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Navigating change: the educational and cultural transition experiences of migrant Filipino nurses

Original article

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Abstract: **Objective:** This research examines the socio-educational and acculturation experiences of Filipino nurse-migrants within the context of international healthcare systems. It seeks to understand the multifaceted emotional and professional system-related difficulties they face and how these impact their adaptation strategies and integration processes elsewhere.
Methods: A qualitative phenomenological strategy, as described by Colaizzi's 7-step analysis method, was employed. A purposeful sample of 10 Filipino nurses deployed to Saudi Arabia, Oman, the United States, Finland, Australia, Ireland, Norway, and Germany was chosen. Participants took part in video conferencing structured interviews, which were conducted remotely. Manually and using NVivo (Version 15, Lumivero, 2024), thematic analysis was conducted to identify important themes from the participants' stories.
Results: Seven major themes emerged: (1) emotional and cultural dimensions of guilt, isolation, and professional identity negotiation; (2) language and communication barriers, which comprise code-switching and cultural deference challenges; (3) systematic barriers such as credential recognition, licensing examinations, and bureaucratic obstacles; (4) gaps in clinical practice standards, patient care ethics, and discrepancy; (5) family and finances as motivation and resilience; (6) bridging programs and adaptation to student-centered learning as educational transitions; and (7) cultural adaptation depicts discrimination, the workplace hierarchical order, discerning and pragmatically fluent challenges. Despite systemic inequities, participants demonstrated remarkable adaptability, which was visibly rooted in Filipino cultural values such as pakikisama, utang na loob, and bayanihan.
Conclusions: The migration experience of Filipino nurses is associated with profound and emotional changes on professional and cultural levels. While these individuals adapt remarkably well due to their multifaceted resilience, they face unforgiving barriers, including credentialing, cultural, and systemic issues. Policies that foster intercultural understanding alongside psychosocial support and fair recognition of foreign credentials would enhance the positive impact of migrant nurses on international healthcare. These considerations will enhance the integration experience for migrant nurses and have a positive impact on patient care worldwide.

Keywords: *credential recognition • cultural adaptation • Filipino migrant nurses • healthcare integration • migration and mobility • internationally educated nurses*

1. Introduction

Shifts in migration patterns have been linked to the global demand for skilled nurses, with a notable cohort of international nursing professionals, including those from the Philippines.[1] The emigration of nurses trained in the Philippines to English-speaking nations, including the United States, Australia, Canada, and the United Kingdom, is chronicled. It stems from a solid nursing education base in the Philippines and good ratings for

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the employability of graduates.[2] With continuing dependence on Filipino nurses overseas and healthcare institutions abroad needing Filipino nurses to fill the gaps, the movement of Filipino nurses has solidified within the framework of global healthcare labor relations. On the other hand, migration presents professional and financial possibilities. However, challenges associated with educational and cultural integration are equally daunting and can be detrimental to the productivity of the migrant nurses in their workplace.

Adjustment to new education systems presents difficulties for ethnic nurses who expect to integrate into foreign healthcare systems.[3] Migrating nurses to another country requires them to undergo an intricate system of change, involving the internationalization of policies, pedagogy, and clinical practices within the specific health system, which is vastly different from what they were trained in the Philippines. Academic and clinical settings in countries where English is spoken may have linguistic challenges due to language barriers and different accents and idioms.[4] Furthermore, certain foreign-educated nurses encounter stress and self-doubt regarding the international licensing and certification processes, stemming from a disparity between their perceived self-competence and actual competencies in the training system or framework.[5] Aside from educational restructuring, cultural change is another prominent facet of the experiences of migrant nurses. A study claims that for a person to adapt to a new situation, cultural differences regarding work practices, methods of communication, and patient interactions must be fully integrated.[3] Put differently, the profound cultural differences intricately shape the earlier stages of adjustment. Most Filipino nurses have an upbringing rooted in a collectivist culture, where respect for authority and avoidance of conflict within groups are emphasized. However, some Western healthcare establishments are more liberal in their nursing practice and encourage direct interaction with other health practitioners and patients. This contradicts Filipino cultural orientation.[1] Social integration away from the workplace is also tricky for migrant nurses because they must adapt to new cultures, form new ties with disparate communities, and deal with feelings of homesickness. These educational and cultural challenges affect their collective confidence, job performance, and wellbeing. With the growing dependence on migrant nursing in most healthcare systems, it has become pertinent for policymakers, educators, and healthcare administrators to understand nurses' educational and cultural transition experiences. Aid mechanisms such as organizational socialization, mentorship, and language and cultural competence programs will likely help sustain integration into the host country's healthcare systems.[5] The growing demand for nurses globally has led to a greater reliance on foreign-trained nurses to assist in managing staffing shortages in various parts of the world.[4] The Philippines has become one of the world's top suppliers of nursing professionals as every year, over a 1000 Filipino nurses relocate to the United States, Canada, the United Kingdom, and Australia.[1] This phenomenon occurs because developed countries have a pressing need for nurses who are paid better than what Filipino professionals can get, and their economic conditions are also better.[2] At the same time, while migration provides good employment and income opportunities, it is also very stressful, especially regarding education and culture.

Adapting to a foreign healthcare system can be difficult for migrant nurses, especially regarding new educational structures, licensing procedures, and clinical practices that differ from their training in the Philippines.[5] Most destination countries have additional certification examinations or bridging programs that aim to assess the competencies of internationally educated nurses (IENs) before issuing a full professional license.[3] These processes are highly complex due to new and different curricula, pedagogical practices with a language barrier, and even a drastically new set of terms. Moreover, assisting nurses from the Philippines entails dealing with an ambivalence toward their competencies that emanates from a comparative analysis of policies, technologies, and procedures based on patient care in the Philippines and host countries.

Apart from the educational problems, another critical dimension of a migrant nurse's experience is adapting to the culture. Differences in communication and other cultural factors, including social structures and patient relationships, profoundly affect their professional and social integration.[1] Filipino nurses, who hail from a collectivist society prioritizing group cohesiveness and subordination, may find workplace dynamics in Western countries challenging.[5] Other factors such as discrimination, isolation, and even language proficiency could challenge their cultural adjustment, self-efficacy, and health.[3]

Comprehending Filipino nurses' educational and culture-specific transition experiences as they are increasingly utilized in healthcare systems across the globe is crucial since it will help improve the mechanisms of support that facilitate their integration. Although specific facets of nurse migration have been studied, more attention needs to be directed toward understanding how these transitions and successful adaptations are attained by Filipino nurses.[3,5] This research examines the experiences and challenges of auxiliary filling positions undertaken by Filipino nurses who migrate abroad.

It also discusses the strategies to cope with these challenges and the available supportive resources. By shedding light on these experiences, this study strives to build policies and aid programs that facilitate foreign-trained nurses' educational and professional transitions to increase retention and job satisfaction in the host countries.

The migration of Filipino nurses has become herculean in tackling the worldwide shortage of nurses because of economic conditions, demographic changes, recruitment policies, and immigration policies.[6,7] As highlighted in a study, the Philippines remains a key source of IENs for the United States, Canada, the United Kingdom, and the Middle Eastern countries.[8] Although Filipino nurses hold higher education qualifications, they face sociocultural and professional barriers, including credentialing obstruction, difficulties with cultural transition, and institutional bias, prejudice, and discrimination.[9–11]

Educational differences present integration barriers. For example, the Philippines uses a competency-based curriculum, while the West teaches critical thinking and independent practice as sustenance.[7,12] Even if migrant nurses possess higher qualifications than what the job requires, they are considered to have additional skills, such as language qualifications and the Objective Structured Clinical Examination (OSCE) or NCLEX-RN.[13,14] Financial, examination, and new clinical practice adjustment stressors add to the clinician's contemporary clinical practice burden.[3,14] Cultural adaptation remains a prominent difficulty. Berry's Acculturation Model (Berry, 1997, 2005)[15] and Oberg's Culture Shock Theory (1960)[16] discuss the psychological challenges associated with coping mechanisms. Filipino nurses tend to prefer an integration approach, but experiences of marginalization due to systemic discrimination can be mentally taxing.[17–19] Language barriers, especially outside English-speaking countries, impede communication and patient care.[13,20,21]

Social integration also impacts adjustment. Community resilience is bolstered by professional groups, such as the Philippine Nurses Association of America (PNAA), as well as other affiliations, support structures, and mentorship.[13,17] Nurses who migrate leave behind families and often become homesick, psychologically distressed, or guilt-ridden for being away from family.[22,23] Coping strategies are grounded in faith, peer support, and community involvement.[24–26]

These challenges are sometimes mitigated through policy initiatives. The U.S. Immigrants in Nursing and Allied Health Act[27] and Australia's streamlined registration processes[28] foster migration. However, persistent barriers such as workplace discrimination and professional isolation[29] highlight gaps in post-arrival support. Israeli Integration Programs and culturally sensitive institutional orientations in the United States and Europe inadequately address these.[30]

Advisory recommendations focus on government welfare reforms, eligibility criteria, integrating mentorship with language training, strengthening labor law protections, and developing leadership roles for nurse migrants.[31–33] Resolving educational and professional barriers, as well as gaps in emotional wellbeing, is essential to fully harness Filipino nurses' potential contributions to improving global healthcare systems.

This qualitative research was conducted to gain a deeper understanding of the life experiences of Filipino nursing migrants in the context of globalization, as well as their roles as educators, cultural sojourners, and teachers. The study employs a phenomenological approach to analyze problems, coping mechanisms, and factors contributing to successful adaptation. By focusing on their experiences, this research aims to contribute to the development of policies and practices that support the transition process of internationally trained nurses. This would benefit the migrant workers and the healthcare institutions that depend on them.

2. Methods

2.1. Research design

This study takes a qualitative phenomenological approach, employing Colaizzi's 7-step process, to investigate the lived experiences of Filipino nurses newly deployed to diverse international healthcare settings. Colaizzi's 7-step approach (1978) comprises familiarization, recognizing noteworthy statements, defining meanings, clustering themes, developing an extensive description, and obtaining verification of the underlying structure.[34] This methodological framework provides a comprehensive understanding of participants' experiences by systematically analyzing their narratives.

2.2. Sample population and sampling strategy

The target population comprises Filipino nurses in the Kingdom of Saudi Arabia (KSA), Oman, the United States, Finland, Australia, and Germany. A criterion-based sampling strategy was employed to ensure the relevance of the participants. The inclusion criteria for participants are as follows:

1. Filipino nationality;
2. This is the first time deployment in the host country;
3. Engagement in direct bedside or clinical work.

A sample of 10 participants were selected. Recruitment was facilitated through network referrals, email, and social media invitations**.** Before participation, informed consent was obtained after the study's goals and methodology, along with the participant's rights, which were explained**.**

2.3. Participants of the study

Coded names were used to protect the participants' identities.

P1D—Female, 42 years old, originally from Manila, Philippines, migrated to Finland, and is currently in her 17th Month. After working as a staff nurse in a government hospital, a Filipino Bachelor of Science in Nursing (BSN) graduate is currently employed in Finland as a hospice palliative nurse.

P2E—Female, 38 years old, from Cavite Province in the Philippines, who migrated to the United States and is currently based in California. She has previously worked as a staff member in the emergency room of a private medical center in the Philippines. She is now an emergency room nurse in the United States, completing her 15th month of training.

P3M—Male, 35 years old, from Bulacan, Philippines, immigrated to Germany. A former rural health nurse in the Philippines now working in the Neuro Clinic in Germany. It has been 24 months since his deployment.

P4M—Female, 42 years old, from Manila. Philippines, immigrated to Australia. A former medical surgical staff member in the Philippines, she works as a Quality Risk Management nurse and is in her 24th month since deployment.

P5O—Female, 42 years old, from Bataan, Philippines. She moved to Oman, where she was a former nurse midwife at a tertiary government hospital in her province. She now works as a rural health nurse in Oman and is in her 24th month of deployment.

P6P—Female, 36 years old, originally from Bulacan, Philippines; moved to Germany. She previously worked as a Clinic Nurse in the Philippines and is now working in Care homes in Germany. It is her 12th month in her current clinical placement.

P7R—Female, 38 years old. Originally from Bulacan, Philippines, she moved to the United States. She previously worked as an emergency room staff nurse in the Philippines and now serves as the Nursing Services Assistant Director at a North Dakota Rural Health Medical Center. She has been on deployment for the past 18 months.

P8Z—Female, 35, originally from Camarines Sur, Philippines. She previously worked as a Delivery Room Nurse in the Philippines and is presently an OB Clinic Staff in the Sultanate of Oman. She is on her 24th month since deployment.

P9O—Female, 35 years old, from Pangasinan, Philippines. After working as an Intensive Care Unit (ICU) nurse in the Philippines, she moved to the KSA where she works as an ICU Nurse at a Cardiac Specialty Medical Center in Riyadh. She has had this position for the past 6 months.

P10L—Female, 34 years old, from Nueva Vizcaya, Philippines. She previously worked as a staff in a clinic in the Philippines before moving to KSA. She is now in her 6th month in her placement.

2.4. Data collection

Data are collected through in-depth structured interviews using a predefined checklist. Given the geographic dispersion of participants, interviews were held remotely via a video conferencing platform. Participants were requested to enable their audio and video devices for better engagement. These data were stored in a secure file on a password-protected hard drive. For future reference, these data can be accessed with the consent of the participants and researchers for future replication of the study. Consent was obtained prior to recording the interview sessions.

2.5. Data analysis

The study followed a structured 7-step data analysis approach, integrating manual and software-assisted thematic analysis through NVivo (Version 15, Lumivero, 2024. https://lumivero.com/products/nvivo/) or similar tools:

1. **Data Collection**—Gathering participant narratives.
2. **Familiarization with Data**—Repeatedly reviewing interview transcripts.
3. **Initial Coding**—Manually identifying key concepts and patterns or using NVivo.
4. **Identifying Themes**—Grouping-related codes into emerging themes.
5. **Reviewing Themes**—Refining and verifying theme relevance.
6. **Defining and Naming Themes**—Clearly articulating the identified themes.

7. **Writing the Findings**—Synthesizing themes into meaningful interpretations.

3. Results

3.1. Theme 1: Emotional and cultural adjustments

3.1.1. Sub-themes: Guilt, isolation, cultural dissonance, professional identity

For many Filipino nurses, the emotional transition into their host country is as significant as the professional one. Participants often described feeling guilty for leaving their families behind, especially when they were the primary breadwinners or parents to young children. One participant from Finland mentioned, "Do not feel guilty or bad about escaping from the Philippines; you have to." This sentiment captures a tension between personal ambition and familial responsibility.

Nurses also shared a sense of cultural dissonance in their new environments. They often struggled to feel "seen" in the healthcare systems abroad. Some described subtle stereotyping or a lack of appreciation for their qualifications and experience. In the United States, one nurse recalled, "I came in with full confidence, but here I had to work all alone, with no mentorship and no support."

Despite the challenges, many highlighted how their Filipino values—particularly resilience, adaptability, and compassion—helped them integrate. However, it was clear that the emotional toll was not just about the workload but also the cumulative pressure of being far from home, operating in unfamiliar systems, and negotiating their professional worth.

3.2. Theme 2: Language and cultural communication

3.2.1. Sub-themes: Tagalog English code-switching, cultural deference, language barriers

The interviews revealed how language is not only a practical barrier but also an emotional and cultural anchor. Nurses often interspersed Tagalog with English, which highlighted their internal negotiation between the world they came from and the one they were adapting to. Words like "*yung*," "*kasi*," "*nga*," frequently appeared even in English-dominated responses, showing the continued influence of Filipino thought patterns and expressions. Participants also noted how cultural deference—respect for authority and hierarchy—sometimes clashed with the more egalitarian or assertive cultures of their host countries. For example, one nurse said, "In the Philippines, we respect our managers and colleagues in different ways." Here, it's more direct, and it took time to get used to." Moreover, some nurses felt that their ability to communicate professionally was underestimated due to their accents or struggles with the host-country language. This was especially pronounced in countries like Germany or Finland, where nurses were required to learn new languages entirely. One participant noted that the *German exam was conducted entirely in German, even the practical part*, adding a layer of stress on top of clinical duties.

3.3. Theme 3: Systemic and licensing challenges

3.3.1. Sub-themes: Credential recognition, exams, bureaucracy

Across all countries, the transition into licensure and recognition of qualifications emerged as a dominant challenge. Many nurses had to undergo additional training, take language proficiency exams, or adapt to new systems of documentation and care.

For instance, a participant in Germany had to pass a rigorous combination of written, oral, and practical exams in German to be officially recognized. "You work with a patient the whole day under observation," she said, describing the clinical part of the test. In Saudi Arabia and Oman, navigating platforms like **MUMARIS** or undergoing **Prometric exams** was described as "tedious," with lengthy verification processes through **data flow** agencies. This bureaucratic overload and the pressure of proving oneself in a new system often led to burnout even before employment began. Still, participants persisted, motivated by financial necessity and long-term goals.

3.4. Theme 4: Quality of care and clinical practice gaps

3.4.1. Sub-themes: Patient safety, hygiene, comparative standards

Many nurses compared the quality of healthcare delivery in the Philippines with that of their host countries. Interestingly, these comparisons were not always in favor of the latter. Nurses often emphasize that *Filipinos are trained with a high regard for patient care and hygiene,* sometimes exceeding the standards they found abroad. One nurse in Oman stated, "Even though we are not fully recognized, Filipinos are still preferred because we are known to be hygienic and thorough." Others described adjusting to environments where specific procedures or

standards seemed more relaxed or culturally influenced, sometimes creating ethical dilemmas.

3.5. Theme 5: Resilience and motivation

3.5.1. Sub-themes: Family, financial security, long-term goals, hope

Underpinning all other themes is a powerful narrative of resilience. For nearly all participants, economic stability and family welfare were the primary drivers of migration. Many entered nursing not just as a career but as a vehicle for mobility—"I wanted to give my parents a decent house," shared one participant working in Oman. The journey often started with uncertainty and struggle—volunteer jobs, unpaid internships, training with limited resources—but was fueled by a clear vision of a better future. Whether through pursuing advanced degrees, supporting family members, or building new lives abroad, these nurses reflect unwavering strength. Even in the face of systemic barriers, they found ways to adapt, evolve, and flourish, carrying their Filipino identity as a source of pride rather than a limitation.

3.6. Theme 6: Educational transition experiences of migrant Filipino nurses

3.6.1. Bridging the gap: Revalidating Filipino education abroad

Filipino nurses consistently emphasized that their nursing education in the Philippines was *rigorous, holistic, and hands-on*. However, upon migrating, many discovered that their qualifications were not immediately recognized in host countries. This mismatch led to a requirement for bridging programs, re-education, or licensure exams, regardless of their years of experience.

- In Finland, nurses had to undergo a 1.5-year bridging course to meet the local nursing standards. One participant noted, "We are trained well in the Philippines, but the laws and protocols here are different … the care planning here is simpler, but the language is the biggest hurdle."
- In Germany, nurses were required to learn the German language up to B2 level and then undergo the Kenntnisprüfung. This comprehensive exam tested both theoretical knowledge and practical skills through oral presentations and direct patient care.
- In Australia, one participant who lacked local experience and qualifications had to repeat the entire nursing course, albeit in an accelerated format due to subject crediting.

This process often felt frustrating and redundant, especially for nurses with substantial clinical experience. However, many acknowledged that while their Philippine education was technically sound, the language, legal frameworks, and documentation standards were different enough to necessitate retraining.

3.6.2. Philosophical and pedagogical shifts: From rote to reflective

Participants described a noticeable shift in teaching styles and learning environments when transitioning to foreign education systems. In the Philippines, education was often described as "rigid, hierarchical, and punitive"—with instructors instilling discipline through fear of failure.

- A Finnish participant shared:
- "In the Philippines, we're afraid of making mistakes because we might be yelled at or scolded. Here, they encourage learning through trial and error. You're not punished for failing—you're coached."

This contrast was echoed in Germany and Australia, where participants appreciated a student-centered, supportive, and less authoritarian learning environment. The fear-based motivation commonly associated with Philippine nursing schools has shifted abroad into a reflective, developmental model—one that emphasizes critical thinking, peer collaboration, and holistic assessment.

3.6.3. Language as a barrier and gatekeeper

Language emerged as both a literal and symbolic challenge in the educational transition. Participants noted struggles with medical jargon, slang, and accents even in English-speaking countries like the United States and Australia.

- In Germany, one participant noted, "I had to start with A1-level German and progress to B2. It felt like I was back in first grade—learning ABCs and numbers."
- In the United States, even fluent English speakers struggled with regional dialects: "The Southern accent eats up consonants. I could understand the words but not the rhythm."

Language wasn't just about communication—it was a measure of competence and confidence. In several cases, nurses' delayed licensure or struggled with exams simply because of language complexity, not lack of knowledge.

3.6.4. Licensing and credentialing: Bureaucracy overload

A near-universal frustration was the bureaucratic burden of credential recognition. Participants reported navigating multiple layers of documentation, translations, notarizations, and verifications.

- In Saudi Arabia and Oman, this involved Dataflow, MUMARIS Plus, and Prometric Exams—systems that required meticulous paperwork and months of waiting.
- One participant from KSA noted:
- "It took me almost four months just to process my Dataflow and get eligibility for the Prometric. And you still have to take an interview and fulfill Ministry requirements."

In contrast, the United States and Australia had smoother but still expensive and time-consuming pathways involving National Council Licensure Examination for Registered Nurses (NCLEX-RN), International English Language Testing System or Test of English as a Foreign Language (IELTS/TOEFL), Commission on Graduates of Foreign Nursing Schools (CGFNS), and visa requirements.

3.6.5. Cost and accessibility of further education

Education abroad was often described as financially draining but necessary. Several participants had to work while studying, take out loans, or rely on support networks to complete programs. A participant in Australia described juggling work, study, and survival:

> "You study during the day, work night shifts, and cook your meals in between. It's all you. No parents, no yaya." Despite this, many saw foreign education as an investment—a ticket to permanent residency, better pay, and career mobility. Some were even inspired to pursue further education, like master's degrees or specialist certifications.

3.6.6. Clinical practice variations and orientation gaps

Another layer of the educational transition was the shift in clinical expectations. Participants noted stark differences in:

- **Documentation systems (paper vs. digital EMRs)**
- **Autonomy and scope of practice**
- **Patient rights and informed consent**

In the Philippines, student nurses are often thrust directly into care roles, whereas in the Western settings, there is a greater emphasis on simulation labs, policy-based care, and patient empowerment.

- A U.S.-based nurse shared:
- "In the Philippines, you just do what needs to be done. You must document, obtain consent, and consult with the care team before every step."

3.7. Theme 7: Cultural transition experiences of Filipino migrant nurses

3.7.1. Work culture shock and professional hierarchies

Sub-theme: From top-down to collaborative models

Many participants described experiencing "culture shock" when entering healthcare systems that operated differently from what they were used to in the Philippines. In the Philippines, hospitals often follow a hierarchical structure, where deference to authority is expected, and decisions are typically made by senior staff without much room for discussion.

In contrast, nurses working in places like Finland, Australia, and the United States found themselves in more collaborative environments, where junior staff are encouraged to speak up, contribute to care plans, and even challenge decisions if patient safety is at stake.

> "In the Philippines, we're used to following orders. Here in Finland, the doctors ask you what you think, and at first, I didn't know how to respond—it felt awkward."

Language and communication barriers

Sub-theme: Beyond words – Understanding tone, humor, and nuance

While language proficiency (e.g., passing IELTS, B2 German, etc.) was a known requirement, the more profound challenge lay in everyday communication, including:

- Understanding local humor or sarcasm
- Interpreting tone or nonverbal cues
- Navigating patient conversations or emotional disclosures

In Germany and Finland, nurses struggled not only with vocabulary but also with cultural nuances of politeness, patient assertiveness, and staff humor that didn't translate well.

> In Germany, patients call you directly by your first name or even challenge your decision—it took a while to realize that's normal and not disrespectful.

Discrimination, stereotyping, and racism

Sub-theme: subtle exclusions and emotional exhaustion

Several participants reported feeling stereotyped or underestimated, especially early in their transition. This phenomenon was more prevalent in Middle Eastern and European countries, although it also appeared in North America.

Common issues included:

- Being assumed to have lower qualifications
- Receiving less critical or prestigious assignments
- Being talked over in team meetings
- Perceived as "just a nurse" versus a skilled practitioner

> "They think you'll just say yes and smile because you're Filipino. We're polite, but we're not pushovers."

Over time, many nurses learned to assert themselves and earn the trust of their teams—but it often took emotional effort and consistent proof of competence.

Patient expectations and cultural values

Sub-theme: From compliance to autonomy

The patient–nurse dynamic was another central area of cultural transition. In the Philippines, patients often defer to nurses and rarely question procedures. However, in Western countries, patients are:

- More involved in their care plans
- Likely to express concerns or reject procedures
- Protected by substantial legal rights

This required shifts in communication strategies, especially around consent, privacy, and autonomy.

> "In Australia, I was surprised how much say the patient has. You can't just clean a wound without explaining everything and getting full consent—even for something minor."

Religious and social norms

Sub-theme: Adapting to faith and gender differences

In the Middle East, nurses faced a different kind of cultural transition—adapting to Islamic values, gender segregation in hospitals, and prayer-based scheduling. Female nurses noted having to adjust to expectations around modesty, interactions with male patients, and cultural etiquette.

> "In Oman, even if the patient needs something urgent, if it's prayer time, everything stops. You have to learn how to work around that with respect."

Meanwhile, in more secular countries like Finland or Germany, some nurses felt spiritually isolated or struggled with finding Filipino communities or churches that helped them feel grounded.

Social integration and sense of belonging

Sub-theme: Finding community vs. feeling "Othered"

Many nurses described a "dual life"—being professionally integrated but socially isolated. This was especially true for those in rural or non-diverse areas, such as small towns in Germany or the United States. Some managed to build community through Filipino church groups, social media, or by meeting fellow migrants at work.

> "We met at the airport, and then we stuck together through everything. That little Pinoy barkada became my home here in Australia."

Others felt a persistent sense of "otherness," especially when holidays, food, or humor reminded them that they were far from home.

Cultural resilience and adaptability

Sub-theme: The Filipino spirit abroad

Despite the challenges, nearly all participants emphasized the resilience they brought with them. Traits like flexibility, resourcefulness, and pakikisama (getting along with others) helped them earn the respect of their colleagues and thrive in unfamiliar systems.

> "At first, they don't know what we're capable of. But when they see our work ethic and how much we care for the patients, they start to treat us as equals—or even better."

4. Discussion

Filipino nurses integrating into foreign healthcare systems represent both a career change and rich emotional, cultural, social, and structural transformation. The study examines the relationship between emotions

and sociocultural factors in the context of professional transitions within a migration phenomenon in the globalized world.

4.1. Feeling shifts and professional integration

The experience of emotional stress caused by the isolation of Filipino migrant nurses is intricately interwoven with their professional integration in host countries. Guilt, solitude, cultural exile, and alienation stand out as some of the most difficult emotional challenges. Many study participants suffered emotionally due to social expectations of parental investment and sociocultural standards of "family first."[2] As primary breadwinners, migrant nurses suffer emotional stress from their family being physically absent from them. One participant encapsulated the tension between personal growth and retention of familial identity, saying, "Do not feel guilty or bad about escaping from the Philippines; you have to." Migratory shifts in employment responsibilities, roles, and job titles compound emotional problems. Participants frequently reported feeling ignored or "overlooked," a term associated with professional invisibility. Migration nurses often experience social isolation due to the absence of mentorship and supportive networks. Working in high-demand positions without supervisory guidance increases the risk of burnout.[35] However, values such as endurance, compassion, and adaptability, deeply entrenched in Filipino culture, serve as protective factors,[34] increasing emotional resilience and professional integration.

4.2. Language, identity, and emotional conflict

Language became an essential tool when traversing new professional and cultural terrains. For Filipino nurses, a working language of the host country embodies more than mere understanding; it entails culturally attuned emotional negotiations. Using English, Tagalog, and "Taglish" demonstrates code-switching as a psychological link to the "other," which accentuates the emotional intricacies of integration[36] Practices like the use of "yung," "kasi," and "nga" in interviews capture the marks of ethnolinguistic identity persistence. Code-switching is employed for deeper functions than communication, articulating belonging and identity. Striking a balance with cultural deference needs in cultures with different social hierarchies of communication further complicates integration.[37] Hofstede's cultural dimensions theory sheds light on the nurses' woes stemming from a transitioning strong power distance culture to more egalitarian healthcare settings.[38] Experiences in language-exotic cultures like German and Finnish add emotionally and professionally to the plethora of constraints, leading to undue assessments of one's abilities.[39,40]

4.3. Licensing, bureaucracy, and professional marginalization

The combination of emotional, financial, and professional challenges with the licensing and credentialing processes created a strong barrier for participants. Registered nurses from the Philippines had to go through bridging programs, licensing examinations, and administrative verifications regardless of the rigor of their nursing education.[41] Participants identified these requalification requirements as mentally draining and, at times, unwarranted. The lack of proper recognition in one's profession is manifested in the customs of Saudi Arabia, Germany, and the United States, which Guevarra[42] explains as a denial of equity for foreign healthcare workers. The rigidity and systemic complexity of verification requirements, such as MUMARIS in Saudi Arabia or CGFNS in the United States, intensified these challenges.[43] A researcher[44] noted that the stress often reported stems from financial and emotional factors shaping the migrant nurse's journey, which is motivated by family, ensuring endurance through inequitable systems even before formal employment begins.

4.4. Clinical practice gaps and ethical conflicts

The Philippines and the host countries' cross-cultural gaps in clinical practices and standards of patient care added another complication. During training in the Philippines, participants observed greater attention to patient and environmental cleanliness, as proprietary hygiene controls were significantly more stringent.[3] Participants experienced ethical dilemmas when what they considered loose hygiene practices were nearly identical to personalized care, while others were different, an issue that has been studied in the migration literature.[45] For instance, some participants recognized the disadvantages in organizational structures in host countries and the increase in patient safety measures.[46] Beyond these benefits, they struggled with their deeply rooted notions of caregiving. The adjustment included primary caregiving, documentation, interdisciplinary teamwork, and independent practice[13] A research study underscored that the clinical skills of Filipino nurses are frequently underutilized owing to preconceived ideas and insufficient information about how these nurses are educated, perpetuating systemic stereotypes.[25]

4.5. Motivation, resilience, and enduring values

Strong motivation and even greater resilience were present alongside the emotional and occupational difficulties. Their drive to provide financial security and fulfill family responsibilities was most striking, closely tied to the Filipino cultural theme of utang na loob (debt of gratitude).[3] Migrants are repeatedly described as not pursuing a career, but rather a family obligation meant to improve the family's prospects, which resonates in studies.[24] Even the most complex licensing processes, including unpaid volunteer work or underemployment, demonstrated resilience among the participants. It has been observed that tenacious and firm goals are achieved through grit, persistence, and steadfast perseverance.[46] Migrant nurses sought socio-professional integration, but many advanced academically, clinically specialized, and sponsored relatives.[47] They framed the Filipino cultural identity not as a setback. Instead, compassion, work ethic, pakikisama (smooth interpersonal relations), and other attributes that enable success, despite systemic barriers, were viewed as strengths.[48]

4.6. Shifts in philosophy and the educational system

Every step of relocating from the Philippines to the academic and clinical settings abroad posed unique challenges. Within-system gaps are represented by identity obliterating masquerade simulation board games, chronic recertification exams, and rehabilitation sham credential programs.[25] As a study puts it, "internationally educated health professionals" sounds the way of "invisibility cloak of skills" bound within frameworks of host countries' systems.[49] Nonetheless, instead of emphasizing rote memorization, as in Leininger's (1995) transcultural nursing theory, participants appreciated the educational approaches in the host countries, which centered on textbook instruction and guided practices that actively engaged students in the learning process, collaboration, and critical thinking.[50] Another modern language barrier persists concerning the gap, which is a far greater difficulty in some places. Possession of linguistic mastery is essential to Germany's licensing exams.[40] Regulatory obstructions further challenge the goals.[43]Complexity in clinical practice models concerning documentation, unit policies, supervisor-nurse hierarchical relations to autonomy requires a fundamental shift in philosophy. This profound, thought-provoking, educational, professional, and emotional transformation triggers upheaval.

4.7. Cultural negotiations, pragmatic fluency, and dual lives

Professional and social spheres were shaped daily through culture beyond formal systems. Migrant nurses, for example, migrated from the Philippines and found themselves working within hierarchical systems to more egalitarian collaborative models. This is what has been termed as lived experience.[51] Nurses expressed surprise at the need to be professional and question authority, suggesting Hofstede's cultural dimensions of power distance describe this culture accurately.[52] Subtle cultural integration, such as humor, sarcasm, and nonverbal communication, brought about new challenges, inducing anxiety and emotional dissonance. A researcher coined the term "pragmatic fluency," the difficulty of interpreting beyond the given words and phrases.[53] Exclusion, stereotyping, and underemployment at the beginning of their careers were other extensive obstacles that several international nurses also faced, and systemic bias was also found to be reflected within the experiences of international nurses. Religious and spiritual contexts are places that add further complexity.[44] Filipino nurses working in Islamic cultures like Saudi Arabia needed to maneuver around gendered prayer times as well as modesty. On the other hand, secular participants from Finland or Germany reported a sense of being culturally dislocated and spiritually isolated.[13] Social support, whether in-person or virtual, was essential for mitigating loneliness and easing the adjustment process.[54]

4.8. Holistic adaptation and the future of integration

The bayanihan (communal unity) and pakikisama values nurtured social resilience of Filipino migrant nurses. These values allowed for enduring and thriving amidst systemic and emotional challenges.[55] The integration stage was more complex than simply a process of adaptation; it also involved the juxtaposition of cultural contexts without loss of form. A balance between adaptation and authenticity is critical. Incorporating Filipino nurses into the host healthcare systems requires considering their emotional and cultural dimensions. Employers and policymakers must shift from providing superficial technical support for language learning and credential recognition to creating responsive culture frameworks that underpin holistic wellbeing and professional growth. Spitzberg and Changnon[56] noted that intercultural competence is essential for communication and inclusion within diverse healthcare contexts for migrants. Increased cultural humility from host institutions, as well

as systemic acknowledgment and support of the distinct life pathways of migrant nurses, is needed as a matter of urgency.[57]

5. Conclusions

In summary, migrating Filipino nurses entails profound emotional, professional, and cultural shifts. Changes of this magnitude cannot be described as technical or linguistic adaptations. Instead, identity, belonging, and meaning shifts must underpin the change. If culturally competent strategies are developed and effective integration mechanisms are implemented, Filipino nurses can be utilized more effectively, contributing to enhanced health systems worldwide. The experiences of Filipino migrant nurses reflect a complex interplay of emotional, linguistic, educational, and cultural transitions. While their technical and caregiving competencies are often exceptional, these strengths are frequently obscured by systemic, linguistic, and cultural barriers in host countries. Despite this, they remain committed professionals, navigating adversities with grace and grit. These nurses adapt and reshape global healthcare landscapes with their values, skills, and cultural humility. However, their journeys highlight the pressing need for more inclusive systems that recognize foreign credentials, support language acquisition, and foster culturally competent work environments.

Practice implications

It is essential to understand the sociocultural transition pathways of Filipino migrant nurses to facilitate their effective integration into the workplace. Healthcare organizations must provide more comprehensive support through organizational mentorship programs, cultural training, language programs, and integration frameworks for better assimilation. This entails that catchment institutions in the host country should further their acculturation programs rather than just focusing on skills-based immersion. The Department of Migrant Workers (DMW), a government institution in the Philippines, should look beyond deployment to ensure the welfare and working conditions of nurses in the catchment facilities abroad. Appreciating and acknowledging the formal qualifications and practical experience of Filipino nurses can enhance their self-esteem, job satisfaction, and quality of care service delivery. The Philippine nursing education system was patterned after the US curriculum creating seamless integration of our nurses to practice in the United States after passing the NCLEX. However, this also becomes a barrier for other nurses being deployed in the other catchment countries because of the incongruencies in the Philippine Nursing curriculum, together with the Nursing Professional Boards (BON) and Nursing Organizations like the Philippine nurses association (PNA), which can look into making the curriculum a foundation-based approach to sync it to the basic core requirements in each receiving country. Strengthening team relations and professional alienation can be improved by developing anti-discrimination measures and promoting intercultural cooperation. Attention to emotional support frameworks is crucial for fostering psychosocial wellbeing, promoting holistic nursing self-care, career retention, sustainable engagement, and sustained active participation in transforming healthcare systems. Furthermore, nurses' welfare should be of the utmost priority. The possible reintegration to the Philippines, as well as the need for contingency plans in terms of managing finances, mental health, and professional development, are deemed necessary.

Ethical approval

This study was approved by the ethics committee of St. Paul University, Philippines (IRB approval number: ERC-SPUP_2025_00095_SR_GV). Additional ethical approvals were obtained from the respective institutions as required.

Conflicts of interest

There are no conflicts of interest.

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