-Present	Florida International University, Program Director, Center for Testing and Career Certification (CTCC), Academic and Career Success FIU: Institution Test Administrator (ITA) - Florida Civic Literacy Exam
2011-2016	Florida International University, Associate Director, Center for Academic Success
2007-2011	Florida International University, Assistant Director, Center for Academic Success
2004-2007	Adjunct Instructor (SLS 1501) First Yr. Experience (FIU)
1999-2007	Florida International University, Coordinator, Academic Support Services, University Learning Center
1996-1997	Barry University, Transcript Evaluator – Division of Enrollment Services
1995-1996	Barry University, Publication Specialist, Marketing, Adv. & Publications

1993-1995	Barry University, Computer room manager/Tutor University Learning Center
1991-1993	Miami Dade Community College, Lab Monitor/ Supervisor/Tutor, Basic Communication Studies Dept.
2009	Florida International University Operational Excellence Award
2004	Dr. Martin Luther King Jr. Employee Service Award F.I.U. ( <i>only one awarded annually</i> )
2004	“Employee in the Spotlight”, Weekly Publication (F.I.U.)
1994	National Dean’s List (Barry University)

#### PUBLICATIONS AND PRESENTATIONS

Moncarz, R., Moncarz, E., & Nimblett D., Toward a University System. (August 2007). *International Trade and Finance Association-Conference Papers* 1100.

Moncarz, R., Moncarz, E., & Nimblett D., The World Economy – Past, Present, And Future. 20<sup>th</sup> International Conference Working Papers

Nimblett, D., Why Dogs Chase Their Tails. “Treasure House One—A Caribbean Anthology.” Macmillan Caribbean, 2006.

The Allegory of Mount Everest: *The Importance of Critical Reflection, and Roleplay in Adult Learning* (AAACE 2016, New Mexico).