Understanding the Integration of Foreign-Educated Cuban Physicians into the U.S. Medical Field

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UNDERSTANDING THE INTEGRATION OF FOREIGN-EDUCATED CUBAN PHYSICIANS INTO THE U.S. MEDICAL FIELD

By

Wendy Jordana Moore

A THESIS

Submitted to the Faculty
of the University of Miami
in partial fulfillment of the requirements for
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A thesis submitted in partial fulfillment of the requirements for the degree of Master of Science in Education

UNDERSTANDING THE INTEGRATION OF FOREIGN-EDUCATED CUBAN PHYSICIANS INTO THE U.S. MEDICAL FIELD

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In the U.S., immigrants and refugees are often unable to continue their profession after arrival. This paper describes a qualitative study of Cuban foreign-educated physicians (FEPs) who have attempted to integrate into the U.S. medical field. Semi-structured interviews were conducted with Cuban FEPs who varied in age, gender, job, marital status, and amount of time in U.S. Participants were recruited via snowball sampling and thematic analysis was utilized to identify various pathways. Findings describe the importance of professional identity and how it influences participants’ transcultural process as well as their journey to find a “match” within the U.S. medical field. This study affirms the value of thinking ecologically about the migration experience by considering the needs of immigrants and refugees within their family units rather than solely as individuals. Furthermore, findings posit that occupational wellbeing for Cuban FEPs goes beyond economic goals, identifying professional identity as a central phenomenon.
To my mom and all of the other hard working migrants doing their best to care for their families.
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# TABLES OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIST OF FIGURES</td>
<td>vi</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>vii</td>
</tr>
<tr>
<td>CHAPTER 1: INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Over-qualification and Under-employment among Immigrants</td>
<td>1</td>
</tr>
<tr>
<td>Cubans in Miami-Dade County</td>
<td>4</td>
</tr>
<tr>
<td>Social Support</td>
<td>7</td>
</tr>
<tr>
<td>CHAPTER 2: METHODOLOGY</td>
<td>14</td>
</tr>
<tr>
<td>Approach</td>
<td>14</td>
</tr>
<tr>
<td>Researcher Positionality</td>
<td>14</td>
</tr>
<tr>
<td>Conceptual Framework</td>
<td>16</td>
</tr>
<tr>
<td>Methods</td>
<td>21</td>
</tr>
<tr>
<td>Analysis</td>
<td>25</td>
</tr>
<tr>
<td>CHAPTER 3: RESULTS</td>
<td>28</td>
</tr>
<tr>
<td>Participant Experience in the Cuban Medical Context</td>
<td>28</td>
</tr>
<tr>
<td>Navigating a Pathway</td>
<td>31</td>
</tr>
<tr>
<td>Themes in the Process of Transitioning to the U.S. Medical Field</td>
<td>35</td>
</tr>
<tr>
<td>Results Summary</td>
<td>56</td>
</tr>
<tr>
<td>CHAPTER 4: DISCUSSION</td>
<td>57</td>
</tr>
<tr>
<td>Study Contributions</td>
<td>57</td>
</tr>
<tr>
<td>Strengths and Limitations</td>
<td>66</td>
</tr>
<tr>
<td>Implications for Future Research</td>
<td>67</td>
</tr>
<tr>
<td>Implications for Action</td>
<td>68</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>69</td>
</tr>
<tr>
<td>APPENDIX A</td>
<td>75</td>
</tr>
<tr>
<td>APPENDIX B</td>
<td>79</td>
</tr>
<tr>
<td>APPENDIX C</td>
<td>81</td>
</tr>
<tr>
<td>APPENDIX D</td>
<td>83</td>
</tr>
<tr>
<td>APPENDIX E</td>
<td>87</td>
</tr>
<tr>
<td>APPENDIX F</td>
<td>88</td>
</tr>
</tbody>
</table>
LIST OF FIGURES

Figure 1 Framework based on Bronfenbrenner's Ecological Model .................................. 17
Figure 2 Pathways for Cuban Physicians................................................................. 34
LIST OF TABLES

Table 1 Participant Demographics........................................................................................................24
CHAPTER 1: INTRODUCTION

“I know neurosurgeons who are working in warehouses or factories or as a gas attendant,” stated Julio César Alfonso, a Cuban medical school graduate who fled to Miami, Florida in the early 1990s (Ojito, 2009, p. 2). Currently, Alfonso works as a hospice admissions nurse as he was unable to pass the second exam required by all foreign-educated physicians (FEPs) before legally practicing medicine in the United States. Alfonso’s employment status is termed as occupational over-qualification or underemployment, a state where occupational status is lower than training; this may occur when immigrants and refugees transition into the labor force of a new country (Chen, Smith, & Mustard, 2010). Newly arrived immigrants and refugees to the U.S. often hold work positions far below their educational training, at times due to low English skills or poor fit between skills and the needs of the labor market (Vinokurov, Birman & Trickett, 2000). The present study focused on understanding the particular experience of Cuban FEPs transitioning into the U.S. healthcare system in Miami-Dade County.

Over-qualification and Under-employment among Immigrants

In the U.S. as well as in other immigrant receiving nations, immigrants and refugees are often unable to continue their previous profession after arrival. A longitudinal study in Canada found that 51.6 percent of most immigrants were over-qualified for their positions after four years after migration (Chen et al., 2010). In addition, job attainment varies depending on country of origin and ethnic stereotypes of some groups (e.g. Hispanics) being lower skilled than others. For example, in one study, when comparing potential employer responses to profiles of immigrants of the same age,
experience, and education, a theoretical Indian man had a 69 percent chance of obtaining a skilled job while a Mexican man had only a 24 percent likelihood (Mattoo, Neagu, & Ozden, 2008). This suggests that it may be particularly difficult for educated Hispanics and Latinos to transition into jobs requiring high skill levels due to negative underlying stereotypes and prejudice.

The consequences of unsuccessful transitions into the U.S. health care system for FEPs and other overqualified professionals can be significant. First, prior research suggests that immigrants who are over-qualified for their positions are also more likely to have poorer mental health (Chen et al., 2010; Vinokurov et al., 2000). Such difficulties with mental health and related issues are associated with loss of productivity and the human costs of adjustment difficulties are high.

More broadly, as the U.S is in dire need of more physicians, having a large number of FEPs as under-employed highly skilled immigrants is a lost opportunity for the country as a whole. An aging Baby Boomer generation has negative ramifications for both the demand and supply of physicians in the U.S. Greater numbers of medical professionals will be needed with the nation preparing for its largest elderly population ever, as well as a projected physician shortage by 2020 (Salsberg & Grover, 2006). About one third of physicians (250,000) will have reached retirement age by 2020, and physicians over the age of 65 will double by 2030 (Salsberg & Grover, 2006). In times such as these, medical associations and policy makers are considering measures needed to secure access to medical care—many are drawing upon history for guidance. During a previous physician shortage after World War II, the U.S. encouraged foreign-educated physicians to enter the country, and licensure was granted to graduates from 41 medical
schools, primarily located in Europe (Shuval, 1985). This approach demonstrated a preference for the credentials of European physicians over FEPs from other world regions. Today, once again, the U.S. acknowledges their need for more physicians, and FEPs provide one potential solution to this looming medical crisis.

In addition, Cuban FEP’s language skills and knowledge can benefit the increasingly diverse U.S. population. According to 2010 census data, there are 40 million foreign born individuals living in the United States—12.9 percent of the total population—with over 53 percent from Latin America. Approximately 460 languages are spoken in U. S. homes and 21 percent of children speak a language other than English at home (Kindler, 2002; U.S. Department of Education, 2010). Integration of highly skilled immigrants into the medical profession can be beneficial to the foreign born population as well as the nation as a whole.

Specifically, research suggests that FEPs can improve the health care delivery system for immigrants and refugees in the U.S. Minority populations tend to be less satisfied with their healthcare experience and use the country’s healthcare system sparingly, suggesting that the system primarily caters to the dominant population (Lin & Guan, 2002). Lin and Guan’s study (2002) found that Caucasian-Americans and Asian-Americans varied in their preferred attributes for physicians. Another study (Saha, Komaromy, Koepsell, & Bindma, 1999) found that African Americans and Hispanic Americans had a more positive experience when paired with physicians of their own ethnicity. Therefore, skills and language training was suggested as necessary (Lin & Guan, 2002); yet FEPs already have the cultural and language competency that could be used to provide culturally appropriate care to immigrant and refugee communities. This is
especially the case for older and recently arrived immigrants who are less likely to be acculturated to the dominant American culture (Berry, 1997) and have less knowledge about how to utilize mainstream medical services. For them, FEPs can help serve as culture brokers between the medical system and the needs of their immigrant patients. When understanding the context of Miami-Dade County, FEPs from Latin America can be especially beneficial to the overarching community, especially Cubans being the largest foreign born group.

**Cubans in Miami-Dade County**

**Why Cubans?**

This study explored how highly educated migrants transition into employment, in particular Cuban FEPs in Miami-Dade County. Besides being the largest Latin American group in Miami-Dade County, Cubans have a unique status and set of privileges in the U.S., such as their straightforward accessibility to permanent U.S. residency. At one point, Cubans were considered “model minorities and builders of the new Miami.” (Portes & Puhrmann, 2015, p. 2) However, divides within the community (which I will detail in a later section) limited social benefits for post-1980 arrivals who could greatly benefit the increasing diverse needs of the U.S. medical field.

In Miami-Dade County, Florida, FEPs from Cuba can be extremely helpful in addressing the healthcare needs of the population because of the large presence of Cubans and Cuban-Americans. Not only does Miami-Dade County have the second largest foreign-born population after Los Angeles County, California (“U.S. Population by State and County,” n.d.), it is also home to the overwhelming majority of Hispanics of Cuban origin in the U.S. (Rusin, Zong, & Batalova, 2015) According to the 2011 PEW
Cuban Profile, 70 percent of the two million Hispanics of Cuban origin/decent in the U.S. live in Florida. Hispanics of Cuban origin comprise only 3.6 percent of Latinos in the United States, but in Miami-Dade County, they are the most represented Latin American nation with a total of 856,007 residents (34.3 percent of the county’s population) (U.S. Census Bureau, 2010; Brown & Patten, 2013). Along with being the largest group of Hispanics in Miami-Dade County, Cubans also have privileges that have not been as widely available for migrants of other Latin American Nations.

**Unique Circumstances of the Cuban Community**

Cubans—especially those who arrived as exiles in the 1960s and 1970s—have been part of an elite class of minorities with levels of education and employment status comparable to or higher than the general U.S. population (Portes & Puhrmann, 2015). For humanitarian reasons and without quota limits or any other particular qualifications, Cubans received access to U.S. permanent residency (after a two-year wait period) in 1966 through the ratification of the Cuban Adjustment Act (CAA). This decreased to a one year wait period in 1976 (Portes & Puhrmann, 2015). Cubans also hold a near-automatic granting of asylum after arriving on U.S. shores, (Portes & Puhrmann, 2015) giving them access to refugee services. As a result of these privileges, focusing on Cubans also highlights challenges experienced by FEPs even when they do not face the additional legal barriers as is the case for foreign professional from other Latin American countries.

In addition to arguably having more resources than other groups from Latin America, Cubans have also gained substantial political power in South Florida by running for local office. “By the mid-1980s, the mayors of Miami, Hialeah, West Miami,
and several smaller municipalities in Miami-Dade County were Cuban born, and there were ten Cuban Americans in the state legislature” (Portes & Puhrmann, 2015, p. 42). Cuban-Americans have since held positions as federal congressional representatives and senators, and two candidates of Cuban decent ran for the 2016 U.S. presidency, although they both lost in the primary stages. Cubans are uniquely in positions of political power when considering Hispanics and Latinos in the U.S. at large.

However, political mobilization has primarily been done by the 1960s and 1970s exiles and their children, largely excluding those who arrived during or after the 1980s Mariel Exodus. Members of this particular wave of migration were harshly looked down upon by earlier arrivals, excluding them from previously established enclave benefits (Portes & Puhrmann, 2015). The earlier exiles saw Mariel and post-Mariel arrivals as different from themselves, more influenced by the revolution and communism (Portes & Puhrmann, 2015). Therefore, the “marielitos”, a derogatory term for post-Mariel-arrivals at the time, did not have the same access to jobs in Cuban firms or “character loans” (p. 43) which made economic mobility and career attainment more difficult for this later group of arrivals (Portes & Puhrmann, 2015). One can tangibly see the effects of the divide in social support by noting that income levels for post-Mariel Cubans are around half of the pre-Mariel arrivals and also lower than for African-Americans (Portes & Puhrmann, 2015). In addition, the children of pre-Mariel exiles do better in educational attainment and employment, and have lower incarceration rates (Portes & Puhrmann, 2015). An increasing majority of Cubans in Florida are now part of the post-Mariel subgroup—approximately 57% (PEW Research Center, 2006). Given that these migrants are not performing as well as their pre-Mariel counterparts; it is important to study their
experience in order to better understand how to best support their occupational integration into the U.S. medical field. Finally, with the “warming up” of diplomatic relations between the U.S. and Cuba through the Obama administration and the transition to the incoming Trump administration, it is unclear whether these noted advantages helped by Cubans will shift in the coming years.

Social Support

A key factor of occupational adjustment of Cuban FEPs in the U.S. medical field is social support. Social support in immigrant communities can be understood as an aspect of social capital. As defined by Bourdieu (1986), “social capital is the aggregate of the actual or potential resources which are linked to possession of a durable network of more than or less institutionalized relationships of mutual acquaintance and recognition…membership to a group” (p. 82). Massey, Alarcon, Durand, and Gonzalez (1987) were the first to connect this term to migrant communities. They found that Mexican peasants in the U.S. had little financial resources, but they were “rich” in social capital which could be used to find jobs (Massey at al., 1987). The literature now suggests that social capital has been useful in the entire process of migration, from initially reaching the U.S. to finding employment and housing opportunities (Espinosa & Massey, 1997; Singer & Massey, 1998; Aguilera, 2002; Espinosa 1997). The use of social ties makes the transition into the U.S. more feasible, especially when formal systems of support are lacking.

Formal and Informal Economies

Finding work for immigrants involves navigating formal and informal economies, which mainly differ by the level of regulation. The informal economy is “a process of
income-generation…unregulated by the institutions of society, in a legal and social environment in which similar activities are regulated” (Portes, Castells, & Benton, 1989, p. 12). Thus, informality is tied to the lack of regulation of the production of an item or service that would typically be regulated through the U.S.’s formal policies. By far, the greatest difference between the formal and informal economy is the manner in which commodities were produced and exchanged instead of the actual item. The lack of access to formal employment options with typical regulation can lead immigrants to turn towards the informal economy.

**Informal Economies and Support**

As the informal economy is unregulated and not necessarily legal, strong social networks and support are necessary to participate in the informal sector. Social capital aids immigrants in finding jobs in the informal economic sector, working “under the table” to bring in wages that are lower and are not accompanied by various benefits. In this way they often become active in the informal economy. For example, in a study of Mexican migrant workers, social capital (i.e. interpersonal migrant networks) was found to influence the process of obtaining work positions and whether those positions were part of the formal or informal sector; social capital also had an effect on wage earnings (Aguilera & Massey, 2003). While it is difficult to keep reliable records of informal economic activity (IEA) since the essence of IEA is to avoid regulation (Marcelli, Pastor, & Joassar, 1999), most agree that in industrialized countries as the U.S., the IEA is primarily comprised of immigrants.

A study of informal economic activity in Los Angeles provides interesting data on the occupational adjustment of immigrants. Similar to Miami, L.A. has a large immigrant
population, which provides a prominent supply of potential informal workers (Marcelli, Pastor, & Joassar, 1999). A study that estimated the level of informal activity in L.A. County found that even though the majority of immigrants engaged in the informal economy were typically employed in less desirable jobs (e.g. farm work, construction, cleaning, etc.), there was a significant number engaged in occupations that one may not typically associate with informal labor, such as sales supervisors, financial record keepers, or engineers (Marcelli, Pastor, & Joassar, 1999). There were also informal laborers in the medical industry. Eleven percent of workers within health/personal service were informal: 5.18 percent were health technicians, 1.97 percent engaged in health assessment and treatment, and 0.84 percent in health diagnostics (Marcelli, Pastor, & Joassar, 1999).

While on one hand informal economic activity is less desirable than participation in the formal sector; on the other hand, it does offer employment opportunities for immigrants who may otherwise be unable to find employment. Marcelli, Pastor, and Joassar, (1999) study suggests that many immigrants working in the informal economy may have jobs that are relatively desirable, leading some typically formalized occupations in immigrant communities to turn towards the informal economy. Since, by definition, the informal economic sector is not institutionalized in mainstream educational and job placement systems, immigrants who obtain these positions do so through informal social networks generally comprised of other immigrants. The immigrant community in Miami attests to the importance of informal networks and social support when attempting to find employment after migration. As mentioned previously, by the 1980s Cubans had established an enclave economy in South
Florida allowing for informal relationships as a vehicle to access formalized labor (Portes & Stepick, 1985). With the growth of Cuban-American businesses, educational institutions, and organizations, ethnic networks became an effective way to access these newly formed formal structures and the job opportunities that they provided. As a result, after the Mariel Exodus in 1980, Cubans in Miami had greater access to formal labor. Other immigrants, such as Haitians, who migrated in large numbers to Miami in the 1980s, resorted more commonly to the informal labor markets because they lacked an enclave option (Portes & Stepick, 1985). Social capital provided by the established ethnic economy gave Cubans access to employment opportunities (Portes & Puhrmann, 2015). While we can assume that informal social networks may assist Cuban FEPs in integrating into the U.S. medical system, there are no studies in the literature that address this specific question.

**Formal Economy and Support**

A government’s policies in relation to immigrants in resettlement seem to also play a crucial role in the formal support of the employment process. For example, the Israeli government supports the integration of Soviet Jews through their “open door policy,” which admits all Jewish immigrants. Because Israel views Jewish immigrants as “returning” to their homeland, they are granted Israeli citizenship upon arrival and the state takes responsibility for integrating them both economically and socially (Shuval, 1985). For FEPs specifically, the Israeli government provided formal resources to facilitate their transition: six months of Hebrew language preparatory courses, two months of Hebrew medical vocabulary training, and a five month course to help them prepare for the medical licensure exam (Shuval & Bernstein, 1996). While enrolled in
these courses, FEPs were also given financial assistance so they could concentrate on their studies. As a result, Israel was very successful in integrating Soviet physicians during the 1980s, despite already having the highest doctor to population ratio in the world (1:351) (Shuval, 1985). Nine months after arrival, 90 percent of the FEPs were licensed (Shuval, 1985). Three years after arrival, all FEPs were practicing medicine (Shuval, 1985).

Even when formal systems of support are in place, as in a country like Israel, integration is not fully understood without the broader ecological and cultural factors that may create barriers to integration. For example, In Israel there was a cultural assumption that Soviet physicians were of a lesser status (Shuval, 1985). Out of the Soviet FEPs in Israel, only 33 percent were practicing their specialties—likely because of negative stereotypes associated with Soviet physicians (Shuval, 1985). Another barrier was differences in the medical systems; some specialties such as public health and infectious diseases were not considered specialties in Israel (Shuval, 1985).

Even with extensive formal supports, not all former Soviet FEPs were able to become physicians in Israel when Soviet FEPs started to come in larger numbers. Between 1989 and 1994, 500,000 Jewish people from the Former Soviet Union migrated to Israel. Of those, 12,000 were physicians, doubling the total Israeli population of physicians at the time (Shuval & Bernstein, 1996). This large influx resulted in an oversaturation of Soviet physicians and new policies made recertification more stringent (Shuval, 1998). Of those 12,000 physicians, there was only the opportunity for 2,000 to be employed as physicians, and many eventually switched to other related professions, such as physical therapy (Shuval & Bernstein, 1996; Remennick & Shakhar, 2003). This
represents an alternative career path for FEPs—finding occupations in the medical field that are less prestigious but have less stringent licensing requirements (such as in physical therapy, nursing, medical laboratory work, or related professions). While some of these occupations involve less complex paths to licensure and employment in the formal economy, others may exist within the informal economy—such as health aids hired privately by families, or other similar occupations. These alternative paths tend to be less desirable for FEPs and are associated with less prestige within the medical care industry.

It is alarming that in the U.S., most immigrant physicians are currently found in low-wage jobs and have few opportunities to continue to work in healthcare (Flowers & Olenick 2014). As a result, several cities have created programs to help FEPs reengage into the medical profession. Florida International University (Miami, FL) gives FEPs the opportunity to practice in the medical profession as a nurse practitioner through an accelerated three-year program called the “Physician Retraining Education Program” (Flowers & Olenick, 2014). This program does not recruit from other nations, but from immigrants who are currently in U.S. Programs such as these provide opportunities for FEPs to continue to work in the medical industry, but as a nurse rather than a physician. One reason for the lack of transition programs into occupations as physicians may be a result of the limited number of residency positions each year (Flowers & Olenick, 2014). In sum, even though there is a need, little government initiatives provide support for FEPs to practice medicine.

I began this chapter with a quote from Alfonso, a foreign medical school graduate. Similar to Alfonso, there are countless immigrants with professional degrees that are denied the opportunity to integrate into their former profession. The literature
reviewed above suggests particular challenges for foreign educated professionals more
generally, and physicians specifically; as well as the benefits of specialized programs
designed to aid in their integration into the medical field, as was done in Israel. However,
little is known about this process for physicians within a community and local economy
characterized by a large concentration of other migrants from the same country. Further,
while the immigrant and Latino populations in the U.S. is increasing, there is little
literature that assesses Latinos’ attempts to integrate into their previously held profession
once they arrive in the country; and there was no literature on Cuban physicians
specifically. Therefore, the purpose of this study was to describe the process by which
Cuban FEPs integrate into the U.S. medical field. The study creates an initial
understanding of the pathways of Cuban FEPs to occupational integration. This
understanding can help inform possible solutions to address the limitations of the current
structures.
CHAPTER 2: METHODOLOGY

Approach

Because little research exists on this topic, this study took an exploratory qualitative approach to understand a range of experience of Cuban FEPs’ integration into the U.S. medical field, identifying barriers and facilitators that they encounter throughout their pathway. Without prior research on the topic, it would have been premature to formulate hypotheses. At the same time, qualitative researchers acknowledge that they approach the research process with a particular perspective that shapes the study and its findings. In order to describe my position with respect to this research, I describe the conceptual framework that shapes my approach to the subject of the study. This framework does not specify a theory of integration of FEPs, but identifies issues and concepts that are important in understanding the phenomenon.

Researcher Positionality

Community psychologists have traditionally valued describing their own position rather than assuming that we can be neutral participants in research (Stein & Mankowski, 2004). As a fellow Cuban migrant, I am particularly interested in this topic because I observed the difficulties in my own family when starting over in a new country. Even though I think it is also important to understand the process of other Latin American migrants in general, I think it is valuable for me to start with focusing on a community that I understand the best and that I have the most access to so that I could generate valid data.
I was interested in developing this study to describe the experience of Cuban arrivals because of my own experience of resettling in the U.S. I thought about my mother’s experience of having to work odd hours and earn a minimum wage because those were the best work opportunities available to her. She tried to find work in her profession as an aviation mechanic, having worked with the electrical pieces of planes in Cuba. However, in the U.S. she was told that because she was trained in Russian technology she would need to do all of her schooling over again. Because she financially supported me on her own, going back to pursue a U.S. based degree was not feasible for her when balancing working and caring for me. My grandmother and great grandmother took care of me while she worked until late at night. I remember often wondering as a child and later in my adolescence how much better her life would have been if she could have continued her profession in the U.S. As a result, I wanted to play a role in sharing the stories of other Cubans that had similar experiences.

In addition, my relationship with my sister affected my understanding of the Cuban medical field. My migration to the U.S. only included my mother and I, so as for my half-sister (on my father’s side), neither she nor our father was able to join us. She remained in Cuba and eventually became a physician. I know how much she loves her profession, but I’m also aware of its sacrificial nature. Since wages are fairly low, she works an additional job, when able, to provide extra income for her family. Understanding her context and devotion to her profession influenced my desire to hear specifically about the experiences of other FEPs from Cuba.

I believe that my status as a member of the Cuban community was helpful in carrying out this study. It not only offered me access to community members who trusted
me enough to share their stories in the first place, but it also helped me understand their cultural context. However, as someone who was born in Cuba, but resettled in the U.S. at a young age, I know that there are some limitations to my understanding of the experiences of Cubans who resettled as adults. Unlike my participants, most of my upbringing and education took place in the U.S. even though it was within a predominantly Cuban community in Miami. In this way, I am a partial insider for my participants, at the intersection of being an insider to the Cuban community in Miami, and an outsider; having grown up within the American culture since early childhood (Haarlammert, Birman, Oberoi & Moore, under review). My participants thought of me as more Americanized than they were. One participant even complimented me on how well I still spoke Spanish. Youth who grow up between two cultures develop skills to live and interact with both in order to adapt well in terms of language and relationships (Szapocznik, Kurtines, & Fernandez, 1980). Latino youth who grow up acculturated to both cultures can serve as a bridge between the American culture and the culture of their families (Birman, 1998). I believe that the “bridging” role I played as a partial insider in understanding both their background and their new context in the U.S. helped me describe the range of their experiences. At the same time, I am certain that my American lens has skewed my understanding of Cuban culture when interpreting their overall experiences.

**Conceptual Framework**

The conceptual framework I used in this study is based upon Bronfenbrenner’s Ecological Model (Figure 1). From the perspective of this model, understanding human development involves the interaction between the individual and their larger conceptual
social contexts (Bronfenbrenner, 1977), both formal and informal. The focus on the environment as well as on the individuals helps identify characteristics of institutions, communities, and societies that influence the ways individuals navigate important aspects of their lives, such as employment. I conceptualize the experience of Cuban physicians as occurring within and influenced by the micro, meso, exo, and macrosystems described by Bronfenbrenner.

![Diagram of Bronfenbrenner's Ecological Model](image)

*Figure 1 Framework based on Bronfenbrenner's Ecological Model*

The range of experiences and integration processes of Cuban FEPs are impacted by the overlapping systems as described in Bronfenbrenner’s model. FEP’s individual characteristics (educational background, English language skills, interests, age, gender, length of time in the U.S.) vary and interact with aspects of the nested systems. Age may play a large role in a FEP’s ability to learn English if language training is necessary, as older immigrants often have a more difficult time learning a new language (Birman &
Trickett, 2001). Language skills play a crucial role in passing the U.S. Medical Licensing Examination (USMLE), the initial step in acquiring a residency in order to practice. Increased amount of time in the U.S. may provide stronger connections to resources and greater opportunities for reintegration or may result in a greater detachment from the field.

The microsystem level refers to the immediate environment where individuals participate directly (Bronfenbrenner, 1977), such as family, friends, workplace, school, religious community, and community organizations. These microsystems play a role, particularly with respect to social support. Community organizations may play a crucial role in finding work or resources to assist in the reintegration process. The presence or absence of family in the U.S. plays a pivotal role in an individual’s level of social support. Friends and religious community may also complement an individual’s level of support. The school environment may have a culture of collective learning and assistance or individualized training. The lack of social support may make finding employment and other resources for new immigrants much more difficult. Overall, social support is dynamic and in some instances it can facilitate integration, while in others, lack of social support may hinder it.

The mesosystem describes the relationships between components of the microsystem (Bronfenbrenner, 1977) that influence the individual even if they do not participate in them directly. These networks of linkages can make it easier for newly arriving immigrants to access educational resources and employment opportunities. For example, an extended family may have a high level of social capital through its extensive network, creating possible connections to employment for newly arrived immigrants or
refugees even if they don’t know the employers directly. In addition, a religious institution working alongside a university may be attempting to increase resources or services for immigrants or refugees within their particular community regardless of whether they participate in it. Networks of ethnic community members create a net of resources that may be helpful to community members indirectly, even though individuals may not encounter particular individuals or institutions directly.

The exosystem depicts larger governmental policies and the interconnection between settings and social structures (Bronfenbrenner, 1977), such as immigration policy, certification policy, and the medical industry. As mentioned previously, immigration status typically serves as a facilitator for Cubans in comparison to other Latinos. The Cuban Adjustment Act (CAA) of 1966, created access to U.S. permanent residency to any Cuban native or citizen that has been present in the United States for over a year, regardless of their form of arrival. On the other hand, the Health Professions Educational Assistance Act of 1976, was the initial barrier for Cuban or other FEPs to practice medicine in the U.S. Visa and testing requirements were mandated along with evidence of 2 years of U.S. residency, passing the two steps of the U.S. Physician Medical Licensing Examination, and obtaining a medical residency program (Flowers & Olenick, 2014). This policy within the medical industry places an additional barrier since few FEPs obtain a residency position after passing the exams (Flowers & Olenick 2014).

The macrosystem refers to cultural values and social norms of the entire cultural/societal system (Bronfenbrenner, 1977). For immigrants, two macrosystems are relevant to their experience, the culture of their country of origin, as well as the culture of the country of resettlement (Birman, 2011). Predominant aspects of culture influencing
FEPs in the U.S. are xenophobia and racism, and the role they play as barriers for FEPs to practice medicine. They may partially be the reason why medical licensing exams are only offered in English (at the exosystem level of analysis) and why the recertification process has caused most FEPs to turn towards other lines of work. With respect to the culture of origin, Cuban cultural norms tied to gender roles may also play a role as reflected within the microsystem of the family--one gender may be given priority over the other when pursuing career aspirations after migration. In addition, unlike physicians in the United States, Cuban FEPs were raised in a historically collectivist culture, which influences their perspective on the medical field as a service occupation with financial gain being secondary. The medical field in the U.S., however, is heavily influenced by the culture of individualism and individual gain that prioritizes self-help rather than formal support, especially towards immigrants. These cultural differences create conflict for immigrants who must balance different priorities.

**Research Question**

Guided by this conceptual framework, the primary question asked by the study was “What is the range of experience of Cuban FEPs’ integration into the U.S. medical field?” Specifically, the study sought to understand barriers and facilitators that they encountered throughout their pathway, such as the formal and informal structures that facilitate Cuban FEPs’ processes of integrating into the U.S. medical field, and the support systems in place for Cuban FEPs in Miami-Dade County. Learning about their experience from the perspective of FEPs themselves was also an important aim of the study.
Methods

Sampling and Data Collection

As this is an exploratory study, I interviewed ten participants who studied medicine in Cuba and live in South Florida to give an initial understanding of the process from both individuals who had successfully integrated into the medical field and individuals who were recent arrivals. This sample size recommended by Miles and Huberman (1994) to enable me to collect rich data and engage in extensive analyses.

I used maximum variation (Miles & Huberman, 1994) sampling approach to document the broad range of experiences among Cuban FEPs and the various pathways taken in attempting to integrate into the U.S. medical field. I began the study by recruiting via convenience and snowball means through familial and personal connections (Miles & Huberman, 1994). Recruitment materials can be found in Appendix E. Following the initial interviews, I focused on recruiting FEPs for maximum variation to capture a range of experience with respect to age, gender, job, and amount of time in U.S. For example, I initially interviewed primarily men, so I recruited women as well.

In order to better understand the process of integrating into the U.S. medical field, I conducted semi-structured interviews using an interview guide (Appendix D) to capture the range of experience systematically while still engaging in a conversation (Patton, 1989). The interviews lasted between 20 minutes to 45 minutes and were all conducted in Spanish. In addition, I administered a brief demographic survey before the interview in order to begin the interview with an initial understanding of each FEP’s process (Appendix C). In order to map the process of integration into the medical field, I then asked the participants to walk me through their experience chronologically. I started with
their expectations prior to leaving Cuba, proceeding to their initial experiences upon arrival, and then subsequent steps to becoming physicians or their current form of employment in the U.S. To ensure that the participants were comfortable with the conversation and open to sharing their experience, the interview was structured as a guided conversation (Charmaz, 2014), letting the participant take the lead in shaping the direction of the interview, while I also probed for issues identified in the literature review above; specifically, for barriers and possible formal and informal facilitators in their process.

With participants’ consent, interviews were voice recorded and then later transcribed and analyzed in its original Spanish. Interview recordings and transcriptions were kept in Box, a hyper-secure online storage drive protected by the University of Miami. To ensure confidentiality, identifying information, such as participants’ names, were removed from transcripts, and participants were identified with numbers, and later given pseudonyms for the purposes of writing this paper. Files were password protected and materials that had to include identifying information (such as contact lists) were kept in a locked cabinet when not in use.

**Study Participants**

Table 1 summarizes participant characteristics, using pseudonyms. Out of the ten study participants, six identified as male and four as female ranging in age from 24 to 59 ($M=42.8$); and from 22 to 51 ($M=33.6$) at the time of arrival. Eight of the ten were married upon arrival and five had children. They varied in the amount of time they practiced medicine in Cuba ranging from one participant that completed his fourth year of medical school (out of six) when he left Cuba to another who had 27 years of
experience in Cuban medical practice ($M=9.3$). Specialties in Cuba varied. Five of the participants were family physicians, with one of the five focusing on adolescent medicine. The remaining four participants focused on one of the following: pediatrics, psychiatry, pathological anatomy, and ophthalmology.

Their time in the U.S. ranged from less than a year to 23 years ($M=9.2$) meaning that all of the participants arrived after the 1980 Mariel exodus (the aforementioned dichotomy described between the pre and post groups of arrival is on p. 5). Participants also ranged in their stage in the process and current jobs. Five of the ten were no longer working towards a professional goal, as they found their best possible fit within the U.S. medical field. Two of them were currently practicing medicine as physicians, one worked as a nurse practitioner, one as a professor for medical assistants at a local college, and the fifth as an office manager for an elderly care facility. The other half had been in the U.S. for a shorter period of time and were weighing their options in order to determine the best route to pursue (see Table 1 for a breakdown of all participants).
Table 1 Participant Demographics

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Sex</th>
<th>Current Age</th>
<th>Years in the USA</th>
<th>Age of Entry</th>
<th>Children Upon Arrival</th>
<th>Married Upon Arrival</th>
<th>Years as Physician in Cuba</th>
<th>Specialty/Focus in Cuba</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adrian</td>
<td>M</td>
<td>42</td>
<td>16</td>
<td>26</td>
<td>No</td>
<td>Yes</td>
<td>2</td>
<td>Family Medicine</td>
<td>Physician in Internal Medicine</td>
</tr>
<tr>
<td>Alison</td>
<td>F</td>
<td>27</td>
<td>0.83</td>
<td>26</td>
<td>No</td>
<td>Yes</td>
<td>2</td>
<td>Pediatrics</td>
<td>Medical Assistant/Studying English</td>
</tr>
<tr>
<td>Angela</td>
<td>F</td>
<td>42</td>
<td>12</td>
<td>29</td>
<td>Yes</td>
<td>Yes</td>
<td>6</td>
<td>Family Medicine</td>
<td>Nurse Practitioner in Family Medicine</td>
</tr>
<tr>
<td>Eduardo</td>
<td>M</td>
<td>59</td>
<td>18</td>
<td>41</td>
<td>Yes</td>
<td>Yes</td>
<td>15</td>
<td>Psychiatry/Professor</td>
<td>Medical Assistant Professor</td>
</tr>
<tr>
<td>Erica</td>
<td>F</td>
<td>40</td>
<td>2</td>
<td>38</td>
<td>Yes</td>
<td>Yes</td>
<td>10</td>
<td>Family Medicine</td>
<td>Job as medical assistant/deciding on program of study to also pursue</td>
</tr>
<tr>
<td>Ivan</td>
<td>M</td>
<td>43</td>
<td>6</td>
<td>37</td>
<td>No</td>
<td>No</td>
<td>12</td>
<td>Ophthalmology/Medical Missions</td>
<td>Medical Assistant/Applying for U.S. residency programs</td>
</tr>
<tr>
<td>Marta</td>
<td>F</td>
<td>47</td>
<td>9</td>
<td>38</td>
<td>Yes</td>
<td>Yes</td>
<td>15</td>
<td>Family Medicine—Communications &amp; Teen Gynecology/Professor</td>
<td>Office case manager at elderly care facility</td>
</tr>
<tr>
<td>Rafael Jr.</td>
<td>M</td>
<td>24</td>
<td>2.5</td>
<td>22</td>
<td>No</td>
<td>No</td>
<td>Medical Student</td>
<td>Finished 4th year/6 of medical school</td>
<td>Working in Home Repair/Studying English</td>
</tr>
<tr>
<td>Rafael Sr.</td>
<td>M</td>
<td>53</td>
<td>2.5</td>
<td>51</td>
<td>Yes</td>
<td>Yes</td>
<td>27</td>
<td>Pathological Anatomy</td>
<td>Working in food service but has also worked as Medical Assistant</td>
</tr>
<tr>
<td>Roberto</td>
<td>M</td>
<td>51</td>
<td>23</td>
<td>28</td>
<td>No</td>
<td>Yes</td>
<td>4</td>
<td>Family Medicine</td>
<td>Physician in Family Medicine</td>
</tr>
</tbody>
</table>
Analysis

Thematic analysis was used to identify patterns and answer the overall research question (Braun & Clarke, 2006), which is to understand the range of experience of Cuban FEPs’ integration into the U.S. medical field. As there is little literature depicting the process of FEP’s integration into the United States medical field, especially from the perspective of Latinos, I sought to generate a rich description of the data (Braun & Clarke, 2006) on the integration process. Braun and Clarke (2006) suggested that inductive thematic analysis, much like grounded theory, does not aim to fit the data into the researcher’s preconceived coding frame; in addition, they view the researcher as an active piece of the research process and should be aware of their own personal bias. Thus the focus was to map the resources and barriers from the participants’ perspective.

Thematic analysis is completed through a series of six phases (Braun & Clarke, 2006). Phase one was the initial process of familiarizing myself with the data. This was done through transcribing each interview, as well as re-reading interviews and taking notes. During phase two I generated the initial codes across the entire data set and then organized the codes into groups. During phase three, the codes were condensed into themes, one overarching theme, and sub-themes. In phase four I comprehensively reviewed the themes. Braun and Clarke (2006) suggest dividing this phase into two levels. Level one is to review the coded data extracted in order to verify the existence of a consistent pattern. Lack of consistency resulted in the termination of a theme or creating a new theme. In level two of this phase, themes were assessed in relation to the entire data set in order to generate a “thematic map” (Braun & Clarke, 2006, p. 91). Phase five consisted of clearly naming and describing each theme and any possible sub-themes.
Phase six, the final phase, consisted of producing a report which is the results section. The results section presents a case in connection with the research question instead of simply describing the data. It includes data extracts as quotes that support the existence of each theme and illustrates the process and range of experiences of the Cuban FEPs. The generation of themes was done in collaboration with the research team, to enrich the development of the emerging themes.

**Data Quality**

In assessing the trustworthiness of data, Guba (1981) proposed measures that align more ideally with qualitative research instead of the previously used measures typically used in quantitative research: credibility, transferability, dependability, and conformability (Shenton, 2004).

**Credibility.** The criterion for credibility is giving confidence in the “truth” and accurate picture of the findings (Shenton, 2004). As a member of the Cuban community, I was reasonably sure that my participants trusted me. I spoke their language and conducted the entire coding process in the original Spanish. In addition, all of my quotes are presented in both the original Spanish and English that I translated myself to convey a similar tone and patterns of speech to most accurately depict the experiences of my participants.

**Transferability.** The criterion for transferability involves providing detailed account of the context in order to relate the findings to other contexts (Shenton, 2004). In Table 1 (p. 24) I present participant demographics and detailed information on the participant’s characteristics: gender, current age, years in the U.S. age of entry, if they had children or were married upon arrival, the years they were physicians in Cuba, and their current
status in the medical field. To describe the context of the study I described the Cuban community in Miami Dade County on p. 4.

**Dependability.** Guba (1981) described the criterion of dependability as accounting for “trackable variance—variance that can be ascribed to sources: so much for error, so much for reality shifts, so much for increased instrumental proficiency (better insights), and so on…” (p. 81). I conducted code checking when developing my coding scheme with another research team member, also a native Spanish speaker of Cuban descent, using my code list (Appendix F). She independently coded one of my transcriptions and then we cross referenced it with how I had coded it. We initially disagreed on the use of three codes: transculturation, gain, and med field connection (3/18 codes that appeared at least once). After discussing our understandings of each code’s definitions, we were able to come to full agreement and further expand the descriptions of the codes. I also cross referenced my findings with some of the literature on occupational identity and systems of social support among immigration populations (Rath & Harter, 2010; Massey, 1990).

**Confirmability.** The criterion for confirmability involves how researchers take steps to demonstrate that findings emerged from the data and consider researcher’s reflexivity when conducting this research (Shenton, 2004). Community psychologists have traditionally valued describing their own position rather than assuming that we can be neutral participants in research (Stein & Mankowski, 2004). Since my interpretations of the data were based on my membership in the Cuban refugee community, I acknowledge my position with respect to the text as mentioned in my approach for the study.
CHAPTER 3: RESULTS

The following section will cover the description of the participant’s narratives. In order to better understand their process, I’ll start by discussing the Cuban medical field and how it differs from the U.S, followed by the participant’s commentary on their experience within the medical system and their process of leaving. Next, I will cover the various pathways that participants took in order to integrate into the U.S. Medical field. Lastly, I will describe the overarching theme of identity and how that fueled each participants’ navigation of their respective pathways, as well as the sub-themes.

Participant Experience in the Cuban Medical Context

Before delving deeper into the participants’ process and pathways, I illustrate the dynamics of the Cuban medical field with respect to my sample. According to Huish (2009), Cuban medical education disapproves of citizens becoming physicians to increase upward mobility because they believe the emphasis on earnings takes away the focus of improving public health for vulnerable communities. As a result, it is no surprise that physicians trained by the Cuban healthcare system are not focused on the monetary benefits.

Cuba is a leading country in sending medical care or “medical missions” to parts of the global south (Central and South America, Africa, and most recently, Oceana)—sending more medical personnel than all the G8 countries combined (Canada, France, Germany, Italy, Japan, Russia, the United Kingdom and the U.S. (Huish & Kirk, 2007). One of the participants, Ivan, an ophthalmologist, conducted eye surgeries in Guatemala, Honduras, Venezuela, and Colombia on medical missions. Medical diplomacy is Cuba’s
primary strategy to garnish international influence and prestige, even exchanging doctors and medical care for Venezuela’s oil (Feinsilver, 2008).

The Cuban government discourages physicians from migrating north to the U.S. Cuba extends these aforementioned ideals at home and in its medical school in Latin America (ELAM – Escuela Latinoamericana de Medicina) (Huish, 2009). Participants described a typical wait of four to five years to obtain permission from the Ministry of Public Health to leave the country. To avoid the wait, some medical students leave school before starting their fifth year, which is when the need for permission begins. Leaving medical school can take a toll, as it did for Rafael Jr:

Entonces este...tuve que...como ya iba...como ya iba ir hacia mi quinto año de la carrera tuve que parar en ese momento...estuve como 8 meses fuera de la...fuera de la carrera esperando a llegar a...a que me llegara la fecha para venir acá a este país y....y nada. Si...este...fue difícil...fue difícil este...lidiar con esas...con esas...e...requisitos que ellos ponían. Con esas trabas que ellos ponían. Entender que uno tenía que pagarle algo que ellos supuestamente ellos decían que era gratis.

Entonces...nada...tuve que...tuve que lidiar con esos problemas al salir. Y creo que unos de los momentos más tristes de mi vida fue cuando tuve que escribir en una hoja con mi puño y con mi letra que la...la decisión de dejar la escuela de medicina...la renuncia a la escuela de medicina. Creo esos han sido unos de los momentos más difíciles porque cuando tú quieres una cosa, cuando tú amas una cosa—lo amas hasta el final. (Rafael Jr.)

So um...I had to...how I was going...how I was going to my 5th year of my career I had to stop in that moment. I had 8 months out of the...out of the career waiting to arrive...so...so that my date would arrive so that I could come here to this country and...and...nothing. Yes...um...was difficult...it was difficult this...dealing with that...with those...um...prerequisites that they placed. With those traps that they placed. To understand that one needed to pay something that they supposedly said was free. So... nothing...I had to...I had to deal with those problems when leaving. And I think that one of the saddest moments of my life was when I had to come forth and sign it with my own hand the decision to leave medical school...quitting medical school...think that has been one of the most difficult moments because when you like something, when you love something—you love it until the end. (Rafael Jr.)
In terms of the healthcare system, Cuba made initial moves towards implementing universal health care when updating the constitution in 1976 to state that everyone has the right to health care (Article 50). Currently, Cuba assumes fiscal and administrative responsibility for the health care of all its citizens and operates a national health system (Morales Suarez, Fernandez Sacasas, & Duran Garcia, 2008). There are no private hospitals or clinics, as all health services are government-run (Morales Suarez, Fernandez Sacasas, & Duran Garcia, 2008). There is a strong focus on primary care, thus family physicians are an integral part of the model.

Differences in training create barriers for Cuban physicians as they transition into the medical field in the U.S. Unlike the U.S., medical education in Cuba is overseen by the Ministry of Public Health and fully subsidized by the government (Morales Suarez, Fernandez Sacasas, & Duran Garcia, 2008). Similar to many other countries worldwide, medical school training is six years instead of four (Morales Suarez, Fernandez Sacasas, & Duran Garcia, 2008). Students typically enter at age 17 or 18, matriculating from what the U.S. considers high school (called pre-university in Cuba) and forgoing the concept of the undergraduate degree as a pre-requisite to medical school.

After the initial six years, students graduate and obtain the title “Basic General Doctor.” Doctors can later pursue a residency in comprehensive general medicine (family medicine) and/or opt for a second specialty (Morales Suarez, Fernandez Sacasas, & Duran Garcia, 2008). The Ministry of Public Heath then places teams of family physicians and nurses in neighborhoods to serve the basic needs of a geographic area through community polyclinics (Morales Suarez, Fernandez Sacasas, & Duran Garcia, 2008). Family physicians are also placed in a wide array of settings: factories, schools,
aboard ships, and where ever else the government sees fit (Morales Suarez, Fernandez Sacasas, & Duran Garcia, 2008). Ivan, one of the study participants, served in a prison as a family physician before obtaining his specialty in ophthalmology. He chose that setting because it gave him the opportunity to serve in the city instead of in a rural community.

The participants’ experience in the U.S. is influenced by their training in the Cuban medical field which largely differs from the U.S. (Cuba having a greater emphasis on public health, primary care, and the humanitarian components of being a physician). There are, undoubtedly, many criticisms of the Cuban healthcare system: the low wages of Cuban doctors, the country’s poverty level, and its lack of resources, etc. However, for this study, it’s more important to understand the context of their medical education and the way it shapes the professional and their identity as a whole.

Navigating a Pathway

Prior to presenting the themes identified through my analysis of the participant interviews, I will first describe the various pathways taken by the participants as they attempt to integrate into the U.S. Medical field. The process is not linear, steps, goals, and outcomes vary with every participant, and options that may have been available for one participant may not be for others.

In general, there were three potential paths identified among participants: to pursue employment outside the medical field; to pursue becoming a physician; or to pursue employment in the medical field, but not as a physician. Figure two is a summary of my participants’ process. I will be referencing this figure throughout this section. The first three circles were part of the process for all participants: training in Cuba, arrival in the U.S, and negotiating with family members about how to pursue their employment and
career options. Once the participants reached the fourth circle, “choosing a pathway”, there were three immediate options: pursue a job outside of the medical field (represented by a blue heart), go through the legal process of translating and confirming Cuban medical degree (circle A), or go straight to pursuing a medically-related certificate or degree at a local college or university (circle C). The latter could be a possible end point or a stop on the way to recertification. Circle A allows participants to later apply to residency programs after taking the USMLE exams, a necessary step for FEPs who want to be recertified in the U.S. (circles D and E) since this process creates a legal document in English showing that they have a medical degree from Cuba. In addition, the translation and confirmation of the Cuban medical degree (circle A) provides the opportunity for FEPs to obtain some technical certifications (circle B) such as medical assistant, phlebotomy, and so on that are available to FEPs because they require basic medical skills that any well-trained physician possesses.

Reaching circle B and obtaining a medical assistant certification was a very popular option among participants since it provides the opportunity to work within the U.S. medical field and it has no language requirement. However, some participants found that only having those technical certificates makes job attainment and job security difficult unless they had a personal contact with whom they could work. Working with one of these technical licensures is a possible end point, but some also moved on to pursuing a medically-related course or degree at a local college or university such as a nursing degree (circle C), which requires at least basic English language competencies. The financial cost for this option varies depending on the type of program. One participant, Angela, described that pursuing a nursing degree at a local university gave
her more work opportunities. Circle C is another possible end point—as it was for
Angela—but some participants, such as Adrian, moved on to study for the licensing
exams after completing a one-year sonogram course.

Lastly, those that pursued becoming a physician took the U.S. medical licensing
exams (USMLE), which as mentioned previously, is a requirement before applying to
U.S. residency programs (circles D and F). Steps one and two are taken before applying
to residency programs, and the cost of taking them is higher for graduates of medical
schools outside the U.S. and Canada. For example, Step 1 costs $600 for U.S./Canada,
while it costs $880 other FEPs. Step 2 Clinical Knowledge costs $600 U.S./Canada and
$880 for other FEPs, and Step 2 Clinical Skills costs $1,275 U.S./Canada and $1,535 for
other FEPs (“USMLE Examination Fees,” n.d.; “Fees and Payment,” n.d.). These exams
are all taken in English. Step 1 and Step 2 Clinical Knowledge are written exams that can
be taken in several countries outside of the U.S. and Canada for an additional fee, but
they are not available in Cuba—likely because of the closed relations between the two
countries. Step 2 Clinical Skills is an oral exam only available in certain U.S. cities:
Atlanta, GA, Chicago, IL, Houston, TX, Los Angeles, CA, and Philadelphia, PA (“Test
Centers,” n.d.). Obtaining a residency allowed participants to obtain their licensure to
practice medicine in the U.S. Ivan, who arrived in the U.S. six years ago at age 37, has
taken Step 1 and both parts of Step 2. He is now in the process of applying to residency
programs.

Even though going through the process of taking these exams and obtaining a
residency is the only way to fully integrate, the other pathways provide opportunities to
work within the U.S. medical field in different capacities.
Figure 2 Pathways for Cuban Physicians
Themes in the Process of Transitioning to the U.S. Medical Field

FEPs in this study described a range of experiences in navigating a pathway, identifying barriers and facilitators they encountered. Throughout their description of the process, they placed great emphasis on their own professional identities as physicians—the overarching theme that emerged from the study. Appendix F contains a summary of the coding scheme. Codes were created and later condensed into the overarching theme of professional identity and several sub-themes. The following sections will cover the participants’ descriptions of their process and the ways they attempted (or are attempting) to satisfy their professional identity by finding connectivity to the U.S. medical field. I will start by providing a detailed description of the main theme that emerged—professional identity—followed by the participant’s description of the sub-themes: their pre-migration expectations, their transcultural process (transculturación), and their journey in finding a “match” (connectivity to the medical field).

Professional Identity

Participants described being a physician as more than just a job title, as it is tied with their sense of “being” and purpose. The way that they approach life’s challenges in general is affected by their profession and they feel tied to it regardless of whether they are practicing medicine or not. As Marta describes her experiences below, it is something that “comes from within” regardless of the external circumstances—her training and way of approaching people does not differ even though she is currently not practicing medicine, her professional identity has not changed.

Porque en realidad soy médico, no lo estoy ejerciendo pero eso uno nunca deja de serlo, ¿ves? Es una actitud ante la vida, Wendy, ser médico es una

Because in reality I am a physician, I’m not practicing but one never stops being one, you see? It’s an attitude towards life, Wendy, being a
actitud ante la vida. Te cambia hasta la forma de--de ver los problemas. Todo porque lo ves como médico, no lo ves como una persona corriente. Eso está dentro de uno. No es--es más que una profesión, es un estilo de vida. (Marta)

physician is an attitude towards life. It even changes the way that...that you see problems. All because you see it as a physician, you don’t see it as a regular person. It’s within you. It’s not...it’s more than a profession, it’s a way of life. (Marta)

Many participants dreamed of being a physician from an early age. It was their first choice when they finished secondary school (called pre-university in Cuba) and several described another profession as being inconceivable.

Bueno, ya desde que era niña me encantaba la medicina. De hecho mi tía que vivía con ella-- siempre eh...era enfermera y a mí me gustaba la medicina. Tú sabes que las niñas juegan a las casitas, a la mamá. No, yo siempre era la doctora. Y cuando termine mis estudios que en Cuba que es lo que es aquí el high school, en Cuba el pre-universitario. Y yo la única carrera que pedí fue medicina. No me di otra opción. Si la cogía, era lo que quería. Si no, pues no hacía nada. (Angela)

Well, since I was a girl I loved medicine. Actually, my aunt that I lived with...always...um...she was a nurse and I liked medicine. You know how girls play house as the mom. I always was the doctor. And when I finished my studies that in Cuba is what they call here high school, in Cuba it’s pre-university. The only career that I asked for was medicine. I didn’t give myself another option. If I got it, it was what I wanted. If not, well then I wouldn’t do anything. (Angela)

Some had parents or family members that worked within the medical field and the impact they saw within their community influenced their hopes to do the same one day.

Ahí mi papá lo iban a la casa personas...a... hacerle preguntas e interrogación. Vea como lo--lo valoraban...eh las personas, a y supe muchas historias de...de personas que él le salvo la vida. Era un cirujano y los cirujanos normalmente eh... tú sabes...son... a veces te sacan de la muerte...creo que eso [me] influenció mucho. (Adrian)

There my dad would have people at the house...to...ask him questions or inquiries. I would see how they valued him...the people and I knew many stories of...of...people whose life he saved. He was a surgeon and surgeons normally um...you know...they...sometimes they stop you from dying...I think influenced me a lot. (Adrian)
Adrian saw his father’s impact on his community as a physician as something to aspire to. Even the few that had not dreamed about the career from a young age were immediately in love with the profession from the beginning.

The first day that I arrived at the university and had my first class in medical school I noticed that I feel in love with the career. It was the most beautiful thing that I had ever see that you could study. Only when I started a conference of a medical professor I said, “I’m passionate about this!” And on that basis I studied medicine for 6 years and later 3 years in my specialty. And I noticed that if I wouldn’t have been a physician, I wouldn’t have been anything else, I wouldn’t have been anything because what I enjoyed was medicine (Roberto)

There was passion and excitement when describing their career as physicians and a sense of this being the ultimate career choice for them, anything else was falling short.

The following sections describe the other themes identified in the coding process: pre-migration expectations, transcultural process (transculturación), and the journey in finding a “match” (connectivity to the medical field). These sub-themes are intertwined with the core theme of professional identity.

Pre-Migration Expectations

The theme of expectations describes both their hopes and worries about the feasibility of being a doctor in the U.S. that they had prior to leaving Cuba. Most participants said that they knew very little about the process before leaving Cuba or that they thought the process of recertification would be a lot easier than it actually was:
In contrast, Rafael Sr. thought that his age, 51 at arrival, and lack of language skills would make it very difficult for him to integrate into his profession in the U.S. He felt the need to prepare himself “psychologically” for working in whichever area became most feasible and having to possibly leave his profession behind after 27 years of medical practice.

Rafael Sr. worried that losing his connection to his professional identity in the U.S. would be so detrimental that it would affect his overall psychological wellbeing. He attempted to prepare himself as much as possible for the potential loss in attempt to decrease the potential trauma he thought he would experience. The use of the concept of trauma to describe difficulties in re-establishing himself as a doctor speaks to the importance of professional identity for the FEPs.

**Transculturación; Transcultural Process**

*Transculturación* (transcultural process), is a theme that emerged describing the process of adapting to the new culture. The term is an “in vivo” code used by one of the participants. New arrivals are transitioning from the culture of their country of origin and
go through this process while learning to understand the norms of the new one and
adapting their way of living to a new cultural context. Components of the transcultural
process include participant’s personal characteristics (e.g. language capability, age); how
spousal dynamics have been affected by the new cultural context; the role of resettlement
organizations in managing the new context; and the losses and gains associated with the
cultural transition. Eduardo describes his definition of *transculturación*:

> [Transculturación] el cambio psicológico de adaptación. Porque llegar en este país es un proceso de transculturación, importante y muy fuerte. (Eduardo)

Others described a similar process but did not refer to as “transculturación”. For
example, learning proper etiquette for a job interview and figuring out how to navigate
the job market within the U.S. medical field was another aspect of transculturation. Going
through the process of applying to jobs in the U.S. and interviewing is completely foreign
for most FEPs before arrival. As mentioned in the description of the Cuban medical
context, physicians in Cuba are matched by the government with serving polyclinics and
never have to go through an intensive job search after graduation. Erica described the
difficulty when interviewing for jobs:

> Yo fui a tres entrevistas de trabajo—el trabajo no me lo dieron nunca. Porque ellos te dicen. Si, te vamos a llamar pero...yo sabía que era porque mi Ingles no era suficiente. Ya, entre en el nerviosismo y...y el...tú sabes. Yo en Cuba yo nunca fui a ninguna entrevista de trabajo. En Cuba tú eras bueno y empezabas a trabajar y yo estuve trabajando mucho tiempo en el mismo lugar. (Erica)

> I went to three job interviews—I never actually got a job. Because they tell you, “yes, we’re going to call you” but...I knew that my English wasn’t sufficient. I started to become nervous and...and the...you know. In Cuba I never went to a job interview. In Cuba you’re good at your job and you start to work and I worked for a long time in the same place. (Erica)
For Erica there were cultural factors affecting the way she found a job even outside of the medical field. She had not previously needed to prepare herself for an interview or a job search process—a practice necessary in the U.S. but not required in Cuba. Work for her in Cuba was much more streamlined and she did not feel the need to frequently change jobs.

Moreover, there are cultural aspects of performance evaluation in the U.S. For example, multiple choice exams that are used in the USMLE and many other U.S.-based examinations are not used in Cuba. This added an extra level of difficulty in regards to adjustment and exam preparation.

_Aquí es distinto el sistema múltiple choice ese que existe aquí no existía en Cuba. Hay otro tipo de manera de examinar. Tienes que ajustar muchas cosas que son complejas._ (Roberto)

_Here it is different, the multiple choice system that exists here doesn’t exist in Cuba. There are other ways to evaluate. You have to adjust to many things that are complicated._ (Roberto)

Roberto is expressing that there are parts of the process that require cultural adjustment, even as simple as understanding the way the U.S. evaluates performance over the way Cuba does. There are tactics that are taught by the Princeton Review and Kaplan among others on how to approach multiple choice testing. These strategies are not necessarily intuitive even for U.S. students who have seen the format throughout their schooling. This alone creates a barrier in being able to perform well on the USMLE, or at least brings about another component that requires _transculturación_, as Cuban FEPs must learn and practice before passing their boards.

Participants, such as Adrian and Roberto, who successfully obtained their medical recertification and became physicians in the U.S., described having to learn how to navigate aspects of the U.S. medical field that were different from Cuba, but required for them to understand in order to retain their profession.
Adrian thought this process of learning the systems of the U.S. medical field was very difficult, especially at the beginning. Learning a new medical system is like learning a sub-culture within the larger American culture, and can possibly challenge the FEPs' identity since it could change the way they approach their patients.

**Personal characteristics.** Within the process of adaptation to a new culture, there are personal factors that affect the pathways which FEPs navigate to retain aspects of their professional identity. Predominately, participants described how their age and language limited their options. Erica mentioned during her interview that she felt that she could not pursue an option that would take her 4 to 5 years or longer to complete because she is 40 years old. She described how she has responsibilities that come later in life like caring for children since she has 2 daughters. Ivan is also worried about his age and how that will affect obtaining a residency program because being in his 40s may deter a program from accepting him. Furthermore, language skills can be one of the greatest barriers or facilitators for FEPs in their integration process. Learning a new language in adulthood is much more difficult. In addition, language issues involved not only personal characteristics of the FEPs, but also resources that had been available to them in Cuba to learn English before migrating to the U.S. In Cuba there is little access to training to become a fluent English speaker. As described by the participants, language courses were
formal and less conversational. Even private instructors did not have advanced
knowledge of English. Erica also pointed out that there is a need to master professional
language, which requires a greater level of language skills. She found that when working
with other professionals the English required surpassed her knowledge base, even though
she took classes in Cuba.

**Spousal dynamics.** Spousal dynamics were interwoven into the process of
adapting to the new culture for the participants. Husbands that may have been the
traditional “breadwinner” in Cuba may have needed to depend on their wives for
economic support for the first time in their lives in order for them to take steps to retain
their professional identity. Two male participants, Eduardo and Roberto, described times
when their female partners had to take on the financial responsibility while they studied
for qualifying exams or completed a certification. The blue text is the interviewer
speaking:

*Me dedique estudiar en los 6 meses...*  
¿Y su esposa estaba trabajando?  
*Sí, (se ríe) me mantenía (se ríe)*  
No ella trabajaba y yo estudiaba. No podía hacerlo los dos a la vez.  
(Eduardo)

*I dedicated 6 months to studying...*  
*And your wife was working?*  
*Yes, (laughs) she ‘sustained me’*[provided for me financially]* (laughs)  
*No, she worked and I studied; I couldn’t do both at the same time.*  
(Eduardo)

By his laughter Eduardo displayed that he was uncomfortable with his wife being the
primary “breadwinner” for six months; doing so might have gone against the cultural
norm he was used to in Cuba. However, even though this may not have been normative in
Cuba, when it was necessary for one spouse to study while the other worked, both men
and women took on the primary economic burden. I found that for all of my participants,
earning money was a responsibility that fell on both men and women as they engaged in
what was necessary to benefit the whole family. Erica’s husband, a trained physical therapist, is currently working in construction so that she can have adequate time to study. Thus negotiating differences in cultural norms regarding gender roles in the process of reintegration into the medical field was another aspect of transculturación for the participants.

**Resettlement organizations.** As most Cubans in the U.S. have access to refugee services, resettlement organizations played a crucial role in the process that Cuban FEPs go through when adapting to the culture of the U.S. Some participants discussed receiving language services, educational opportunities, housing assistance, and employment opportunities through resettlement organizations, such as Church World Service, South Florida Work Force, Lutheran Services, etc. However, participants also felt that resettlement organizations, even though they do focus on employment, tend to pay little attention towards helping FEPs integrate into their former professions.

*Marta* mentioned that it was helpful for resettlement organizations to assist in overcoming cultural barriers and learning the new cultural environment. However, by and large, participants felt that resettlement organizations failed to consider participants’ professional identities.
Costs and gains. Even though there were many unknowns before leaving Cuba, part of the process of adapting to the new culture involved the costs and gains associated with adapting to life in the U.S. However, the gains were not related to their professional identities. No one talked about moving to the U.S. in order to have a more lucrative medical career. Instead, these gains referred to opportunities that made the losses regarding professional identity less heart breaking. For example, several participants, such as Erica, Marta and Eduardo, talked about the opportunities that their children will have or have had as a result of growing up in the U.S. Others talked about gaining freedom of expression, particularly freedom of religion. Rafael Sr. described feeling forced to leave Cuba and his profession because of the persecution that he and his wife experienced from the Cuban government on account of their religion. There are also tangible financial costs associated with the integration process, such as paying to translate a medical degree, taking out loans for an educational program, or the costs of the USMLE. There are also basic costs associated with daily living—such as paying for rent, what was less prevalent in Cuba; or the high cost of food, or the need to buy a car. Most salient, however, was the professional loss of no longer being a physician. Professionally, Rafael Sr. felt that he had to start at zero after entering the U.S., and he knew that this loss would have an effect on his psychological wellbeing.

*Una nueva experiencia, por lo menos en...yo hice mi carrera en Cuba, todo mi perfil, todo. Y aquí tuve que hacer algo nuevo. ¿No entiendes? Totalmente (se ríe) opuesto a lo que yo vine...opuesto a lo que yo estudie en Cuba. Fue...es como volver a nacer. Si empezar de cero. (Rafael Sr.)*  
*A new experience, at least in... what I did in my career in Cuba, all of my accomplishments, all of it. And here I had to do something new. Do you understand? Completely (laughs) the opposite of what I was when I arrived...opposite of what I studied in Cuba. It was...it is a rebirth. Yes, starting from zero. (Rafel Sr.)*
**Finding a “Match”: Connectivity to the U.S. Medical Field**

“Match day”, the third Friday of March, is the day the results are announced for residency, internships, and fellowship programs in the 155 medical schools in the U.S.’s National Resident Matching Program (“Main Residency Match Calendar,” n.d.). Obtaining a match is necessary for FEPs who want to practice medicine as physicians in the U.S. *Ivan* is currently applying for this step of the process. However, half of the participants (*Angela, Eduardo, Erica, Marta, and Rafael Sr.*) sought to find their connection—through an alternative “match”—a position within the medical field but not as a physician. This theme—finding a “match”—refers to match day metaphorically to represent the ways that participants described their need to acquire a level of connection to the medical field. Within the process of finding a match, I will describe alternative “matches” to remain connected within the medical field. Furthermore, I will describe the participants’ systems of “support”, which lead to access to information that helped them in the “match process; and the participant’s thoughts and concerns regarding the fairness of the process.

Personal satisfaction is described by the FEPs when there is connectivity with their professional identity. However, FEPs balance satisfying the economic needs for themselves and their families while working towards that connection. Job opportunities that were more readily available after arrival (e.g. construction, food service) satisfied some of their basic economic needs, but had no connection to the medical field and created dissatisfaction for participants.

*Roberto* took the USMLE after a new policy gave FEPs in the state of Florida the option to obtain recertification through an alternative process. He passed Step 1 and Step
2 clinical knowledge exams, but instead of taking the oral examination went to work under a physician for two years as an alternative residency program that can lead to eventual recertification. Before this policy came into place, he had given up hope and worked in construction for ten years. He also witnessed the struggles that many of his colleagues faced. He feels that when FEPs and other professionals are unable to connect to their profession, it is a waste of talent.

Aquí se ve mucho, médicos que están trabajando en la construcción... hasta limpiando piso, haciendo cosas que teniendo cierto talento—han estudiado para algo y vez que eso se está desaprovechando. Es penoso realmente. (Roberto)

Alternative “match”. Participants who realized that obtaining the full certification was not an option for them described their reasoning for pursuing an alternative route that still provides a connection to the medical field. Erica is attempting to reconcile finding her connection while also having responsibility for her family:

No quiero estudiar una cosa que lleve 4 o 5 cinco años. Uno tiene que ser realista yo tengo 40 años, no--no puedo. Tengo también las 2 niñas. Tengo que trabajar. Tampoco puedo hacer una cosa que me tome "full-time" estudio porque tengo que también atender a las niñas y trabajar, ¿no? Para ayudar a pagar los biles. Alguien tiene que pagar los biles en la casa. (Erica)

Similarly, Marta described the process of recertification as difficult because she and other FEPs often worry about their family responsibilities.

Tienes que examinarte, eh...tú sabes, cumplir los requisitos que ellos te piden una vez del examen, aplicas. Eso

Here you see many doctors that work in construction...even cleaning floors, doing things that with having a certain talent—they’ve studied something and you see that it’s being squandered. (Roberto)

I don’t want to study something that will take me 4 or 5 years. You have to be realistic I’m 40 years old, I can’t—I can’t. And I have 2 girls. I have to work. I also can’t do something where I have to study full-time because I have to attend to the girls and work, right? To help pay the bills. Someone has to pay the bills in the house. (Erica)
FEPs describe how their skills and their experiences as physicians have helped them while working in other capacities in the medical field and how that has indirectly connected them to their professional identity. Since Eduardo arrived in the U.S. when he was 41, he felt that it was more important for him to study for a short period and find another position in the medical field because it was more important for his teenage daughter to have educational opportunities. He enrolled in a counseling course at a local university that connected well with his specialty in psychiatry.

Matricule desde allá [California] en un curso aquí en la universidad. Eh...sobre consejería. Por su puesto al yo sido psiquiatría me convalidaron unos cuantos créditos. (Eduardo) I enrolled from there [California] in a counseling program here in the university. Of course since I had been a psychiatrist it counted as equivalent to a few credits. (Eduardo)

The university was able to consider some of his educational background as equivalent to what he would be learning, and use it toward some credits, which lessened his overall course load. For Marta, she appreciates how she still works indirectly with patients. She is the office manager of an elderly care facility and uses her medical background to ensure that medical files look correct.
Access to patients, even indirectly, helps Marta to not feel “frustrated” and disconnected from her professional identity. Both she and Eduardo said during their interviews that they did not feel frustrated by the fact that they were no longer physicians in the U.S. because they found a place within the medical field where they were still able to practice what they learned as physicians and find meaning in their work. As she states above, she is still a doctor and her current job gives an outlet for using the skills she has acquired over the years.

Finding an alternative “match” was at times assisted by participating programs in institutions of higher education. Eduardo and Angela both found an alternative “match” to connect to their professional identity through pursuing academic programs from local universities in South Florida that had some similarities to their specialties as physicians in Cuba. As mentioned previously, Eduardo’s Cuban specialty was in psychiatry and he also taught at the university level. In the U.S. he pursued a counseling program and later became a professor for medical assistants. Similarly, Angela (a family physician in Cuba) went back to school and pursued her bachelor’s and master’s degree in the U.S. with a focus on family medicine. However, institutions of higher education that have had little interaction with foreign professionals may be poorly equipped in serving their needs.
Erica, for example, first attempted to find information about her options from a community college in Central Florida and was told that in order for her to become a physician in the U.S. she would need to first complete a GED program, implying that her medical degree from Cuba did give her the credentials even for a high school diploma. Erica described this experience as negative and partially the reason why she hopes to pursue educational opportunities in her field in South Florida because colleges/universities seem to be better equipped to serve her needs.

**Systems of “support”**. Marta described the assistance FEPs receive that allows them to reconnect to the medical field using the English word “support”. This section describes the broad range of systems of support—family, friends, and acquaintances—that were helpful guides in the process of finding a “match”. I’ll start by focusing on the role of family members and move to describing others within the Cuba community that helped guide participants and later helped them access information.

For participants in this study support typically started with the family. Immediate and extended family members assisted with navigating the basics of the new country, such as finding housing or temporary work. Family played a role in the amount of responsibility and support that participants had after arrival. Adrian arrived in the U.S. with his wife at age 26. They were both family physicians in Cuba for two years after graduating from medical school. In the U.S. they together graduated from an ultrasound technical course as an alternative in case they were not able to obtain medical licensure. Shortly after finishing these courses, they switched their full time focus to studying together for their USMLE. He took about a year to prepare for each portion of the exam (Step 1, Step 2 Clinical Knowledge, and Step 2 Clinical Skills) and passed them
successfully. He started a U.S. medical residency program about six years after arrival. They had a lot of support from their family, which allowed them to study full-time. His wife decided to delay taking Step 2 clinical skills and applying to residency because of worries about her English skills, but did not start a residency program until shortly after Adrian finished. They both currently work as physicians in South Florida. Adrian and his wife were able to support each other in the years of preparation before residency, while taking turns with their spouse in carrying the financial burden. Similarly, other participants described the support they received from their families as well as their spouses (for those who were married upon arrival) in finding their “match”.

However, unless family members also worked in the medical field, they were not able to assist participants in navigating that process. Former colleagues and acquaintances supplemented that role by providing direction or possible work opportunities within the medical field for several participants.

Teníamos...teníamos familia...yo tenía familia y él [su esposo] también pero...su sabes que la familia te ayuda por un tiempo pero no era una familia tan cercana como que te diera la opción de... “dedicate a estudiar, no trabajes que yo te mantengo”. No, no era ese tipo de familia. Era una familia que te ayudaba a empezar pero te tienes que independizar. (Angela)

We had...we had family...I had family and him [her husband] also but...you know that family helps for a little but it wasn’t family that was so close that would give you the option to dedicate of... “dedicate yourself to studying, don’t work and I’ll support you financially.” No, it wasn’t that type of family. It was the sort of family that helps you get started but then you have to be independent. (Angela)

Social support played a consistent role in helping FEPs find job opportunities. Erica was initially living near her father in Central Florida, but she was unable to obtain a job after being there for about two years. She moved to Miami because she had a job waiting for her. In addition, she explained that there seemed to be better opportunities for
her in Miami and access to organizations that were helping her in the recertification process.

Me voy para Miami porque ahí conseguí trabajo. Tengo un amigo que me va...me está haciendo la gestión de conseguir trabajo en oficina de un médico que es un amigo de las...como asistente de médico y ahí puedo estar para estudiar...tú sabes...para pasar el tiempo que yo quiero para ya estudiar lo que yo quiero. (Erica)

I’m going to Miami because there I found a job. I have a friend that that is going to...is figuring out getting me job in an office of a physician that’s a friend of his...as a medical assistant and there I can study...you know...spend the time I want to study what I want. (Erica)

Knowing someone who successfully followed a pathway that they wanted to take helped reassure participants that their hopes were possible. For Adrian, it was helpful to obtain advice and resources from another Cuban FEP who had completed the certification process.

Ahí en el curso de ultrasonido había una doctora que era dermatóloga de Cuba, una señora que era ya mayor que había decidido no hacer los boards pero la hija....hizo los boards y estaba haciendo una residencia. Estaba en el primer año de la residencia. Yo [la] pude contactar que me dio más información. Eh también había en la escuela de ultrasonido...un doctor que era pediatra...súper inteligente, muy brillante y él había ya hecho los dos primeros exámenes, estaba aplicando a la residencia, lo único que le faltaba para hacer. Y eso yo lo vi como un ejemplo. It is possible! You can do it! (Adrian)

There in the ultrasound course there was a doctor that was a dermatologist in Cuba, a lady who was older that had decided not to take the boards but her daughter...did her boards and she was doing her residency. She was in her first year of her residency. I was able to contact [her] and she gave me more information. Um also in in the ultrasound school...there was a Cuban doctor that was a pediatrician...super intelligent, very bright and he had done the first set of exams, was applying to a residency, the only thing that he was missing. And I saw that as an example. It is possible! You can do it! (Adrian)

Similarly, through an acquaintance that Rafael Jr. met while working for his uncle’s flooring company, he met another Cuban FEP who, like him, left Cuba in the midst of medical school to avoid the waiting process—she has been helping him figure
out his next steps. Moreover, Alison learned from the FEP who conducted her refugee health assessment how she could translate/confirm her Cuban medical degree through a Lawyer’s instead of paying a third party organization. Participants described a common thread of Cubans helping other Cubans, specially those they met with ties to the medical field, regardless of whether they previously knew each other.

**Information access.** FEPs primarily gained access to information through systems of social support. Historically, access to information for Cuban FEPs prior to migration is minimal because of the closed relationship between the two countries. As a result, FEPs in the study had to seek out information after arrival through their systems of support—both individuals and organizations. Having arrived in the 1908’s or 1990’s, the FEPs in this study described the challenges associated with scarce access to information.

*Yo creo que es unas de las barreras más grandes que uno tiene, la falta de información. Eh, la familia no sabe cómo orientarte, no sabe cómo decir... Eh básicamente conociendo personas...eh oyendo historias que uno va a contactando personas y te van guiando un poco...uno va...eh tomando información y armando un poco eh en tu mente, cual es el camino. Pero es bien “confus--confusing” una nebulosa muy grande de cómo...cómo...cuál es el proceso. (Adrian)*

*I think that one of the biggest barriers that one has is the lack of information. Um, the family doesn’t know how to orient you. They don’t know what to tell you, um basically knowing people...um hearing stories that one starts contacting people and they guide you a little...and you go...um taking information and building a little um in your mind what is the journey. But it’s very confus—confusing, a big fog of what...what...is the process. (Adrian)*

Some participants moved from other cities or states to South Florida in order to have better support from colleagues, organizations, and job opportunities that could help with their “match” process as they searched for connectivity to their professional identity. The participants that initially resettled in a different U.S. state or city in Florida did so in order to have greater access to information from former colleagues, a type of secondary migration (Massey at al., 1993). In California, Eduardo lacked support from other
Cubans who could help guide him in finding a pathway. His former colleagues guided him to a counseling program at a local South Florida university that later led to him finding his niche in the U.S. medical field.

Nosotros tres con la familia de mi esposa en California. Pero bueno, nadie sabía de ellos. Ninguno de ellos era médico o nada relacionado a la salud. Y no, solamente ellos decían que no—no sabían nada. Esa fue la decisión que me hizo venir de California para Miami. Eh...California me gustaban algunas cosas excepto la grande desinformación...aquí [Garden Grove, CA] era muy difícil y entonces cuando ya comienzo hablar con mis compañeros que estaban en Florida fue la decisión en la que bueno, pues nada, y...umm...me metí así de lleno, matricule desde allá en un curso aquí en la universidad. (Eduardo)

Similarly, to Eduardo, Angela and Erica relocated South Florida after initially seeking out information in two different cities in Central Florida. Their cities—being a few hours from the Miami metropolitan area—did boast a larger number of Cubans than California did, but still they found few resources for their “match” process. Given this, they moved to Miami in order to obtain further information and support.

Yo primero que me fui directo a Tampa y cuando llegue a Tampa como todo se me hiso un poco más difícil. Dos, tres meses de estar en Tampa, no me gusto y ya yo había venido aquí a Miami. Me pareció que aquí era mejor la oportunidad y vine a Miami y aquí si me establecí y ahí empecé a averiguar. (Angela)
Ill-fitting process? Participants had a difference of opinion on whether the U.S. medical system is fair and just and whether there should be another way to approach the adjustment of FEPs into the US medical field. They wondered if it made sense for FEPs with many years of experience to go through the same process as current medical students with little experience.

Roberto described how it does not make sense to that there are so many foreign professionals whose talents are being squandered without adequate help and support. However, Alejandro and Marta described the positive benefits of FEPs being treated similarly to the American physicians by needing to go through the same exam and residency programs as them.
que siempre...me parece que el proceso es bien "equal", inclusive eh... es el mismo examen que toman los graduados nacionales de aquí y los graduados internacionales del mundo entero. No es un examen ni más difícil, ni más fácil, es el mismo examen. Eh la residencia--igual dura para todos. Y para uno con las limitaciones del idioma se te hace un poco más difícil al principio sobre todo y bueno, conocer la logística de...del...del hospital, como funciona un hospital--ya después te sientes bien a--pero los primeros seis meses sobre todo son bien difícil. Es un periodo de ajuste muy violento--es muy difícil.

(Adrian)

Their difference in opinion may vary because Roberto was initially unable to continue being a physician in the U.S., even though he did his part in remaining connected to other physicians while he was unable to practice. He spent 10 years without practicing medicine, giving him a glimpse of what it was like to lose and then regain his professional identity. A change in the system facilitated that process for him, which is likely why he feels that system change would be highly beneficial to other FEPs as well.

In addition, he brought up how these exams are also more difficult for those who have spent a longer time in their specialty since the test materials are very broad. He described that the USMLE does not make sense for someone who has been in a specialty for many years, since they would need to relearn broad areas of medicine that they have not used in a long time.

Son exámenes duros y hay personas y muchos que llega--llegamos no tan jóvenes que son gente que 60, 70 años y cuando vienen entonces muchos de

They are difficult exams and there are people that aren’t so young when they arrive that are 60, 70 years old and when they come they try to navigate
Roberto questions whether the recertification exams make sense for FEPs that have working in a specialty for many years because they are too general.

**Results Summary**

To obtain a full sense of their process one must first understand the importance of the participant’s **professional identity** (the overarching theme) as well as sub-themes that are related to the process of connecting to their professional identity 1) **pre-migration expectations** 2) **Transculturación** (the transcultural process), and 3) the components of **finding a “match” in the U.S. medical field.** Participant's description their professional identity was tied to their sense of purpose (in part because of the unique stances of the Cuban medical field) and their desire to feel connected to their field in the U.S. fueled their pathways. The sub-themes are interrelated with one another as well as intertwined with the theme of professional identity. With minimal prior knowledge of the U.S. medical field, participants described their process of balancing between their pre-migration expectations with what would be the best pathways for their family units. In the midst of their pathways they had learn to navigate a new cultural context (**transculturación**) while simultaneously working towards finding a connection to their profession.
CHAPTER 4: DISCUSSION

This exploratory qualitative study sought to further understand the process that Cuban FEPs go through when attempting to integrate in the U.S. Medical Field. Guided by an ecological conceptual framework, the primary question asked by the study was “What is the range of experience of Cuban FEPs’ integration into the U.S. medical field?” In addition, the study sought to understand barriers and facilitators that they encountered on their pathways. In this chapter I will discuss the implications of the themes identified in the study for the field’s understanding of experience of foreign educated professional. The findings of the study provide an initial understanding of Cuban FEPs and how their professional identity is central to their acculturative and adaptive processes in an increasingly Cuban context. The study also highlights the role of social support that is a resource for the participants as a result of the enormous Cuban population in Miami. I will conclude by discussing the strengths, limitations, and implications for future research and action.

Study Contributions

Professional Identity and Wellbeing

Professional identity was the overarching theme that emerged in the study. All other components of their acculturative and adaptive processes were connected to the participants’ desire to find a “match” for them in the U.S. Medical field. Some participants described how being a physician was tied to their sense of “being” and purpose. They found meaning and passion, and separating from their profession could cause them a tremendous amount of hurt. For example, Rafael Sr. described preparing
himself psychologically for possibly being unable to work as a physician and the “trauma” it could cause him. Rafael also described how he prepared himself psychologically to move to the U.S. because it was highly likely that he wouldn’t be able to reconnect to his profession. Occupational wellbeing (or career wellbeing) is described as a key factor in overall wellbeing (Rath & Harter, 2010). Prilleltensky et al. (2015) defined occupational well-being as “the state of satisfaction with one’s job, vocation, or avocation, as determined by individuals themselves” (p. 4) and as a key component of overall wellbeing. The ways that participants described their professional identity is consistent with this previously established concept of occupational wellbeing as they also referred to their career as a sense of vocation and, fueling their desire to integrate into the U.S. medical field. The study findings suggest that it is important to focus on this concept when working with immigrants and refugees to improve their wellbeing rather than only on economic survival.

For the participants, professional identity was an emotional connection to the field rather than a matter of income or prestige. Being able to practice medicine or use the skills they acquired as physicians provided them with an outlet to make a contribution and feel connected to the field even when they were not physicians anymore. Similar to a study on Russian physicians in Israel who converted to physiotherapy (Remennick & Shakhar (2003), participants who transitioned to another role in the medical field highly valued having an outlet to use their medical training and incorporating that training into their new roles. Previous studies (Birman, Simon, Chan & Tran, 2014; Vinokurov et al., 2000; Shuval & Burnstein, 1998) supported the importance of occupational identity for psychological adjustment of former Soviet professionals who were more positive about
their lives when connected to their pre-migration profession. Findings of this study are consistent with this literature. In addition, the qualitative method used in this study provides a deeper view into the lived experience of Cuban professionals going through this process, allowing for a rich description of the importance of their professional identity for their wellbeing.

Given the importance of occupational wellbeing for overall wellbeing and psychological adjustment, the finding of what participants described as an “ill-fitting process” illustrates the inefficiencies in the process and also questions the wisdom and fairness of existing laws and structures. As Prilleltensky suggests, “Migrant well-being is not a matter of chance, or charity, but a matter of justice” (Prilleltensky, 2008, p. 5). Migrants’ well-being is dependent on risk and protective factors at various ecological levels and access to resources is affected by justice in the host society (Prilleltensky, 2008). The concern with justice in the host society is articulated by some of the participants as they question whether their processes are fair or not. It is important to note that the Cuban participants in this study questioned fairness of the recertification process even though they had a number of advantages relative to other migrants from Latin America going through this process. The participant’s questioning of the fairness of the recertification process could potentially lead to future research that questions the fairness of the current system. From an ecological perspective, the challenges FEPs faced are not just a function of their personal characteristics and skills, but the interaction of their personal backgrounds with the policies and procedures applied to them by the U.S. medical certification system. For example, research investigating how components of the macrosystem—such as nationalism, xenophobia, and elitism—in the U.S. are manifested
in policies related to recertification of physicians and other foreign trained professionals may help challenges these policies. The U.S. may learn from Israel where the potential contributions of Soviet trained physicians to the large former Soviet émigré community were recognized, and policies that resulted in more successful and faster reintegration of physicians who were able to then serve this community.

**Transculturación (Transcultural Process)**

The theme of *transculturación* (transcultural process), was described by one of the participants as the process of adapting and acculturating to a new culture that new arrivals go through in a new cultural context. The importance of this process for the FEPs in this study is not surprising, given that these components of the migration experience have been thoroughly discussed in the literature on acculturation and adaptation. Berry (1997) defined acculturation as “the general process and outcomes (both cultural and psychological) of intercultural contact” (p. 8). The development of well-being and social skills that assist in navigating the new culture are known as adaptation, thought to have both psychological and sociocultural components (Ward, Bochner, & Furnham, 2001). Most research on acculturation and acculturative stress of Cubans in the U.S. primarily took place in the 1980s and 1990s (Szapocnik & Kurtines, 1980; Black & Markides, 1993; Gil & Vega, 1996) and little to none has focused on their attempts to connect to their profession. Therefore, this study updates this information by describing this experience of acculturation and adaptation for Cubans today and focusing on the professional status which was previously missing.

The findings of this study affirm the ecological perspective on acculturation that suggests that for migrant acculturation to the host and heritage culture both contribute to
positive adjustment but through different paths (Birman et al., 2014); and that the type of acculturation that is adaptive is dependent on the context. With respect to acculturation to American culture, these study findings are consistent with other research on acculturation and occupational adjustment of refugee professionals that finds that acquiring the language of the host culture (as well as younger age) facilitate the employment process (Vinokurov et al., 2000; Yakushko et al., 2008; Chen, Smith, & Mustard, 2010; Birman et al., 2014, 2014). Participants described English to be a barrier to certain pathways (e.g. taking the medical licensing boards or obtaining U.S. nursing degree) when English language capacities were minimal. Employment beyond a technical area, such as medical assistant, would have been unavailable with English language proficiency. Participants described the difficulty they faced when learning English, especially those that were older. Even for those that took English classes in Cuba, there were limitations on their conversational abilities since they know had to now speak it outside of a classroom, as well as lacking training in formal language useful in managing the U.S. professional context. There was a pathway available when English skills were lacking (e.g. medical assistant) which was a certification available once the FEP’s Cuban medical degrees had been confirmed and translated (a legal process described previously), but job attained seemed highly linked to finding employment through social networks. Having the potential option of working within the medical field with little English skills is likely linked to the large volume of Spanish speakers that seek medical services in Miami-Dade County.

At the same time, acculturation to the heritage culture was also helpful to occupational adjustment of the participants in a number of ways because of the
prevalence of other Cuban émigrés in the Miami area. Though counterintuitive given the general assumptions about the benefits of assimilation for immigrants, similar to prior literature (Vinokurov et al., 2000), acculturation to the heritage culture and participation in the surrounding ethnic community was helpful to the participants in the process of occupational adjustment.

**Access to Network of Co-Ethnic Social Support**

The theme of “support” was a key component in the participants’ ability to find a “match” in the medical field and satisfying their desires associated with their professional identity—interrelated with both the transcultural process and finding a “match”. This suggests that reestablishing professional identity was not an individual process, but happened in the context of the ethnic community. As previously stated, systems of social support resulting from membership of a group link individuals to networks or acquaintances (Bourdieu, 1986). The findings of this study are consistent with previous research on other groups of migrants, particularly Mexican Americans in California who had little financial resources but were “rich” in social capital that they used to find jobs (Massey et al., 1987). Similar to literature on Mexican migrants, Cubans in the study found jobs, educational opportunities, and mentorships in relation to their professional identity from other colleagues and acquaintances in Miami-Dade County that had gone through the process of recertification or finding an alternative match. However, because of the ethnic context in Miami, bonding capital (their ethnic ties) creates a bridging component (“Social Capital Glossary,” n.d.) to resources that the newly arrived Cuban FEPs may not have necessarily had access to—showing the strength of “weak ties” particularly in an ethic community.
The support of the ethnic community gave access to Cuban connections that helped not only with emotional support but also professional connections within the large Cuban community of Miami, Massey suggests that social ties to others from the country of origin already resettled in destination country reduce the costs of migration, not only financially but also the costs associated with a lack of tangible and emotional support. Once a group has established itself in a community, social structures encourages others, including family, friends, and other co-ethnic migrants to come, increasing the likelihood of further migration to the area (Massey, 1990). Similarly, some participants in the study initially resettled in another U.S. city or state because of family but eventually moved to Miami to have access to resources (formal and informal) that led to the medically related jobs and educational opportunities referenced above.

Not only family and friends but acquaintances were also great sources of support. “Weak ties” felt stronger because they occurred within a shared ethnic community. The strength of “weak ties” has been discussed between groups, bridging micro-level interactions with macro-patterns (Granovetter, 1973). However, the large size of the Cuban population created opportunities for guidance and mentorship from Cuban FEPs that participants barely knew—stressing the importance of understanding the unique context in Miami. There were several examples of these interactions that illustrate the strength of “weak ties” within this particular ethnic community in Miami. Adrian described the guidance he received from other FEPs that he met in a class with other Cuba FEPs, even though had not known them previously. One FEP lent him books to study for the USMLE so that he wouldn’t need to purchase them himself while another gave him advise on steps to take. Rafael Jr. met an FEP that similar to him, left medical
school early to not be affected by the sanctions and is now a practicing U.S. physician. That FEP is now serving as a mentor for him and guiding him during his process. *Alison’s* physician for her refugee medical examination was a fellow Cuban FEP who connected her to a less expensive alternative to translate/confirm her Cuban medical degree. It is interesting to consider why weak ties were so readily turned into strong relationships within the ethnic community. Perhaps when meeting other FEPs while struggling in resettlement participants felt a kinship that created a stronger relationship than they otherwise would have had if they met a stranger in a different context.

Surprisingly, participants did not talk about the help they received from connections to Americans, and in this way, while American acculturation and access to resettlement organizations allowed them to participate in the profession through language and understanding of aspects of the culture in the U.S., it may have played less of a role in the process of finding a “match” within the medical field for this sample of Cubans living in a predominantly Cuban community in Miami. This affirms the importance of viewing acculturation as a contextual phenomenon, because different ways of acculturation are adaptive in different contexts (such as Miami Dade). However, as described above, more recent arrivals benefit from the resources of the established Cuban community in Miami but likely have less access to the same level resources as the pre-Mariel exiles (Portes & Puhrmann, 2015)

With respect to adaptation, the study suggests the importance of understanding occupational adjustment of individuals ecologically, in the context of the family and spousal dynamics in resettlement. Often studies on refugee employment conceptualize it as an experience of an individual migrant (Chen et al., 2010). However, in this study it
was apparent that in the process of transitioning into the new culture, couples negotiated how to invest in developing each family member professionally while also meeting more immediate family responsibilities such as having an income to support the family. Couples took turns in pursuing educational opportunities while the other (or other family members) took on the financial burden. These findings suggest that the process of employment for refugees should not be thought of as an individual process but a contextual one, dependent on the family context. For example, an individual may not be perceived as having successfully connected to the profession when their individual career path is examined, but at the family level, the decisions and choices may make sense and contribute to the overall wellbeing of the family; with some partners prioritizing the professional pursuits of their spouse or the future pursuits of their children.

In sum, the study provides an initial understanding of how Cuban FEPs attempt to integrate into the U.S. medical profession. It supports the idea that migrants’ professional identities (rather than income) drives their search for occupation wellbeing. Since there was little to no information in the literature on the transition of Cuban physicians in the U.S. medical field or more broadly on the transition of Latinos with professional degrees, the study lays a foundation for further research on the topic. Although the Cuban FEPs experience cannot be generalized to the experiences of other Latinos or Cubans in other professions, the rich and detailed descriptions of their process identify themes in their experience that add to the literature on the acculturative and adaptive process of Latinos, focusing on their strengths and the benefits that professionals can provide to the U.S. work force. This extends the conversation on occupational wellbeing of Latino immigrants to the experience of professionals.
The study also demonstrates the importance of thinking ecologically about the migration experience through considering the needs of immigrants and refugees not as individuals, but within their family units, surrounding communities, and the larger societal context that dictates policies that govern how they adapt and whether they are able to achieve wellbeing. Viewing this process ecologically allowed the study to discover the ways in which the process of connecting to professional identity was experienced as a family rather than an individual process and within the context of social support in the surrounding community. The study also draws attention to the macrosystem of the U.S. society and the ways in which it shaped this process for the FEPs through particular policies governing recertification, possibly influenced by negative attitudes toward immigrants in the larger society.

**Strengths and Limitations**

Several limitations of the study are worth noting. The purpose of the study was not to draw generalizations from the participant’s experience, but to describe the range of ways that Cuban FEPs pursue pathways to occupational wellbeing. While a number of pathways were identified among the 10 FEPs interviewed in this study, other pathways may be available that were not captured in this study.

Since I used a snowball sample by means of personal and familial connections, access to participants was limited by my own social network. However, as participants connected me with other FEPs that were interested in the study, it broadened my reach and allowed me to capture a broader range of experience. Although the sampling was not initially purposeful, I aimed to have a diversity of participants varied with respect to gender, age, time in the U.S., age of arrival, marital status at arrival, children at arrival,
and current status in the medical field. However, all of the participants arrived in the U.S. during the 1990’s or later. I could have captured on changes within systems of support for Cubans if I had some participants that arrived in the 1960s, 1970s, or 1980s. At the same time, as a member of the ethnic group, I had easier access to an under researched group of participants than if I were not Cuban. I believe that being Cuban myself also created a more comfortable and trust worthy environment for participants to share their experiences in their native language.

**Implications for Future Research**

Expanding this study to participants with diverse experiences and representing FEPs from a broad range of Latin American countries would allow future studies to discover if the themes identified in this study are similar across ethnic groups; or apply to highly trained professionals in other fields. In addition, one important question to approach in future research may be to focus on the U.S. medical system and ask what factors influence the gatekeepers and the structures and hurdles they believe are important for reintegration of physicians. For example, why might there be a preference for younger migrants with less experience, as some of the participants suggested? These studies would allow researchers to examine the broader macrosystems that have affected current structures for foreign professionals within the U.S., specifically since the skills of medical professionals would intuitively be one of the most transferable—the human body remains the same across borders.

In terms of further assessing the systems of support for foreign professionals, participants described the level of support that some of them received from institutions of higher education. This scenario raised the question of how well are institutions of higher
education equipped in serving foreign professionals. Other studies have theorized these processes by studying particular career fields (Iredale, 2001) as this study did as well, but a comprehensive look at the structures at local community colleges to larger research institutions may provide a broader understanding of this potential gap in higher education. Perhaps, it is important to consider how the institutions themselves can “acculturate” to newcomers.

**Implications for Action**

As Cubans often have access to refugee services in the U.S., resettlement organizations are an initial source of information for most. Participants described resettlement organizations as helping them navigate the new culture, finding employment, and obtaining educational opportunities, but not help introduce FEPs in terms of “who they are” as physicians. Resettlement organizations may able to improve the overall wellbeing of their service population if they asked questions around professional identity and how to assist refugees in finding meaning in their work in the U.S. In addition, since the need for access to information was a commonly talked about among participants, it may be useful for resettlement organizations to explain the potential pathways that I have collected through this study for incoming FEPs. Providing this information would help newly arriving FEPs make educated decisions and weigh the pros and cons of different paths. Lastly, alternative residency programs, similar to Roberto’s two-year program in Florida with a fellow family physician after obtaining sufficient scores on the USMLE, may be a way to increase access to the field for older professionals with many years of experience, and decrease the projected 2020 physician shortage mentioned in the introduction above.
REFERENCES


APPENDIX A

Informed Consent (English & Spanish)

University of Miami

CONSENT TO PARTICIPATE IN A RESEARCH STUDY
Understanding the Integration of Foreign-Educated Cuban Physicians into the U.S.
Medical Field

The following information describes the research study in which you are being asked to participate. Please read the information carefully. At the end, you will be asked to sign if you agree to participate.

PURPOSE OF STUDY:
The purpose of the study is to describe the process by which Cuban foreign-educated physicians (FEPs) succeeded in integrating into the U.S. medical field.

PROCEDURES:
You’ll start by filling out a one-page questionnaire, followed by participating in an interview for about one hour. With your approval, the interview will be voice recorded. I will ask you about the process you went through to become employed in the medical field, starting with becoming a doctor in Cuba and later the process you’ve gone through in the United States. The length of time you are expected to participate in the study is a total of one hour and 15 minutes.

RISKS AND/OR DISCOMFORTS:
We do not anticipate that you will experience any personal risk or discomfort from taking part in this study.

BENEFITS:
No benefit can be promised to you from your participation in this study. The study is expected to benefit foreign-educated physicians by increasing the understanding of their process of occupational integration and finding possible solutions to address the limitations of the current structures and policies affecting them.

CONFIDENTIALITY:
Identifying information, such as participants’ names will not be on the transcripts and replaced with numbers. Materials that must include identifying information, such as consent forms or contacts sheets, will be kept in a locked cabinet in the primary investigator’s office.

For audio recording:
The audio recordings will be turned into written form, kept in their original language, and will be used to see how other physician’s process has been similar. They will be kept in a
password protected online storage system regulated by the University of Miami for a maximum of five years. Audio recordings may be requested to be turned off during any point of the interview if discomfort arises.
By signing this consent, you authorize the investigators(s) and their staff to access your questionnaire or interview recording as may be necessary for purposes of this study.

**COSTS:**
There are no costs associated with your participation in this study.

**COMPENSATION:**
There will be no compensation.

**RIGHT TO DECLINE OR WITHDRAW:**
Your participation in this study is voluntary. You are free to refuse to participate in the study or withdraw your consent at any time during the study.

If you are an employee or student at the University of Miami, your desire not to participate in this study or request to withdraw will not adversely affect your status as an employee or grades at the University of Miami.

**CONTACT INFORMATION:**
Dina Birman (305-284-3001) will gladly answer any questions you may have concerning the purpose, procedures, and outcome of this project. If you have questions about your rights as a research participant you may contact Human Subjects Research Office at the University of Miami, at (305) 243-3195.

**PARTICIPANT AGREEMENT:**
I have read the information in this consent form and agree to participate in this study. I have had the chance to ask any questions I have about this study, and they have been answered for me. I am entitled to a copy of this form after it has been read and signed.

____________________________    ____________________
Signature of Participant         Date

____________________________    ____________________
Signature of person obtaining consent     Date
University of Miami

CONSENTIMIENTO PARA PARTICIPAR EN UN ESTUDIO DE INVESTIGACION
Entendiendo la Integración de Médicos Cubanos en el Campo Médico de los EE.UU.

La siguiente información describe el estudio de investigación en el que se le está pidiendo a participar. Por favor, lea cuidadosamente la información. Al final, se le pedirá que firme si está de acuerdo en participar.

OBJETIVO DEL ESTUDIO:
El propósito del estudio es describir el proceso en que médicos cubanos logran integrarse en el campo médico de los EE.UU.

PROCEDIMIENTOS:
Vamos a empezar por llenar un cuestionario de una página. Después participara en una entrevista por aproximadamente una hora. Con su aprobación, su voz en la entrevista será grabada. Voy a preguntarle sobre el proceso que pasó para lograr trabajar en el campo de medicina, desde convertirse a médico en Cuba y más tarde el proceso que haya pasado por en los EE. UU. La cantidad de tiempo que se espera que participes en el estudio un total de una hora y 15 minutos.

RIESGOS Y / O MOLESTIAS:
No anticipamos que va a experimentar un riesgo personal o molestia de participar en este estudio.

BENEFICIOS:
Ningún beneficio se le puede prometer por su participación en este estudio. Se espera que el estudio va a beneficiar a los médicos educados afuera de los EE.UU al aumentar el entendimiento de su proceso de integración y la búsqueda de posibles soluciones para minimizar las limitaciones de las estructuras y políticas que les afectan.

CONFIDENCIALIDAD:
Información de identificación, como los nombres de los participantes no estará en las transcripciones y serán reemplazado con números. Materiales que van incluir información de identificación, tales como formularios de consentimiento o hojas de contacto, se mantendrán en un armario cerrado con llave en la oficina de la investigadora principal.

Para la grabación de audio:
Las grabaciones de audio se convertirán en forma escrita, se mantendrán en su idioma original y se utilizarán para ver cómo proceso de otros médicos han sido similar. Ellos se mantendrán en un sistema de almacenamiento en línea protegido por contraseña regulado por la Universidad de Miami por un máximo de tres años. Las grabaciones de audio pueden ser solicitados para ser apagados durante cualquier punto de la entrevista si se presenta malestar.
Al firmar este consentimiento, usted autoriza a la investigadora y su personal para acceder a su cuestionario o la grabación de la entrevista que sean necesarias a los efectos de este estudio.

**COSTOS:**
No hay costos asociados con su participación en este estudio.

**COMPENSACIÓN:**
No habrá compensación.

**DERECHO A RECHAZAR O RETIRAR:**
Su participación en este estudio es voluntaria. Usted es libre de negarse a participar en el estudio o retirar su consentimiento en cualquier momento durante el estudio. Si usted es un empleado o estudiante de la Universidad de Miami, su deseo de no participar en este estudio o solicitud de retiro no afectará negativamente a su estado como empleado o grados de la Universidad de Miami.

**INFORMACIÓN DE CONTACTO:**
Dina Birman (305-284-3001) puede responder a cualquier pregunta que pueda tener en relación con el propósito, procedimientos, y el resultado de este proyecto. Si usted tiene preguntas sobre sus derechos como participante de la investigación puede comunicarse con la Oficina de Investigación de Sujetos Humanos de la Universidad de Miami, al (305) 243-3195.

**ACUERDO DEL PARTICIPANTE:**
He leído la información de este formulario de consentimiento y acuerdo en participar en este estudio. He tenido la oportunidad de formular todas las preguntas que tengo acerca de este estudio, y han sido contestadas. Tengo derecho a una copia de esta forma después que la ha leído y firmado.

__________________________  ____________________
Firma del participante        Fecha

__________________________  ____________________
Firma de la persona que obtiene el consentimiento oral  Fecha
APPENDIX B

Audio Consent (English & Spanish)
Authorization for Audio Recording in a Research Study

I hereby authorize the University of Miami, Department of Psychological and Educational Studies, to take sound recordings of me.

I authorize the University to use in any manner said audio recordings, in whole or in part as follows:

(Please read and check box next to appropriate permission statement):

☐ For the purpose of teaching, research, scientific meetings and scientific publications, including professional journals or medical books;

☐ For research purposes only.

I agree that the University of Miami, its Trustees, officers, employees, faculty and agents will not be responsible for any claims arising in any way out of the taking and use as described above of such recordings. I understand that I will not have an opportunity to inspect and approve such recordings prior to their use.

_____________________  ____________________  __________________
Signature of Participant  Printed Name of Participant  Date

_____________________  ____________________  __________________
Signature of person obtaining consent  Printed Name of Participant  Date
Autorización para la grabación de Audio en un Estudio de Investigación

Yo autorizo que el departamento de psicología y estudios educacionales de la Universidad de Miami tome grabación de mi voz.

Autorizo a la universidad que use en cualquier forma dicha grabaciones de audio, en todo o en parte, de la siguiente manera:

(Por favor lea y escoja en donde quiera dar permiso):

☐ A los efectos de enseñanza, investigación, reuniones científicas y publicaciones científicas, incluidas las revistas especializadas o libros de medicina;

☐ Sólo para fines de la investigación.

Estoy de acuerdo en que la Universidad de Miami, su patronato, facultad, empleados y agentes no serán responsables por cualquier reclamación en que surja de alguna manera de tomar y utilizar como se describió anteriormente de tales grabaciones. Entiendo que no voy a tener la oportunidad de inspeccionar y aprobar dichas grabaciones antes de su uso.

___________________   ______________________________   ______________
Firma del Participante   Nombre en letra de molde   Fecha

___________________   ______________________________   ______________
Firma del Testigo   Nombre en letra de molde   Fecha
APPENDIX C

Demographic Questionnaires (English & Spanish)

*Please answer each of the following questions and let me know if anything is unclear.*

1. **Gender:** Female____ Male____

2. **How old are you? _____**

3. **How many years have you lived in the United States? ______**

4. **How old were you when you arrived to the United States? ______**

5. **How many years ago did you leave Cuba? ______**

6. **Since leaving Cuba, have you lived outside of Miami-Dade County?**

   Yes_____ No_____

7. **If you answered **yes** to question #6, where else have you lived and for how long?**

   *If you run out of space, please write on the back of this page.*

   City/State/Country: ______________________ Years: __________

   City/State/Country: ______________________ Years: __________

   City/State/Country: ______________________ Years: __________

8. **For how many years were you a medical doctor in Cuba? ______**

9. **What was/were your specialty (ies)? ______________________________**

10. **What is your current job? ______**

11. **How long have you been doing this job? ______**
Cuestionario Demográfico para los Doctores Cubanos

Por favor responda a cada una de las siguientes preguntas y déjame saber si algo no necesita clarificación.

1. Género: Femenino______ Masculino______

2. ¿Cuántos años tienes?______

3. ¿Por cuántos años has vivido en los Estados Unidos?______

4. ¿Cuántos años tenías cuando llegues a los Estados Unidos?______

5. ¿Hace cuántos años te fuiste de Cuba?______

6. ¿Desde qué te fuiste de Cuba, has vivido afuera del condado de Miami-Dade?
   Sí______         No______

7. Si respondisteis **sí** a la pregunta #6, ¿en cuál otro lugar has vivido y por cuánto tiempo?
   **Si te quedas sin espacio, por favor escriba al dorso de esta página.**
   Cuidad/Estado/País: ______________________ Años: __________
   Cuidad/Estado/País: ______________________ Años: __________
   Cuidad/Estado/País: ______________________ Años: __________

8. ¿Por cuántos años fuiste un médico en Cuba?______

9. ¿Cuál fue tu especialidad(es)?_______________________________

10. ¿Cuál es tu trabajo actual?_______________________________

11. ¿Por cuántos años has estado en este trabajo?_______
APPENDIX D

Interview Guides (English & Spanish)
Thank you for participating in this project. As a fellow Cuban immigrant, I’m particularly interested in this topic because I’ve observed growing up how these processes affected my own community. I really value having Cubans in the medical field as I know how much it benefits my own family as well as the Miami community as a whole. For my master’s thesis, I am interested in learning about how foreign-educated Cubans doctors have become part of the medical field in the United States. I think it’s important to hear from your personal experiences, along with several others, to have a clearer understanding of the process. Let’s start from the beginning.

1. When did you know you wanted to be a doctor and what made you decide to be a doctor?

2. Did you think you would practice medicine in the U.S.?

Probes:
- When did you first decide to come to the U.S.?
- What did you hear about (in terms of the process) while you were still in Cuba?
- Who did you hear this from?
- What were your hopes, in terms of career, when coming to the U.S.?
- How did you prepare for the move before coming to the U.S.?
- Did being a doctor make it more difficult to leave Cuba?

3. How did it go when you first arrived in the U.S.?

Probes:
- Did you have family/friends in Miami?
- What type of support did your family/friends give you?
- Where did you seek out information on working in the medical field in the U.S.?
- Who helped you?

4. Did you have to pursue further education?
Probes:
- What helped you decide the best education path for you?
- Did you seek help from an organization/university?
- What made it difficult to study?
- What made it easier to study?

5. What was your first job when you arrived in the U.S.?

Probes:
- How did you find this job?
- Who helped you get it?
- Did you seek any guidance from employment agencies or resettlement agencies?

6. Tell me about your current job.

Probes:
- How did you hear about the position?
- Did someone tell you about it?
- Did an organization help you?

7. (For those in an alternative profession and not physicians) What made becoming a ________________ (nurse/physician assistant/lab technician/etc.) a better option?

Probes:
- What program did you do?
- How did you find out about that program?
- How did family/friends support you?
- Did you work while studying?

8. Is there anything else you would like to say about your process of working in the medical field in the U.S?
Guía de Entrevista para los Médicos

Gracias por participar en este proyecto. Siendo cubana, estoy particularmente interesada en este tema porque he crecido observado cómo estos procesos afectan mi propia comunidad. Realmente valoro tener cubanos en el campo de la medicina como yo sé lo mucho que beneficia a mi propia familia, así como la comunidad de Miami en conjunto. Para mi tesis de maestría, estoy interesada en aprender acerca de cómo médicos cubanos se han hecho parte del campo de la medicina en los Estados Unidos. Creo que es importante saber de sus experiencias personales, junto con varios, para tener una comprensión más clara del proceso. Vamos a empezar desde el principio.

1. ¿Cuándo supiste que querías ser médico y lo que te hizo decidir ser médico?

2. ¿Pensasteis que ibas a practicar medicina en los EE.UU.?

   Probes:
   a. ¿Cuándo decidisteis venir a los EE.UU?
   b. ¿Qué oiste (en términos del proceso) cuando estabas en Cuba?
   c. ¿De quién oísteis?
   d. ¿Cuál eran tus esperanzas, en términos de su carrera, en los EE.UU?
   e. ¿Cómo te preparasteis para la venida a los EE.UU?
   f. ¿Por ser un médico se te hizo más difícil irte de Cuba?

3. ¿Cómo te fue cuando llegasteis a los EE.UU?

   Probes:
   a. ¿Tenías familia/amigos en Miami?
   b. ¿Qué tipo de apoyo te dio tu familia/amigos?
   c. ¿A dónde buscasteis información sobre el trabajo en el campo médico para usted?
   d. ¿Quién te ayudó?

4. ¿Tuviste que hacer algún programa de estudio?

   Probes:
   a. ¿Qué te ayudó decidir el mejor plan de estudio para usted?
b. ¿Busco ayuda de alguna organización o universidad?
c. ¿Qué le hizo difícil estudiar?
d. ¿Qué le hizo más fácil estudiar?

5. ¿Cuál fue su primer trabajo cuando llegaste a los EE.UU.?

Probes:
- ¿Cómo encontrasteis ese trabajo?
- ¿Quién te ayudó obtenerlo?
- ¿Buscó alguna ayuda de las agencias de empleo o agencias de reasentamiento?


Probes:
- ¿Cómo supisteis de la posición?
- ¿Alguien te contó?
- ¿Te ayudó alguna organización?

7. (Para aquellos en una profesión alternativa y no médicos.) ¿Qué hizo para convertirse en un ________ (enfermero(a)/asistente médico/técnico, etc.) una mejor opción?

Probes:
- ¿Cuál programa hiciste?
- ¿Cómo supisteis sobre este programa?
- ¿Quién te ayudó? ¿Una persona? ¿Una organización? ¿En el internet?
- ¿Cómo te apoyaron tu familia/amigos?
- ¿Trabajasteis mientras estudiasteis?

8. ¿Hay algo más que le gustaría decir acerca de su proceso de obtener trabajo en el campo médico de los EE.UU?
APPENDIX E

Recruitment Materials (English & Spanish)

¿FUISTES MEDICO EN CUBA?

¿Estas trabajando en el campo medico de los EE. UU.?

¡Las universidad de Miami quiere saber sobre tu experiencia!

Contacta Wendy
305-282-7192
wjmoore@miami.edu

¿WERE YOU A DOCTOR IN CUBA?

Are you working in the U.S. medical field?

The University of Miami wants to know about your experiences!

Contacta Wendy
305-282-7192
wjmoore@miami.edu
## Code List

<table>
<thead>
<tr>
<th>CATEGORY: CONTEXT</th>
<th>ABBRIVIATION: CTXT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Context: Before</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brain Drain</td>
<td>CTXT-BF_DRN</td>
<td>The Cuban government wants to avoid losing doctors so there is a special process that they must go through when attempting to leave Cuba.</td>
</tr>
<tr>
<td>Migration Context</td>
<td>CTXT-BF_MGTN</td>
<td>It is important to note the reasons that led FEPs to leave Cuba (political persecution, future for their children, etc.) as it may affect their expectations in the US.</td>
</tr>
<tr>
<td>Expectations</td>
<td>CTXT-BF_XPCTN</td>
<td>The FEPs' expectations on continuing their profession before and after moving to the United States.</td>
</tr>
<tr>
<td>Cuban Medical Context</td>
<td>CTXT-BF_CU-MED</td>
<td>The FEP's description of the Cuban medical field.</td>
</tr>
<tr>
<td><strong>Context: Arrival</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economic Needs</td>
<td>CTXT-AR_ECON</td>
<td>The balance between work and educational opportunities. Individuals often have to weigh between the cost and benefit of each when deciding the best route for them. Some are able to dedicate time to educational opportunities that later furthers their employment opportunities. For others, their economic and family responsibilities disallow them to invest into educational opportunities.</td>
</tr>
<tr>
<td>Transculturación</td>
<td>CTXT-AR_TRNS-CU</td>
<td>A process described by one of the participants as the experienced that Cubans go through when moving to the U.S. (a transcultural experience). They are transitioning from one culture to understanding the norms of another. Others described similar processes but didn't not call it this. For example, learning how to manage the US job market, learning property etiquette for a job interview, etc.</td>
</tr>
<tr>
<td>Spousal Dynamics</td>
<td>CTXT-AR_SPOUSE</td>
<td>Traditional gender roles may vary depending on necessity. For example, historically men have been the primary &quot;bread winners&quot;. However, when it was necessary for one spouse to study while the other worked, both men and women took on the primary economic burden.</td>
</tr>
<tr>
<td><strong>Context: Med Field</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer of Skills</td>
<td>CTXT-MED_TRANS-SKL</td>
<td>FEPs describe how their skills and their experience as physicians helped them while working in other areas of the medical field.</td>
</tr>
<tr>
<td>Context</td>
<td>Table Code</td>
<td>Description</td>
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<tr>
<td>Ill-fitting Process (Ill-fitting Exam)</td>
<td>CTXT-MED_ILL-PRSS</td>
<td>Are the systems in place fair? Should there be another way to approach the adjustment of FEPs into the U.S. medical field? Does it make sense for FEPs with many years of experience to go through the same process as current medical students with little experience? The materials are very broad and some FEPs describe it to be very difficult for someone that has been in one area of medicine for many years. Does this mean that FEPs with more experience have a disadvantage?</td>
</tr>
<tr>
<td>Med Field Connection</td>
<td>CTXT-MED_MED-CON</td>
<td>Describing the level of connection as well the lack of connection to the medical field. As FEPs arrive in the U.S. they seek to find a balance between finding connection to their professions in Cuba and satisfying their economic needs for themselves and their families. Earlier job opportunities tend to be more disconnected with their profession as physicians. Personal satisfaction is described by the FEPs when there is connectivity with their past profession.</td>
</tr>
<tr>
<td>Perceptions</td>
<td>CTXT-MED_PERC</td>
<td>The way FEPs feel that they are perceived by U.S. professionals. Some felt that when they applied to non-medical jobs and stated that they were doctors that it could hurt their ability to get even a low paying job.</td>
</tr>
</tbody>
</table>
One was told they were called "overqualified" in a job interview because her background as a physician.

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<thead>
<tr>
<th>CATEGORY: BARRIERS</th>
<th>ABBREVIATION: BR</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>BARRIER: Responsibility</td>
<td>BR-RSPNS</td>
<td>Familial responsibilities tend to be a large barrier for FEPs to invest into a long-term process in order to go through the revalidation process.</td>
</tr>
<tr>
<td>BARRIER: Time</td>
<td>BR-TIME</td>
<td>Time available in their every day schedule to move forward in the process.</td>
</tr>
<tr>
<td>BARRIER: Age</td>
<td>BR-AGE</td>
<td>The age of the FEPs affects the process that they go through when integrating in the US medical field.</td>
</tr>
<tr>
<td>BARRIER: Language</td>
<td>BR-LNG</td>
<td>Language skills can be one of the greatest barriers or facilitators for FEPs in their process of integrating into the U.S. Medical Field. Learning a new language in adulthood is much more difficult, which prior research depicts, but that in Cuba there is also little access to becoming fluent English speakers before coming to the U.S. The English that is taught in school is British English. As described by the participants, it's formal and less conversational. Even if you were to hire a private instructor, they depicted that their experience moving to the U.S. was that their English still needed a lot more work, especially in becoming conversational. The level of language skills needed when working with other professionals (physicians and nurses) also surpassed the basic English knowledge base.</td>
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</tr>
<tr>
<td>BARRIER: Political</td>
<td>BR-POL</td>
<td>Does experiencing persecution lower their expectations in a new country? What other aspects of the political system in Cuba created a barrier for their process?</td>
</tr>
</tbody>
</table>
Through the various experiences of the participants of the study, there were some barriers affected their ability to become employed. Some basic ones were simply having a car for example or the ability to pay for the licensing exams.

<table>
<thead>
<tr>
<th>CATEGORY: FACILITATORS</th>
<th>ABBREVIATION: FCLTR</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitators</td>
<td>FCLTR</td>
<td>Individual efforts are not enough. Facilitators are aspects that have assisted the FEPs in their process in attempting to work within the U.S. medical field. They go beyond their individual characteristics. For each of these cases individual effort was not enough to assist them to become physicians. Similar to barriers, their age, language skills, social support, and year of migration are factors in their ability to reintegrate in the field.</td>
</tr>
<tr>
<td>Facilitator: Social Support</td>
<td>FCLTR-SCL_SPPRT</td>
<td>Any time someone talks about social support (family, friends, etc.). Family assists in some processes when first arriving in the U.S. but when learning how to navigate the U.S. medical field, FEPs often cannot rely on their families for assistance if they do not understand the field themselves. However, friends and acquaintances</td>
</tr>
</tbody>
</table>
often supplement that role by providing direction or possible opportunities for FEPs when family members aren't able.

<table>
<thead>
<tr>
<th>Facilitator: Social Support: Bonding Capital</th>
<th>FCLTR-SCL_SPPRT-BC</th>
<th>As an aspect of social support, bonding capital, provides resources for oppressed or marginalized groups. Other Cubans provided physical resources, such as providing books for another FEP that hasn't yet gone through the process or recommending a pathway to take.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitator: Social Support: Bonding Capital: Success Stories</td>
<td>FCLTR-SCL_SPPRT-BC-STORIES</td>
<td>BC= Bonding Capital. As an aspect of social support, bonding capital, provides resources for oppressed or marginalized groups. Stories shared: 1) Knowledge on the process 2) Physical Resources (e.g. books) 3) Motivation/Encouragement. For Cubans, those that can share success stories of medical integration are able to be guides for new FEPs after arrival.</td>
</tr>
<tr>
<td>Facilitator: Social Support: Employment</td>
<td>FCLTR-SCL_SPPRT-EMP</td>
<td>Informal avenues that have assisted an FEP to obtain a job (e.g. a friend or family member as the referenced or employer. This also includes finding out about job opportunities through some acquaintances, family member, or friend.</td>
</tr>
<tr>
<td>Facilitator: Social Support: Family</td>
<td>FCLTR-SCL_SPPRT-FAM</td>
<td>Family dynamic: Anytime someone talks about family. Family is the primary social support for Cuban migrants. My description of family includes children, spouse, and extended family since Cubans often live in multi-generational housing in Cuba. The careers of the spouse affect the process of the other while the responsibility of children also affects the decision making process. Cubans place a strong emphasis on family. As well some decisions as which career path will be taken/ where one live are will highly influenced to family.</td>
</tr>
<tr>
<td>Facilitator: Organizations</td>
<td>FCLTR-ORG</td>
<td>The names of organizations as well as the process of becoming connected with organizations and deciding if they're a good resource. Organizations play a crucial role in the resettlement process of Cubans. They play an initial role in guiding FEPs into deciding steps to take to find work as well as assist in other economic needs.</td>
</tr>
<tr>
<td>Facilitator: Organization: Education</td>
<td>FCLTR-ORG-ED</td>
<td>The role that organizations have played in assisting an FEP to find educational opportunities.</td>
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</tr>
<tr>
<td>Facilitator: Organization: Employment Process</td>
<td>FCLTR-ORG-EMP</td>
<td>The role that organizations have played in assisting an FEP to find employment opportunities.</td>
</tr>
<tr>
<td>Facilitator: U.S. Policy</td>
<td>FCLTR-US-POL</td>
<td>Policies that have assisted the process that FEPs go through when attempting to work within the US medical field.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CATEGORY: INFO ACCESS</th>
<th>ABBREVIATION: INFO</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>INFO ACCESS: Cuban Politics</td>
<td>INFO-CU_POL</td>
<td>Comparison of access of information for Cuban FEPs in comparison to FEPs in other nations. Some participants described their interaction with FEPs from other nations and how the political disconnection between the US and Cuba affects the lack of information and they had before leaving the island. In addition, FEPs in other nations can start participating in the process before even leaving their countries by taking the first steps of the licensing exams.</td>
</tr>
<tr>
<td>INFO ACCESS: Geography</td>
<td>INFO-GEO</td>
<td>Access to information about this process may vary depending on the region of the United States where an FEP initially arrives. Other states and other parts of the state of Florida may have less preparation and less knowledge in where/how to direct FEPs.</td>
</tr>
<tr>
<td>INFO ACCESS: Internet</td>
<td>INFO-INT</td>
<td>The depiction of how the internet has affected access to information, ability to study for the medical boards, etc. The internet has widely affected individual's access to information all over the globe. Over the last 20 years, the internet itself has transformed and the level of information has multiplied. However, Cuba remains the country in the Western Hemisphere with the least access to internet.</td>
</tr>
<tr>
<td>INFO ACCESS: Social Support</td>
<td>INFO-SCL_SPPRT</td>
<td>FEPs described a link between access to information and the people around them. Some FEPs moved to Miami, FL because it provided a greater network of Cubans that could provide more information about the revalidation process, such as a larger network to former colleges that could tell them about their experiences with the process and connect them to organizations that they had found helpful.</td>
</tr>
<tr>
<td>INFO ACCESS: Time Period or Year</td>
<td>INFO-YEAR</td>
<td>The internet has widely affected individual's access to information all over the globe. Over the last 20 years, the internet itself has transformed and the level of information has multiplied. When thinking ecologically, the Chrono-system is shown to have affected the level of information accessible to more recent migrants.</td>
</tr>
<tr>
<td>INFO ACCESS: US Higher Ed</td>
<td>INFO-US_COLLEGE</td>
<td>The varying level of access of information that can be available in US institutions of higher education.</td>
</tr>
<tr>
<td>-----------------------------</td>
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<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>INFO ACCESS: Secondary Migration</td>
<td>INFO-SEC-MIGTN</td>
<td>Moving from one city or state to Miami to gain access to information.</td>
</tr>
</tbody>
</table>
VITA

Wendy Jordana Moore (nee de los Reyes Jordana) was born in Havana, Cuba on September 25, 1989. Her parents are Jacqueline Jordana Lopez and Enrique de los Reyes Alvarez. She received her elementary education from Shenandoah Elementary and her secondary education from Hammocks Middle, West Miami Middle, and Coral Gables Senior High School. She graduated in May 2013 with her Bachelor of Science in Education from the University of Miami with majors in Human & Social Development and Psychology. In August 2014 she was admitted to the Graduate School of the University of Miami where she is pursuing her M.S.Ed. in Community & Social Change. She currently lives with her husband, Nick, in Nashville, Tennessee.