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ORIGINAL RESEARCH

The Recruitment Experience of Foreign-Educated Health Professionals to the United States

A report on the current state of recruitment and our study findings.

Over the last decade, our knowledge of the practices and policies of the recruitment industry for foreign-educated health professionals (FEHPs) has gradually increased. But the industry's lack of transparency and an overall dearth of research have made it difficult to understand various aspects, including how health professionals can be vulnerable to exploitation and which factors determine their successful integration into the U.S. workforce.

In 2006, AcademyHealth, a health care think tank, convened a multistakeholder task force to research the international nurse recruitment industry.[1] The project's purpose was to better understand the processes and challenges of international nurse recruitment; to mitigate its harms and increase its benefits for individuals and source countries; and to ensure that such recruitment occurs in a safe, orderly, and ethical manner.

Phase one of this project led to the publication of *U.S.-Based International Nurse Recruitment: Structure and Practice of a Burgeoning Industry*, which reported on the emergence, structure, and practices of the nurse recruitment industry during the 2003 through 2006 "boom" years.[1] CGFNS International, Inc., formerly known as the Commission on Graduates of Foreign Nursing Schools, participated in this project, partnering with AcademyHealth to conduct focus groups and providing data from CGFNS International surveys among both foreign-educated nurse (FEN) applicants and recruiters. Phase two of the project involved multistakeholder efforts to develop and reach consensus on "standards of practice" documents, as well as recommendations for their implementation.[1] Although perspectives differed greatly, there was a general understanding of the recruitment landscape. It was acknowledged that employing best practices could help to maximize recruitment benefits and reduce its harms.

Ethical codes. One result was the creation and publication of a voluntary code that is currently known as the *Health Care Code for Ethical International Recruitment and Employment Practices* (the Alliance Code). It was developed by a multistakeholder contingent from across the health care sector including unions, employers, and recruiters. The first edition was issued in 2008, in conjunction with the establishment of the Alliance for Ethical International Recruitment Practices (the Alliance), which was tasked with informing stakeholders of this Code, encouraging them to get certified, and overseeing their compliance.[2] Compliance was voluntary, owing to jurisdictional issues that made access to national legal systems difficult. In 2014, CGFNS International acquired the Alliance, which published the second, current edition of the Alliance Code in 2017 (available at www.cgfnsalliance.org/

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ABSTRACT

Background: In 2007 AcademyHealth published a landmark report on the U.S.-based international nurse recruitment industry. This article provides an update to that report, describing the current state of recruitment of foreign-educated health professionals (FEHPs), in particular foreign-educated nurses (FENs), to the United States. Areas covered include the regulatory landscape, economic issues, recruitment industry changes, and current demographic and migration trends.

Purpose: To learn more, CGFNS International, Inc., formerly known as the Commission on Graduates of Foreign Nursing Schools, and its Alliance for Ethical International Recruitment Practices division conducted a study designed to elicit qualitative and quantitative data that would further illuminate the recruitment experience.

Methods: Researchers conducted a survey of FEHPs, recruited from those who used VisaScreen services between 2015 and 2017, designed to assess their recruitment experiences. They also conducted interviews with a smaller sample of FENs and recruiters to elicit greater detail.

Results: While there was evidence of progress relative to the ethical recruitment of FEHPs, issues such as high breach fees, inadequate orientation, and misalignment of expectations regarding work environment and location were also revealed.

Conclusion: Given that FEHP migration to the United States is likely to continue its upward trajectory, better strategies to implement market-wide practices that ensure the safe, orderly, and ethical recruitment of FEHPs are needed.

Keywords: foreign-educated health professional, foreign-educated nurse, health worker shortage, migration, nursing policy, recruitment

wp-content/uploads/2019/03/Health-Care-Code-for-EIREP-Sept-2017_FINAL.pdf).

The first edition also served as a precursor to the World Health Organization (WHO) document, *The WHO Global Code of Practice on the International Recruitment of Health Personnel* (available at www.who.int/hrh/migration/code/code_en.pdf), which was adopted by all 193 WHO member states in 2010.[3] The WHO Code provides guidance for countries, encourages international cooperation and data exchange, and establishes reporting requirements. It also seeks to ameliorate "brain drain" from developing countries with chronic health care shortages by discouraging recruitment from those countries.[4] Whereas the WHO Code is "top down" and applicable to countries, the Alliance Code is "bottom up" and provides best practices that employers and recruiters can incorporate into their recruitment methods and contracts. Since 2014, the number of recruitment firms certified as compliant with the Alliance Code has risen by 300%. But further increasing that number is essential to reaching a "critical mass" that will alter standard market practices.

In addition to the Alliance's efforts in the United States and the WHO's global efforts in the health care sector, there are non–sector-specific initiatives in development. The International Organization for Migration is developing the International Recruitment Integrity System Standard, a voluntary certification scheme designed to promote ethical labor recruitment across sectors.[5] The International Labour Organization is also addressing recruitment issues, including defining which charges borne by job seekers qualify as "recruitment fees."[6] Whether such efforts succeed largely depends on the incentives for stakeholders to comply.

Our purpose. The first half of this article describes the current state of recruitment of FEHPs, in particular FENs, to the United States. We provide an update on the regulatory landscape, economic issues, recruitment industry changes, and current demographic and migration trends in the United States.

As part of this effort, CGFNS International and its Alliance division conducted a study designed to elicit qualitative and quantitative data that would further illuminate the recruitment experience. The second half of this article reports on our study findings. Although our primary focus was on FENs, we also collected data on FEHPs, as is reflected in our analysis.

THE CURRENT LANDSCAPE

The FEHP migratory landscape. In 2017 the WHO reported that, over the past decade, the number of FEHPs working in Organisation for Economic Cooperation and Development (OECD) countries had increased by 60%,[7] and experts anticipate increasing disparities between the supply of and demand for health workers. The "blurring" of FEHP migration patterns, increases in temporary migration, and rising numbers of source and destination countries

have also been observed.[7] Increases in population aging worldwide will further strain the health care workforce, which already struggles to meet demand. Indeed, international experts have declared a global crisis in long-term and home-based care; nations are turning more frequently to FEHPs to address health care needs.[8]

The state of the U.S. nursing workforce. Nursing continues to be the largest and fastest-growing health care profession in the United States.[9,10] Although estimates vary, in 2018 the RN workforce stood at 3.1 million, according to the Bureau of Labor Statistics; that number is projected to rise to 3.4 million by 2028.[11] Yet experts also predict that there will be more than 1 million nursing vacancies by 2024.[12] And according to the U.S. Department of Health and Human Services (HHS), supply and demand will manifest unevenly from state to state, with some states experiencing shortages, and others surpluses.[13] For more details, see *The U.S. Nursing Workforce: Supply and Demand*.[14-19]

The U.S. Nursing Workforce: Supply and Demand

On the supply side, factors such as the aging of the nursing workforce, insufficient numbers of nursing faculty, and job dissatisfaction contribute to nursing shortages. The most recent National Council of State Boards of Nursing National Nursing Workforce Survey found that more than half of RNs were over the age of 50.[14] Attrition is high. An estimated 30% to 50% of RNs either change positions or leave the profession altogether after just three years of practice, citing unfriendly workplaces, recurrent emotional distress related to patient care, and exhaustion as factors.[15] More than 75,000 qualified applicants were rejected from U.S. baccalaureate and graduate nursing programs in 2018 owing to insufficient funding, faculty, clinical sites, and classroom space.[16]

On the demand side, an aging U.S. population, physician shortages, health care reform, and increased employment opportunities contribute to an increasing need for nurses. By 2030, all baby boomers will be age 65 years or older, and the ranks of older adults will increase by 55%.[17] The number of elders ages 85 and older is expected to double, from 6.3 million in 2015 to 13 million by 2035.[18] As such, the need for geriatric care will increase drastically, leading to a greater demand for nurses. Physician shortages are also expected.[19] Some RNs will become NPs to fill gaps in primary care; others will likely move into non–staff nurse roles (such as midwives and nurse anesthetists).

Supply of and demand for FENs in the United States. It's estimated that between 8% and 15% of the U.S. nursing workforce is foreign educated,[12,20] with the majority coming from the Philippines.[21] FENs seeking employment in the United States must obtain an employment-based (EB) visa: an EB-2 visa for those with advanced nursing degrees, an EB-3 for those with associate or bachelor's degrees.

Previously, nursing shortages motivated U.S. employers to recruit FENs.[22] But since about 2000, there has been a shift away from foreign recruitment and toward building the domestic nursing workforce.[23] One analysis found that the number of nurses annually obtaining associate or bachelor's degrees in the United States more than doubled over a 10-year period, from 74,000 in 2002 to 184,000 in 2012.[24] And since 2007, the OECD has recorded dramatic decreases in the annual inflow of FENs to the United States, from about 24,000 in 2007 to less than 6,500 in 2015, the most recent year for which data are available.[25]

Two primary factors help explain this last trend: visa retrogression and the last economic recession.

Visa retrogression. Visa retrogression occurs when the number of visa applications within a particular country or category exceeds the number of available visas, causing the cutoff date to move backward in time instead of forward. Visa applicants must have a priority date (the date the application was filed) earlier than the cutoff date in order to adjust their status to legal permanent ("green card") residents. Retrogression has a serious impact on FEN recruitment, particularly from source countries with large numbers of nurses who want to apply, such as China, India, and the Philippines. Sometimes no visas have been available; at other times, the waiting period has exceeded a decade. For example, for a U.S. entry date of September 2018, the cutoff date for a FEN from India seeking an EB-3 visa was January 2003.[26] Such significant delays make U.S. employment less appealing to FENs and their prospective employers.

As this journal goes to press, there is pending legislation—the Fairness for High-Skilled Immigrants Act of 2019 (HR 1044 or S 386 in the 116th Congress; www.congress.gov/bill/116th-congress/house-bill/1044)—that would eliminate per-country limitations on visas and would dramatically affect the composition of the green card population.

The 2007–2009 economic recession. Unlike employment in most sectors, health care employment doesn't typically decline during a recession, as the demand for health care and medical services remains constant. Indeed, during the 2007–2009 recession, the health care industry actually grew.[27] But open positions were largely filled by domestic health care workers. There was also less turnover in the nursing workforce. This wasn't unexpected, as during recessions part-time workers tend to move

into full-time positions and older workers delay retirement in an effort to maintain financial security.

Even so, the recession contributed to a decline in FEN recruitment, as employers became more cautious about sponsoring visas. Recruitment slowly began to increase again as the economy recovered, though the numbers remain significantly lower than their peak in the mid-2000s.[28]

THE RECRUITMENT INDUSTRY

Recruitment business models. There are three main FEHP recruitment models: direct recruitment, placement, and staffing.[1] Direct recruitment is conducted by health care organizations themselves. The organizations shoulder the financial burden of FEHP migration and employ the newly arrived recruits in their own facilities. Placement agencies act as recruitment contractors. They handle immigration procedures and place FEHPs with the health care organizations that have contracted their services. In this model, the FEHP initially signs a temporary contract with the agency, then upon placement signs a contract with the organization. Staffing agencies operate as both recruiter and employer. They handle immigration procedures and cover FEHPs' migration costs. After arrival, FEHP employment contracts remain with the staffing agency, not the health care organization where they work. This model is the most lucrative for recruiters.

The trend toward consolidation among health care staffing firms, first noted by Pittman and colleagues a decade ago, has continued.[1] Of the 15 largest U.S. health care staffing firms in 2004, only nine remain. At this writing, the five largest U.S. firms are AMN Healthcare, CHG Healthcare, Cross Country Healthcare, Jackson Healthcare, and Aya Healthcare.[29] Three of these—AMN Healthcare, Cross Country Healthcare, and Jackson Healthcare—recruit internationally. They aren't wholly representative of the international FEHP recruitment industry; many smaller domestic firms have international offices as well, and foreign recruitment firms often participate in sending FEHPs to the United States.

Among the top five staffing firms, two of their international subsidiaries have achieved the status of certified ethical recruiter by the Alliance.[30] To be so certified, an organization must establish that it's in compliance with the standards set forth in the Alliance Code, agree to be monitored by the Alliance, and agree to participate in mediation and remediation processes as necessary.

State regulation. Regulation of the FEHP recruitment industry is limited. Laws in the District of Columbia, Illinois, Maryland, and Minnesota mandate the registration of health professional staffing agencies that employ domestic workers, foreign-educated workers, or both. The goals of such legislation are twofold: to ensure that health professionals employed by registered agencies meet minimum standards for public safety, and to protect the jobs of domestic health care workers. While limited in scope, these laws indicate some progress toward greater transparency in this industry.

It's estimated that between 8% and 15% of the U.S. nursing workforce is foreign educated.

The staffing recruitment model is generally considered controversial—despite wide variance in business models and adherence to ethical principles—because of the potential misalignment of incentives between the staffing firm and FEN. The firm is seeking to ensure that the individual is employed, whereas the worker may have location or work preferences that may or may not be accommodated. These firms sometimes do not provide information to the FEN—such as where they will live or work—before their arrival in the United States. In extreme cases, some firms withhold documents, like the FEN's passport or green card.

The financial costs associated with FEHP recruitment can be high for recruitment firms. Travel, testing, credentialing, and licensing expenses are generally covered by the recruiter.[1] Other expenses such as housing and training—both professional and cultural—may also be covered by recruiters. There are indirect costs as well, including firm overhead, infrastructure expenses, and recruiters' time.

The Joint Commission offers Health Care Staffing Services certification,[31] although agencies are not legally mandated to obtain it. Certification involves a thorough evaluation of an agency's ability to verify the credentials and ensure the professional competence of the health care workers they are providing. At this writing, 438 staffing agencies are so certified.[32] Health care staffing agencies that have received Joint Commission certification are primarily headquartered in California, Florida, New York, and Texas. While these data include domestic recruitment firms, it's important to note that large numbers of FENs work in these states as well. All states accept FEHPs if they meet state licensing requirements.

Legal issues. Breach fees for contract termination are a persistent and worsening issue, with fee levels

increasing markedly over the last decade. Breach fees, which are embedded in the business model for many staffing and placement firms, leave foreign-recruited workers vulnerable to exploitation.

There has been some progress in challenging this practice. For example, in 2010, a New York judge denied a motion by Sentosa Care aimed at making 27 Filipino nurses pay damages of $25,000 each for failing to complete three years of service, as specified in their contracts.[33] In 2018, a federal judge certified a class of Filipino nurses bringing human trafficking claims against Sentosa Care, allowing them to sue as a group rather than individually.[34] But in general, the legitimacy of breach fees remains unquestioned, and the difficulty of obtaining legal counsel leaves most health professionals vulnerable to demands that they stay on the job.

As noted above, we conducted a study in order to learn more about the recruitment experience.

METHODS

Sample. CGFNS International and its Alliance division surveyed FEHPs and also conducted interviews with FEHPs and recruiters. CGFNS International offers VisaScreen, a service that lets FEHPs verify their credentials and establish their eligibility for EB visas in the United States. (CGFNS International is the only entity authorized by the U.S. government to provide this service.) The survey sample was drawn from all FEHPs who were issued a VisaScreen report between January 1, 2015, and December 31, 2017. These 8,894 professionals were sent an e-mail that explained the project and included a link to the online survey. A total of 1,017 people responded, for a response rate of 11%.

The last survey question asked respondents to indicate whether they were interested in participating in a follow-up survey in about 12 months. Those who answered yes were contacted and scheduled for interviews. Of the 33 respondents who had indicated that they were interested, 21 actually scheduled an interview time. A limited number of interviews were also conducted with recruiters. We sent unsolicited e-mails describing the study to recruiters at certain staffing firms certified by the Joint Commission but received minimal response. We then e-mailed all Alliance-certified firms as well as the largest staffing firms (based on CGFNS applicant numbers).

Instruments. The survey questionnaire, which was created for this project, was based on a version used in earlier research by CGFNS International and the Alliance. The survey was conducted online via SurveyMonkey and comprised a battery of questions regarding demographics and migration. The most pertinent migration questions asked about one's country of initial education, country of initial registration, number of registrations held (by country), visa type, and first state of practice. The survey also included questions designed to help us better understand the FEHP's recruitment experience (see Table 1 at http://links.lww.com/AJN/A164). Survey data collection took place between April 19 and May 10, 2018.

CGFNS International Interview Formats

Survey respondents who had indicated interest in participating in a follow-up conversation about their recruitment experiences were contacted via e-mail, as follows:

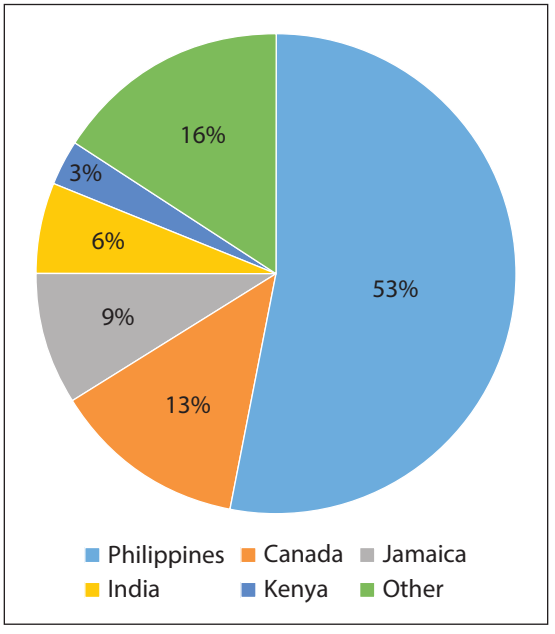
You are receiving this message because you participated in a survey conducted by CGFNS International and its Alliance for Ethical International Recruitment Practices division last year and indicated that you were interested in a follow-up conversation about your recruitment experience. Ideally this follow-up will take place via a phone call. Topics of conversation will include

- your initial recruitment experience and any changes in the past year.
- your journey as a migrating health professional.
- expectations about what being a health professional in the United States was like and whether these expectations were met.
- any emerging trends that you, as a health professional, see within your field.

The goal of this effort is to gain a deeper understanding of the successes and challenges of the recruitment experience, to advance research, better support migrating nurses, and potentially determine strategies to combat problems. If you are interested in this opportunity, please respond to this e-mail and the Alliance will reach out to you. Thank you for all your participation thus far.

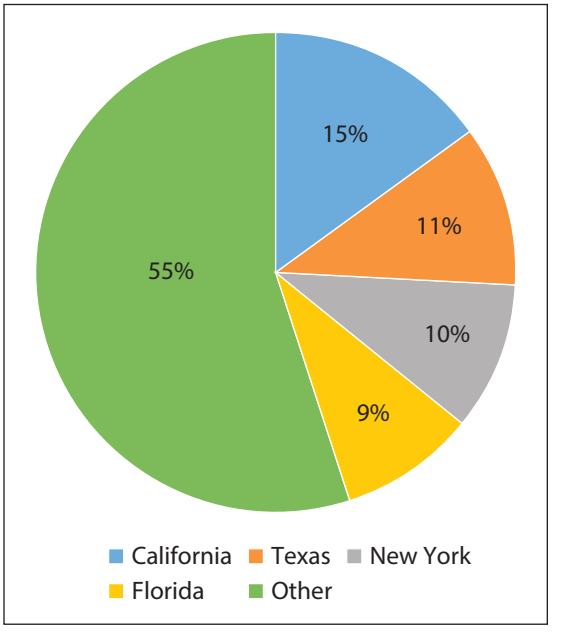
Recruiter interviews took the form of a more informal conversation. Each conversation began with questions to elicit the recruiter's perceptions of both the overall and the company-specific recruitment business, followed by questions about perceived challenges and changes the recruiter experienced during their time in the FEHP recruitment sector.

Figure 1. FEHP Survey Respondents' Country of Initial Registration (n = 992[a])



FEHP = foreign-educated health professional.
[a]Of the 1,017 survey respondents, 992 answered this question.

Figure 2. FEHP Survey Respondents' First State of Practice (n = 533[a])



FEHP = foreign-educated health professional.
[a]Of the 1,017 survey respondents, 533 answered this question. At the time of the survey, many respondents had not yet migrated.

Although a formal interview guide wasn't used for the interviews, the interviewers tried to follow the outline as presented in the e-mail invitation, although they diverged as needed based on an interviewee's particular experience and issues. They asked questions designed to elicit more detail about interviewees' initial recruitment experience, their "journey" as a migrating health professional, their expectations and whether these were met, and any emerging trends (see *CGFNS International Interview Formats*). It's important to note that the FEHP interviewees were at different points in their migration journeys. Some were still in their countries of origin; those conversations tended to be shorter, but still provided insight into the migration challenges they faced before arriving in the United States.

Interviews were conducted primarily by phone and lasted between 15 and 30 minutes. One of us (NF) interviewed the FEHPs and one of us (MAB) interviewed the recruiters. Field notes were taken. Six interviewees couldn't participate by phone and e-mailed their responses. All interviews were conducted either between July 23 and August 3, 2018, or between June 25 and July 8, 2019.

RESULTS

Sample demographics. A total of 1,017 FEHPs from 56 countries completed the survey. Survey respondents represented six health professions: RNs, LPNs, and advanced practice RNs (877); medical technologists and clinical laboratory scientists (88); physical therapists (20); speech language pathologists (16); occupational therapists (2); and physician assistants (1). Eight hundred and four respondents identified as female; 200 identified as male, and six preferred not to answer. A few people did not respond to each question.

A total of 30 people were interviewed: 21 FEHPs and nine recruiters. Of the 21 FEHPs, 20 were FENs and one was a speech language pathologist. Sixteen were female and five were male. Of the nine recruiters, five were female and four were male.

Findings. The migration-related survey questions were designed to inform our understanding of where FEHPs came from and went to during recruitment. Of those surveyed, the majority (53%) were initially educated and registered in the Philippines (see Figure 1). Canada and Jamaica were the next largest sources (13% and 9%, respectively). Of the FEHPs interviewed, eight came from the Philippines, four from Nigeria, three from Canada, two from Kenya, and one each from Ghana, India, Iran, and Jamaica.

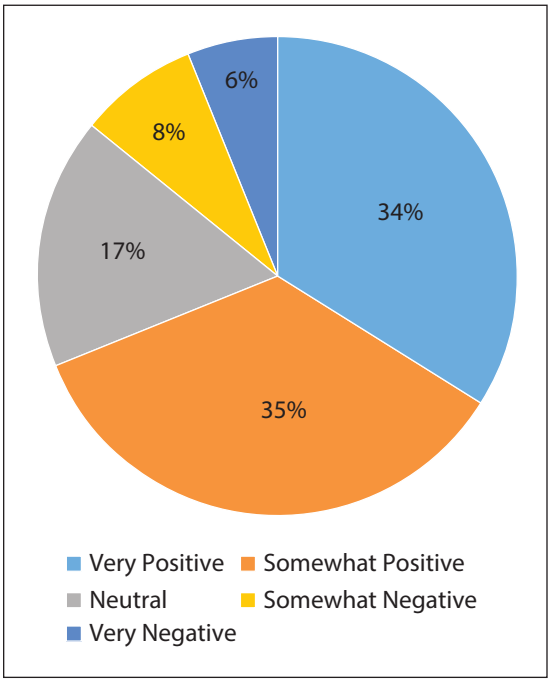
According to our data, FEHPs migrated to 47 U.S. states and territories. Of the 533 FEHPs who answered question 12 ("In which U.S. state/territory did you first apply to practice?"), the top four states or territories of first practice were California (15%), Texas (11%), New York (10%), and Florida (9%) (see Figure 2).

Among all survey respondents, 969 answered question 14 ("Did you work with a local recruiter in your country of origin?"). The 618 respondents who answered no were directed to the last question ("Are you interested in receiving a follow-up survey in 12 months?"). Only the 351 respondents who had worked with a local recruiter were asked more specific questions about their recruitment experiences.

Subgroup findings. *Overall perceptions.* Most of the subgroup of 351 respondents indicated having a generally positive perception of their recruitment experience. Among the respondents to question 34 ("Overall, how would you rate your experience with your recruiter?"), 69% reported that it was either "very positive" or "somewhat positive," while just 6% reported having a "very negative" experience (see Figure 3). Some respondents stated that their recruiters were "trustworthy" and "professional." One Filipino FEN stated, "They are always beside you and help [you] in [the] transition period and to start your American dream." Another reported,

> The agency regularly updated me regarding the status of my application; they are very prompt in answering my queries and clarifications. They are very professional to work with and always remind me about deadline[s] submitting the needed documents.

Figure 3. FEHP Survey Respondents' Overall Perception of Their Recruitment Experience (n = 269[a])



FEHP = foreign-educated health professional.
[a] Of the 351 survey respondents in the subgroup (those who worked with a local recruiter), 269 answered this question.

Respondents were then asked (question 36), "Were there any specific aspects about the recruiter with which you were not satisfied?" Respondents were given a list of answer options and could choose all that applied. Not all respondents answered, but of those who did, 136 indicated they were "completely satisfied." Thirty respondents indicated that their recruiters were dishonest in describing opportunities. Eighteen reported that their recruiter's fees were too high, 14 indicated that their recruiter was unable to find them a job, and 12 noted that their recruiter couldn't secure a visa for them. Three respondents reported that their employer changed without their consent.

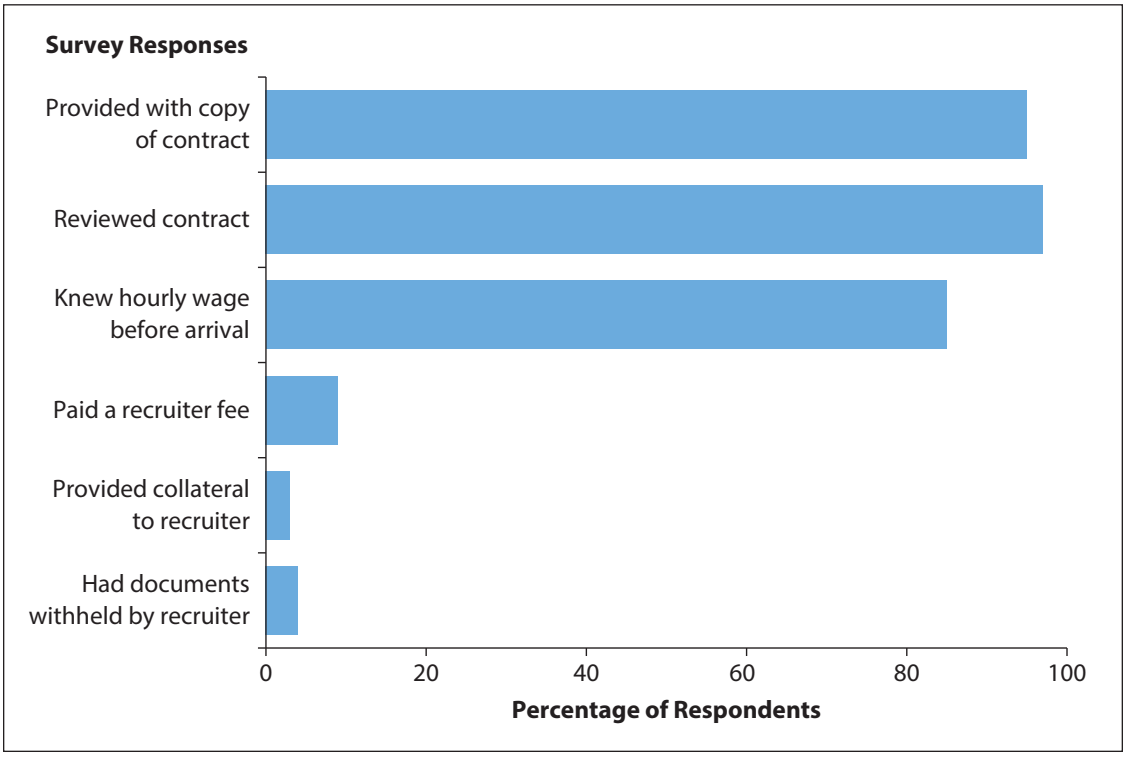
Transparency. Regarding transparency, 97% of subgroup respondents were permitted to review their contracts, and 95% were provided with a copy (see Figure 4). One respondent indicated that she didn't have time to review her contract, as her recruiter insisted on immediate turnaround so as not to lose an employment opportunity (which never came to fruition). A total of 266 FEHPs answered question 29: "Did you know and agree to the duties of the position you were recruited for?" Of these, 249 (94%) answered in the affirmative. Question 30 asked: "Did you receive an explanation of compensation and benefits before or when you signed the contract with an employer or staffing agency?" Of the 267 FEHPs responding, 214 (80%) indicated that they had. To question 31, "Did you know your hourly wage prior to arrival?," 228 of 267 respondents (85%) answered yes. That said, some respondents reported that, on arrival, they received lower pay than their domestically educated counterparts, as well as no added pay for working nights or weekends.

Recruiter fees and collateral. Only 27 of 303 respondents (9%) indicated that they'd had to pay a recruiter fee; these respondents further indicated that the fee mainly covered immigration-related expenses, specifically visa application fees. Regarding collateral, only 10 of 305 respondents (3%) reported that they had to provide their recruiter with some form of collateral to guarantee services. Of these 10, five reported that the collateral was eventually returned.

Breach fees. Question 27 asked whether breach fees were part of the contract. Of the 266 FEHPs who answered this question, 48 (18%) reported fees under $15,000, 81 (30%) reported fees between $15,000 and $30,000, and 46 (17%) reported fees over $30,000. Thirty respondents (11%) reported none, and the remainder answered "don't know."

During interviews, when asked whether they preferred positive incentives such as bonuses over breach fees, one recruiter responded,

Figure 4. Details of FEHPs' Recruitment Experiences[a]



FEHP = foreign-educated health professional.
[a] There were 351 survey respondents in the subgroup (those who worked with a local recruiter), but not all respondents answered each question. Percentages given are based on the number who did answer.

> Absolutely! I'd rather pay an employee a loyalty bonus or referral bonus because they've enjoyed working with us and want to continue and share their experience with others than get a breach fee from an employee who might not have had a positive experience with us or found another position [or] company to be better.

But some FEHPs reported otherwise. A nurse from Taiwan said, "I pay too much money, about $11,000 for [a green card]." When she tried to leave her low-paying job, the recruiting agency demanded "liquidation damages [of] at least $15,000. . . . It's not fair." And a Filipino nurse pointed out a lack of transparency:

> On the contract, it was not stipulated the amount you have to pay when you breach or decide to leave early due to personal/family circumstances. [The agency] will only determine the amount once you present your intention and the amount is ridiculously high. Otherwise, they will ask you to relinquish your visa/green card and settle the damages.

Cultural transition. Details about the cultural transition emerged during interviews. Two FENs indicated that they were particularly satisfied with their recruitment firms' cultural education. They reported that the initial education program helped them feel less overwhelmed about the U.S. health care system and their new positions. One, an RN from Nigeria, noted that her recruiter provided culturally relevant written materials and a class called "Cultural and Clinical Transition." This class taught recruited FEHPs how to drive and helped them prepare for the driver's license test; it also covered what to expect regarding U.S. weather, popular foods, and dressing for different seasons. A Filipino nurse said that her recruiter explained everything and had helped with opening a U.S. bank account, getting a social security card, and connecting with the Filipino community. She indicated that this also eased her clinical transition because she did not have to worry about those things and felt she had support.

Misalignment of expectations. Evidence of misalignment of expectations regarding work environment and location was revealed in interviews. A Nigerian RN reported that although she'd worked in an ICU setting in Nigeria, her international training wasn't considered sufficient by U.S. employers. She has since gained more experience in a U.S. hospital and believes she will be able to get an ICU

position soon. Similarly, a Filipino nurse was initially assigned to work in Louisiana but was jobless for four months because of a problem getting her nursing license; the recruiter was supposed to fix this situation, but it took a while. Now employed in Pennsylvania, she continues to find the transition difficult. In the Philippines she worked on a medical–surgical unit, but now she's assigned to a long-term acute care unit. Her recruiter gave her materials to prepare her only for medical–surgical nursing. She also stated that international nurses are asked to do more than their domestic counterparts.

Regulation of the FEHP recruitment industry is limited.

One Filipino FEN described her experience as "very traumatic." In her home country, she'd been a staff nurse for 12 years, but the recruiter "made" her a travel nurse, and as such she received no orientation. Describing the transition, she stated:

> The hospital is expecting you to work independently the moment you step in the unit. . . . It was difficult for me because the practice where I came from is really different. I need some time to adjust and be oriented, but I was not given that chance. I think the recruiter is selling us to hospitals as an "experienced nurse" and by that, I mean a nurse who has been working in the USA for so long. It was really hard for me. I can't sleep at night because of what happened to me.

A Kenyan nurse reported feeling generally positive about his transition. But his contract indicated that he'd be working day shifts; yet since his arrival, he has only been given night shifts. He cannot refuse these shifts because he's under contract. But working only night shifts has made it difficult to build a life here.

Other difficulties. Some survey respondents reported other troubling problems. In one case, a Canadian FEN reported that a recruiter became ill and "shut down her company without notice." This nurse was left without access to her passwords and had difficulties "with CGFNS, NCLEX [National Council Licensure Examination], . . . and multiple state boards of nursing" in completing the process.

Another survey respondent indicated that her visa paperwork was denied twice by U.S. Citizenship and Immigration Services with no explanation from her recruiter. It's also worth noting that one FEN faced a new migration challenge: Executive Order 13769,[35] more commonly known as President Trump's "Travel Ban." This nurse is part of a group of Iranian-educated health professionals whose immigration processes have stalled. Their professional future remains uncertain as they cannot leave Iran.

DISCUSSION

Regarding demographic data, for context, we looked not only at our survey results but also at earlier data collected through the National Council of State Boards of Nursing and the National Forum of State Nursing Workforce Centers, which have partnered to produce the National Nursing Workforce Survey every two years; the HHS's National Sample Survey of Registered Nurses (NSSRN); and AcademyHealth's 2007 report. According to 2008 NSSRN data (the most recent available), half of FENs who migrated to the United States came from the Philippines (50%), followed by Canada (12%), and then India (10%).[20] These source countries were also the top three identified in the AcademyHealth report.[1] Our results were largely comparable, although Jamaica surpassed India as a source country.

We also found that the top four states of first practice were California, Texas, Florida, and New York. Similarly, the AcademyHealth report found that the highest concentrations of foreign-born nurses were in California, New York, New Jersey, and Florida.[1] And a 2016 report by Hohn and colleagues stated that the top four states of practice for foreign-born nurses were California, New York, Florida, and Texas.[12]

Both the survey and interview data suggest that there is substantial transparency in the recruitment industry, with nearly all respondents reporting that they were permitted to review their contracts and were given copies. Nearly all respondents also indicated that they knew and agreed to the duties of the positions they were recruited for. And a majority knew their hourly wage before arrival and had received an explanation of compensation and benefits before or upon contract signing.

Several FENs reported that their recruiters provided cultural orientation sessions before arrival, an encouraging finding. These orientations included classes on American culture, weather, food, how to open a bank account, and how to obtain a driver's license. In some cases, the recruiters also connected nurses with people from their home countries. Those interviewed reported that this orientation made the transition to American life significantly easier and allowed them to focus their attention on their new jobs. They did not have to worry about logistical details and found a support system within the communities of FEHPs from their home countries.

That said, it's evident from survey responses that various problems remain. Thirty of the subgroup survey respondents indicated that their recruiters exhibited dishonesty. One hundred twenty-seven—nearly half of those answering this question—reported that their recruiters included high breach fees ($15,000 and above) in their contracts. Some FEHPs who later tried to leave their jobs were threatened with breach fees as well as revocation of their visas and green cards; at least one was threatened with prosecution for "immigration fraud." Some respondents reported being assigned different jobs on arrival than what they had contracted for. A few disclosed pay inequities. Some FEHPs received inappropriate orientation or none at all.

Many interviewees also revealed problems with transparency and other aspects of recruitment. Their experiences were similar to those found in the 2007 AcademyHealth report, in which nurses in focus groups said they were not allowed to keep a copy of their contracts, were asked to sign multiple documents without having adequate time to read them, and were locked into contracts via exorbitant breach fees.[1]

Limitations. The primary limitation of this study is the lack of diversity among survey respondents. We conducted this study with the intent to examine the migration experiences of FEHPs as a group, which includes FENs. We acknowledge that nursing is the largest health care profession and that nurse migrants are the predominant group that CGFNS International focuses on; 86% of survey respondents were FENs. Thus, while our sample size was reasonable, the distribution of professions was not representative. Furthermore, most survey respondents were female Filipino nurses between the ages of 22 and 35 years. These nurses reported similar experiences when it came to their education, recruitment, contract signing, migration, employment, and orientation to life in the United States. This lack of variance skewed the statistical results. Our respondents weren't representative of the larger health care recruitment industry, and as a result, we did not gain much insight into the experiences of nonnurse FEHPs.

CONCLUSION

The problems that led to the creation of the Alliance and its code persist 12 years after AcademyHealth's landmark 2007 report. Although a majority of locally recruited FEHPs reported generally positive recruitment experiences, our findings show that some FEHPs are mistreated and breach fees continue to be an issue. Given projected shortages of health professionals, the aging U.S. population, and other factors, it's likely that our health care system will become increasingly dependent on FEHPs. An opportunity exists for progress, particularly in terms of clarifying the differences between problematic and ethical recruitment and providing recruited professionals with the tools to make better-informed career decisions. At the industry level, better strategies to implement market-wide practices that ensure the orderly and ethical recruitment of FEHPs are needed.

The implications for clinical practice may not be obvious. But the recruitment experience directly affects the work of recruited health professionals. During interviews, FENs spoke to how the professional and cultural orientations they received during recruitment eased their transition to living and working in the United States. Providing a better recruitment experience allows FENs, and other FEHPs, to dedicate more time, effort, and energy to their patients. Workforce cohesion and, ultimately, the quality of patient care depend on ensuring that all colleagues are treated fairly, trained well, and positioned to succeed in demanding health care environments. ▼

For two additional continuing nursing education activities on recruitment, go to www.nursingcenter.com/ce.

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