CGFNS INTERNATIONAL
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The **OFFICIAL GUIDE** for Foreign-Educated Nurses

What You Need To Know About

NURSING AND HEALTH CARE IN THE UNITED STATES

BARBARA L. NICHOLS • CATHERINE R. DAVIS
EDITORS

SPRINGER PUBLISHING COMPANY

The Official Guide for Foreign-Educated Nurses

What You Need to Know About Nursing and Health Care in the United States

CGFNS International, Inc.
(Commission on Graduates of Foreign Nursing Schools)

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EDITORS

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Springer Publishing Company, LLC
11 West 42nd Street
New York, NY 10036
www.springerpub.com

Acquisitions Editor: Margaret Zuccarini
Project Manager: Julia Rosen
Cover design: Steve Pisano
Composition: Apex CoVantage, LLC

Ebook ISBN:

09 10 11 / 5 4 3 2 1

Library of Congress Cataloging-in-Publication Data

The official guide for foreign-educated nurses : what you need to know about nursing and health care in the United States / CGFNS International, Inc. (Commission on Graduates of Foreign Nursing Schools) ; Barbara L. Nichols, Catherine R. Davis, editors.
p. ; cm.
Includes bibliographical references and index.
ISBN 978-0-8261-1065-7 (alk. paper)
1. Nurses, Foreign—United States. 2. Nursing—United States. I. Nichols, Barbara L. II. Davis, Catherine R. III. Commission on Graduates of Foreign Nursing Schools (U.S.)
[DNLM: 1. Nursing—United States. 2. Delivery of Health Care—United States. 3. Emigration and Immigration—United States. WY 300 AA1 O32 2009]
RT4.O44 2009
362.17'3—dc22 2009012551

Printed in the United States of America by Victor Graphics.

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Nancy C. Sharts-Hopko, PhD, RN, FAAN, is Professor and Director of the Doctoral Program in the College of Nursing at Villanova University, in Villanova, Pennsylvania. As a veteran of nearly three years working in Asia, first as a short-term consultant for WHO and then as an Overseas Associate of the Presbyterian Church (USA), she understands the challenges associated with living and working in an international context. She has served as an advisory committee member and consultant for the United States Food and Drug Administration since 1992.

Theresa M. "Terry" Valiga, EdD, RN, FAAN, received both her master's and doctoral degree in nursing education from Teachers College, Columbia University in New York. She held faculty and administrative positions in five different universities over a 26-year period, and served as the Chief Program Officer for the National League for Nursing. In July 2008, Dr. Valiga joined Duke University's School of Nursing (Durham, NC) to create and direct their new Institute for Educational Excellence. She has received several awards for excellence in nursing education, and consulted with nursing faculty groups in the United States, Canada, Japan, and China.

Foreword

Nurses migrate to the United States for many reasons. First, nurses in the United States are among the highest paid in the world. Many migrating nurses come to make a better living and, in many cases, share that income with their families back home. Second, U.S. nursing is arguably more complex than nursing in most other countries, in large part due to the pervasive technology for screening, monitoring, and delivering care. Whether the migrating nurse plans to work in acute care, public health, long-term care, or another part of the U.S. health care system, the experience gained in the United States will prepare the nurse with clinical and leadership skills that can be invaluable. Third, some nurses come to the United States to acquire graduate degrees in nursing. Nursing education in the United States is among the most progressive in the world, and there are many opportunities for furthering one's education and qualifications for advanced positions here and abroad. Finally, some nurses may come to the United States for the experience of living in another country. Travel nursing is popular within the United States among nurses who want to see other parts of the country and interact with other cultures—and there are many different cultures within the various geographic regions of the United States. Many of the companies that have specialized in travel nursing within the United States have been expanding their business to other countries, providing another vehicle for nurses to migrate to the United States for work.

Regardless of why you want to work as a nurse in the United States, your entry and transition to working here will be smoother and your contributions more significant if you are knowledgeable about how the health care system functions, what is expected of nurses, what your rights are, how to prepare for the journey, and how to adapt to your new

community. No one is better suited to advise you about these matters than Barbara Nichols and Catherine Davis, both with the Commission on Graduates of Foreign Nursing Schools (CGFNS) International, Inc., an internationally-respected, nonprofit organization that evaluates the credentials of health care workers seeking employment in the United States. They have prepared this essential book, *The Official Guide for Foreign-Educated Nurses: What You Need to Know About Nursing and Health Care in the United States*, which will serve as your guide before and after you come to the United States. This book is a "must-read" for every nurse who is contemplating migrating to the United States. I know of no better resource for you, even if you're not yet certain that you want to go to the United States. The guide may help you to make that decision and can assist you in ensuring that you're coming on contractual terms that are clear and beneficial to you.

Once you're in the United States, the book can help you to understand the U.S. health care system and your rights and roles within that system. It can help you determine if your experiences are normal or contrary to the rules that apply to everyone, and it can guide you in your work with U.S. nurses, patients, and families. The book also can help you to figure out ways to avoid being misunderstood in your communication with others and how to increase the likelihood that you'll form enduring relationships with your American colleagues, joining them in working to improve the quality of nursing and health care provided in this country—and worldwide.

I hope that your experience working as a nurse in the United States will be a rich and rewarding one. This nation is often imperfect, as all are, and because of that, it can be an exciting, confusing, joyous, and complicated place to be. While some may assume that you will be the beneficiary of migrating to the United States, I expect that those whom you meet and care for will benefit even more. I have worked with many nurses who migrated to this country and have usually been impressed with their commitment to excellence in nursing, their intellect, and their compassion. Immigrant nurses have become leaders in U.S. nursing and have helped to shape the profession and health care worldwide. During a time of a nursing shortage in the United States, your contributions will help to meet the health care needs of the nation.

Of course, that shortage is worldwide, and there have been many conversations, debates, and arguments about whether nurse migration serves nations well. As the International Council of Nurses (ICN) has argued, migration must be a right for all nurses (read the ICN position statement on the ethical recruitment of nurses in Appendix C or on the ICN Web site at http://www.icn.ch/psrecruit01.htm). At the same time, we must be mindful of the extent to which developed nations are depleting developing or underdeveloped nations of one of their most precious resources—nurses. How can nations such as the United States pay back poorer nations to equalize this shift in resources? You can help to answer this question—whether through sharing your income with your family back home, finding other ways to support the education of nurses in your country, or simply discussing your ideas on this important issue with nurses and others here and abroad.

Our world needs nurses who will be fearless in their commitment to promoting the health of individuals, families, communities, and nations. I urge you to use this book to guide your professional life in the United States, a life that is filled with a sense of responsibility to yourself, your country, the United States, and excellence in nursing. Whether my country or yours, we need your leadership and contributions to the profession and health care.

May your journey to, and within, the United States be resoundingly satisfying, exciting, and enriching. And if our paths happen to cross, please do tell me about your journey.

Diana J. Mason, PhD, RN, FAAN
New York City

Preface

When the Commission on Graduates of Foreign Nursing Schools (CGFNS) International was created in 1977, I was a member of the American Nurses Association Board of Directors and party to the many debates on the efficacy of recruiting foreign nurses to provide patient care to the U.S. population. I was intrigued with the discussion about the advantages and disadvantages of foreign-educated nurses being a temporary or permanent element of the U.S. nursing workforce. What evolved from those discussions was the need to create a program of credentials evaluation that was professionally ethical and responsible to both the foreign-educated nurse and the U.S. public.

The need for an entity such as CGFNS was a novel, yet controversial idea—especially for foreign-educated nurses who felt that assessment of their nursing credentials and a pre-immigration exam to test their nursing knowledge was burdensome and unnecessary. Nevertheless, CGFNS was created at the bequest of the U.S. Department of State, the then–Immigration and Naturalization Service (INS), the U.S. Department of Labor (DOL), and the then–U.S. Department of Health, Education, and Welfare (HEW). Then and now, the need for such an organization emerged from the migration of nurses. Now, as then, a rapidly expanding health care industry welcomes foreign-educated nurses to fill vacancies and to provide care to the U.S. populace.

Adele Herwitz, RN, MS, founding Executive Director of CGFNS, who previously served as an Executive of the American Nurses Association and the International Council of Nurses, played a major role in establishing CGFNS's credibility and guiding the organization to achieve its dual mission—protecting the public of the United States while fostering equitable treatment of nurses around the world.

For over 30 years, CGFNS has served as a valuable resource by reviewing and validating the credentials of migrating nurses seeking employment in the United States. We have vigorously fulfilled our mandate from federal and state governments to uphold the educational and professional standards created to protect the well-being of U.S. citizens receiving care from internationally prepared nurses.

The genesis of this book has emerged from CGFNS's years of dialogue with foreign-educated nurses using our services. The global nursing shortage serves as an ongoing context for our work and intensifies our commitment to both the American public and nurses around the world. We are both respectful and proud of our global presence, its import and impact. We understand that many foreign nurses who migrate do so to improve their lives and those of their families. This fact links the moral substance of our work to reality and challenges us to consider what roles we might play to ensure ethical responses to migration practices.

This book is organized into 11 chapters that present information to assist the reader in what to do when coming to the United States to practice nursing. No doubt the contents of the book will be viewed differently among a variety of readers, but hopefully, all will benefit from the perspective presented.

In chapter 1, "Foreign-Educated Nurses in the United States Health Care System," Barbara Nichols, Catherine Davis, and Donna Richardson briefly trace the history of supply and demand of foreign-educated nurses in the U.S. health care system. The focus on immigration laws, policy, and practices that have influenced the migration of nurses to the United States is informative. Key points for successful adaptation to U.S. nursing practice are succinctly described.

In chapter 2, "Preparing to Leave Your Home Country," Catherine Davis and Donna Richardson identify the many reasons that nurses migrate. The factors that make a host country a favorable destination are depicted. Pitfalls to avoid and ways to reduce the risk of abuse and intimidation also are emphasized. The chapter identifies what you should do in your home country once you decide to move to the United States to work.

In chapter 3, "Entry into the United States," Donna Richardson and Catherine Davis explain the visa requirements to work as a nurse

in the United States. Tips for successfully navigating the process for obtaining a visa and a VisaScreen® certificate are provided.

Marcia Rachel, in chapter 4, "Entry into the United States Workforce," addresses nursing licensure in the United States, emphasizing that licensure is at the state level. She provides detailed information on the process to obtain a U.S. nursing license, discusses the requirements for state licensure, and describes both the CGFNS and NCLEX® examinations.

In chapter 5, "Employment in the United States," Michael Evans explains the rights and responsibilities of employees and employers. He spells out the fundamental issues for work success across a variety of health care settings.

Nancy Sharts-Hopko, in chapter 6, "The U.S. Health Care System," offers a broad overview of the scope and structure of the U.S. health care system and how individuals access care. She underscores the importance of knowledge of the health care system as a key to success.

In chapter 7, "Nursing Practice in the United States," Winifred Carson-Smith and Barbara Nichols define and describe nursing practice and the laws and standards that govern professional practice in the United States. They provide a framework for understanding the legal and social elements of professional nursing practice.

In chapter 8, "Communicating in the U.S. Health Care System," Catherine Davis and Donna Richardson focus on interpersonal and English language proficiency challenges that many foreign-educated nurses face as they enter practice in the United States. Through their thorough and thoughtful analysis, they explore the meaning and impact of English language proficiency and interpersonal skills on safe nursing care.

Virginia Alinsao, in chapter 9, "Adjusting to a New Community," provides useful information for newly arriving immigrants adjusting to a new community in the United States. She addresses the major concerns about housing, transportation, and personal safety, all factors that must be considered when adapting to a new country and work environment.

In chapter 10, "Continuing Your Education," Theresa Valiga discusses academic and nonacademic educational programs for nurses

in the United States. This chapter outlines the types of nursing education programs and the requirements for academic entry and discusses continuing education programs. The author conveys that a spirit of continuous learning is central to adjusting to working and living in the United States.

Lucille Joel, in chapter 11, “Resources at Your Disposal,” provides both a philosophical and practical overview of the U.S. culture and nursing as practiced within that environment. She pursues the theme that success in adapting to a new country is, in part, tied to understanding its culture and its people.

The six Appendices supplement the primary content and are summarized as follows: Appendix A focuses on what you will need as you search for a job in the United States. It contains a sample cover letter requesting an interview, a sample résumé, and a sample letter of thanks following an interview.

Appendix B provides selected U.S. government visa information, focusing specifically on the H-1B and other temporary visa categories as well as permanent visas.

Appendix C provides you with some materials that may be helpful as you begin the process of migrating to the United States. It contains the International Council of Nurses (ICN) Position Statement on Ethical Recruitment as well as forms that you might use to track your correspondence and expenses during migration.

Appendix D provides samples of the CGFNS reports that you may need as you seek a U.S. occupational visa and license to practice. It contains copies of the types of Credentials Evaluation Service (CES) Reports required by many of the State Boards of Nursing, sample Pass and Fail letters for the CGFNS Qualifying Exam℠, and an explanation of the Client Need categories used for the CGFNS and NCLEX-RN® examinations.

Appendix E describes the common slang terms, idioms, jargon, and abbreviations you will encounter in the United States and U.S. Nursing Practice.

Appendix F lists educational resources, namely, a select listing of U.S. schools that provide online nursing degrees.

In creating this book, CGFNS has attempted to provide a bridge that will foster a successful transition for those whose journey brings

them to the United States to work. We hope as you read the chapters that not only will we answer your questions and inquiries, but also that you will find the book both informative and helpful.

Barbara L. Nichols, CEO, CGFNS International
Spring 2009

Acknowledgments

We thank the authors for not only taking time to prepare the manuscripts but also for their scholarship, diligence, and enthusiasm. We are indebted to each for helping us realize our goal of creating a helpful, readable book.

Special thanks go to Melanie Jones and Amanda Nickerson, whose attention to detail and indefatigable work to meet deadlines made the book possible, to David Keepnews for his professional assistance, and to Donna R. Richardson for her keen eye and continued support.

We thank Springer Publishing Company, especially Margaret Zuccarini, Executive Acquisitions Editor, and Brian O'Connor, Assistant Editor, for the trust and support they provided throughout the development of the book. Their thought-provoking questions and skill with words transformed a manuscript into a book.

Our gratitude is extended to our colleagues who helped with their encouragement and conversations. They include the CGFNS International Board of Trustees, CGFNS administrative, managerial and operational staff, and the nurses who shared their migration journey with us.

1 Foreign-Educated Nurses in the U.S. Health Care System

BARBARA L. NICHOLS
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In This Chapter

U.S. Immigration Patterns

History of Foreign-Educated Nurses in the U.S. Workforce

Transition to Nursing Practice in the United States

Acculturation

Summary

Keywords

Adjudicate: To settle a case by lawful procedure.

Codified: Signifies that laws have been collected and arranged in a systematic order.

Credentials evaluation: An analysis of an individual's qualifications, for example, education and licensure documents, to ensure that they are comparable to U.S. qualifications.

Department of Labor (DOL): The U.S. government department responsible for improving working conditions and promoting opportunities for profitable employment in the United States.

Department of State (DOS): The U.S. government department that sets and maintains foreign policies, runs consular offices abroad, and makes decisions about nonimmigrant and immigrant visas that are processed through U.S. consulates.

Educational comparability: Where instructional coursework under one educational system is mostly equivalent to that of another.

Internship: Where one works as a trainee gaining practical, on-the-job experience for a specified amount of time, for example, as a new nurse graduate in a hospital critical care unit.

Labor certification: Process of proving that an employer has ensured that there are no qualified U.S. workers for the position being offered to a foreign worker.

Mentor: A senior or experienced person in a company or organization who gives guidance and training to a junior colleague; a wise and trusted teacher and counselor.

Preceptor: A specialist in a profession, especially health care, who gives practical training to a student or novice in a profession.

Prevailing wage: Defined as the hourly wage, usual benefits, and overtime paid in the largest city in each county to the majority of workers.

Union: An organization of workers who have banded together to achieve common goals in key areas such as wages, hours, and working conditions.

U.S. Citizenship and Immigration Service (USCIS): The U.S. government agency that oversees lawful immigration to the United States. It establishes immigration services, policies, and priorities and **adjudicates** the petitions and applications of potential immigrants.

Since World War II, foreign-educated nurses have played a vital role in the U.S. health care system. They have augmented the workforce during periods of shortage and continue to be an essential part of the U.S. nursing profession. However, migratory patterns always have been tied to U.S. immigration policy, with changes based on

environmental, economic, and political considerations. This chapter will discuss the history of foreign-educated nurses in the United States and the U.S. immigration policies that influenced that history. It will identify the challenges faced during transition to U.S. nursing practice and how they can be minimized and discuss the process of effective acculturation.

U.S. IMMIGRATION PATTERNS

Since its founding, the United States has depended on workers from other countries to provide the labor and skills necessary to ensure development of the U.S. agricultural, manufacturing, and export industries. Early immigrant workers ranged from indentured servants and African and Caribbean slaves to Irish, Italian, and Polish mill and mine workers and Chinese railroad builders. Today, the face of the immigrant is changing.

Early Immigration Trends

While immigration has been ongoing since the time of the early U.S. settlers, the United States experienced a major wave of immigration in the 1800s as people began leaving their home countries because of crop failures, land and job shortages, rising taxes, and famine. Many came to the United States because it was seen to be the land of economic opportunity. Others came seeking personal freedom or relief from political and religious persecution. The majority of immigrants during this intense period of immigration arrived from Germany, Ireland, and England.

Migration Trends in the 20th Century

Migration patterns changed considerably in the 1900s. Not only did the number of immigrants increase, but the countries from which they came also changed—with the majority of immigrants coming from non–English-speaking European countries. The principal source of immigrants was now southern and eastern Europe, especially Italy, Poland, and Russia, countries quite different in culture

and language from the then-population of the United States, making adaptation to the new country more challenging than for previous immigrants.

Although each ethnic group demonstrated distinctive characteristics, they shared one overarching feature: They settled in urban areas and worked in jobs that native-born Americans were prohibited from applying for or did not want. In fact, they made up the bulk of the U.S. industrial labor pool, making possible the emergence of such industries as steel, coal, automobile, textile, and garment production and enabling the United States to move to the front ranks of the world's economic giants.

By the mid-1900s, migration patterns changed again. Restriction of immigration occurred sporadically over the course of the late 19th and early 20th centuries, but immediately after World War I (1914–1918) and into the early 1920s, Congress changed the nation's basic policy on immigration (Library of Congress, 2004).

Legislating Immigration

National Origins Act

The National Origins Act (also known as the Reed-Johnson Act) of 1924 not only restricted the number of immigrants who could enter the United States but also assigned slots according to quotas based on national origins. The Act limited the number of immigrants who could be admitted from any country to 2% of the number of persons from that country who were already living in the United States based on the 1890 census. Approximately 86% of the 165,000 permitted entries were from the British Isles, France, Germany, and other northern European countries.

The law was aimed at further restricting the southern and eastern Europeans who had begun to enter the country in large numbers beginning in the 1890s. However, it set no limits on immigration from the Western hemisphere, thus ushering in a new era in U.S. immigration history. Immigrants could and did move quite freely from Mexico, the Caribbean (including Jamaica, Barbados, and Haiti), and other parts of Central and South America.

Immigration and Nationality Act

The Immigration and Nationality Act (INA) was created in 1952. Before the INA, a variety of rulings governed immigration law but were not organized in one location. The INA collected and **codified** many existing provisions and reorganized the structure of immigration law. The Act has been amended many times over the years, but it is still the basic body of immigration law. The INA of 1952 upheld the national origins quota system established by the National Origins Act of 1924, reinforcing this controversial system of immigrant selection.

The Hart-Celler Act

Immigration policy changed with passage of the Hart-Celler Act of 1965. This Act was an amendment to the INA and was a by-product of the civil rights revolution and a much more liberal immigration law.

The Hart-Celler Act replaced the quota system with preference categories based on family relationships and job skills, giving particular preference to potential immigrants with relatives in the United States and with occupations deemed critical by the U.S. **Department of Labor (DOL).** Immigrants were to be admitted on the basis of their skills and professions rather than their nationality.

Immigration Today

The result of the Hart-Celler Act was that most legal immigrants now come to the United States from Asia and Latin America, rather than Europe. The Act also began the rejuvenation of the Asian American community in the United States by abolishing the strict quotas that had restricted immigration from Asia since 1882. After 1970, following an initial influx from European countries, immigrants began to come to the United States from countries such as Korea, China, India, the Philippines, and Pakistan, as well as countries in Africa, such as Nigeria, Egypt, and Ethiopia. By the beginning of the 21st century, immigration to the United States had returned to its previous volume in the 1900s, and the United States once again became a nation formed and transformed by immigrants.

HISTORY OF FOREIGN-EDUCATED NURSES IN THE U.S. WORKFORCE

U.S. immigration policy has evolved over time to respond to the country's need for not only various labor skills but also health care delivery. Foreign-educated nurses have been a part of the U.S. workforce since the 1940s. However, their recruitment has ebbed and waned as the health care system has been challenged by demographic and economic changes and changing immigration laws.

Legislating Nurse Immigration

Because of cyclical and often severe nursing shortages, several immigration laws and regulations were implemented to facilitate the migration of foreign-educated nurses to the United States, and many foreign-educated nurses were designated with special status. Still others were considered *persons of distinguished merit and ability,* a designation that resulted in open-ended stays in the United States but unfortunately led to an abuse of the temporary visas. In the late 1980s, it was discovered that there were upwards of 27,000 nurses who had been allowed to stay longer than 5 years even though their visas were temporary. Because of these issues, Congress not only tightened the oversight of nursing visas but also granted amnesty to some nurses because of the adverse impact the deportation of foreign-educated nurses would have on major hospitals and emergency care. The Immigration Nursing Relief Act of 1989 was the outcome of discussions among Congress, hospitals, nursing organizations, and **unions.**

Immigration Nursing Relief Act

The Immigration Nursing Relief Act of 1989 created the H-1A visa category for registered nurses for a period of 5 years. There were no limits placed on the number of nurses who could enter the United States under this visa category, a move that was intended to relieve the nursing shortage of the 1980s.

Also under the Immigration Nursing Relief Act, the DOL established a special category, referred to as *Schedule A,* in recognition of the continuing shortage of registered nurses and physical therapists. Schedule A continues to be in effect in the United States.

Schedule A alleviates some of the documentation required of a sponsoring employer by the DOL for its **labor certification** process. Just as immigration can be an expensive process for foreign-educated nurses, labor certification is a complicated, labor-intensive, and costly process for employers. Schedule A's core premise is to precertify those occupations for which there are few qualified, willing, and available U.S. workers. For Schedule A occupations, the **prevailing wage** determination request form that employers must complete goes directly to the **U.S. Citizenship and Immigration Service** (USCIS) for processing, bypassing DOL and streamlining the labor certification process. The Immigration Nursing Relief Act sunsetted (or expired) in 1995, which left foreign-educated nurses without a special visa category of their own and resulted in a return to the quota system of previous years.

Illegal Immigration Reform and Immigrant Responsibility Act

The enactment of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA) on September 30, 1996, resulted in significant changes to existing U.S. immigration laws. Although IIRIRA was promoted as an illegal immigration law, its far-reaching provisions have had a serious impact on legal immigration as well.

The Act requires that select health care professionals, excluding physicians, seeking an occupational visa to enter the United States for employment purposes undergo a federal screening program. The law further requires that foreign nurses have their education, licensure, and experience evaluated to ensure their comparability to those of an entry-level U.S. nurse. The Commission on Graduates of Foreign Nursing Schools (CGFNS) was named in the law to conduct such a screening program and developed its VisaScreen program to meet the law's requirements (see chapter 3 for more on the 1996 law and its requirements).

Profile of Foreign-Educated Nurses in the U.S. Workforce

The history of foreign-educated nurses in the U.S. workforce mirrors the immigration seen in the United States from the early 1960s through the present time. Cumulative CGFNS data from 1978 to 2000 indicate that the majority of foreign-educated nurses seeking to migrate to the United States came from the Philippines (73%), followed by the United Kingdom (4%), India (3%), Nigeria (3%), and Ireland (3%). By 2008, that profile had changed. Data from CGFNS show that nurses educated in the Philippines continue to be in the majority, but the overall percentage declined from 73% to 59%—while the percentage of nurses educated in India increased from 3% to 19%. Canada (5%) and the Republic of Korea (3%) are now among the top countries of education of nurses seeking an occupational visa, while the number of nurses coming from the United Kingdom and Ireland has declined (CGFNS International, 2008).

Registered Nurses

Registered nurses entering the United States for purposes of employment tend to be female, younger than their U.S. counterparts, and educated in either diploma or baccalaureate programs in their home countries. They are generally licensed in their home countries and have worked for a number of years before migrating to the United States. First-level general nurses are known in the United States as registered nurses and are entitled to use the designation RN after their names once they pass the NCLEX-RN® examination. Foreign-educated RNs tend to work predominantly in hospitals in the areas of critical care and adult health (CGFNS, 2002).

The 2004 National Sample Survey of Registered Nurses (Bureau of Health Professions, 2004) indicated that the number of RNs who received their education outside of the United States increased by about 1.3% between 2000 and 2004. Nearly 90% (89.2%, or 89,860) of foreign-educated RNs were employed in nursing, with the majority

concentrated in a handful of states in 2004. Nearly 70% of foreign-educated RNs worked in six states:

- California (28.6%)
- Florida (10.7%)
- New York (10.4%)
- Texas (7.5%)
- New Jersey (6.9%)
- Illinois (5.6%)

The survey also found that foreign-educated RNs are more likely than the U.S. RN population overall to be employed in hospitals (64.7% versus 56.2% of employed RNs overall) and more likely to be staff nurses (72.6% versus 59.1% of employed RNs overall).

Licensed Practical Nurses

Foreign-educated nurses entering the U.S. licensed practical nurse workforce tend to be female, older than their U.S. counterparts, and educated in either secondary or post-secondary nursing programs in their home countries. They maintain nursing licensure in their native lands and have practiced nursing for several years prior to immigrating to the United States. The majority of those educated as practical nurses come from Canada, Haiti, Jamaica, and Kenya.

Second-level, or enrolled nurses, are known in the United States as practical nurses. Once they achieve U.S. licensure, they receive the title licensed practical nurse or LPN. The U.S. licensure examination for practical nurses is different from that for registered nurses and is known as the NCLEX-PN® examination. To be eligible for the NCLEX-PN examination, the individual must have graduated from a government approved, practical nurse program. It should be noted, however, that many nurses who were educated as RNs in their home country have taken the NCLEX-PN examination in the United States. This has occurred for two reasons: (1) their education as a first-level general nurse was not deemed comparable to the education of an RN in the United States, or (2) the nurse was unable to

pass the NCLEX-RN examination and then sat for the NCLEX-PN examination, which is allowed in some states.

The majority of those working as LPNs in the United States work in long-term care facilities, followed by hospitals and home health agencies. When working in hospitals, LPNs tend to work in gerontology and adult health. Most LPNs work in the state of New York, followed by the states of New Jersey, Florida, Texas, and Illinois (CGFNS, 2005).

Establishment of CGFNS

In the late 1960s and early 1970s, the United States was facing a critical nursing shortage. Large numbers of foreign-educated nurses were being recruited to the United States by employers and recruiting agencies. Unfortunately, only 15%–20% of those nurses were able to pass the State Board Test Pool Exam (SBTPE), the then-licensure examination for U.S. nurses. Those who failed the exam could not work as registered nurses. They either returned home to their country of origin or were employed as technicians, medical assistants, or nurse's aides. In some instances, dishonest employers expected those who were employed in such a capacity to perform the functions of an RN. However, the nurses did not have the protection of licensure and were being paid less than RN wages. These unlicensed personnel and their employers were violating states' laws—laws that prohibit the practice of nursing without a state license.

Government Review

These circumstances came to the attention of the federal government. In 1972, the Secretaries of the DOL and the Department of Health, Education, and Welfare (HEW) engaged the American Nurses Association (ANA) and Pace University to study the issue, and the findings were published in 1975. Subsequently, a conference of stakeholders was called by HEW. The participants were the DOL, the **Department of State (DOS),** the Immigration and Naturalization Service (INS), the American Hospital Association (AHA), and several nursing organizations. The participants assessed whether or not a preliminary

examination could be used to predict a nurse's potential to pass the SBTPE, which was administered by the individual states with various minimum score requirements.

The idea of a predictor examination administered overseas seemed logical for two reasons: (1) foreign-educated nurses could determine if they were eligible for the U.S. licensure examination and if they had a reasonable chance of passing it before they left their home countries, and (2) potential employers could determine the nurse's potential to be U.S. licensed before he or she was sponsored for a visa.

CGFNS Origins

The conference finally recommended that a predictor exam be established and administered by a single, independent body. For this purpose, the CGFNS was created in 1977. CGFNS was initially cofunded by ANA and the National League for Nursing (NLN) as well as by a grant from the W. K. Kellogg Foundation. CGFNS was established to validate and evaluate the credentials and nursing knowledge of foreign-educated nurses in order to minimize adverse incidents, to ensure safe care to the public, and to provide a stable workforce for employers.

At that time, CGFNS was housed at the Educational Commission on Foreign Medical Graduates (ECFMG) in Philadelphia, Pennsylvania. ECFMG had been performing a similar screening function for foreign-educated medical graduates who wanted to practice as physicians in the United States. CGFNS adopted the concepts of **credentials evaluation** and **educational comparability** used by ECFMG.

CGFNS Today

CGFNS is an immigration-neutral, nonprofit organization, internationally recognized as an authority on credentials evaluation related to the education, registration, and licensure of nurses and other health care professionals worldwide. It protects the public by ensuring that nurses and other health care professionals educated in countries other than the United States are eligible and qualified to meet licensure,

immigration, and other practice requirements in the United States. CGFNS not only validates international professional credentials but also supports international regulatory and educational standards for health care professionals.

CGFNS Programs

CGFNS has four programs that are used by foreign-educated nurses to meet federal and state requirements for employment as a nurse in the United States: the VisaScreen program, the Certification Program, the Credentials Evaluation Service, and the New York Credentials Verification Service. The VisaScreen program is required for nurses seeking an occupational visa to work as a nurse in the United States. The visa gives entry into the country. To work as a nurse, you must have a license to practice in a particular state. The license is granted by the State Board of Nursing in the intended state of practice. Many State Boards of Nursing require foreign-educated nurses to have their nursing credentials (education and licensure) reviewed, their nursing knowledge evaluated, and their English language proficiency scores verified by CGFNS as a prerequisite for state licensure (see chapter 4). The individual State Board of Nursing will advise you as to their CGFNS requirements. Generally, states use one of the four CGFNS programs:

- *Certification Program* (CP), which includes a review of your secondary school and nursing education; verification of your initial licensure in your country of education as well as your current licensure; the CGFNS Qualifying Exam; and an English-language proficiency examination;
- *Credentials Evaluation Service* (CES), which provides a written analysis of your education and licensure in terms of U.S. comparability;
- *VisaScreen program,* which is a government-mandated program ensuring that your education, licensure, and experience are comparable to those of U.S. graduates; that your license is valid, current, and without penalties; that you have proficiency in written and oral English; and that, if you are a registered

nurse, you have passed a test of nursing knowledge, either the CGFNS Qualifying Exam or the NCLEX-RN examination; or

- *New York Credentials Verification Service* (NYCVS), which obtains your academic transcripts and licensure validations from the issuing agencies, verifies their authenticity, and provides a report to the New York State Department of Education. The state then evaluates your credentials to determine comparability to U.S. education and licensure.

State Licensure

Unlike countries that have a national licensure system, licensure in the United States is at the state level, and each state sets its own requirements. You cannot work in the United States without a nursing license, therefore, you should contact the Board of Nursing in your intended state of practice as soon as possible to determine the requirements for that state before you begin the licensure process (see chapter 4 for more information on state licensure). Success on the U.S. licensure examination is linked to the amount of time that has passed since you graduated from nursing school. The shorter the time between graduation from your school of nursing and taking the NCLEX-RN examination, the greater the chance of passing the exam (CGFNS, 2007). Once you are licensed in your state of intended practice and ready for employment, there are many ways in which you can move smoothly to nursing practice in the United States.

TRANSITION TO NURSING PRACTICE IN THE UNITED STATES

Beginning nursing practice in a new country can be both exciting and challenging. You will meet new colleagues and friends, and you will be introduced to a new health care system and new technologies. Initially, you may feel intimidated, but over time you will begin to understand the new system and how nursing care is provided within that system.

Navigating immigration, moving to the United States, obtaining state licensure, and becoming comfortable in a health care system

different from your own can be a lengthy, sometimes challenging process—a process that balances the needs of migrating nurses with protection of the U.S. public. However, meeting the challenges of migration provides unlimited career opportunities.

Orientation to Practice

Preparation is critical to safe practice, therefore, hospitals and other employing facilities want the foreign-educated nurse to succeed and are willing to create an orientation that truly facilitates each nurse's transition to U.S. practice. It is your responsibility to let orientation leaders know how effective the orientation is, answering such questions as: What made sense and what did not? Did you need more information about or assistance with a specific aspect of nursing care? Did you need more time to process the information? In other words, do not be afraid to speak up so that the orientation is meaningful for you.

Support Systems

Another factor that is crucial to having a smooth transition to practice is having a support system in place. Support systems have been identified by nurse executives as vital to an international nurse's ability to adapt to nursing practice in the United States (Davis, 2004). Be sure to ask if the hospital has an **internship** program for international nurses, or if the hospital will provide you with a **preceptor** to assist you through the transition period. The delivery of nursing care in the United States can be complex and challenging. For many foreign-educated nurses it is the first time to manage a group of patients and use unfamiliar technology. A **mentor** or preceptor can guide you through the transition and help you to understand how hospital processes relate to each other, thus ensuring safe practice. A mentor is a senior or experienced person in a company or organization who gives guidance and training to a junior colleague. A mentor is considered a wise and trusted teacher and counselor. The mentor relationship is not limited to a specific task or timeframe but generally lasts over a period of years. A preceptor is a specialist in a profession, especially

health care, who gives practical training to a student or novice in a profession. The relationship may or may not last after completion of the period of preceptorship.

Challenges During Transition

Most foreign-educated nurses work in hospital settings when they first come to the United States, typically specializing in adult health and critical care; therefore, an awareness of the challenges of entering nursing practice in the United States can be helpful. While most nurses look forward to working in the United States, adjustment to practice can be affected by several factors, such as the health care system of the nurse's home country, language competence, knowledge of medications and their administration, and familiarity with technology (Edwards & Davis, 2006).

Variations in Health Care Systems

The more similar your health care system is to that of the United States, the easier your transition and the more comfortable you will be in the clinical setting. You can then focus on specific practice needs rather than the transition process. Information about the U.S. health care system is cited most frequently as a necessary component of clinical orientation by foreign-educated nurses. Because health care systems vary greatly from country to country, it is essential that you have an understanding of how the U.S. system works. This includes a description of the health team, its members, and their roles. Information on health insurance and how the system is accessed by patients also should be included. Although you will not come to understand the system thoroughly until you work within it, preliminary knowledge helps to make the transition to U.S. practice less stressful.

Language Competency

Nurses for whom English is a second language have repeatedly indicated to CGFNS that perception of their nursing competence by patients and health care personnel is tied to their ability to speak

English. Employers cite language competence as the most critical skill that foreign-educated nurses need during their first year of practice in the United States.

If English is a second language for you, it is best to increase your English language skills as you transition to living and practicing in the United States. Language skills, like practice skills, are primarily obtained through experience. Exercise your language skills by using English as much as possible in your new environment, even if it makes you feel uncomfortable or embarrassed at first. If you do not understand a term, ask for clarification. Look for publications that describe the idioms, abbreviations, and slang terms used in nursing practice in the United States.

Most of all, do not feel that you have to apologize to your employer or your colleagues for your attempts at using this new language. If you ask for help, most staff will try to help you to understand the nuances of the language. If one colleague does not take the time to assist you, it does not mean that others will react in the same way. While it may be difficult to say, "I don't understand what you mean," it is the only way to begin understanding the use of words within the context of U.S. nursing care.

Knowledge of Medications and Pharmacology

Western medicine relies heavily on drugs to treat patient illness, many of which are not used in other countries. Some drugs that are available internationally have different trade names, while others may be experimental and not yet known internationally, making it difficult for the nurse entering U.S. nursing practice. Pharmacology can be intimidating, mainly because of the volume of medications given on a daily basis in the United States and the various medication routes. Most of the errors made by foreign-educated nurses in their first year of practice are related to medication administration.

Proficiency in Technology

The U.S. health care system relies heavily on technology for diagnostic, preventive, and palliative care—much more so than other

countries around the world. Because foreign-educated nurses tend to work in adult health and critical care units in hospitals, they are confronted with technology on a daily basis as they transition to U.S. practice. However, international nurses participating in a joint CGFNS/Excelsior College study on their perception of readiness for practice in the United States indicated that technology is one of the areas in which they felt least prepared (Edwards & Davis, 2006).

ACCULTURATION

Acculturation—the process of adapting or learning to take on the behaviors and attitudes of another group or culture—is an essential aspect of working in a host country. For nurses transitioning to practice in the United States, it generally takes 4 to 6 months to become fully productive and 12 months to feel fully acclimated to the new setting.

Phases of Acculturation

Acculturation can be divided into four phases: acquaintance, indignation, conflict resolution, and integration. Familiarity with the process of acculturation will help you to know what to expect within your first year of practice in a new culture and new work environment.

The *acquaintance* phase of acculturation occurs from entry into the culture to 3 months post arrival. It is the stage of initial contact, during which time you will be excited about your new life and your new place of employment. This is the time in which you will become oriented not just to the practice environment but also to the community—the time during which you will begin to develop a supportive social network of both colleagues and friends.

The *indignation* phase occurs 3 to 6 months post arrival. The feelings of excitement about your new environment give way to feelings of anxiety, which can lead to a sense of isolation and psychological discomfort. Understanding the U.S. health care system and your role in it—what is expected of you and how quickly it is expected—can become overwhelming. It is during this time that a mentor or

preceptor will be critical. The support that mentors or preceptors can provide is invaluable because they have knowledge of the system and contacts within and outside of the system; most importantly, they are willing to work with you so that your experience is a positive one. This also is the time to rely on family, friends, and colleagues for support—and especially those who have been through a similar experience.

It also may be helpful to seek out regional support groups. There are support groups within the United States designed to help immigrants adapt to their new life. These support groups are generally composed of individuals of the same ethnic background who have been through the immigration and transition processes and are willing to share their experiences with those who are new to this country. The Chamber of Commerce in the city or town in which you intend to practice can provide you with a list of support services that are available.

The *conflict resolution* phase generally occurs 6 to 9 months post arrival. This is the time to clarify new roles and development, to gain insight into problem solving, and to make personal and professional decisions about your new workplace and your new community. You may feel that you are a part of two cultures—your native culture and its work values and the culture of the U.S. health care system and U.S. nursing.

Now is the time to determine what values and beliefs are essential to you. What values and knowledge from your own culture make you comfortable as a nurse in the United States? Which of the values of the new culture and the new workplace can you incorporate into your practice as a nurse? What aspects of nursing practice in the United States do you find difficult to adopt—and why? Again, exploring these issues with a mentor, a preceptor, or someone familiar with the process of adapting to a new culture and work environment will be invaluable.

The *integration* phase occurs 9 to 12 months post arrival. It is the phase of renewed enthusiasm for your work and your new country, a time when you have reconciled the differences between your native culture and your host culture, and a time when you feel confident in your ability to practice as a nurse in the new culture. It is a time when you know you made the right decision to migrate and

a time when you will have a sense of belonging to the new culture and, most importantly, a sense of the skills and knowledge that you bring to the profession (Adeniran, Davis, & Nichols, 2005).

SUMMARY

The demand for nurses in the next decade is expected to increase substantially in the United States. International nurses will continue to have a significant impact on the U.S. nursing workforce and contribute to its growth. The migration of nurses across international borders and their assimilation into the U.S. workforce enables nursing to grow, to broaden its perspective, and to increase its diversity; therefore, the successful adaptation of foreign-educated nurses to U.S. practice is critical.

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