Doctorate Studies

The learning experiences of immigrants who are graduates of an entry-level baccalaureate nursing program: A hermeneutic phenomenological study

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ABSTRACT

International migration of individuals or families seeking to improve economic conditions or escape political oppression increases each year. With migrant movement, there is a need for appropriate health care to meet their health beliefs and cultural health traditions. Nurses comprise a large portion of the healthcare workforce and yet, the number of immigrant nurses educated in their adopted country remains low. The aim of this study was to understand the learning experiences of immigrant registered nurses who graduated from an entry-level baccalaureate nursing program in the United States. A hermeneutic phenomenological approach with a Gadamerian focus was utilized. Purposive sampling identified five immigrant graduates who were individually interviewed using several open-ended questions in a non-structured format. Analysis identified an overarching theme, "being on the outside." Five subthemes emerged: harsh realities, disruptions, nurturance, resilience, and propagation. Recommendations from the interviews include: recognition and appreciation of each student, the nurse educator coming to know oneself first, followed by dialoguing with each student to perpetuate deeper understanding. Rather than accommodating the ethnically diverse immigrant nursing student through targeted interventions, the nurse educator should maintain an all-inclusive learning environment.

1. Introduction

International migration continues to increase affecting all countries around the globe (Connor, 2016). Reasons for migration range from improving economic status to relief from political oppression (Connor, 2016). Worldwide migration has exponentially grown from 173 million in 2000 to 244 million in 2015 (United Nations, 2016, p. 5). The United States currently ranks first in receiving the most immigrants (Connor, 2016). Immigrants arrive to their adopted country with individual and cultural health beliefs, adding considerable diversity to a country's healthcare system (The Sullivan Commission, 2004).

Every immigrant has an individual perspective of health that is influenced by their primary culture, newly introduced culture, health definition or conception, religious affiliation, spiritual convictions, previous healthcare experiences, cultural traditions, and their traditional health care. All influence health behaviors when approaching United States health care (Carroll et al., 2007; Hasnain et al., 2011;

Rogers, 2010; Sanchez-Birkhead et al., 2011; Shah et al., 2008; Yosef, 2008). As immigrants seek health care, they often prefer to receive care from someone they believe understands and supports their customs and cultural health beliefs (The Sullivan Commission, 2004). Nurses play an integral role in providing and directing appropriate cultural health care for an increasingly diverse population. Budden et al. (2013, p. 7) identified "19% of registered nurses are from the minority population." As such, a call for an increase in practicing ethnically diverse immigrant registered nurses, specifically within the immigrant community is essential in reflecting the needs of a diversifying population.

2. Background

Ideally, the proportion of working ethnically diverse immigrant registered nurses within the United States would mirror the influx of immigrants. Without ethnically diverse immigrant registered nurses caring for culturally, racially, and ethnically similar patients, there

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remains a potential for patient disparities and dissatisfaction from misunderstandings of cultural beliefs. Increasing a diverse immigrant nursing workforce will decrease healthcare disparities and improve patient outcomes among diverse populations (Institute of Medicine, 2011).

Nursing educators and researchers recognized the need to increase the number of ethnically diverse nurses (Ackerman-Barger, 2010; Alicea-Planas, 2009; Amaro et al., 2006; Beacham et al., 2009; Giddens, 2008). Underrepresentation of ethnically diverse nursing students' and specific educational barriers and interventions implemented to improve retention in a nursing program has been studied. Barriers to retention of ethnically diverse nursing students have included discrimination, personal barriers such as finances, and study workload especially related to language barriers (Amaro et al., 2006; Bond et al., 2008; Evans, 2008; Gardner, 2005a).

Individual interventions such as general programs aimed at the overall educational experience for ethnically diverse nursing students have been studied (Abriam-Yago et al., 1999; Gordon and Copes, 2010; Ormeaus and Redding, 1990; Sutherland et al., 2007). Other interventions specifically focused on ethnically diverse nursing students' perceived educational barriers (Bosher and Bowles, 2008; Cantu and Rogers, 2007; Carr and Dekemel-Ichikawa, 2012). Focused interventions specifically targeted one barrier such as communication or cultural awareness. Other programs entertained a variety of strategies that attempted to cover as many barriers as possible (Anders et al., 2007; Gardner, 2005b; Nnedu, 2009). Generalized programs, focused interventions, strategy variations, as well as untested teaching strategies have been studied with limited success and improvement in the numbers of ethnically diverse nurses.

Studies have noted the deficiency of nursing faculty in cultural awareness and proposed, that since over 80% of nurses and nurse educators are white middle-class women, they lack cultural skills to meet all student needs (Terhune, 2006; Yoder, 1996). Narin et al. (2012) explored culture and submitted that racism and cultural differences in nursing programs are not easy to discuss yet, can encourage cultural competence by nurse educators.

Studies often identified nursing students as ethnic minorities, ethnically diverse nursing students, and ethnically diverse nurses without delineation between participants born in or outside the United States. Recent literature identifies nursing students as "culturally and linguistically diverse nursing students" (Fuller and Mott-Smith, 2017, p. 390) and "international students" (Mitchell et al., 2017, p. 16); however, does not specify if these students relocated to their adopted country, illustrating a gap in the literature. In spite of the literature published, a single question remains. What are the learning experiences of immigrants who have successfully completed an entry-level baccalaureate nursing program?

3. Research design

3.1. Study aim

The aim of this study was to understand the learning experiences of ethnically diverse immigrant registered nurses and the strategies used to successfully complete an entry-level baccalaureate nursing program. This study contributes to nurse educators' and clinical mentors' awareness of ethnically diverse immigrant registered nurses' struggles as a nursing student and the resilience required for successful completion.

3.2. Methodology

Hermeneutic phenomenology integrating Heidegger's (1927/1962) and Gadamer's (1960/2004) methodologies was chosen to fully understand the ethnically diverse immigrant registered nurse's learning experiences. Employing the hermeneutic circle with a methodology

expert assisted in uncovering the underlying meaning of the participants' stories. The hermeneutic circle "recognizes the inherent circularity of all understandings: the fact that one can understand the parts online in terms of the whole, and the whole in terms of the parts" (Saks, 1999, p. 4). Hermeneutic phenomenology assisted in discovery of meaning through story enhancement without decontextualizing to achieve an understanding of the phenomenon.

3.3. Sampling and sample

A purposive and snowball sampling of registered nurses was used who completed an entry-level baccalaureate nursing program within the last 3 years, were foreign-born, and entered the United States legally on a visa, through employment, or an education program. While saturation occurred within the first three interviews, two additional participants were recruited to substantiate and improve rigor.

3.4. Ethical issues

Recruitment of participants began after approval from university and hospital institutional review boards. Also, institutional review board approval was given by two hospitals. Participants were introduced to the study and given an opportunity to ask questions prior to signing a consent form. A potential risk for participants' was reliving unpleasant memories and the interviewer was professionally prepared. Each participant understood they could withdraw at any time without penalty or retaliation. Confidentiality was maintained by participants choosing a pseudonym. Each participant who completed the study was given a gift card.

3.5. Data collection

The study phases included locating and maintaining contact with the participants, reviewing eligibility criteria, obtaining consent, completing and transcribing the interviews, and interpreting, journaling, and dialoguing with a hermeneutic expert (Fig. 1). A journal was maintained throughout the data collection and analysis to support reflexivity. Reflexivity allowed for reflection on perceived ideas, assumptions, thoughts, and reactions (Clancy, 2013). Consistent journaling throughout the interview process allowed awareness of repressed thoughts and the uninhibited interpretation of each participant's story.

To enhance participant recall, a week prior to the interview, each participant was given a contemplation exercise to facilitate memory recollection. Emotional memory enhances the experiences involving stressors and unfamiliar events that trigger the release of adrenaline, cortisol, and adrenocorticotropic hormone (Cahill et al., 1994). These chemicals within the body are released to secure that specific memory therefore, increasing easier recall (Jensen, 1998).

Interviews were held in a setting of the participant's choice. Locations were discrete, quiet, and without interruptions. Each interview combined a collaborative and open unstructured approach to elicit an intimate data collection with full immersion by both parties. The interview began with an open-ended statement or question. This permitted the participant's story to emerge while allowing for co-creating realizations of the phenomenon. The one-on-one interviews contained questions developed from participant answers in recognition of experience details they may have forgotten or repressed (Heidegger, 1927/1964).

Each interview was then transcribed using WavePad Masters Edition by NCH software – Fastfox 2.35 and interpreted integrating the hermeneutic circle, the first author's journal, and a hermeneutic expert.

3.6. Data analysis

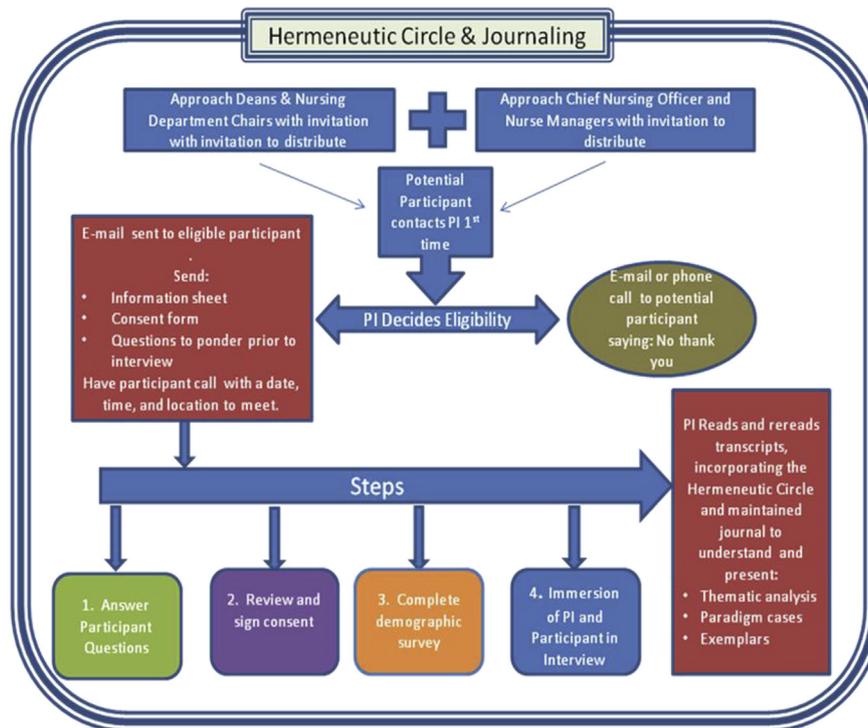Analysis began during the interviews with immersion of the

Fig. 1. Procedural Steps Taken that Represent the procedural steps taken to contact, approve participant, conduct the interview, and interpretation.

researcher and participant. As the interviews were completed, transcribed, and observational notes finished, the interpretation began with identification of "thematic analysis," "identification of stories," and synthesizing paradigm cases" that teased out the understanding of the lived experience (Leonard, 1994, p. 59). Reading and rereading transcripts with exemplars written and rewritten transformed the interviewer into the interviewee. The hermeneutic circle was incorporated throughout the study by journaling, rereading the transcripts, and discussions with a hermeneutic expert to identify patterns and themes. The objective was to uncover hidden meanings and meaningful terms through themes, paradigm cases, and exemplars or short stories (Benner, 1985).

3.7. Methodological rigor

Methodological rigor and trustworthiness were maintained integrating Lincoln and Guba's (1985) criteria for rigor to accurately portray the results through continuous free flowing movement within the hermeneutic circle of language and thoughts. Credibility was established by earned trust and rapport with each participant. To determine accuracy of participant stories, the primary author clarified, reflected, and interpreted throughout the dialogue. Using an unstructured interview format, questions were designed to meet the needs of each participant and interviewer in understanding. Transferability was achieved through triangulation with outside resources such as published literature, philosophy, and discourse in the hermeneutic circle with an expert in hermeneutic phenomenology. Dependability occurred when the data obtained were reviewed while dialoguing with the hermeneutic phenomenological expert in the hermeneutic circle. A sixth participant was recruited who became a member checker to confirm the results.

4. Findings

Five graduates completed interviews. Each chose a pseudonym to use and provided some demographic data (see Table 1). Age ranged from 25 to 54 years. Participants came from four different countries. All

but one attended a public educational institution.

The findings from the hermeneutic phenomenology analysis produced one overarching theme and five subthemes. Each participant felt alone in their learning and ignored by their peers, faculty, and nurse preceptors because of their race, communication struggles, ethnicity, cultural beliefs, and learning strategies. These barriers interfered with acceptance by people unwilling to recognize the significance for the participants entering nursing. Their stories contained a similar, overarching theme of *being on the outside*.

Each participant experienced the juxtaposition of being on either the inside or outside with their peers, nursing faculty, staff nurses, and patients in healthcare institutions. They felt excluded, ignored, ridiculed, and questioned. Mary affirmed these feelings of being an outsider or alone:

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

The participants experienced similar feelings of loneliness through difference in language, culture, and being a newcomer to a community. Omolo stated, "It was difficult to get into a clique or different cliques because uh, of the different [sic] in culture and language." They diligently thought about how to create openings into nursing as a student and as a new graduate. Suzhen was informed by other students, family, and friends that "because you're a foreigner, you need to do much [sic] perfect than anybody else because if you make [a] mistake, the consequences for you is much worse than everybody else." Each participant developed strategies to be successful and patient with the group of nursing insiders.

The totality of five subthemes: harsh realities, disruptions, nurturance, resilience, and propagation, contributed to the formation of the central theme, *being on the outside*. Each of these subthemes combines to become a whole; demonstrating how each participant was successful in

Table 1
Participant demographics.

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

a nursing program.

4.1. Harsh realities

Harsh realities of nursing justified their struggles and reasons for requesting special treatment from their peers. Through justification or excuses, these participants unknowingly labeled themselves as different. This was prominent when they identified themselves as being English language learners and requiring more time for exams, reading, and written assignments. When Suzhen was asked why she thought learning was harder for her than her classmates she stated:

When I started I think because English is not my first language. And then, I really feel like maybe I just don't understand the questions, like they did or take me longer time to understand the question or understand the book or maybe even I understand a better way at interpret [*sic*] that is different. I feel like sometime I got the question wrong because I interpret the question wrong. Yeah.

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

I did uh find it difficult tooooooooo (he draws out the word), uh, to get all the homeworks [*sic*] done on time and all the readings done …. uh, learning, I don't call it a disability, but ta, the learning challenge of the language, one is a translation … from my language to the English language and then to the nursing language.

The length of time for Omolo to process information left peers with the perception that, "I cannot contribute enough or equal to …. some of my peers just thought I was just not smart enough to do it."

According to the participants, the formats for exams or tests were essay in their home countries. They were unfamiliar with multiple choice tests until they entered the educational system in the United States. Suzhen emphasized:

We don't have multiple choice tests. Like most of them are essay tests. Like if you study biology and then they will have a question just ask you what is the structure of a plant and you need to write out all of the plant have [*sic*], leaf and this and that.

Tim clarified more about testing through incorporation of how British English played a role.

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

Another issue was lengthy exam questions as Suzhen explained. By the time she had completed the four line stem of the multiple choice question, she had forgotten what she had read. Processing a second language, pronouncing words, defining American English grammar and sentence structure, understanding multisyllabic words, and communicating clearly with peers and nursing faculty were the barriers that added to challenges faced by the participants.

4.2. Disruptions

Disruption in growth and professionalism of the participants happened during and after their nursing program. The participants noted that when incivility or oppression occurred between faculty, faculty and student(s), or between student(s), they became anxious, stressed, distraught, and self-esteem was challenged. Misunderstandings as a result of communication, skin color, and garments worn perpetuated incivility and oppression through stereotyping or assumptions. Ashley, who entered the United States when she was 3-years-old and displayed unbroken unaccented English, relayed an experience between herself and the department chair at the beginning of her nursing program. Ashley recalled:

The first thing she said to me was, 'So I see that um, you have been accepted to the bachelor of nursing program that is set to start next fall. I am just wondering if maybe um, the associate degree might be a better fit for you seeing as English is your second language.' The first thing I said to her was, 'Who told you English was my second language? No, that's not really an option. It might have been a better idea to speak with me before you would have made that assumption that English is my second language.'

Ashley has smooth dark brown skin and wears a hijab. Stereotyping or creating assumptions was an unnecessary disruption to receiving a nursing education.

The participants were exposed to incivility and oppression. Omolo told of a clinical day experience where he was in the breakroom and a peer looked directly at him and stated, "So, you came from Africa, you know, you brought all of the diseases from there." He then explained what his other peers' reactions were, "Some of my other peers were upset about it … some brushed it off." Further, Omolo told a story of his capstone clinical and an oppressive student – preceptor relationship:

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

Nursing faculty incivility or demonstrated disrespect of the participants occurred throughout their learning experience. Omolo revealed an instance where a nurse educator accused him of cheating on a quiz by looking at the student's quiz next to him. Nurse educators were also skeptical of learning performance of participants, especially of those who were English language learners. Omolo's ability to learn was questioned as he emphatically stated with his face showing disgust:

I asked the instructor you know, I am ill, really ill, I need a break, here I can come and do this exam at a different time and her

perception was that I was trying to avoid the exam because I was not ready for it. Uh, and that makes the hair on the back of my head just rise.

Another common denominator among the participants was feeling like an inconvenience to the hospital nursing staff. Nursing hospital staff also questioned the aptitude of the participants to learn as expressed by Mary:

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

Ashley expressed this best, "They [nurse working with her] already think it's going to be a burden on them because they have to do so much more." Ashley sensed that the nurse was "already … on edge." Suzhen perceived being ignored by her hospital nurse when in her Advanced Medical-Surgical clinical:

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

Professional growth and learning were slowed. The participants' stories revealed disruptions in their learning through uncivil behavior shown by nurse educators, peers, and nurse preceptors.

4.3. Nurturance

Successful participants incorporated several strategies to support their learning. Tim asked peers to help him understand words during lectures.

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

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

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

Mary sought out videos related to nursing skills to further examine the process. She also made friends with another peer. Her peers assisted her through participating in a study group. Participants' emotional strength, self-nurturance, positive self-esteem, and motivation were self-sustaining in completing their nursing programs.

Nurturance, by others or self, has a unique relationship with resiliency. The component that substantiates this relationship is how each participant coped or adapted to their nursing program, faculty, peers,

and clinical nurses. Omolo coped through the emotional release of crying when accused of cheating. Mary offered, "You just have to shut down and take [a] deep breath and give a [*sic*] room and balance yourself to be ready for next." These were some of the ways the participants maintained incentive and motivation while in their nursing program.

4.4. Resilience

Resilience illustrates how the participants recreate themselves to resume their studies, become resilient to negativity, and eventually prove successful in their nursing program. Though participants experienced challenging periods of stress and adversity, each developed a way to adapt to their situation. Their actions resulted in resilience. For instance, Omolo, when made fun of by his peers stated, "I took it positively and just jumped back or something and then brushed it down and made a good working relationship with them after." Omolo looked at the overall situation of being in nursing school with Euro-American students and faculty and revealed that, "At the end of the program … there was a very good understanding and I do not blame some of this [*sic*] peers for this since because it is … cultural shock for them just as much as it was for me." He had many years of career searching and when he realized what his life goal was, nothing was going to interfere.

Mary demonstrated control over her life. She raised six children and received a degree in education while in Ukraine. Success for Mary was having "a very strong work ethic" and "being a life-long learner." When faced with a "threatening environment" by a nurse educator who told her, "We change the test, content of test every single, 2 years, and we make it difficult for you guys and we made its [*sic*] difficult with [*sic*] a reason. We want you to throw up before [the] test, we want you to be in fear and scared." Mary admitted how she dealt with this situation, "I am an age when um, I can balance myself. I said to myself, 'I [am] not going to be threatened by you.'"

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

Ashley employed a different approach through her struggles. She expressed, "People only treat you the way you allow them. I am not going to give them the chance to treat me disrespectfully." All five participants relayed resilience with their inner strength, determination, and assistance of supportive peers and nursing faculty. The successful participants were efficacious when they decided to take control over their learning, demonstrating inner strength.

4.5. Propagation

Each participant grew from their nursing school experiences. They suggested strategies that faculty could integrate into their classrooms. Mary and Suzhen indicated that increasing case studies to effectively follow a process or improve their hands-on nursing experience would be helpful. Suzhen gave an example, "You see a patient passing [*sic*] out on the floor, what [is] the first thing you need to do?" Mary explained that completing projects such as presentations or having the ability to apply a concept was the most helpful way to understand the nursing material. This allowed creativity and prompted further questions.

Omolo suggested designating a nursing faculty to "facilitate aggregation to help the immigrant to get immersed into the culture and class." He explained that "grouping people with like minds" when completing a group assignment would be beneficial. Omolo's rationale was grouping students together by age was more beneficial than placing students together by cultures. Having a mentor who could guide immigrants through American English and United States culture would greatly assist them through their nursing program.

Suzhen requested a part-time program or offering of summer classes. "Because I have just one class, I feel I learn, not even learn more, it just retained more." Suzhen spoke of a time she precepted a nursing student at a hospital. Suzhen, although just out of school herself, was self-assured that she could be a positive "role-model for my student." She demonstrated pride as she told how she assisted the student to learn. Finding ways to teach the students brought her gratification.

Working in a hospital, Omolo found contentment in orienting new graduates to the cardiovascular-thoracic unit. He identified "with the new graduates and helped them along cause [*sic*] I am also still learning."

Successful participants enjoyed employment and giving back to the community. The participants had the ability to distribute constructive criticism, obtain employment, and orient or precept new nurses. They noted that when embraced by their nurse educators, peers, and staff, they flourished in their career and volunteered to teach new graduates by orienting them to nursing units and skills. Success sprouted highly intelligent self-assured ethnically diverse immigrant registered nurses who willingly shared their insights, suggestions, and assistance with others.

5. Discussion

Imagine having left a country, the only home known for many years, to enter a new country with unfamiliar laws, customs, traditions, holidays, educational opportunities, and a complex healthcare system. Empathizing with students through recognition of the difficulties they encounter helps nursing faculty and nurse preceptors to understand and better assist them in their learning. The students look to faculty and nurse preceptors to guide their learning while faculty and nurse preceptors look to them for guidance in understanding their culture, language, and traditions.

The participants desired to belong through respect and acknowledgement. A sense of community should be sought through a recognizable solidarity. A community of nurses in a healthcare facility or a community of nurse educators with nursing students in an educational institution requires caring, compassion, understanding, and teamwork among all.

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

An informal study through writings of 261 nurse educators identified 10 subthemes under the overarching theme of "10 Joy-Stealing Games" (Heinrich, 2007, p. 35). The detachment of relationships by nursing educators' characterizes a dysfunctional nursing education for nursing students (Heinrich, 2007). All nursing students observe these games between and within nursing faculty and act on them by producing similar types of incivility. Changing the rules of the game "from competition to cooperation and tipping the culture from joy stealing to zestful collaborations" can refocus nursing educators, nurse preceptors, and students in relating to each other respectfully (Heinrich, 2007, p. 38). We suggest that faculty members and nurse preceptors maintain a dialogue with their peers to relinquish the games played within the nursing department. This also models respectfulness and appreciation

for uniqueness to nursing students.

Nursing scholars, educators, and nursing preceptors need to examine assumptions and conceptualizations. Theorizing provides opportunity for labeling of differences between cultures and ethnic groups that leads to categorizing, fallacies, and compromises development of solidarity (Vandenberg, 2010). Vandenberg (2010) recommended that nursing scholars and educators continue to examine assumptions and conceptualizations about culture that are multifaceted and dynamic.

We recommend that in addition to accommodating the ethnically diverse immigrant nursing student through interventions specifically planned for the group as a whole, nurse educators should maintain an all-inclusive learning environment where differences are respected and appreciated to encourage solidarity within the nursing profession. An inclusive education encompasses "communities of caring, ethical pedagogy, advocacy, reflective teaching, and social justice" (White and Jones, 2011, p. 216). Inclusive teaching and learning begins with active listening and learning from each student. Dialoguing with each nursing student utilizes a transformational style of teaching that changes relationships and improves learning. Rather than interventions aimed at specific populations or subgroups, activities created by the nurse educator should encourage engagement and interaction among all nursing students.

We posit that nursing educators and nurse preceptors need to seek to understand the meaning of being an immigrant in a nursing program. Faculty and nurse preceptors, who actively seek to understand the ethnically diverse immigrant nursing student's learning strengths and weaknesses, ask how they can best assist them and be attentive to their needs.

6. Limitations

A small participant size was encountered when saturation was met with the first three participants who were known to the interviewer. Hence, two more were recruited that provided further saturation. This study was conducted in one state of the United States and would be appropriate to conduct in other states or countries. The interviewer is a Euro-American Caucasian woman who journaled prior prejudices and biases then, actively listened to the participants who were knowingly different in race, ethnicity, culture, language, beliefs, values, and dress.

7. Conclusions

In order to better understand and appreciate each student, the nursing educator should come to know him or herself first, then dialogue with each student to begin an understanding of that student. This action models acceptance for each other's uniqueness. All participants desired to be recognized and heard by nurse educators for their thoughts and ideas.

Liberating nursing educators, nurse preceptors, and nursing students from incivility and oppression through an all-inclusive teaching environment contributes to successful practicing nurses, enhances teaching fulfillment, and improves patient satisfaction with nurses united and committed to treating each other respectfully. Nurse educators and preceptors welcome students and assist them towards resilience while thriving in the nursing world.

Conflicts of interest

No conflict of interest has been declared by the authors.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.nepr.2018.12.002.

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