

NURSES CARING FOR BIRTH TOURISM FAMILIES IN NEONATAL  
INTENSIVE CARE UNITS: A PHENOMENOLOGICAL INQUIRY

DISSERTATION

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Tamara LaCroix

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by

Tamara LaCroix

2021

APPROVED BY:

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Jessie M. Colin, Ph.D., RN, FRE, FAAN  
Chairperson, Dissertation Committee

---

Claudette R. Chin, Ph.D., APRN  
Member, Dissertation Committee

---

Ferrona A. Beason, Ph.D., APRN  
Member, Dissertation Committee

---

Tony Umadhay, Ph.D., CRNA, APRN  
Interim Program Director, College of Nursing and Health Sciences

---

John J. McFadden, Ph.D., CRNA  
Dean, College of Nursing and Health Sciences

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## Abstract

**Background:** Birth tourism families plan their birthing experience that includes purchasing a maternity care package, traveling internationally to a preferred destination, and the delivery of a healthy newborn in an expected short hospital stay. However, some families admit a premature or ill infant into a South Florida neonatal intensive care unit. When admitted into this setting, neonatal nurses are unique in providing quality nursing care to birth tourism infants and their parents as a family unit. There remains a gap in nursing research in understanding neonatal nurses' lived experience caring for birth tourism families in the neonatal intensive care unit.

**Purpose:** The purpose of this hermeneutic phenomenological study using van Manen's (1990) methodology was to understand the lived experience of neonatal nurses caring for birth tourism families who admit a newborn into South Florida's neonatal intensive care units.

**Philosophical Underpinnings:** Max van Manen's (1990) hermeneutic phenomenology guided the question: "What is the lived experience of neonatal nurses caring for birth tourism families who admit their infant into South Florida's neonatal intensive care units?"

**Methods:** The target population was neonatal nurses working in South Florida's neonatal intensive care unit. Purposive and snowball sampling were used. Collected data from semi-structured interviews and participants' artworks were entered in NVivo 12-Pro software. Max van Manen's (1990) six procedural activities and Miles, Huberman, and Saldaña's (2014) data flowing activities, line-by-line theming, and interpreting were adopted to organize, code, and categorize the gathered texts.

**Results:** From 22 neonatal nurses interviewed, four themes emerged. Interpreted data yielded the funneling of cultural care in a continuous phase of *recognizing cultural interactions, acknowledging cultural consciousness, canalizing compassionate care, and bridging family-centeredness.*

**Conclusions:** This study revealed the participants' experiences caring for birth tourism families who unexpectedly admit newborns into the neonatal intensive care unit. When caring for a sick or ill newborn, neonatal nurses do not always recognize birth tourism families in the unit, hindering supporting their needs and delivering culturally competent care. Neonatal nurses experience the funneling of cultural care in a continuous phase of recognizing cultural interactions, acknowledging cultural consciousness, canalizing compassionate care, and bridging family-centeredness to provide quality family-centered and culturally competent care to meet the needs of birth tourism families.

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## DEDICATION

This dissertation is dedicated to my God, who is forever faithful even when I am not. To my children, my angel, *Tatiana R. Naar* (1989-2010) (left me too soon), my princess, *Katrina B. Naar*, my only son and hero, *Army Sergeant Naar, Wladimir Dimitri* (HHC 2-35 IN 3IBCT), and my little prince *Malachi Moxey* (grandson). You are my reasons for living and embarking on this journey. I love you to the moon and back. Blessings to all who God placed on my path to love, pray, support, and encourage me during this journey.

*"The LORD is my shepherd, I lack nothing.*

*He makes me lie down in green pastures, he leads me beside quiet waters,  
he refreshes my soul. He guides me along the right paths for his name's sake.  
Even though I walk through the darkest valley, I will fear no evil, for you are with  
me; your rod and your staff, they comfort me. You prepare a table before me in  
the presence of my enemies. You anoint my head with oil; my cup overflows.  
Surely your goodness and love will follow me all the days of my life, and I will  
dwell in the house of the LORD forever." Psalm 23*

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## CHAPTER ONE

### PROBLEM AND DOMAIN OF THE INQUIRY

Every family who chooses to have children deserves to give birth in the hospital and country of their choice for a beautiful beginning. South Florida, being a popular gateway for tourism, receives pregnant women who travel from abroad with their expectations of delivering a healthy American baby before immediately returning to their home country (Grant, 2015; Mikhael et al., 2016; Nori, 2016). This group of women practices birth tourism—the act of a pregnant woman traveling internationally to a preferred destination to give birth on foreign soil (Folse, 2015; Grant, 2015). Birth tourism families travel with a birthing plan that often includes the purchase of a maternity care package, the travel to a destination that is offering the best maternity and newborn healthcare, the expectation of delivering a healthy newborn, and a short hospital stay (Folse, 2017; Ji & Bates, 2018). However, at times, some birth tourism families end up admitting their ill or premature newborn into the neonatal intensive care unit (NICU) (Folse, 2015; Grant, 2015; Mikhael et al., 2016; Nori, 2016).

When admitted to the NICU, neonatal nurses provide specialized care to the neonates and are in the best position to integrate their nursing philosophy into the care rendered to all families admitted. Although neonatal nurses rely on theoretical and conceptual models serving as a platform for disseminating nursing care, there remains a gap in the nursing literature regarding the quality of care delivered to birth tourism families (Marcotte, 2017; Mikhael et al., 2016; Purnell, 2012). Nursing research is scant on the evidence, from neonatal nurses' perspectives, about the care that birth tourism families receive or on the quality of care rendered to them. Therefore, this hermeneutic

phenomenological nursing inquiry utilized the methodology of Max van Manen (1990) to explore the lived experience of neonatal nurses caring for birth tourism families in the context of providing quality nursing care in South Florida's NICUs.

### **Background of the Study**

Birth tourism quickly gained media attention in myriads of reports presenting this practice in (a) internet advertisements from travel agencies and maternity hotels in the sale of birth tourism packages, offering the best maternal healthcare in the United States (U.S.); (b) newspapers portraying birth tourism as an illegal act of mothers in the attempt of obtaining citizenship rights for their newborn; (c) media reports referring to mothers with de-humanizing words such as “Amerimama” for obtaining birthright citizenship for their newborn right after their delivery; and (d) political and immigration discourses, including numerous law studies suggesting that birth tourism negatively impacts U.S. communities financially, socially, and medically (Freere, 2015; Folse, 2017; Ford, 2017; Grant, 2015; Heaton & Dean, 2016; Sheehan, 2015; Passel & Taylor, 2010; Petersen, 2015; Carlson, 2015; Wang, 2017). Apart from birth tourism ringing the alarm through the American media, attention to birth tourism and healthcare has raised controversies. During the U.S. 2016 presidential election, the topic of birth tourism emerged from non-empirical evidence such as anecdotal data, editorials, politics, and immigration discourses, highlighting the practice of seeking maternal healthcare in high resource countries as an illegal or manipulative act (Barreto, Cooper, Gonzalez, Parker, & Towler, 2011; Grant, 2015; Nori, 2016; Staudt & Coronado, 2016; Wang, 2017). Literature (Feere, 2015; Folse, 2017; Ford, 2017; Grant, 2015; Heaton & Dean, 2016; Nori, 2016; Petersen, 2015; Wang, 2017) exposes birth tourism in prolonged public disputes, causing

diverse conversations to spark, debating on several issues from immigration and economy and to healthcare affecting the country that receives birth tourism families.

The term "birth tourism" is described as the act of pregnant women traveling from developing countries to give birth to their newborn in a high resource country that withholds the law of *jus soli* (Latin for the right of the soil) (Folse, 2017; Grant, 2016; Heaton & Dean, 2016; Ji & Bates, 2018; Mikhael et al., 2016; Nori, 2016). This law means that anyone born on the country's soil will automatically receive birthright citizenship regardless of their parent's country of origin (Feere, 2010). Birth tourism quickly grew over the past decade in countries abiding by this law, and through this healthcare practice, pregnant women across international borders to seek maternal healthcare as well as other benefits that could secure a future for their unborn child and sometimes for the entire family in the receiving country (Barreto et al., 2011; Grant, 2015; Nori, 2016; Staudt & Coronado, 2016; Wang, 2017). Several terms such as "maternity tourism," "transnational citizenship," and "reproductive tourism" describe the act of birth tourism. Birth tourism, in some anecdotal data, is also associated with idioms such as "anchor babies" or "fetal citizenship" (both terms referring to parents' use of the birth of the infant to obtain citizenship from the receiving country), and "Amerimama" (the term used by tourism agencies to solicit pregnant women from other countries to deliver their newborn in America) (Nori, 2015; Wang, 2017).

These set phrases, as mentioned above, create de-humanizing appellations such that of capturing rhetoric associated with illegality, criminality, and illegitimacy toward these international mothers for choosing to travel abroad to deliver their baby in a country other than their own (Henderson, 2014; Lederer, 2013; Lugo- Lugo & Bloodsworth-

Lugo, 2014). Anecdotal discourses on birth tourism may have created misperceptions in some cases, which are evident in the de-humanizing titles used to characterize these families. To some against the practice of birth tourism, pejorative rhetoric has become familiar especially in news report headlines and political conversations involving immigration. To others who support birth tourism, these de-humanizing names should never exemplify this population because it consists of the vulnerable (pregnant women and their infants). Besides, such titles often create misperceptions about birth tourism families. They are misconstrued, taken for being undocumented immigrants, who may negatively impact maternal healthcare provision for this population. To uninformed constituents, birth tourism equates to women who enter the country excessively drawing on expensive healthcare resources and leaving without paying for the hospital bills (Cohen, 2014; Illingworth & Parmet, 2017). Seeking maternal healthcare in a foreign country other than the pregnant woman's country of residence may be viewed as an unacceptable practice. Nevertheless, birth tourism families practice migration and mobility by making decisions in choosing a country's destinations, allowing utilization of the best maternity care in an environment assuring a safe delivery and care of their infant.

### **Scope and Global Presence of Birth Tourism**

For decades, people have been traveling worldwide and staying in places outside of their residence for not more than 1 consecutive year seeking leisure, business, or medical care. Historically, several countries have in place laws that encourage birth tourism, such as the law of "jus soli," meaning birthright to the soil or allowing birthright citizenship to any child born on their soil. The World Tourism Organization (WTO, 1997) claims that tourism is a global phenomenon, and among the various forms of

travel, birth tourism is a very prominent form that offers vacation, leisure, and healthcare for mother and baby. The Center for Immigration Studies reports that birth tourism is currently part of the world's largest industry. Although the birth tourism business remains clandestine in some countries, this practice involves birth tourism families choosing the best and popular countries to give birth for purposes such as obtaining a passport in the receiving country, social benefits, and securing a stable future for the entire family (Camarota, 2015).

Anecdotal evidence and media reports shed light on the global presence of birth tourism practices are throughout the world on continents such as Europe, Africa, Asia, the Americas, and Australia (Crush, Chikanda & Maswikwa, 2013; Freere, 2015). There are no statistics on the percentage of citizens who participate in birth tourism; however, the Central Intelligence Agency (CIA) World Factbook has published countries that hold citizenship laws worldwide and countries that recognize and support particular circumstances surrounding foreigners obtaining citizenship rights through birthright citizenship. (see Figure 1).



*Figure 1.* Birthright citizenship around the world year 2018 (LaCroix, 2020, adapted from The World Factbook, 2021).

*Note.* Figure 1 is displaying countries that offered birthright citizenship around the world in 2018. According to The World Factbook from the Central Intelligence Agency (2021), the above countries currently offer birthright citizenship laws depicted in blue-shaded areas. The red shaded countries offer birthright citizenship in some cases or with some conditional laws. Gray shaded areas represent countries that do not offer birthright citizenship.

Although, some countries have amended their laws to include circumstances beneficial or disadvantageous to birth tourism families in recent decades. Ireland, the last European country offering unconditional citizenship rights to children born to two

foreign parents, amended its constitution to end their birth tourism practice (Coleman, 2018). Other countries, such as Australia, have similarly tightened their birthright citizenship laws to reduce the number of families migrating to give birth. New Zealand, South Africa, and the United Kingdom modified their laws by granting citizenship by birth only if at least one parent is a citizen of the country or a legal permanent resident and lived in the country for several years (Central Intelligence Agency World Factbook, 2018). Germany, in turn, never granted unconditional birthright citizenship; nonetheless, traditionally, it used the law of "jus sanguinis," that is a nationality law by which citizenship is determined or acquired by the nationality or ethnicity of one or both parents (Cheng, 2016; Shachar, 2003; Tabachnik, 2019). Tanzania in East Africa and some Asian-Pacific countries also grant unconditional birthright citizenship, which offers what is called "absolute jus soli "(absolute right to soil) (Azizi, Hajiazizi, & Hassankhani, 2012; Coleman, 2018). In Asia, Mainland, Chinese parents who are Chinese citizens living in the continental region of East Asia often seek to give birth in Hong Kong to obtain the "right of abode" (right to take up residence in the country) for their children (Cheng, 2016). To illustrate, these birth tourism families are Chinese citizens who become Hong Kong citizens with special privileges to reside in Hong Kong (Cheng, 2016; Coleman, 2018).

In the Americas, most countries, such as the United States and Canada, grant birthright citizenship. South American countries such as Panama, Brazil, and Argentina encourage birth tourism by promoting their quality medical care and sparing costs in advertisements of their world-class facilities. Subsequently, birth tourism families are attracted to the promise that giving birth in these countries will be a wonderfully

luxurious experience and sometimes for their economical maternity care packages compared to North American countries. Caribbean countries such as Dominica and St. Kitts sell economic citizenship for six-figure price tags and charge for birth tourism children to receive a passport. Other North American countries, such as Belize, offer citizenship by investment programs and attractive birth tourism options (Surak, 2016; Xu, El-Ashram, & Gold, 2015). By investing in the host country's economy, citizenship by investment programs is obtaining a second citizenship and passport (Surak, 2016). Holders of second citizenship and a passport facilitated by birth tourism have access to Schengen Areas (European zone allowing the use of a single visa to cross borders within European countries), making it easier to travel within that area. Holders of passports from Argentina, Costa Rica, Mexico, Panama, St. Kitts, Uruguay, and Venezuela can travel visa-free to all Central and South American countries and Europe's borderless Schengen Areas as well as every country in Europe (Timothy, 2019). Numerous countries have ended their policy of giving citizenship based on birthplace; these include Australia, most recently, and New Zealand, Ireland, France, Malta, and India (Feere, 2010). However, birthright citizenship laws remain in the West where the United States (U.S.) continues to facilitate the practice of birth tourism, encouraging families to enter the country for the needed maternal and infant care and the right of being a citizen of that country.

Among the 3.9 million births registered in the U.S. by the National Center for Health Statistics, the Center for Immigration Studies in 2016 reported that 36,000 birth tourism mothers delivered in U.S. hospitals (Camarota, 2015; Jaramillo, 2018; Medina, 2011). The Center for Immigration Studies estimated that 300,000 to 400,000 anchor babies (the term used to describe birth tourism infant) are born each year (Higdon, 2015;

Wydra 2010). Online tourism reviews (Folse, 2015; Grant 2015; Nori, 2016) reported that in 2014, 60,000 Chinese women arrived in the U.S. to give birth. Other pregnant women practicing birth tourism are traveling from Canada, China, Russia, and Nigeria to enter the U.S seeking the best maternal healthcare.

Florida is known as one of the most significant gateways for tourism. It houses hospitals with international departments that provide maternal and infant healthcare services to an array of patients, of which some are expectant mothers traveling from Central America, South-America, and the Caribbean. Data (Folse, 2017; Ji & Bates, 2018; Sammour et al., 2012) over 5 years (2010 to 2015) revealed a marked increase of pregnant women who travel internationally to give birth in South Florida, which ranges from 550 to 625 births per year, with the largest group of birth tourists found in Miami-Dade County. Whether for vacation or to obtain maternal health care, birth tourism families choose leading destinations such as South Florida to utilize the healthcare systems offering services such as high-risk obstetrics, pediatric cardiovascular, neonatology, trauma, and neurology services, which may be unavailable in their developing countries (Ji & Bates, 2018; Mickael et al., 2016; Nori, 2016; Phillimore, 2016).

Over recent decades, evidence shows a global growth in international patients seeking medical care and the flow of pregnant patients crossing national borders (Lunt et al., 2011). According to the U.S. Cooperative for International Patient Programs, which represents 70 hospitals and health systems that provide medical care to patients who travel internationally, it is tough to pinpoint and quantify the number of patients arriving in America for medical services each year (Sandberg, 2017). Nevertheless, data (Davis et

al., 2014) highlighted that the American Health Association recorded from July 2014 to June 2015 patients from more than 150 countries received healthcare treatment in U.S. hospitals. Moreover, several hospitals and healthcare systems provide care to several international patients. The following are examples of these healthcare systems serving this population: (a) Louisiana-based Ochsner Health System treats between 2,800 and 4,000 international patients a year; (b) Houston Methodist Hospital treats about 3,000 international patients a year, particularly from Mexico, Central America, and South America; (c) John Hopkins Medicine International treats about 4,500 international patients; (d) Baptist Health International in Florida cares for about 9,000 international patients a year, primarily from the Caribbean and Latin America; (e) Stanford University Medical Center treats about 2,700 international patients a year; (f) University of California Los Angeles Health sees between 2,500 and 3,000 international patients per year (AHA, 2016; Kehoe, 2016). Data remain challenged in reporting the number unique to maternity patients who travel internationally amongst these hospitals; however, anecdotal evidence reveals data illustrating inside the shadowy world of birth tourism. For example, *The Washington Post* in 2015 reported that more than 30 maternity hotels in Southern California and New York served wealthy foreign pregnant women who traveled internationally to give birth and obtain the significant perk of a U.S. passport for their newborn (Phillip, 2015). In 2018, *The New York Post* published that court documents cited that 40,000 children are born to women in the U.S. who travel on a tourist visa each year (Fonrouge, 2018). Although there is no assurance to the definitive source that aggregates birth tourism data and the trend analysis on this practice, birth tourism's scope and global presence are prevalent and indicate futuristic growth (Freere, 2015).

## **Social Aspects of Birth Tourism in the United States**

As a form of cross-border healthcare practice, the literature uses different social aspects to address birth tourism. Social immigration studies illustrate the social aspects that families from abroad partake in birth tourism practice and is known as a form of "aspirational migration" (Folse, 2017). Folse (2017) coined this term "aspirational migration" to fit the phenomenon of birth tourism and describes it to be a form of migration (illustrating future movements enabled through the receipt of a passport for the newborn), and aspirational (highlighting the hope of securing a future through obtaining alternative citizenship in a country offering better opportunities for their unborn child). Aspirational migration helps answer the "why" and the "how" questions of birth tourism. In conceptualizing this term, Folse (2017) helped to understand the parents' decision-making aspects resulting in their choice to travel to a foreign country for their newborn's best healthcare and health outcome.

Furthermore, in an immigration law aspect, birth tourism is a subcategory of the broader birthright citizenship law topic. Concerning birth tourism, birthright citizenship serves as a gateway for pregnant women to visit a nation briefly, have a child, and automatically acquire that nation's citizenship (Freere, 2015). In an ethnic and racial aspect, birth tourism conceptualized with the term transnationalism (operating across national boundaries), which is to indicate that migration of these families causing different cultures to merge as well as creating new ethnic identities for the infant born from birth tourism mothers (Balta & Altan-Olcay, 2016). Subsequently, there is a relationship between birth tourism, racialization, and ethnicity evident by the pattern of birth tourism, which encourages racial and ethnic variation within a society when

pregnant birth tourists deliver a newborn abroad. Birth tourism in the literature is mentioned as a form of transformative citizenship in which historical facts have underscored the way mothers from across the world acquire an American passport for their infants (Balta & Altan-Olcay, 2016). This way to citizenship is not about creating egalitarian political communities. However, instead, birth tourism is to create future possibilities of easier entry for the child and family, hoping to transform the country's future into a politically more desirable one (Balta & Altan-Olcay, 2016). In other words, birth tourism, conceptualized as transformative citizenship, may be beneficial to America as it would create more citizens able to vote for political issues, and these votes will emerge from the legal child who obtained their passport during their parent's vacation.

From a political aspect, birth tourism is a stamp in American leaders' political agenda and using the expression of "reproductive futurism" to define birth tourism is utilized mainly in the growing region of California (Wang, 2017). In the contexts of citizenship and migration, Wang (2017) explained that reproductive futurism is when citizens of a country seek to preserve the population's future. It allows women from foreign countries to give birth on the receiving country's soil to increase their future population. Often intertwined between immigration, socioeconomic, and healthcare issues, political leaders underscore birth tourism families' entry as being an illegal practice. Perspectives from the uninformed consumer place pregnant women practicing birth tourism as illegal aliens who enter the country to have their baby and have their medical bills paid by citizens' tax dollars from the receiving country (Galvez, 2011).

According to some immigration reform aspects, birth tourism families entering the country may not be well-received due to immigration policies' negative uproar. Birth

tourism is a subset of a broader matter in which infants born of non-citizen visitors instantly gain citizenship from the nation. These benefits, especially when women are facing complicated pregnancies, include acquiring birthright citizenship, access to public schooling in the future life of that infant, receipt of best and specialized maternal and pediatric healthcare, sponsorship for the parents to gain legal entry in the future, and escape of families from countries with birth restriction policies (i.e., China's two-child policy before 2013) (Folse, 2017; Grant, 2015; Mikhael et al., 2016; Nori 2016).

Although no official data on these reported birth tourism activities exists, birth tourism families often perceived as undocumented immigrants anecdotally said to plan to remain in the receiving country without legal documentation of residence. Instead, birth tourism families travel across borders to receive high-quality healthcare not available in their home country. This social aspect of birth tourism influences immigration lawmakers and immigration policies utilized during the 2016 presidential election to push U.S. leaders' political agendas, highlighting their promise to Americans of "making America great again." However, some may view this agenda as social injustice because it denies healthcare to a vulnerable population in need. Besides, healthcare is a human right, and nursing is about caring for another human (Illingworth & Parmet, 2017; Ji & Bates, 2018).

Birth tourism families are not only seeking maternal healthcare from abroad, but some are seeking additional benefits. Birth tourism families are assumed by many to be among affluent pregnant women who can afford to engage in traveling on a tourist visa; many women who do come to the U.S. to give birth are also from the middle class (Jaramillo, 2018). From the aspect of social affluence, gaining social benefits in the

receiving country, negative uproars are often found in current events about birth tourism families seeking not only maternal healthcare (Goudie & Markoff, 2019; Jaramillo, 2019; Santhanam & Frazee, 2018; Hong & Dollinger, 2020). Thus, many consumers believed that birth tourism families create economic burdens by not paying their hospital bills or applying for welfare to pay for the newborn's hospital bill.

### **Birth Tourism Integrated in Business**

For decades, the tourism industry integrated healthcare in this market, offering quality patient care to international clients for a price (Debata, Patnaik, Mahapatra, & Sree, 2015). Scientific research (Holloway & Taylor, 2006; Lee, 2006) points out that birth tourism is a global business categorized under medical tourism. International publications (Folse, 2017; Ji & Bates, 2018; Lee, 2006) conceptualized this practice using many terms to explain and support birth tourism as a global business, consumed in medical tourism in which pregnant women seek medical care from abroad. Birth tourism, a growing segment of medical tourism, is the merging of healthcare and tourism businesses in the United States (U.S.) hospitals to provide obstetric services to international families (Grant, 2015; Nori, 2016). International departments are selling this business from an array of American healthcare systems, bringing in sizeable revenues through large hospitals' marketing departments, which include the sale of maternity care, nursing care, and pediatric care (Cheng, 2016; Edel, 2014; Grant, 2015; Nori, 2016). For example, "Doctores Para Ti," based in Texas, runs a maternity tourism program to facilitate childbearing services to foreign women who wish to receive safe and adequate medical care (Nori, 2016).

Birth tourism patients travel internationally with purchased plans resembling a vacation; pre-purchased maternity care packages which advertised to include maternity hotels, or pre-purchased of hospital's maternity suites, and everything included, from transportation to layette shopping arrangements to facilitate their best birthing experience (Harwell et al., 2015; Heaton & Dean, 2016; Passel & Taylor, 2010). These arrangements are often interpreted as by the majority in the U.S. to take advantage of the receiving country (Grant, 2015; Petersen, 2015). Research (Folse, 2017; Ji & Bates, 2018; Lee, 2006) documents individuals or future parents are practicing birth tourism as cultural groups traveling seeking medical care in the form of "lifestyle migration." This concept helps explain how future parents are motivated by travel agencies to give birth abroad by alluring them with internet advertisements promising a better future. Maternity care packages sold via hospitals' international departments to birth tourism families are overlooked in nursing research, especially families' experiences and nurses providing for families' needs (Folse, 2017; Ford, 2017). Maternity care packages sold to birth tourism families promising the best quality of care with luxurious amenities during their visit bring substantial revenues to American healthcare systems (DeMicco, 2017; Ji & Bates 2018). As birth tourism families purchase maternity healthcare packages from hospitals' international departments, they expect to receive the highest quality care for mother and infant as promised in their purchased packages (Grant, 2015; Koblinsky et al., 2016; Mikhael et al., 2016; Petersen, 2015).

Health care systems are not the only businesses profiting from birth tourism. The commercialization of maternity care packages appearing in some studies (Voigt & Laing, 2010; Murray, 2016) as reproduction tourism capitalizes on pregnant women searching

for access to maternal healthcare services outside of their own country. Also, numerous commercial organizations such as travel agencies are profitable in the market of birth tourism, where pregnant women purchase not only the travel arrangements nonetheless, but products also related to their pregnancy for a deluxe and memorable childbirth experience (Murray, 2016). Companies offer prenatal massages, pregnant yoga classes, shopping sprees for maternity clothing or designer baby items, and baby bottles. Other products, such as hotel baby programs to include a crib and infant's car seat/carrier, as well as a merged hospital and hotel package to provide extravagant and luxurious recovery plans (an extra two nights stay to get proper rest required after birth before returning to home country) (Voigt & Laing, 2010). The growing birth tourism niche in consumer use or as a business product is in the airline industry, which provides safe travel methods and freedom to move around in the chosen destinations (Voigt & Laing, 2010). Birth tourism families have the choice of adding a car to the travel packages or a guided tour of the city and hospital grounds before the delivery of their newborn in the hospital (Watts & Parks, 2018). The internet also cushions the increase of birth tourism as it provides a platform for pregnant women to effectively do all background research before their travel (Hall, 2011). Literature (Voigt & Laing, 2010) reports that the process of childbirth rendered as a good or service is widely available and highly interchangeable among hospitals. Many hospitals compete for birth tourism patients by advertising the quality of care they will receive; thus, all amenities that come with their maternity packages for patients' comfort and convenience. Birth tourism experience is brought to the market with monetary values at high rates as the U.S. \$50,000 (Grant, 2015; Magidenko, 2015; Nori, 2016). Although some businesses provide travel packages

tailored for birth tourism families, research remains scarce on healthcare costs for birth tourism families when admitted into the neonatal intensive care unit.

### **Birth Tourism Integrated in Healthcare**

Birth tourism is a form of tourism involving patients travel borders to receive maternal healthcare (Kunwar, 2019). In this context, birth tourism is cohesive in the healthcare industry. As this growing trend over the past decades, both healthcare and tourism industries use effective marketing strategies underscoring excellent medical services and beautiful destinations (Kunwar, 2019). Although some engage in birth tourism for maternal healthcare services, it usually includes leisure, relaxation, and fun. To others, engaging in birth tourism creates opportunities for survival among pregnant women and their unborn children, especially when these women and their infants face health risks that cannot be cared for in their home countries or that low resources inhibit the provision of adequate care in those countries (Illingworth & Parmet, 2017). For many birth tourism mothers, choosing to deliver their infant in a hospital abroad is their only access to maternal healthcare. Research (Mikhael et al., 2016) supports that some birth tourism families have needs and face unanticipated medical, social, and financial challenges when delivering in a foreign land. The American media displays conversations on the potential repercussions of birth tourism on American communities. These reports fail to highlight that the birth tourism families purchase advertised maternity care packages at a high price for the best Western medical care (Folse, 2017; Ji & Bates, 2018). Regardless of these publications, which may invoke negative perspectives, an emphasis is that birth tourism families represent a group of patients, inclusive of pregnant mothers making the best decision in obtaining maternal healthcare and travel

internationally to deliver their newborn in the best U.S. hospitals. Although there may be some resistance due to the influence of public opinion against birth tourism practice in America, it is sometimes a chance for women traveling from low resource countries to survive and to give their infant a chance for life, significantly when maternal and infant deaths projected are on the rise (Jaramillo, 2018; Passel & Taylor, 2010).

Access to quality healthcare is a human right and providing a voice to experiences surrounding birth tourism families will provide evidence on disregarded nursing care while this population is in the neonatal intensive care unit (NICU) (Breakey et al., 2016; Illingworth & Parmet, 2017; Kinney, 2010; Mikhael et al., 2016). To date, scant attention has been paid to the nursing aspect of birth tourism, specifically nursing services offered in online sales of maternity care packages. Hospitals' International Departments advertise online for the purchase of maternity healthcare in the form of packages offering specialized healthcare with expert physicians and in state of the art healthcare facilities; however, the disseminated information does not always mention the nursing care that should complement the needs of pregnant mothers and their infants (Cheng, 2016; Edel, 2014; Grant, 2015; Nori, 2016). Nursing research has not looked at the quality of nursing care promised in purchased maternity care packages, nor the nurses' perspectives of the care rendered to birth tourism families, expressly with an admitted newborn into the neonatal intensive care unit.

### **Birth Tourism and Risk Factors for Admissions**

Irrespective of the intent of pregnant women deciding to travel while pregnant, research (Mikhael et al., 2016) characterizes birth tourism women as pregnant women with high-risk pregnancies. Some of these characteristics, such as race/ethnicity,

advanced maternal age, and anxiety, are common demographic characteristics reported to support these high-risk factors (Mikhael et al., 2016). The Centers for Disease Control and Prevention (CDC) classifies pregnancy stages during travel as low risk, moderate risk, and high risk and advises pregnant women to travel before 36 weeks gestation to avoid additional high risk. High-risk factors in any pregnant woman bring risks of a wide range of adverse perinatal outcomes, including pre-term delivery of the infant (Singh & Yu, 1996). Birth tourism women with high-risk symptoms during pregnancy have higher odds for preterm births and combined with traveling, may face an increased risk of many adverse health outcomes. (CDC, 2016; Mikhael et al., 2016; Sammour et al, 2012). Correlation of mothers' high-risk factors on NICU admission rates revealed in the literature (Mikhael et al., 2016) that 10% of admissions into the neonatal intensive care unit (NICU) are birth tourism families.

The emergence of premature births causing an increase in NICU admission rates poses an alarming concern in any country. Premature birth is any infant's birth before 37 weeks gestation and is the leading cause of an infant's death (CDC, 2016). Globally, the rate of preterm births in 2015 is on the upsurge, ranging from 5% to 18% of infants born prematurely (World Health Organization, 2016). Nationally, data indicate an increase in the national preterm birth rate from 2014 to 2015, which averages about 1 out of 10 babies born too early in the U.S. (CDC, 2016). Locally, data from the National Center for Health Statistics (NCHS) birth rate files give Florida a grade C (10.0% rate range) on the 2016 Premature Birth Report Card (PBRC) (March of Dimes, 2016). Regardless of the CDC's recommendations on reducing risk during pregnancy and travel, birth tourism

mothers face additional risks that they may not be aware of (Mikhael et al., 2016; CDC, 2016).

A scant amount of literature (Mikhael et al., 2016) reported birth tourism mothers' characteristics and their pregnancy outcomes by analyzing the impact of birth tourism on international families and the United States (U.S.) health care systems. Research showed objective evaluations looked at birth tourism admitted into the neonatal intensive care unit and resulted in factors of causes and effects of birth tourism and unexpected medical, social, and financial challenges. Factors such that of birth tourism mothers are older (34 vs. 29 years;  $p < 0.001$ ) and are delivering via cesarean (72 vs. 48%;  $p < 0.007$ ). Birth tourism newborns are hospitalized due to prematurity, requiring more extended hospital stay (15 vs. seven days;  $p = 0.02$ ), more surgical intervention (50 vs. 21%;  $p < 0.001$ ) as well as they have a higher percentage of neonatal death in the hospital (8.6%) in comparison to the 1% of the non-birth tourism group (Mikhael et al., 2016). Objective evaluations found in research also made apparent the association of birth tourism unplanned NICU admission and distress and anxiety outcomes (Mikhael et al., 2016). Despite these measurable differences between birth and non-birth tourism groups affecting patient outcomes, the nursing care rendered to birth tourism families has not been investigated (Mikhael et al., 2016).

### **Neonatal Nurses in the Neonatal Intensive Care Unit**

When admitted into the neonatal intensive care unit (NICU), the newborn faces more complex hospitalization. Mikhael et al.'s (2016) study affirmed that birth tourism families have longer hospital lengths of stay and high mortality rates. When working in the NICU, neonatal nurses care for this patient population of the newborn who faces

complicated hospitalization. According to the World Health Organization, some newborns admitted into the NICU are born before 37 weeks of gestation, and the admitted preterm or sick newborns are in the neonatal period, which entails from birth to 28 days after. The neonatal intensive care environment is equipped with highly sophisticated technologies and often exposed to situations and challenging issues such as death and dying. Neonatal nurses caring for infants and their families recognize that families face many complexities (Hendson, Reis, & Nicholas, 2015). Numerous studies (Chang, 2014; Rubin & Chung, 2013; Ango, 2016; Williams, Nandyal, Hutson, & Welch, 2017) address several issues supporting that the NICU environment correlates with factors cause parental distress and poor infant outcomes. Neonatal nurses have varying levels of training that complement the infant's complicated status. Moreover, neonatal nurses provide age-specific care aligned with the Joint Commission's requirement for healthcare professionals; they care for unstable infants according to their level of acuity and follow the recommendation of the Institute of Medicine (IOM), *Keeping Patients Safe* document (Milette et al., 2017; Rogowski et al., 2015). Although theories are in place outlining consideration of patient needs and nurse qualifications yielding optimal match of higher-acuity infants to more qualified nurses, the nursing care for high-acuity birth tourism neonates is minimally apparent in nursing data (Rogowski et al., 2015).

Neonatal nurses in the NICU must contend with personal ethical obligations to provide the best quality care to infants while providing support and guidance to the entire family (Webb, Passmore, Cline, & Maguire, 2014). Accordingly, political and social climates may cause preconceived notions within healthcare systems for the international population resulting in cultural misunderstanding (Doucette et al., 2017). Public opinions

often create deep conflicts in any consumer, and nurses are subject to hearing about birth tourism from the media (Lippmann, 2017). Research (Butt, McGrath, Samra, & Gupta, 2013; Doucette et al., 2017; Henderson et al., 2015; Obeisat & Hweidi, 2014) suggests that there may be a connection with; 1) presumed biases influenced by negative public opinions; subtlety in unmet constructs from cultural models or theories; 2) lack of intuitive perceptions of families' needs; and 3) less-than-optimal NICU care, to health disparities and adverse health outcomes in infants and family. This evidence supports the obligation that neonatal nurses have, despite negative public highlights, to give the best nursing care. Therefore, neonatal nurses must follow the Code of Ethics for Nurses and collaborate with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities among birth tourism families (ANA, 2017; Doucette et al., 2017).

Although neonatal nurses are the primary health care providers for neonates in the NICU, they care for the family as a unit. Nursing philosophy integrated into the care enables the families to become their primary care providers to their infants (Marchuk, 2014). The atmosphere created by neonatal nurses while providing care to the newborn must contain conditions that encourage parents to care for their infant. Neonatal nurses integrate nursing philosophy into the care rendered to all families who admit an infant into the NICU. The nursing philosophy is about caring for the patient as a whole in all their uniqueness and complexity. The nurses have a large and complex clinical role and an emotional role in supporting parents in the NICU and providing psychosocial support to parents whose hospitalized infants in the NICU can improve parents' functioning and their relationships with their babies (Hall et al., 2015; Turner, Chur-Hansen, & Winefield,

2014). Therefore, exploring the voices of neonatal nurses caring for birth tourism families may offer more knowledge to the body of nursing.

There is limited research investigating neonatal nurses' perspective delivering quality care that is culturally appropriate to birth tourism families' needs when facing a sick or premature newborn in the NICU. Given the complexities surrounding birth tourism, there remain unanswered questions about the care rendered to birth tourism families, and nursing may not understand the perspectives of neonatal nurses and the different facets they face when caring for birth tourism families in the NICU, nor the challenges of nurses and families that could subsequently alter the care during NICU hospitalization. To date, nursing has not advanced its knowledge regarding the nursing care promised from the sale of birth tourism packages in various South Florida healthcare systems and about neonatal nurses' responsibilities in serving birth tourism families in the NICU. There remains a gap in nursing literature about the quality of care neonatal nurses render to birth tourism families when their infants are in the NICU. Therefore, exploring the experience of neonatal nurses caring for birth tourism families with their infants in the NICU may create an understanding of the essence of this phenomenon.

### **Statement of the Problem**

Nurses provide quality care to all patients seeking nursing services. It is especially true for neonatal nurses caring for birth tourism families who unexpectedly find themselves with their newborn admitted into the neonatal intensive care unit (NICU) (Mikhael et al., 2016). Quality care is pertinent in delivering nursing care to help birth tourism families feel comfortable receiving nursing services while their infant is in the NICU (Giger & Haddad, 2020; Purnell, 2013; Rose, 2012). The Joint Commission

recognizes that, as basic patient needs go unmet, hospitals will continue to put themselves and their patients at risk for adverse consequences (Milette et al., 2017). Nursing literature is scarce concerning the nursing care rendered to birth tourism families in the NICU. Without an understanding of the lived experience of neonatal nurses caring for the birth tourism population, the needs of both birth tourism families and nurses will go unrecognized and unmet, causing further health disparities in South Florida's NICUs.

### **Purpose of the Study**

The purpose of this hermeneutic phenomenological study using van Manen's (1990) methodology was to understand the lived experience of neonatal nurses caring for birth tourism families who admit a newborn into South Florida's neonatal intensive care units. This research aimed to give neonatal nurses a voice to express their individual experience of caring for birth tourism families, inductively interpret their everyday experience in their lifeworld, and understand the essence of caring for this unique population.

### **Research Question**

The overarching question guiding this nursing inquiry was: "What is the lived experience of neonatal nurses caring for birth tourism families in South Florida's neonatal intensive care units?"

### **Philosophical Underpinnings**

The term philosophical underpinnings, when used in nursing inquiries, is associated, and often used interchangeably with concepts such as paradigms, philosophical stances, and or theoretical perspectives. These terms, used to inform the researcher's worldview, are utilized to drive qualitative research (Crotty, 1998; Munhall,

2012; Creswell, 1998). Philosophical underpinnings provide a context in qualitative research and help conceptualize the researcher's belief on how they view themselves and their topic of interest in the world they embark on studying (Crotty, 1998). Kuhn (2012) associates the term *philosophical underpinnings* to the term *paradigms* and defines it as a type of cognitive framework or a set of solutions to a problem shared by a specific group of scientists to generate and solve a problem in their field. He also addressed paradigms in his writings as worldviews, which break down the natural world's complexity (Kuhn, 2012). In the language of worldviews, it is essential to understand and differentiate among paradigmatic or philosophical underpinnings genres surrounding the nurse researcher's worldview, which will help guide the research process during the exploration of neonatal nurses caring for birth tourism families in neonatal intensive care units.

Within this hegemony of philosophical underpinnings, positivist, post-positivist, and post-modernist views exist (Munhall, 2012). According to Denzin and Lincoln (2018), these views have been well-established and well-received as conventional philosophical underpinnings. However, as we advance to the 21st century, new philosophical underpinnings such as postmodern paradigms surfaced to help researchers position new research topics in qualitative inquiry. Amongst the various mentioned in nursing research textbooks, only philosophical underpinnings that have become dominant will apply in this section. It is essential to understand the different philosophical underpinnings to comprehend the researcher arriving at the chosen worldview platforming this study. Although in contention and incommensurable, the understanding of assumptions in philosophical underpinnings allows the proper application to help the researcher answer the research question posed on neonatal nurses' lived experience caring

for birth tourism families in the NICU. Nurse scientists are no longer from the world seen in one color. Instead, novice researchers express the diversity found in today's world and reflect on diverse patient populations through their writings. Therefore, Denzin and Lincoln (2018) challenged novice nurses to integrate philosophy in inquiries as in a bricolage, meaning to create or construct from a diverse range of emerging paradigms.

Philosophical underpinnings such as positivism, post-positivism, interpretivism, constructivism, and constructionism positioned as frameworks in research are dominant groundworks. According to Guba and Lincoln (1994), philosophical underpinnings, informed as paradigms, are supported by individuals' scientific assumptions in a social setting. It is the fundamental belief system based on ontological, epistemological, methodological, axiological, and rhetorical ways to view the world during the study's development. Munhall (1994) posited that assumptions serve as a roadmap for the researcher to apply philosophical underpinnings when used in research. Five overriding assumptions help understand the philosophical underpinnings used in this study: ontological, epistemological, methodological, axiological, and rhetorical. Guba and Lincoln (1994) explained three assumptions to help understand the multivocality and meanings for the use of each philosophical stance in a study. The ontological assumption refers to the researcher's beliefs about the nature of reality, what is true, or what is to know about reality. The epistemological assumption denotes how the researcher comes to the knowledge is acquired, and the methodological assumption is the systematic way the researcher goes about discovering this knowledge.

Additionally, Creswell and Poth (2016) elucidated that axiological assumption allows the researcher to bring his values to the study. Thus, in qualitative research, values

are made known in the study. Axiological assumption illustrated by the researcher actively reporting own values and admitting formed biases are value-laden from information gathered during data collection. Lastly, rhetorical assumption guides the researcher to using terms, narrative, or language unique to a qualitative approach (Creswell & Poth, 2016). Further discussions presented in this section will include philosophical underpinnings shaped by their interrelated assumptions through the lens of post-positivism, interpretivism, constructivism, and constructionism.

### **Post-Positivism**

Post-positivism rejected the central tenets of positivism. Although both positivism and post-positivism share the standard ontological view that social reality is external and objective and epistemologically advocates using numeric measures to generate knowledge, they use different philosophical assumptions. From a qualitative perspective, post-positivism challenges the belief in absolute truth concerning human behavior study. Post-positivism holds a realist stance, which means that understanding social reality needs to be a frame in the context of relevance. A phenomenon is observable within the social world, and through the lens of a post-positivist, knowledge will result from the social conditioning within that world. Guba and Lincoln (1985) affirmed that in moving toward post-positivism as a philosophical underpinning, researchers could not attempt to measure the one truth, and thus, there is one truth that can never be known because it would be beyond human comprehension. Post-positivism, as a theoretical perspective, trails the philosophical underpinning of positivism (Crotty, 1998). Post-positivism commences with the test of the theory in the form of a hypothesis and involves statistical

tests in the research process. Accordingly, positivist and post-positivist views rest in an objective view of one reality, and meanings exist in the world outside of consciousness.

Science changes in its view of reality, and as Kuhn (2012) conceived of what was a paradigm shift, the positivist understanding of reality changed to the post-positivist reality to attain certainty within uncertainty. Advancing knowledge to a post-positivist worldview, Karl Popper (1902-1994) challenged scientific truth by claiming that absolute or objective truth may not be accurate, but simply something that scientists have not been able to prove false. According to Popper (1959), this means that absolute certainty is only in subjective experiences of conviction or subjective faith. In a post-positivist stance, characteristics such as deductive and objective truths, absolute principles, statistical testing of hypothesis, and predictions are within this worldview's application (Polit & Beck, 2017). The ontological assumption argues that the state of reality is offering a priori theory about the world's organization (Weaver & Olson, 2006). The epistemological assumption, which demonstrates the view of knowledge, is not a form of relativism. Thus, it retains the idea of absolute certainty. In this context, the nurse researcher believes that human knowledge is on estimations. The methodological assumption in post-positivism refers to the instrumentation or objective measurement of the phenomena. The role of values supporting axiological beliefs encourages the researcher to control biases and not express them in the study.

Post-positivism sets the researcher to work with well-defined concepts when researching a nursing problem. In this approach, deductive methods such as testing theories, specifying essential variables, and making comparisons among groups are significant. The researcher uses precise instrumentations and empirical testing to

conclude objective truths. These objective truths are then inferred with subjective experiences and become absolute truths that cannot be falsified (Guba & Lincoln, 1985). For example, studying the topic of birth tourism philosophically underpinned in a post-positivist stance will allow the researcher to associate the constructs of a chosen theory to the subjective experiences of birth tourism families. Hence, this approach will allow predictions, rules of logic, and measurements that will explain the universal feature of the phenomenon (Polit & Beck, 2017).

### **Interpretivism**

Interpretivism is the school of thought in the research process, which involves the researcher interpreting the study's philosophical elements while integrating the human interest into the phenomenon. Interpretivism was developed based on the disagreements amongst worldviews of positivism and post-positivism in the social sciences. In contrast to positivism, the interpretive stance looks for culturally derived and historically situated interpretations of the social life-world (Fay, 2003). Through a change in underlying assumptions, interpretivism moves entirely away from the positivist and post-positivist paradigms by emphasizing the multiple truths individuals ascribe to their actions and reaction to others (Weaver & Olson, 2006). Crotty (2012) explicated that an interpretive philosophical stance reflects the beliefs, values, and assumptions about human beings' nature, the nature of the environment, and the interaction between the two. The axiological assumption is engaged in the nurse researcher's value in all stages of the research. Through an interpretivist lens, the nurse researcher is part of the research and so will be subjective.

Lincoln and Guba (1985) explained interpretivist philosophical underpinning as a perspective characterized by three assumptions: (a) Ontological assumption elaborates on the nature of reality based on multiple realities needed to create meanings; (b) Epistemological assumption based on the acquisition of knowledge that is socially constructed rather than objectively determined; and (c) Methodological assumption of interpretivism focuses the inquiry on understanding and interpreting the knowledge gained (Lincoln & Guba, 1985). Overall, in an interpretive stance, the researcher assumes that reality is socially constructed, and only through social constructions such as language, consciousness, and shared meanings that the world may be understood (Munhall, 2012; Crotty, 1998). Rooted in Max Weber's (1864-1920) writings, he explains that interpretivism came about because of the need to emphasize understanding human and social research. Human sciences needed to understand the individual and his action as the basic unit of interpretive sociology, not just explaining the cause found in natural sciences (Crotty, 1998; Weber, 1978). Through Weber's writings, researchers who seek to understand human's platform their worldview in the interpretivist paradigm. Gaining access to humans' experiences and their perceptions of multiple realities in the world will be the product of this perspective or philosophical underpinning (Munhall, 2012).

Wilhelm Dilthey (1833-1911), another prominent philosopher of interpretivism, assumes that reality and social reality are unique. Dilthey proposed that interpretivism in social research should explore lived experiences to reveal the influences of historical, social, and cultural aspects of participants' lives while understanding the context in which actions happen (Crotty, 1998). A phenomenon studied through people's eyes in their lived situations positions the researcher in the research by interpreting the data's meanings,

influenced by the researcher's background, own experiences, and self-awareness (Weaver & Olson 2005; Creswell, 2012). Therefore, engaging in an interpretive view for inquiring about the meaning neonatal nurses ascribe to caring for birth tourism families will allow the researcher to understand the multiple realities which exist about this phenomenon. Therefore, research focuses on gaining in-depth insight into participants' lives is appropriated in researching the perceived nursing problem, which will allow the researcher to understand the experience of neonatal nurses delivering care to the birth tourism population. As the nurse researcher explicates a nursing problem from a topic of interest, the researcher must embed every step of the inquiry within the paradigm grounding their worldview. The perceived nursing problem explicated from the topic of birth tourism is planned to be researched in the interpretive stance, which Max Weber (1964-1920) suggests being the worldview concerned with verstehen (meaning, understanding) (Crotty, 1998). This philosophical underpinning of interpretivism frames the phenomenon of interest with the unique goal of understanding neonatal nurses' lived experience and their social realities in caring for birth tourism families who unexpectedly admit an infant in South Florida's neonatal intensive care units.

### **Constructivism**

Linked within interpretivism is constructivism. Constructivism is one philosophical stance where researchers attempt to understand and explain human and social reality by constructing meanings as human beings engage in the world they are interpreting (Crotty, 1998). Social constructivism is the idea that people "construct" their realities (Avis, 2005). The philosophical position of rejecting the objectivist view allows the researcher to be the social actor and appreciate differences between participants in the

study. It recognizes that reality is a product of human consciousness interacting with the experience in the real world (Munhall, 2012). Constructivism relates to the Socratic method, and as a philosophy, is based on cognitive psychology. Piaget (1973) explains that constructivism relates to the study of knowledge, a philosophy of learning founded on the premise that reflects on individual experiences and understanding of the world that is lived in and constructed. In constructivism, each experience allows generating an individual's perspective or rule and mental model to make sense of the experience.

In the research process, worldview embedded in constructivism, the researcher examines the interaction between human experiences and their behavior patterns. Constructivism reflects the basic tenet that reality is socially constructed. Also, it is one of the two theoretical perspectives within the interpretivist paradigm used to support how meanings constructed are about the phenomenon. Constructivism holds a worldview of relativism in which the world exists and cannot be objectively grasped (Crotty, 1998). The constructivist paradigm basic assumptions are that knowledge socially constructed is by the researcher's actions and being active in the research process (Crotty, 1998). Distinctively proposed assumptions give this philosophical underpinning character differences in conceptualizing and conducting research in the constructivist paradigm.

Ontologically, as reality is socially constructed, multiple mental constructions can be held, and perceptions of reality may change throughout the study. Epistemologically, the assumption is in the data, interpretations, and outcomes rooted in the context studied, apart from the researcher. According to Lincoln and Guba (2000), methodologically, constructivism's assumption is an interactive approach that the social construction of reality is conducted only through interaction between and among investigators and

respondents. Axiologically, individual values are honored and are negotiated among individuals (Creswell & Poth, 2018). Rhetorically, the narrative is literary to a qualitative approach gearing toward a constructivist language focusing on how language and rhetoric construct the social reality.

### **Constructionism**

Kuhn (1970) assumed in his writings that despite verification and falsification of the positivist paradigm, there ought to be a change in underlying assumptions or paradigm shifts. Constructionism, also well removed from objectivism, found in the positivist stance, claims that human beings construct meanings as they engage with the world they are interpreting (Munhall, 2012). In this view, the researcher will not create meaning from the study's phenomenon; instead, it will construct meaning from what already exists, the world, and objects (Crotty, 1998). Therefore, in understanding constructionism in the context of knowledge, different people may construct meaning in different ways, even concerning the same phenomenon according to the world around them (Crotty, 1998). Constructionism views of the world involve creating through constructs of internal models, which often have an unrealized effect on the researcher's perceptions (Galbin, 2014).

Immanuel Kant (1724-1804) noted that creating a schema by adding categories would best illustrate this concept in considering constructionism. Social constructionism does not create maps; it focuses on how the maps are formed based on how experiences are perceived. The reality is socially constructed, and the numerous realities so formed comprise the world's imagination (Galbin, 2014). Epistemologically, constructionism is concerned with how knowledge is historically situated and embedded in cultural values

and practices (Gergen & Gergen, 2012). Methodologically, the challenge is not to prove and persuade the other about the correct interpretation of the phenomenon, thus broadening understanding possibilities. Social constructionism can be a valuable way to address changes in researching birth tourism in neonatal intensive care units. Given this, the task of research is to unmask objective knowledge claims by revealing the underlying truths and recognize that claims to know reality are socially constructed expressions of power (Cruikshank, 2012).

### **Qualitative Research**

Qualitative inquiries focus on finding answers to questions centered on human experience, how that experience is created, and how meaning is given to human life (Cypress, 2017). Historically, this philosophical underpinning referred to as "soft science," means unscientific, exploratory, or subjective science. According to Denzin and Lincoln (2018), this criticism was in response to "hard" scientists who refuted the paradigm shifted from the positivist perspective. Qualitative worldview embeds itself in the tradition of multiple "truths," "value-laden," and supports interpretive paradigms that constitute a representation and description of the world (Denzin & Lincoln, 2018) (p. 71). Although continually shifting to interweave across disciplines, the history of qualitative research is complex (Lincoln & Guba, 1985). The key to understanding qualitative research lies in the idea that a phenomenon's meaning is socially constructed by social actors or participants interacting with their world. The meanings of the social actors can only be through close interaction between the researcher and participants. The aim is to work toward constructing the social milieu that is consistent with the participants' experiences.

To some scientific researchers in inquiry, many perspectives connected to cultural and interpretive genres to study a phenomenon surround qualitative research (Munhall, 2012). Studies utilizing perspectives, such as foundationalism, post-structuralism, postmodernism, post-positivism, or post-humanism, to name a few, are used to embed the many qualitative approaches found in research. According to Denzin and Lincoln (2018), in this present decade, researchers highly respect the method of qualitative inquiries that possess interdisciplinary capabilities, multi-paradigmatic focus, and multimethod approach. This genre of research method permits a naturalistic perspective with an interpretive understanding of human experiences. Qualitative research is a way to organize a nursing inquiry. There it is seen as "the strategy, plan of action, process, or design" lying behind the choice and "use of the particular method" as well as "linking" these choices to the "desired outcomes." (Crotty, 2003, p. 3). In this plan of action, the researcher included long-term observations, in-depth interviews, content analysis of the gathered data, all unique approaches to the qualitative research method. Other qualities typical to the qualitative genres allowing this approach to appropriate in the human social sciences are: (a) takes place in the natural world; (b) draws on multiple methods that respect the humanity of the participants in the study; (c) focuses on context; (d) it is emergent and evolving rather than tightly prefigured; and (e) it is fundamentally interpretive (Marshall & Rossman, 2014). These qualities allowed the researcher to view a social phenomenon holistically and inductively. Although these qualities give qualitative research strength, the research's dependability weakens because the process relies on the observer's insight and ability (Lincoln & Guba, 1985; Duffy, 1985).

## **Approaches to Qualitative Research**

A qualitative approach to research offers a platform to the worldview and understanding of the researcher's way of seeing self in the world, the researched population, the multi-worlds in which others live, and the meaning ascribed to the time lived (Munhall, 2012). It requires researchers to be systematically reflexive on who they are in the inquiry and bracket the sensitivity to their biography. The qualitative stance is the backbone of the qualitative approach to inquiry. It shapes the study and uses complex reasoning that is iterative to conduct a systematic inquiry (Creswell, 2013; Marshall & Rossman, 2016). There are five qualitative approaches frequently used in nursing research dedicated to studying social phenomena. A systematic approach provides guidelines for writing a thorough, convincing, reliable, and substantial nursing inquiry with the various genres used. These types of approaches or traditions in qualitative research each have their unique goals and consequently help the researcher inquire about others' experiences in a phenomenon (Chin, 2011).

Borrowed from Creswell's (2013) writings, these five approaches are: (a) the narrative approach, where the researcher gathers data through individual stories of life experiences; (b) the grounded theory approach intends to move beyond description and generates a theory for a process or an action; (c) the ethnography approach to research focuses on culture-sharing in order to examine shared patterns of behavior, beliefs, and language; (d) the case study approach being the naturalistic approach to the inquiry involving experiencing the phenomenon as it takes place in its circumstances and within its real-life setting, and (d) the phenomenological approach where the researcher assumed

for this nursing study to describe the collective meaning from several participants of their lived experiences with the researched phenomenon.

### **Scientific Assumptions in Qualitative Inquiry**

Qualitative nurse researchers dive into their study using any of the five research approaches. However, it is the philosophical assumption that drives the decision of the chosen qualitative approach or design. These assumptions are sometimes hidden but serve as the guiding philosophy behind qualitative research making the research process sound. It is only through understanding the philosophical assumptions that qualitative inquiry is a sound science (Cypress, 2017). Lincoln and Guba's (1988) assumptions are *ontological* (nature of reality), *epistemological* (what counts as knowledge and the nature of knowledge), *methodological* (the process of research), *axiological* (role of value in the researched phenomenon), and *rhetorical* (language used in the research genres), bring clarity to the accuracy of this research genre (Creswell, 2013; Munhall, 2012). These qualitative assumptions are essential and serve as a framework at specific research levels to assure the readers of the worldview chosen to inquire about the studied phenomenon.

The ontological assumption in qualitative inquiry represents how social actors construct realities. These realities are relative, and no reality is considered "truer" than any other. The worldviews or realities are dynamic and not at all single, fixed, or measurable. Ontology is concerned with investigating a particular world, the structure of reality, and the nature of existence (Crotty, 2003). This assumption allows the informed researcher to be within the social actors' lives. An ontological assumption assumes that the investigated world populated with humans is with their thoughts, interpretations, and meanings. Therefore, multiple truths exist, and the focus is on individuals' prior

experiences and social action while living the phenomenon. During the ontological phase, the researcher reports participants' perspectives using their words verbatim to gain multiple perspectives on the phenomenon (Creswell, 2013).

The epistemological assumption is a way of understanding and explaining how knowledge is attained (Crotty, 2003). Understood through Crotty's (2003) writings, epistemology is concerned with providing philosophical grounding to decide what kind of knowledge is possible and how it is adequate and legitimate. This assumption accepts that the researcher interacts with the object of research and can affect that object. The findings created are through the interaction between the researcher and the researched phenomenon. Epistemological assumption points to the researcher's essential features closely involved in the study, emphasizing the strategies used to create a closeness between the researcher and what is studied. Empathy is a feature of this type of research. In this qualitative study, the epistemological assumption flourished as the researcher conducted the study in the natural setting with the participants or social actors, thus obtained a thorough perspective of the participant's world (Creswell, 1998).

The axiological assumption deals with the nature of value, value being, and what human state is to be valued (Heron & Reason, 1997). The nature of value has a privileged position in a nursing study, and often, there is a value-laden purpose to the researcher's worldview. The researcher was not hesitant to be openly passionate about pursuing the phenomenon of interest as axiologically; the phenomenon was intrinsically worthwhile. The researcher interconnected with the researched phenomenon and may see the research as a means to an end. This understanding of axiology, the nature of value, enabled the researcher to be involved by practicing reduction and to reflect on the sensitivity of his or

her personal bias, which shaped the study during the phase of complex reasoning (Creswell, 2013; Marshall & Rossman, 2014). According to van Manen (1998), the researcher will understand what is essential from the phenomenon by reflecting on it. The researcher adopted the several levels of reduction that are distinguished by the following: (a) awakening of a profound sense of wonder at the belief in the world; (b) overcoming private feelings, preferences, inclinations that would prevent the researcher from coming to term with the phenomenon; (c) seeing the phenomenon in a non-abstracting manner by stripping away thematizations that overlay the topic of the study; and (d) seeing the essence of the phenomenon that lies in the concreteness of lived meaning (van Manen, 1998).

The rhetorical assumption depends on the approach chosen in a study and serves as the basis for the written research structure. The research written in the language of research is in a literary format (Creswell, 2013). It is not a written report of an investigation, but instead, it is a report of what reality is and interpreted through the eyes of social actors or the research participants (Creswell, 2013). Consequently, the researcher reported the participants' lived experience in a narrative, rich context word-by-word. A rhetorical assumption is humanistic, descriptive, and interpretive writing of the gathered data (O'Neil, 1998). In this qualitative study, the researcher's rhetorical assumption was to report what was seen and heard most objectively without involving quantitative data such as statistical tests.

Methodological assumption considers the researcher's approach to conducting or finding out about the phenomenon of interest (Denzin & Lincoln, 2011). The methodological assumption within a qualitative description describes the phenomenon

literally as a starting point to the method chosen, ending in interpreting the findings. For qualitative description, the researcher utilized methodological assumption to move beyond the literal description of the data and attempted to interpret the findings without moving too far from its literal description. This understanding helps readers on how research methods are decided, for example, data collection, data analysis, interpretation, findings presentation, and rigor.

### **Phenomenology**

The term *phenomenology*, derived from the Greek word ‘phenomenon,’ means “that which appears or brings to light,” and the Greek word “logos,” which translates to “word, reason, or plan” (Heidegger, 1927). A phenomenon is something that shows itself in the world as it is lived. It is not an unexplainable occurrence; it is very concrete, yet not a simple concept to be perceived, understood, or struggled with (Vagle, 2018). Van Manen (1998) supports that phenomenology means “appearance” and explains that, as the science of phenomena, phenomenology is the study of lived experience, human beings experiencing something or being something. Some phenomenologists (Munhall, 2012; van Manen, 1998) treat the term phenomenon and lived experience as synonymous. Others feel that phenomena are constantly at work in the world, one is lived experience of a phenomenon, and that the phenomenon itself is not necessarily the same. According to van Manen (1998), phenomenology is the study of meaning used to understand the person who has experience. Whenever a phenomenon forms understanding, it involves a dialogue that encompasses both self-understanding and understanding the phenomenon (Munhall, 2012). Therefore, the nursing phenomenon studied using phenomenology guided the researcher to produce a study about the meaning individuals ascribe to or the

lived experience of individuals living that phenomenon and the self-understanding of the researcher exploring it. Phenomenology guided the researcher to question whether a phenomenon's meaning, or essence is lived experience for this participant or group of persons (Patton, 2015).

As a means of pursuing knowledge development for nursing, phenomenology presents research based on two types. Phenomenology is a type of qualitative method, and it is a type of philosophy. Based on philosophy, phenomenology construed itself in Germany in response to an alternative to the dominion of positivism worldviews or philosophical underpinnings (Munhall, 1994). Edmund Husserl's (1859-1938) works, the founder of this school of thought and philosophers like Heidegger, Merleau-Ponty, Gadamer, Ricoeur among the many phenomenologists, phenomenology began as a philosophical approach to understanding human life and living. It evolved as a research method over time. Phenomenology based on an approach is a method that attempts to uncover all phenomena' essence. According to Husserl (1970), the researcher explores the phenomenon's essence and establishes a direct relationship with it. The phenomenology method is subjective, uses inductive reasoning, is descriptive, contains multiple realities, is socially constructed, and is process-oriented (Polit & Beck, 2017). The researcher inquiring about the lived experiences of neonatal nurses caring for birth tourism families in the context of providing quality care in the neonatal intensive care unit, the researcher, through the lens of phenomenology, engaged with the phenomenon in the world and make sense of it directly and immediately (Crotty, 1998).

The central theme oriented toward the lived experience remains and engages in interpretation (*hermeneutic*) life texts (Creswell, 2013). The perception of the lived

experience and the interpretation of such experience from the individual's unique experience of an event is vital in understanding this worldview. Therefore, a researcher aiming to employ a phenomenological approach must not only describe his or her perception of that phenomenon but the interpretation of the experience as well (Munhall, 2012). The phenomenological approach contains four key constructs. These key constructs or concepts are consciousness, embodiment, natural attitude, and perception. The first construct of consciousness means sensory awareness of and response to the environment. According to Merleau-Ponty's writings, consciousness is life: "It is not an inner existence, it is the existence in the world through the body" (Munhall, 1995) (p. 32). This construct explains that through consciousness, we are aware of the being-in-the world. Siding with this premise, the researcher understood that the world is known as one that defines it as being in the world.

Phenomenological research is the explication of phenomena as they appear into the consciousness (van Manen, 1990). The nurse researcher understands that phenomena experienced are before becoming a part of the participant's consciousness. In some sense, the participant becomes aware, recalls, and reflects as the experience presents itself to consciousness. Therefore, van Manen (1990) eludes that there is no definition for the idea of consciousness directly since consciousness is the object of itself, and consciousness is not the same in the act in which it appears. Through consciousness, the nurse researcher explores the lived experience of the participant's reflection on the experience. The second construct of embodiment explains that, although one becomes aware of being-in-the-world through consciousness, body access to the world uses all sensory organs (Munhall, 1995). One can relate to lived experience becoming alive in consciousness through

feeling, thinking, tasting, touching, and hearing to understand embodiment. Through embodiment, a perspective or worldview exists based on the participant's history, knowledge of the world, and openness to the world (Munhall, 1994).

Next, the third construct of the natural attitude is a mode of consciousness that promotes interpreted experience (Munhall, 1995). Understanding this concept can help comprehend the world as experienced by the individual at their level and interpreted. The natural attitude is then the reality in this process of experience and interpretation. In a phenomenological study, a natural attitude is not related to an object. It is part of a person and his or her attitude toward the world. Any physiological or perspective alteration in life results in a disruption of the natural attitude (Munhall, 1995). Perception is the fourth construct that an individual's access to experience in the world (Munhall, 1995). As Husserl (1970) postulated in his writings, perception takes place through the body and is the original mode of consciousness that varies in the context of its experience, creating its interpretation and meaning when the individual accesses the world or she experiences. In this phenomenological study, perception of the experience is what matters. The aim of phenomenology is for the nurse researcher to describe the lived experiences by describing the participant's perceptions of that lived experience. Consequently, interpretation of the experience from the neonatal nurses' unique perception of the care is a critical part of this study.

### **Phases of Phenomenology**

Examining phenomenology from history to the present time helps assure the phenomenological approach that guides this study. There are different types of phenomenological approaches, and each assumes different effects about what it is to

know and be in the world. To further understand the philosophical approach afforded in this qualitative research, it is indispensable to discuss the emerging history through the lens of a branch divided into three phases. These three phases offered by Cohen (1987) are the preparatory phase, the German phase, and the French phase. Within these phases, discussions of two the most used types of phenomenology in nursing inquiries, transcendental (descriptive) phenomenology and hermeneutic (interpretive) phenomenology, will be interwoven within the following paragraphs.

**Preparatory phase.** During the last half of the 19th century, philosopher Frank Brentano (1838-1917) wrote phenomenology as an inquiry method. Brentano's discussion revolved around phenomenology as a concept of intentionality, implying an inseparable connectedness of human beings to the world (van Manen, 1990). Carl Strumpf (1848-1936) significantly contributed to phenomenology in this phase. Strumpf believed that the essence of experience should not be by examining the relative component part of the experience. This preparatory phase offers researchers the opportunity to describe the phenomenon or behavior before testing the traditional scientific method's behaviors.

**German phase.** From the 19th century, German philosopher Edmund Husserl (1859-1938) coined the term "phenomenology" in his unique epistemological views of transcendental phenomenology. Husserl was the first philosopher to propose phenomenology as a creative attempt to capture meaning through the study of human experience. To describe the lived experience is the essence of this phenomenology, and of the researcher having to "bracket" to the best of his or her ability helps to understand and let the experience of the phenomenon speak at first hand (Crotty, 1998; Creswell,

2013). Another aspect of Husserl's writing is "phenomenological intuiting," which grasps the essential structure of a phenomenon as it appears in the consciousness (Munhall, 1994; van Manen, 1990).

Further into Husserl's writings are two significant concepts in the world of lived experiences, "intersubjectivity" (what researcher needs from the participants for dialogic relation with and about the phenomenon), and "lifeworld" (the world of living of every day's experiences) (Munhall, 1994). Husserl attempted to restore humans' reality in their lifeworlds, capture its meaning, and revive philosophy with new humanism (Munhall, 1994). Although these unique concepts surrounded the philosophy of phenomenology, other authors' worldviews expanded on phenomenology to underline this philosophy in the meaning of being human, being in the world, being present, and coming into being (Munhall, 1994).

**French phase.** Subsequently, phenomenology moved from Germany to France post World War II and the Nazi regime (Cohen, 1987). Three French authors continued the work of Husserl: Gabriel Marcel (1889-1973), who used phenomenology as a valuable introduction to the analysis of "Being"; Jean-Paul Sartre (1905-1980), expanded phenomenology as a method of inquiry; and Maurice Merleau-Ponty (1908-1961) related phenomenology to experienced time, space, body, and human relation as it is lived. The writings of Merleau-Ponty emphasized that phenomenology represents the human experience as it is lived. Munhall and Oiler (1986) point out that Merleau-Ponty describes phenomenology as:

the study of essences, a transcendental philosophy that questions facts about our world more adequately, and a philosophical stance or position that attempts to

describe the experience as it is lived without concern for how it came to be the way it was (p. 48).

Accordingly, the continuation of their philosophy with Gadamer and Max van Manen also leaned toward interpreting, not just reading into some meaning, but a clear revelation of what the phenomenon itself already points to (van Manen, 1990). Furthermore, the views on contemporary phenomenologist Gadamer's writings (1900-2002) and Hans-George Gadamer connect the approach of hermeneutic to the concept of pre-judgment. All interpretations prejudged are to allow the researcher to enter a dialogue with the researched phenomenon. Gadamer acknowledges that pre-judging can sometimes distort the process of understanding; thus, pre-judging is a character of understanding. The evolution of research led to two branches, descriptive and interpretive phenomenology.

***Transcendental (descriptive) phenomenology.*** Husserl attempts to uncover the meaning of participants' experiences through descriptive phenomenology. Husserl's descriptive approach calls for the use of bracketing as the ability to suspend one's judgment or belief. A descriptive phenomenology is a research approach keeping with Husserl's phenomenological philosophical ideas known as Husserlian phenomenology. The unit of analysis is the phenomenon, and one fundamental assumption of this phenomenological methodology is the described phenomenon has an essence. This phenomenological approach is one of the possible ways to craft phenomenological research equating to Husserlian-oriented descriptive phenomenology.

Consequently, Martin Heidegger (1889-1976), a Husserl student, also contributed to the German phase. Heidegger examined the ontology of being in the world of objects and focused on interpreting the phenomena' meaning. Heidegger, the second influential

German philosopher, surrounded his worldview of hermeneutic phenomenology as “Being.” This fundamental term of “being” in human science inquiries into the nature of the meaning of that phenomenon under study (Munhall, 1994). Heidegger surrounds his writing the thoughts that human beings exist, act, or are involved in the world. For example, an individual in a cultural, social, historical setting of the world explains the concept of “to be in the world” (Munhall, 1988). Over time, Heidegger fully developed Husserlian phenomenology. In his Heideggerian vision of phenomenology, the phenomenon's intentionality was not focused on consciousness, as in transcendental. Instead, phenomena show themselves in the world (Vagle, 2018). To illustrate this premise, Smith (2013) wrote:

For Heidegger, we and our activities are always “in the world,” our being is being-in-the-world, so we do not study our activities by bracketing the world; instead, we interpret our activities, and the meaning things have for us by looking to our contextual relations to things in the world (p. 18).

Although Husserl’s phenomenology was a departure from Descartes’ separation of the human from the world, Heidegger felt that Husserl’s solid and consistent focus on consciousness still held too much of Descartes’ philosophy (an assertion that the mind and everything outside of the mind is separate from one another).

***Hermeneutic (interpretive) phenomenology.*** Heidegger attempts to uncover the meaning of participants’ experiences through interpretive phenomenology. Heidegger believed that participants in a study could not separate themselves from the world. Therefore, interpretive phenomenology for this study will help understand the phenomenon, not describe it (Creswell, 2018). The interpretive phenomenological

research approach that is keeping with Heidegger's phenomenological philosophical ideas is Heideggerian phenomenology. The unit of analysis is also the phenomenon, and one fundamental assumption of this phenomenological methodology is that the phenomenon manifests ontologically in particular situations and contexts and that understanding the phenomenon is an act of ongoing interpretation.

Max van Manen also leaned toward interpreting and not just reading into meanings for a clear revelation of what the phenomena itself already points to (van Manen, 1990). Although phenomenology orients toward the lived experience, it engages the interpretation (hermeneutic) of life texts (Creswell, 2012). According to van Manen (1990), phenomenology is a philosophy of uniqueness and is interested in what is not replaceable. He believed that a person could only understand phenomenology by doing it. Van Manen (1990) positioned that phenomenology's significance is only understood when the researcher understands the amount of work, time, reflection, and rewriting required for a sound phenomenological study. Phenomenon rooted in the word phenomenology is not viewed as a "thing itself" that one finds in intentional consciousness. Thus it is "brought into being" in day-to-day contextualized living in and through the world (Vagle, 2018). This view affirms that hermeneutic phenomenology sits in an interpretive philosophical underpinning and supports a worldview that allowed the study of neonatal nurses caring for birth tourism families as it is in the world of each participant of the study.

Hermeneutic phenomenology aims to be interpretive and explorative to understand the participant's experience of a phenomenon (Munhall, 2012). As a methodology, this genre is attentive to being phenomenological as to descriptive (how

things appear) and to being hermeneutic as interpretive because “there is no such thing as uninterpreted phenomena” (van Manen, 1990) (p. 180). The nurse researcher aimed to capture another’s lived experience in language, which is inevitably an interpretive process (van Manen, 1990). The phenomenon came into being in the four existential life-worlds. The four existential life-worlds influenced by Husserl’s writings and, according to van Manen (1990), served as a guide when reflecting on the phenomenon. Each life-worlds, spatiality (lived space), corporeality (lived body), temporality (lived time), and relationality (lived relations), served as vital tenets of phenomenology to help understand the lived experience of another:

- 1) *Spatiality*, described as felt space that affects how a person feels, is categorized for inquiring into how neonatal nurses experience the day-to-day affairs of life. This felt space is where each neonatal nurse cares for birth tourism families in the neonatal intensive care unit.
- 2) *Corporeality* involved being bodily present in the world. To neonatal nurses’ physical presence, corporeality may reveal aspects of the patient, the family, and any encountered person during the experience of caring for birth tourism families in the NICU. In the context of this study, the researcher met the participant in his or her world. The researcher and participant revealed or/and concealed the involvement, skill, practice, or understanding while being physically present in caring for birth tourism families.
- 3) *Temporality* is the temporal way of being in the world. Past, present, and future will become neonatal nurses’ temporal landscape where they will be recounting in their time (subjective versus clock time). The researcher

expected neonatal nurses to have a clear perspective of what took place and life to come regarding the phenomenon.

- 4) *Relationality*, also known as communality, demonstrates the researcher who has lived concerning the shared interpersonal space participant. The researcher approached each neonatal nurse participating in this study in a corporeal way by gaining the impression that they are physically present to the researcher. Even through Skype, this indirect relationality amounted to a conversational relation, which allowed the researcher to transcend herself into the experience.

According to Husserl (1970), each life-world shows structures, and Heidegger (1962) gave the idea of lifeworld structures in a more worldly meaning by associating phenomenology to the study of ways-of- being-in the-world. Van Manen (1990) inferred that being of something is to inquire into the phenomenon's nature or meaning. Consequently, as hermeneutic is the practice of interpretation, and being-in-the-world refers to the way human beings exist, act, or are involved in the world, that the understanding of the quality of care rendered to birth tourism families in the NICU can be understood (Heidegger, 1962; Husserl, 1970; van Manen, 1990).

### **Relationship of Hermeneutic Phenomenology to the Study**

Hermeneutic phenomenology, influenced by van Manen's (1990) approach, will guide the exploration of this nursing inquiry. Inquiring on a nursing topic within hermeneutic phenomenology will allow the researcher to construct a full interpretive description of some aspect of the lifeworld and remain aware that lived life is always more complicated than any explication of meaning reveal (van Manen, 1990). Only through van Manen's (1990) combination of hermeneutics and phenomenology and his

proposed six activities for research that the nurse researcher reflected and interpreted the lived experience of neonatal nurses caring for birth tourism families' lifeworlds. Munhall (2012) offers that a researcher conducting qualitative research in hermeneutic phenomenology or must refer to the life-worlds of individuals: (a) how they perceive time and the history they lived through; (b) how they gain access to the experience through their bodies; (c) the relationships with others, and the world and space in which they are standing in the moment (Munhall, 2012). In this hermeneutic phenomenological study, the researcher explored the neonatal nurses' "life-worlds" with feelings, emotions, and questions concerning their experiences of caring for birth tourism families, which helped understand the essence of providing the care these families admitted in the neonatal intensive care unit (NICU).

In this context, the researcher engaged with the world's phenomenon and makes sense of it directly and immediately (Crotty, 1998). This phenomenological methodology oriented toward the lived experience engages this nurse researcher in making explicit and seeking meaning from the hermeneutic texts of life (Creswell, 2013). Characterizing Creswell's view of hermeneutic phenomenology asserts the relationship of this genre of qualitative research to what the study brought. Therefore, it is only through the collection of multiple realities that are subjective, descriptive, and socially constructed from neonatal nurses that the nurse researcher constructed a full interpretive description of some aspect of the lifeworld to understand neonatal nurses' lived experience of caring for birth tourism families admitted into the NICU. It is only from the lived experiences that the nurse researcher discovered the essence of consciousness, embodiment, natural

attitude, and perception to inductively reason and interpret the text (of human actions, behaviors, intentions, and experiences) as it is met in the life-world (van Manen, 1990).

### **Significance of the Study**

This study aimed to understand the experiences of neonatal nurses caring for birth tourism families who unexpectedly admit their infant into the neonatal intensive care unit (NICU) in the context of delivering quality care to that population. This study's knowledge may help publicize evidence related to the organized maternal health care services pre-planned and sold by international departments to birth tourism families. This population is among the diverse populations in which neonatal nurses serve and providing quality care when admitted into the neonatal intensive care unit is one crucial aspect that makes this study significant. This study serves as a way to disseminate information regarding the nursing process in the context of assessment regarding the culture of birth tourism families in a variety of ways, primarily through the different encounters in order to create a unique understanding of the values, beliefs, attitudes, lifeways, and worldview of this population. Affirmed by Purnell (2005), when caring for a population, nurses need both culture-general and culture-specific information to provide culture-sensitive care, and nurses who can assess, plan, intervene, and evaluate in a culturally competent manner will improve their care of patients. Therefore, this study is significant in advancing nursing knowledge in the context of providing culturally sensitive and competent care to birth tourism families.

In the context of caring for birth tourism families made up of an international community of pregnant women, the World Health Organization must take notice revealed from the nurses' voices through this study. This study will disseminate evidence based on

the underscored needs discovered during this study, which birth tourism families have when admitted into the NICU. Some developing countries cannot facilitate primary healthcare needs or adequate maternity care, therefore escalating maternal and infant mortality rates. Identifying barriers that limit access to quality maternal health services improves maternal and infant health (World Health Organization, 2019). International department of hospitals platformed by the hospitals' department of business and finance may find this nursing study significant. This study may assess the purchased promises of receiving quality care that these hospitals sell through maternity packages. The significance of this study also involves the mobilities of many concepts traversing disciplinary boundaries. For example, improving communication between the international departments and neonatal nurses when they arrive and with the social work department will offer a better experience for birth tourism families.

This phenomenological study provided data on tourism and healthcare, migration, immigration and healthcare, and social policies and healthcare. Evidence (Mikhael et al., 2016) demonstrates that birth tourism families travel abroad to receive maternity and newborn care. Although pregnant women who travel internationally have the right to seek maternity healthcare wherever they wish, public opinion reveals that the practice of birth tourism is a burden on immigration. There should be immigration policies familiarizing and educating the public about the legalities and specifying the service given to birth tourists, including the tourism branch's revenues. Societies need to understand that this form of healthcare access moves toward global health and is not a punishable act (Illingworth & Parmet, 2017). Health care is a human right. Therefore, access to healthcare should not be punished or biased. Familiarization about birth tourism

by creating inclusive immigration policies may improve the relationships between consumers and healthcare stakeholders.

As international departments attract communities of birth tourism families, the bureau of tourism may find interpreted data helpful in preparing and providing hospitality to our international families traveling to obtain maternal health care and enjoy the touristic attractions during their travel. Neonatal nurses provide care to birth tourism families; they will reveal these families' possible needs through their interviews. Social work departments may find significance in this study as it will accentuate the services and resources needed to provide holistic quality care to our birth tourism families. Consequently, as this global community served in United States hospitals, a better understanding of the service provided may enlighten public health discipline on a local and global aspect. This study may inform the importance of caring for birth tourism families as it may provide a framework for applying global health ethics to maternal and infant issues in global health.

A previous study (Mikhael et al., 2016) revealed the findings of the reported stress and anxiety birth tourism families endure during their admittance into the NICU. The disciplines of psychiatry/psychology and the branch of mental health nursing may gather further evidence from this study to better serve birth tourism families in South Florida's hospitals, specifically to alter possible postpartum depression in birth tourism mothers. Healthcare providers seek to demonstrate that it is morally good for nations to treat all patients' health interests with respect and dignity besides dismissing any myths about any groups of patients (Breakey, Corless, Meedzan, & Nicholas, 2015). Policymakers for global healthcare strive to emphasize class equality and advocate for all

patients to receive care without feeling biased to promote all patients' health interests. This study's significant findings may speak loudly to health policymakers and global healthcare organizations: (a) to better understand the nurses' experiences about caring for birth tourism families, (b) to serve, and (c) create policies that will ameliorate the receipt of healthcare among this population.

### **Significance of the Study to Nursing**

This study on the lived experience of neonatal nurses caring for birth tourism families in the NICU is to advance nursing science, such that other disciplines and nursing may better understand this patient population as it relates to this phenomenon. This study is vital to nursing, and its need supported is by the lack of evidence on this topic in nursing literature. Although some families travel internationally from low-resource countries seeking better health care in the U.S., the care that neonatal nurses render must reflect the quality of care given to everyone. Research already reveals that the lack of quality care may not allow neonatal nurses to address the practical barriers faced during direct bedside care for a diverse population (Hendson et al., 2015). Neonatal nurses can meaningfully improve in providing quality care to birth tourism families by respecting human caring when international mothers and fathers find themselves in a foreign environment. The dynamics when giving quality care to birth tourism families and the needs and challenges surrounding birth tourism families need to be highlighted and disseminated to advance nursing knowledge.

United States hospitals receive a melting pot of patients, and birth tourism families make up part of that pot, causing constant changes in the hospitals' ethnic and cultural composition (Darnell & Hickson, 2015). These changes pose challenges for the

nurses to incorporate their patients' diverse needs into quality nursing care. This study is significant to nursing to meet a culturally diverse population's demands and needs in this aspect. Moreover, considerable attention has been directed toward numerous developed models and theories to help neonatal nurses recognize and respect transcultural diversity. In ethnic, cultural, and socioeconomic groups, neonatal nurses provide for families' needs; however, there is a gap in nursing literature concerning the care provided to birth tourism families in the United States (U.S.) hospitals (Higginbottom, Hadziabdic, Yohani, & Paton, 2014; Leininger, 1988; Nicholas, Hendson, & Reis, 2014; Purnell 2003; Ramezani, Shirazi, Sarvestani, & Moattari, 2014). Without significantly exploring neonatal nurses' lived experience caring for birth tourism families, further health disparities will continue in South Florida neonatal intensive care units (NICUs). Birth tourism families admitting their infants into the NICU face unanticipated medical, social, and financial challenges and may not communicate their needs, especially during the political and immigration tensions across the U.S (Mikhael et al., 2016). However, this study is significant to nursing as the evidence may escalate specific barriers created by being in a foreign country that could potentially contribute to additional stress, depression, and anxiety. According to Creswell and Poth (2018), providing qualitative evidence may add discoveries to nursing knowledge, and this study will attempt to bring meaning elicited from neonatal nurses' voices to missing research on the quality of care.

### **Implications for Nursing Education**

Understanding the essence of neonatal nurses caring for birth tourism families through this research will contribute to nursing students' general knowledge in the United States' universities and worldwide. This study may also guide the education of current

and future nurses who choose to specialize in neonatology about the specific healthcare needs of birth tourism families in the neonatal intensive care unit (NICU). Neonatal nurses may be able to use this study's results to develop sensitive, anticipatory guidance that may be produced online and distributed through travel agencies for pregnant patients wanting to engage in the practice of birth tourism. The information learned in this study may also be used to educate practicing health professionals on effective strategies to meet birth tourism families' needs. Furthermore, this study may provide information on neonatal nurses' possible needs to care for birth tourism families, which will allow the creation of ideas such as innovative techniques via digital divides to provide birth tourism patients when shopping for information through the Internet. This study's findings may increase the nursing knowledge base regarding birth tourism families' culture in the NICU. Accordingly, this study may help develop curricula that increase cultural competence in nursing education among pre-licensed and post-licensed nurses to improve the nursing services rendered to birth tourism families. Nurses being culturally competent is part of the holistic quality care rendered to that population.

### **Implications for Nursing Practice**

Among the implications for nursing practice that will derive from this study is the empowerment that neonatal nurses will receive in understanding the meanings and experiences of caring for birth tourism families when their newborn is in the neonatal intensive care unit (NICU). Neonatal nurses build multiple facets of understanding when caring for diverse families with a sick or premature infant. They will also include a clearer understanding of the care given to birth tourism families instead of relying on anecdotal evidence received from the news media about this population. Anecdotal

evidence may influence neonatal nurses' world view on diverse patient populations or may influence their stance; however, this study may emerge new perspectives regarding caring for a patient population underscored as a burden to the American healthcare system. Biases formulated on social justice from anecdotal evidence when providing care to diverse patient populations may change from an experiential approach to hearsay evidence. The neonatal nurses' testimonials may challenge nurses in practice to be aware and embrace cultural differences birth tourism families bring and lessen societal injustice by minimizing biases when caring for birth tourism families in the NICU.

Furthermore, these qualitative research findings may support evidence-based practice to promote cultural awareness and improve culturally competent care when caring for birth tourism families. Although applying theories helps deliver standard neonatal nursing care to diverse patient populations, this study may also show how applying these theories to birth tourism families highlights areas in which these theories are underspecified and suggest diverging paths for filling the gaps caring for this population. The NICU nurses have a unique role in contributing to a more connected and positive experience for birth tourism families when providing quality nursing care. This study's findings may enhance the nursing care for birth tourism families who are a marginalized population that faces challenges in achieving optimal access and utilization of maternal and infant healthcare when they unexpectedly admitted their newborn into the NICU.

### **Implications for Nursing Research**

Research advances knowledge on the topic of birth tourism by presenting empirical data from a quantitative perspective where scientists looked at the impact of

birth tourism on NICU admission rates. However, there is limited research investigating neonatal nurses' perspective delivering care to birth tourism families when facing a sick or premature newborn in the NICU. The findings of a hermeneutic phenomenological study on this population will contribute to scientific discussions about the phenomenon. Without a paradigm shift seeking an interpretivist worldview, nursing may not understand neonatal nurses' perspectives when caring for birth tourism families in the NICU or the challenges of nurses and families that could alter the care during birth tourism NICU hospitalization experiences. Neonatal nurses use research-based practice in caring for neonates and their families. To date, nursing research has not explicitly examined the quality of nursing care promised in purchased maternity packages, nor the nurses' perspectives of the care rendered to birth tourism families, especially when their newborns are admitted into a NICU. As with all healthcare, quality and safety concerns surround the provision of services to birth tourism families. Moreover, such issues have not yet been the subject of sustained academic study. Strengthening the knowledge base on quality, safety, and liability of birth tourism families and the care rendered by neonatal nurses is an important step forward, and it is in hopes that the evidence generated from this study will help inform the development of future research on policy and practice in the area of neonatal nursing.

### **Implications for Health and Public Policy**

Exploring the quality of care received by patients who travel internationally, and the care rendered to birth tourism families in the United States (U.S.) is eminent. Hospitals servicing these patients may lead in conversations to influence South Florida legislators' dialogues to benefit birth tourism patients accessing healthcare. Research

(Mikheal et al., 2016) underscores that formulated biases in American communities are influenced by discourses highlighting that birth tourism practice is causing burdens and negatively affects health care systems socially, politically, and financially. Although these dehumanizing discourses may cause biases, this study clarified what is happening within that population. This study may serve as a guide for healthcare providers to deliver quality nursing care free from biases and stigmatizations. The driving forces from the narrative chosen in the media fuel negative uproar toward the act of birth tourism; this study highlighted the need for health and public policy driving this global business to sustainable international healthcare providing business. Developing inclusive policies will support efforts on healthcare and migration grounded in respect for human rights. In accordance, through the lens of social justice, every family who is envisioning birthing children worldwide needs access to skilled maternal care during childbirth and supportive care following the weeks of birthing their newborn (WHO, 2018).

Furthermore, this study's implications provided insights for sound health policies that are needed globally to protect pregnant women seeking maternity care abroad. From a nursing perspective, emerging needs of birth tourism families will ring the alarm to constituents and create conversations at the International Council of Nurses (ICN) table who usually presents to the national nurses' associations in more than 130 countries. The poignant needs of ensuring the health and public policy that protect the interest of birth tourism families precisely when they end up admitting an infant into the neonatal intensive care unit (NICU) will evolve and become the focus of nurse advocates as they take place at the table to shift the social, political, and cultural views of this population.

This study's implications may also explain the quality of care birth tourism receives and include policies that would apply to birth tourism's different social aspects.

In the concept of migration, this study may reflect various perspectives to support public health policies that would protect and offer inviting narratives, which will influence the decision-making of birth tourism families when looking for and choosing a destination country to give birth to their newborn. This study will provide education to diverse stakeholders, enlighten the diaspora who shares information worldwide to attract families in engaging in birth tourism and safeguard this population against xenophobia. The immigration aspect addresses implicit assumptions that can stimulate discussions about healthcare reform integrated into immigration policies to protect birth tourism families. They are temporary legal immigrants who travel to the United States intending to give birth and return to their country. Although the current political narrative informs that birth tourism is a burden in some receiving countries, implications from this research may encourage to explore meanings shared from this study to translate the importance for the need of nursing advocacy and action by the response to policy changes that will promote and protect the well-being of the birth tourism population.

Collaboration with departments of tourism, travel agencies, and health care systems' international departments may benefit from this study's results to start the conversation on visible regulatory policies assuring the delivery of quality nursing care. Hospital management can initiate policies giving birth tourism families further information on admissions to the neonatal intensive care units, including detailed information on risks and expectations if premature or sick infants are born. In this context, the lack of evidence on birth tourism families limits the possibility of informed

decision-making for the pregnant traveler. Moreover, findings of their birthing experience's complications highlight the need for quality of care received and are likely to mirror current international maternal healthcare policies. In this context, it seems opportune for policymakers within the United States to further explore lessons from birth tourism travel.

### **Scope and Limitations of the Study**

This qualitative nursing study included the scope of neonatal nurses caring for birth tourism families who admit a newborn into South Florida's neonatal intensive care units (NICUs) who were willing to share their experience with the researcher. Furthermore, this study included registered nurses (RNs) who hold an Associate degree in Nursing (ADN), a Bachelor of Science degree in Nursing (BSN), a Master of Science degree in Nursing (MSN), or a Doctorate in Nursing, and who worked a minimum of 6 months in a South Florida Hospital with newborn and neonatal services. Interested participants voluntarily recruited to obtain an experiential description from neonatal nurses' lived experience of caring for birth tourism families in the NICU. This study relied on the lived experiences of the participants and not the researcher. Therefore, this is consistent with van Manen's hermeneutic phenomenological method of inquiry. Among the anticipated limitations in this study, the lack of experience of a novice researcher in conducting a hermeneutic phenomenological study, as this inquiry involved a complex and lengthy process that challenges even the most experienced and proficient researchers. Accordingly, the novice researcher sought guidance from the dissertation committee for direction during the research process.

Although trustworthiness and rigor are maintained, potential limitations exist in the study. The data collected was based on the stories and perceptions of the participants. One of the limitations is that participants might have said what they believed the researcher wanted to hear during the study's interview process. The participants may also not be truthful or have divulged in their experiences out of embarrassment. Additionally, the participants might not be willing to complete the interview process or commit to the necessary time to complete the interview. According to van Manen's hermeneutic interview procedure of close observation, there may be a limitation for interviewing participants via Skype. Although maintaining a particular orientation of reflexivity, the close observation method compromised may have been when the nurse researcher failed to guard against manipulative and artificial attitudes.

Furthermore, consistent with van Manen's hermeneutic phenomenology, the process of reflexivity requiring reduction to permit the discovery of spontaneous surge of the lifeworld may be challenging to achieve as a novice researcher. Consequently, overcoming one's subjective or private feelings, preferences, inclinations, or expectations may prevent coming to terms with the phenomenon as it is lived through (van Manen, 1990). The novice researcher's comprehension of an accurate methodical structure consistent with this hermeneutic research may also pose limitations to this study. Van Manen's approach consisting of six research activities requires familiarization and understanding of the complex concepts; thus, the researcher needs to understand how to apply them to the study.

## Chapter Summary

This chapter introduced the explored phenomenon. Discussion of the current state of birth tourism globally and in the United States focused on infants with their families' admissions and neonatal nurses' caring experiences in the neonatal intensive care unit. The presented discourses were on the background, the problem statement, the purpose of the study, and the research question. The philosophical underpinnings of qualitative research and van Manen's hermeneutic phenomenology were explored. The study's significance, the significance of the study to nursing, implications to nursing education, practice, research, and health policies, and the study's scope and limitations were also discussed.

## CHAPTER TWO

### REVIEW OF THE LITERATURE

The purpose of this hermeneutic phenomenological study using van Manen's (1990) methodology was to understand the lived experience of neonatal nurses caring for birth tourism families who admit a newborn into South Florida's neonatal intensive care units (NICU). This research aimed to give neonatal nurses a voice to express their individual experience of caring for birth tourism families, inductively interpret their everyday experience in their lifeworld, and understand the essence of caring for this unique population. Fry, Scammell, and Barker (2017) reported that a review of the literature serves to inform the researcher of the present state of knowledge on the topic of interest and constitutes an integral part of the research process in the qualitative paradigm.

It facilitates exposure to the phenomenon, provides context, discovers the gaps in knowledge, and provides a rationale for new research (Munhall, 2012; Polit & Beck, 2017). According to van Manen (2014), the review of the literature is the preliminary research process that involves orienting to the phenomenon so that the researcher begins to "wonder" or "question the meaning," "displace and dislocate" the phenomenon and enable thoughtful insight (p. 40). Since this research underpins phenomenological philosophy, Munhall (1994) supported that phenomenologists acquire insights on the phenomenon by turning to the literature before the actual research. This review of the literature is also set to (a) inform the research question, (b) guide the development of a research plan, and (c) expand the understanding of the phenomenon from multiple perspectives (Polit & Beck, 2017).

A search conducted was for relevant literature that surrounds the phenomenon of neonatal nurses caring for birth tourism families in neonatal intensive care units.

Literature was accessed from the following computerized databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Dissertations and Theses, Elton Bryson Stephens Company host (EBSCOhost), Medline, ProQuest, PubMed, Ovid, and Science Direct. Keywords included: *birth tourism*, *healthcare*, *birth tourism families*, *admissions in the neonatal intensive care unit*, and *families in the neonatal intensive care unit*.

Exploring the birth tourism concept led to seminal writings on medical tourism, referred to as healthcare tourism, as birth tourism subsumed in the healthcare and tourism industries. Limitations imposed were that the literature was in the English language and research dated since 2014 to reflect current literature on the phenomenon.

Exploring further into the literature, the researcher extended the search parameter across disciplines. This search yielded studies addressing birth tourism in numerous contexts and through diverse perspectives. This literature review discussed the historical context, birth tourism and birthright citizenship, studies addressing birth tourism benefits, birth tourism and healthcare, and studies addressing admissions into neonatal intensive care units. Subsequently, a synthesis of the literature will confirm the significant gap in nursing knowledge regarding neonatal nurses providing care to birth tourism families who admit an infant into the NICUs. Finally, a discussion through the researcher's experiential context will acknowledge any presuppositions about neonatal nurses' lived experience caring for birth tourism in the NICU.

## Historical Context

A historical context presents all views on the phenomenon from past literature as it existed and appeared, particularly in a place and during a time (Creswell, 2013). The literature and collected data on neonatal nurses caring for birth tourism in the neonatal intensive care unit are scant. The term “birth tourism” appears in seminal research dated as early as 2006. Rooted within the practice of medical tourism and conceptualized as a form of healthcare tourism, birth tourism denoted in some literature is as *maternity tourism, maternity migration, birthright citizenship, citizenship tourism, fetal citizenship, reproductive tourism, and reproductive futurism*. These terms surfaced from anecdotal literature, news reports, and political and immigration debates over birthright citizenship across countries promoting the law of citizenship. The World Health Organization (WHO) (2003) explained no agreed definition for birth tourism. Overtly, Tourism Research and Marketing (TRAM) (2006) expounds that birth tourism involves a pregnant woman who travels to another country to receive maternal healthcare and give birth to a baby.

Birth tourism subsumed into medical tourism is contextualized in the business of healthcare. The business of tourism described is an act of traveling across international borders to pursue recreation activities while using the commercial provision of maternal healthcare services (TRAM, 2006; Sweet, 2000). Published studies mounting the topic of birth tourism are outside of nursing research, thus published in tourism and business journals. A product of a modern social process, tourism had antecedents in the Classical Age, which began in the 17<sup>th</sup> century where people crossed borders for not only explorations nonetheless, pilgrimage (Hopkins, 2011). At the end of the 18<sup>th</sup> century, the

term tourist was coined, and the process of tourism involving pleasure-seeking activities also included other shared categories such as business tourism, sports tourism, and medical tourism (international travel organized to receive medical care) (Urry, 2002; Urry & Larsen, 2011). By the early 19<sup>th</sup> century, tourism journeys for health, leisure, and culture became standard practices among the middle classes to acquire various medical care, cultural knowledge, and experience. Tourism became even bigger business internationally in the latter half of the 20<sup>th</sup> century as airborne package tours to sunny coastal destinations became the basis of an enormous annual migration from northern Europe to the Mediterranean, expanding from the United States to Mexico and the Caribbean (World Tourism Organization, 1997). By the early 21<sup>st</sup> century, international tourism became one of the most important economic activities (Smith & Eadington, 1992). Although the World Tourism Organization tried to count tourists globally by giving numerical values to visitors attending seaside resorts, international travel agencies took the lead in selling tourists' journeys to the coast, city, and countryside, which made it difficult in the accuracy of the data (World Tourism Organization, 1997).

After World War II, governments around the globe became interested in tourism as a tool of diplomacy. As a result, nationality laws were enacted to support the United Nations Universal Declaration of Human Rights of 1948 stating that, "everyone has the right to a nationality." This interest in diplomacy led to inquiries addressing Nationality laws, birthright citizenship across many countries, as well as the agreement of the United States fourteenth Amendment, which awards birthright citizenship to every infant born on the United States (U.S.) soil. In 1868, the United States Constitution adopted the 14<sup>th</sup> Amendment claiming the birthright citizenship of persons born in the U.S. and controlled

by its citizenship clause expounding that: “Persons born or naturalized in the U.S., and subject to the jurisdiction thereof, are citizens of the U.S. and the state wherein persons reside” (United States Constitution Amendment XIV). This clause was created to support and protect the Civil Rights Act, make it easier for individuals to gain citizenship, and create citizenship for anyone born on the territory claimed by the U.S. Government.

Therefore, the 14th Amendment contributed to the unique phenomenon of birth tourism in the U.S., allowing international families to legally gain birthright citizenship for their infants born in the country. This law permitted pregnant women to travel internationally and to have a child on receiving country’s soil with the following benefits: (a) cemented immigrant’s presence; (b) access to welfare benefits; and (c) initiate chain migration of child’s extended family (meaning, the child may apply and provide legal residence to family). These benefits have contributed to the growth of birth tourism in the industries of tourism and healthcare. During the latter part of the 21<sup>st</sup> century, in the context of historical precedents such as the Second World War and the catastrophe of September 11, 2001, terrorist attacks in the United States (U.S.), concerned governments of countries around the world started addressing unsettled questions on nationality (Bakan & Stasiulis, 2003). These concerns sprung debates about birthright citizenship of individuals born on U.S. territory, and the phenomenon of “birth tourism” emerged in newspaper reports associating this healthcare-seeking practice with nationality laws.

Framed in the literature (Knight, 2005) as a possible illegal practice, birth tourism is an act calculated by foreigners exploiting America’s tradition of obtaining birthright citizenship. Also, it is to produce “anchor babies” (infant born of birth tourism mothers serving as a bridge for legal residence) that will allow families to obtain U.S. citizenship

through their U.S. born child. In 2011, the topic of birth tourism grew in popularity. Despite the lack of literature addressing birth tourism in hospital settings, writings from various scholars across disciplines and anecdotal evidence saturating the media confirmed that women continue to cross international borders searching for maternity healthcare. Scholars associated birth tourism with idioms such as birthright citizenship, globalization, transnationalism, neoliberalism, aspirational migration, and racialization. These terms conceptualize and contextualize how patients understand and practice seeking healthcare and how they perceive and negotiate their agency for obtaining healthcare. These concepts are related to tourism and maternal healthcare services, bringing clarity to the phenomenon of birth tourism and offering reasons for practicing birth tourism.

Nyers (2006) conducted a qualitative study to understand the topic of birth tourism better. This study was the earliest mention of birth tourism, addressing this concept as *accidental citizenship*, and expounded that birth tourism is a pejorative way of describing the birthright citizenship of infants born from birth tourism parents. There was no sample size given in this study. However, the researchers conducted a concept analysis utilizing several political cases that yielded the different techniques women employ to decide where to deliver their infant when nationality laws are involved. This study aimed to explore the act of sovereignty and nationality laws by which citizens and foreigners are “made” and “unmade.” The collected data was analyzed to demonstrate various dimensions of politics in the context of each political case to provide an illustrative example and detailed discussion of ‘acts of citizenship. This analysis presented the implication that birthright citizenship contributed to birth tourism in the

U.S. through accidental citizenship. This study's findings emerged from conversations on how birthright laws' effacement yields to “accidental citizens,” resulting in birth tourism. The researcher suggested that legal citizenship is to account for birth tourism. The study recommended that birth tourism embraces a practice for augmenting citizens of a country and contributing to borders' democratization. This study also explains that although some experiences with obtaining citizenship are by accidental citizens and that birth tourism is viewed through a negative lens is plausible, more positive birth tourism versions are encouraged.

Lee (2006) conducted a qualitative study to clarify birth tourism's concept to analyze issues surrounding this medical tourism segment. There were no sampling strategies, or any sample size reported; however, this study gave detailed descriptions of the different birth tourism segments within healthcare tourism. The study aimed to explore medical tourism in the healthcare industry and its many segments while associating birth tourism with emerging entrepreneurship opportunities. In exploring the concept of medical tourism, this study clarified the terms medical tourism and healthcare tourism, each reflecting the different segments, frameworks, and scope of healthcare and medical tourism. This descriptive study resulted in a comprehensive summary of events affirming that Tourism Research and Marketing (TRAM) promotes medical tourism as a travel activity involving medical procedures, giving birth, and contributing to the tourist's wellbeing.

Besides, the findings offered a framework that reflected the interchangeable use of the term “medical tourism” and “healthcare tourism.” The segments labeled as “illnesses,” “enhancement,” “wellness,” and “reproduction” tourism, as well as the

description of birth tourism as the pregnant mother who traveled to another country to give birth to her baby and the patient who sought fertility-related treatments such as In Vitro and In Vivo fertilization and other similar procedures. Furthermore, this study's results implicated that since medical services are an essential part of life and living and people have always traveled for health reasons, there will be rapid developments of all medical tourism segments. The findings concluded that birth tourism will soon become more significant and that Asian countries are creating a new profitable and sustainable medical tourism industry. The researcher recommended that the new and emerging international business of birth tourism present future entrepreneurial opportunities. Subsequently, there will be a need to regulate and monitor institutions to ensure the medical tourists' health and safety. This study also recommended that research focus on what remains in the future about birth tourism and the countries that will acclimate and be proactive rather than reactive about this genre of patients seeking healthcare.

Lee and Spisto (2007) utilized a qualitative inquiry method to publish their research in *Tourism Research and Marketing (TRAM)*, giving a general overview of birth tourism embedded in medical or healthcare tourism. This descriptive study did not include a sample size. The researchers defined *medical tourism* as the travel involving more than one night away seeking medical procedures, promoting health and wellness, or giving birth. The purpose of this study was to evaluate, analyze, and discuss the growth and development of these acts of seeking healthcare categorized under medical tourism utilizing the factors from the Porter's diamond theory. The researchers utilized this modern international trade theory, Porter's diamond, to conceptualize four necessary conditions for international business in healthcare: factor conditions, demand conditions;

firm strategy structure; related and supporting industries. The scope of this inquiry focused on and evaluated medical tourism areas that rely on medical and healthcare interventions, which often save lives, give birth, relieve pain, and provides various surgical procedures. The findings revealed that among the forms of medical tourism, birth tourism categorized under “reproduction tourism,” is under this constituent, are pregnant women seeking fertility-related treatments from abroad. More specifically, the study asserted that birth tourism is pregnant women involved in traveling to another country to give birth and to use healthcare services. The researcher expounded that business is an integrated part of healthcare and that birth tourism is a component of medical tourism emerging in international business. They recommended more research on birth tourism as it is becoming more critical as the new global trend for providing maternal medical services to international patients, services disseminated to birth tourism women.

Voigt and Laing (2010) utilized a qualitative study to trace the genesis of birth tourism’s trend. Although the trend of birth tourism ignored in tourism literature was in this study as a preliminary attempt to call attention to and integrate issues surrounding pregnancy and childbirth into tourism. The researchers did not reveal a sample size. However, they analyzed the literature from few statistical studies on tourism packages, academic research, anecdotal evidence forming online forums, the media, and promotional materials to demonstrate that the mass tourism industry's reproduction appeared to be new and emerging on an unprecedented scale. The research aimed to explore how this paved the way for understanding birth tourism development, known as reproductive tourism, as a commodity. This study also examined this new tourism product's marketing, which offers parents-to-be services for the best experiences of

pregnancy and childbirth. This study's findings provided a conceptual framework of birth tourism through four examples: babymoos, hotel baby programs, reproductive tourism, and procreation tourism programs. In providing this framework for analysis, this research outlined critical issues associated with packaging birth tourism as tourist commodities. This work acknowledges that birth tourism in the context of the commodification of pregnancy and childbirth proposes issues.

This study asserted that the transformation of birth services and people into objects of trade offered as commodification and exploration of the tourism marketers raises awareness and provides responses to ethical dilemmas surrounding this new product of commodity- birth tourism. This awareness helped facilitate other parents' desire for a child, and that birth tourism may be an actor of symbolic marker for transformative events in human lives, thus, for others, a negative outcome. This study's findings suggested that ethical dilemmas around birth tourism remain unresolved or unexplored and that further research is needed to evaluate birth tourists' characteristics, motives for being birth tourists, different forms of pregnancy, and childbirth tourism.

Nicolaides and Zigiriadis (2011) used a qualitative descriptive study to identify the healthcare-seeking model for South African medical tourism and its use as a strategy for alluring health tourists, including pregnant tourists, to travel to the South African region for healthcare. The study did not provide a sample size. However, it examined different areas and aspects surrounding the act of seeking healthcare as a tourist. Areas included destination areas, hospitals, medical and hotel staff, and quality of care offered to healthcare tourists. The purpose of this study was to address issues from these areas and to make suggestions on how medical tourism and birth tourism services can be

improved in South Africa to make this service increase in volume. This study did not discuss the data analysis process; however, the data collected disseminated pertinent information addressing birth tourism issues and medical services surrounding this practice in South Africa.

The findings gave underlining reasons why and how countries wanted to attract tourists and explained that this practice boosts the receiving country's economy by seeking medical care abroad. The findings also revealed that consumers' affordability was underemphasized, and as this study focused on birth tourism, the data collected supported that this practice boosted the economy in two countries located in South Africa. This study reported the gross revenue equivalent to \$4 million U.S. dollars in 2010, with an estimated growth in the industry of \$5 billion U.S. dollars for 2012. Additionally, charges for \$8,000.00 U.S. dollars to include hospital fees for birth tourism patients. Despite the significant reported revenues in South Africa, the study gave other reasons for increased birth tourism in other parts of the globe. Although the study concluded with a model providing a road map for the future framework to systematize and develop research on birth tourism, the researchers emphasized that healthcare quality should be one of South Africa's strategies to impress and attract patients who practice healthcare and tourism. Therefore, studies exploring the quality of care disseminated among birth tourism are in need.

According to Nyers (2006), the practice of birth tourism in the nationality and citizenship laws is politicized and viewed as a burden. Although research conceptualizes the term as accidental citizenship to explain this act, subsequently, Lee and Spito's (2007) and Lee's (2006) research gives detailed descriptions of birth tourism to reflect

that there has been a substantial shift in how pregnant women seek healthcare internationally and obtaining birthright citizenship as the major reason. Nicolaidis and Zigiriadis (2011) addressed issues surrounding birth tourism services, and the researchers emphasized that quality of healthcare should be one of the strategies South Africa should utilize to impress and attract patients who practice healthcare and tourism. What is known is that through birth tourism, international pregnant women travel not only to obtain birthright citizenship, thus engage in this practice to utilize healthcare services to obtain quality healthcare. Lee and Spisto (2007) also focused on explaining how birth tourism subsumed medical tourism as the segment of reproductive tourism to becoming the new global trend for providing maternal healthcare services to pregnant women internationally. Statistical data are slim to none on birth tourism. Thus, Voight and Laing (2010) traced the genesis of the birth tourism trend and provided an analysis of anecdotal evidence, news reports, and tourism research that paved the commodities of birth tourism. No statistical data or qualitative data focus on nursing care services and the issues affecting families who engage in birth tourism, specifically nursing services offered when birth tourism families admit an infant in the NICU. Accordingly, an inquiry on the lived experience of neonatal nurses caring for birth tourism families in the NICU may add new knowledge to the body of nursing. The phenomenon of birth tourism will continue to exist as long as birthright citizenship laws affect the receiving country. Therefore, birth tourism is evolving and will be applicable in modern times.

### **Birth Tourism and Birthright Citizenship**

Stock (2012) explored in qualitative research the practice of birth tourism relating to the Citizenship Clause of the 14th Amendment of the United States Constitution. The

researcher did not include sample size; however, through this research's interpretive descriptions, the study proposed changes to the Citizenship Clause and how proving one parents' birthplace to receive citizenship was related to the phenomenon of women practicing birth tourism internationally. The purpose of this study was to debate whether this clause should be applicable in the United States. This descriptive law study provided an overview of the Citizenship Clause's history, including the Naturalization Act of 1790, the United States Supreme Court case of Sandford versus Scott (the Dred Scott case), and the constitutional law which emerged from the Citizenship Clause. This descriptive study did not analyze the data collected but compiled facts surrounding birthright citizenship.

This study provided discussions on the impact of the proposed changes to the Citizenship clause, including an increase in citizenship lawyers and government tax revenue. These findings provided opposing views of birthright citizenship, explaining that the path given to babies born in the United States from birth tourism mothers is terrible for America. The researcher also discussed opposing views on birth tourism, encouraging immigration laws in America to follow the trends in other countries, and the need to advance in eliminating birthright citizenship. Further findings revealed that birthright citizenship has not just been of benefit in a moral sense but has been socially, economically, and politically beneficial to Americans as well. The research recommended that proponents of a change in birth tourism solved are by altering the Citizenship Clause. Thus, future studies involving changes in the 14th Amendment's Citizenship Clause are recommended. The study recommended looking at the future social, economic, and political consequences of implementing such a rejection of birth tourism attaining birthright citizenship.

Balta and Altan-Olcay (2015) conducted a qualitative descriptive study among Turkish citizen families, analyzing the process of mobilizing their resources so that their children receive by birthright the receiving country's citizenship. A purposive and snowball sampling method yielded 40 Turkish families who had given birth in the United States, along with four representatives of health tourism companies (two in Turkey and two in the U.S.) that organized travel packages were interviewed. Data collection during 2012 and 2013 based on the following demographic principles where the authors aimed to achieve diversity: (a) time of birth; (b) couples' occupations; (c) connections to the U.S.; (d) social class; (e) purpose of living in the U.S.; and (f) level of education. Data analysis completed through statistical calculations did not reveal in the study. However, the calculations reflected approximations from birth tourism families residing in Turkey with their infants born in the United States.

The findings reflected the emergence of birth tourism in the markets of healthcare, travel, and real estate and the actors with means who can acquire U.S. citizenship for their children in expectation of future benefits. Additionally, the researchers concluded that there is an emergence of new inequalities connected by citizenship, global and local political communities, and the government in the age of globalization. Furthermore, the study revealed that for those living in the Third World, acquiring an American passport for their children by giving birth in the U.S. is an attempt to position themselves and children within the privileged networks. The study recommends paying attention to the transnational communities for whom birthright citizenship will consolidate U.S. benefits.

Nori (2016) led qualitative research involving birth tourism in the context of racialization. This descriptive study did not give any sample size; though, it emphasized what it means to be an American citizen when born as a birth tourism infant by utilizing a compilation of news reports surrounding the topic of birth tourism businesses and connected them to a theory identified as racialization. The purpose of this research was to discuss the impact of birth tourism and present a broader conversation about Asian immigrants and citizenship rights. This central concept of racialization in the study is associated with race and racism deriving from sociology. The researcher defined this concept as the process of ascribing ethnic or racial identities to a social practice or group. From this definition, the researcher expounded that racializing one group of pregnant women in the news bring issues affecting this group and every American. The interpretive description of birth tourism explained in four parts is as followed: (a) The first part supplied a general background of the birth tourism industry and the issues and fears; (b) The second part explored the history of citizenship in the United States, which the researcher drew comparisons from other theories of citizenship; (c) The racialized identity of Asians in America by considering birth tourism conversations and its relationship to Asian-American identity examined in the third part; and (d) The fourth section of this research addressed the potential repercussions of birth tourism in the future.

This scientific finding reported that immigration has long been a hot topic in American media and has recently been at the forefront of the political playing field. As part of hot immigration topics, birth tourism elaborated in this study to educate on birth tourism women's destinations and how birth tourism women practice this phenomenon.

The researcher further reported that birth tourism women use online advertising travel agencies, which encourage them to sign up for tour packages with maternity hotels/motels located in places where tourism occurs. Popular destinations include major cities, small towns, and beach towns in the United States, Canada, and Hong Kong. Hong Kong was isolated as the mainland Chinese citizens travel to give birth and gain the “right to abode” (a status under immigration law that gives an unrestricted right to live in the country of birth). Some of the findings also addressed the potential repercussions of birth tourism that may occur in the future. The findings encouraged: (a) to consider ways in which birth tourism children (transnational citizens) impact the concept of American citizenship, (b) to ask about the meaning of birth tourism children accessing country’s beneficial systems while having no ties to the country aside from a birth certificate, and (c) to adapt to the changing face of global citizenship. Consequently, these pieces of evidence from this study reflect that birth tourism impacts many facets of the social life of U.S.-born children and that future research regarding the impact of birth tourism is needed.

Wang (2017) used a qualitative, descriptive study to explore the controversies over birth tourism in the context of birthright citizenship conceptualized as a fetal citizen and reproductive futurism. The researcher reported no sample size. However, the collected controversies from newspaper reports hallmarked what the researcher called racialized reproductive futurism and related how they shaped the contours of the locals’ responses toward birth tourism in one particular area of the United States. The purpose of this study was to examine the effects of past and future temporalities, which came to shape politics on birth tourism. The researcher used controversies in 2012’s news reports

to show how the birth tourism practice is being encouraged. According to the researcher, panic over Chinese birth tourism shows how “backward” racialized citizenship is, and discourses of “worthy immigrant” and “anchor babies” exist only to determine who may give birth to citizens in the United States.

Through textual analysis of media representations of birth tourism, the researcher explained how pro and anti-birth tourism’s rhetoric shaped the receiving country's ideology. Findings revealed that dehumanizing appellation for the women who practice birth tourism implicates accusations of being illegal immigrants. These findings further suggest the dilemmas of reproductive futurism in concert with the United States’ immigration politics. The researcher recommended that concerns be on Chinese women's well-being and their fetuses despite the adverse reports and controversies producing a panic over Chinese birth tourism. The study concluded that these controversies, landing in American society’s ears, may cause the uninformed to prejudge without knowing about birth tourism patients, therefore reject birth tourism as a healthcare practice. Future research is recommended on racialized citizenship to determine who may give birth to citizens in the United States.

Folse (2017) conducted a qualitative study examining birth tourism in “*aspirational migration*.” There was no reported sample size. However, this researcher explained that birth tourism was also known as “*maternity tourism*,” involved Chinese pregnant women who visited for a brief time to give birth in that country and acquire birthright citizenship. This descriptive study aimed to explore individuals who are motivated to travel worldwide for reasons that included birthright citizenship. This purpose was to describe the patterns that drive birth tourism families to seek maternity

healthcare abroad. The study's findings revealed other reasons for birth tourism, such as access to public schooling, healthcare, sponsorship for the parents in the future, and circumvention of China's two-child policy. By analyzing the motivations that drive many parents to give birth abroad, this research sheds light on the complex and risky process, and the researcher recommended a study that involves the host of players in birth tourism, including family and global birth tourism infrastructures.

In the study by Stock (2012), the researcher suggested that birthright citizenship has been socially, economically, and politically beneficial, involving America's Citizenship Clause, the 14th Amendment's Citizenship Clause, and birth tourism. The qualitative study by Balta and Altan Olcay (2015) reflected findings supporting the idea that birth tourism is emerging in the markets of healthcare, travel, and real estate. The results yielded that birth tourism not only offers the benefit of acquiring birthright citizenship; therefore, future benefits can be expected as well. Moreover, Folse's (2017) research listed additional benefits for birth tourism other than just obtaining birthright citizenship. Collectively, these studies' findings underscored that despite the negative attention and the emergence of new inequalities connecting birth tourism, birthright, and politics, and the age of globalization, birth tourism is part of a transnational community. Future research is needed for this population to gain knowledge on the different benefits from the U.S. perspectives. Finally, Nori's (2016) study discussed the responses to birth tourism shaping Americans' understanding of citizenship and national identity, and Wang's (2017) study, revealing that the use of dehumanizing appellation for the women who practice birth tourism. Despite the negative attention toward birth tourism, these studies encourage further research on birth tourism and its future as a global population in

the U.S. This study addressed neonatal nurses' lived experience caring for birth tourism families who admit their infant into South Florida's NICUs. Birth tourism provides birthright citizenship for the newborn, but there are also other reasons making this practice an affluent business continually growing in countries embracing the law of the "right to soil" by birth.

### **Studies Addressing Benefits of Birth Tourism**

Grant (2015) led a descriptive study on birth tourism exploring transnationalism's riches within a social policy context. The researcher did not provide any sample size, however, highlighted within this study is the idea that birth tourism is a growing trend causing effects on the economy, healthcare, and immigration policy at a global and local level. This research aimed to connect the concept of transnationalism and the trend of birth tourism. This study expounded a transnationalism meaning of multiple ties and interactions linking people and institutions across borders of nations' states and suggested a weakening of control a nation has over its borders, inhabitants, and territory. Narrative data were analyzed and included experiential content and anecdotal data to support birth tourism being a growing transnationalism trend. Findings revealed that some effects of birth tourism practice on healthcare and immigration policy might be positive, such as economic stimulus of countries that strive to cater to those seeking low-cost healthcare; however, this trend comes with a cost. This cost in countries like Taiwan and the United States manifested as maximizing taxpayer revenue to keep healthcare services affordable for its constituents. Subsequently, although other findings revealed that birth tourism in the context of transnationalism is a neglected area in research, countries like Taiwan, China, and the United States must decide how best to respond to this trend. This study

warrants addressing and discussing how policymakers respond to birth tourism, a growing market that can produce wealth.

Cheng (2016) conducted a quantitative study to investigate the prosperities of Chinese maternity tourism or birth tourism to Hong Kong in neoliberalism in sustaining economic growth. Using a sample size of 21 women from Hong Kong, the researchers aimed to examine the combined effects of the ruling of Chinese babies born in Hong Kong with the “right of abode” (meaning-freedom from immigration control in a country) and the launch of individual’s visit schemes for Mainland Chinese tourists on maternity tourism to Hong Kong. Following a quantitative design, the researchers utilized the Autoregressive Distribution Lag cointegration methodology. Additionally, a statistical parsimonious infinite lag distributed model cointegrated statistical properties on a series of variables. Data were analyzed using the bounds testing of Pesaran, Shin, and Smith (2001) for the level of relationships over a period from 1991 to 2011. Although small, the robustness of empirical results was checked by re-estimating two sub-sample models. Statistical results reported a computed F statistic 9.92 more remarkable than the upper bound of the critical value 5.473 at the 5% significance level.

The result implied a long-run relationship among the variables. Empirical results showed that income and exchange rates have no transitory effect on maternity travel since maternity tourists usually plan at least one year for international travel. The long-run elasticity of income = 0.98 (close to unit elastic). Chinese parents consider maternity tourism as a normal good. The statistical results revealed that with strong economic growth over the last two decades, Chinese parents have a higher demand for maternity tourism to Hong Kong. The study also reported Chinese parents choosing countries with

wealthy economies as their maternity travel destinations as this practice provided citizenship to anyone born on their soil. The study's implications for further research are to examine countries such as Hong Kong and the United States and their privileged circumstances for birth tourism women, such that their ability to support high-quality, safe birthing procedures and the rendering of birthright citizenship.

Ji and Bates (2017) examined the affluence of birth tourism in this descriptive study by how pregnant women are encouraged to leave their homelands and give birth abroad. The study's purpose was to examine how birth tourism agencies frame birth tourism and the persuasive tactics used through neoliberal appeals to commodify birth and pregnancy. A sample size of 34 birth tourism agencies' Internet websites advertised pages persuading women to travel to destinations, such as the United States or other ideal places to give birth. The researchers utilized neoliberalism (a political approach that favors free-market capitalism, deregulation, and government spending reduction) as an analytical framework to examine how birth tourism may enhance inequality in health resource distribution both domestically and internationally. This thematic approach revealed the results in four themes: 1) Citizenship as an investment; 2) American providers as superior care providers; 3) Whiteness as evidence of superior care; and 4) Access to Chinese traditions. These themes provided clarity on the multiple reasons which agencies gave pregnant Chinese women to make birth tourism appealing. This study provided a background for further studies of the birth tourism phenomenon, and these perspectives helped to understand birth tourism both as a health-related behavior and as a cosmopolitan or multicultural issue. This research contributed to health neoliberalism conversations since they have postulated that the sphere of global health

organizing, neoliberalism seems to have crossed national boundaries. The researchers recommended that further investigations are needed to elicit dialogues among birth tourism patients.

Chawanpaiboon et al. (2019), in a qualitative study, addressed birth tourism in the context of globalization (the process by which this business develops international influence to operate on an international scale). This retrospective study gave a sample size of 194 countries that are members of the World Health Organization. Data were systematically examined on preterm births from 1990 to 2014. The study highlighted crucial needs to safeguard the health and well-being of all women and their infants around the world, including ensuring access to high-quality and respectful healthcare services. Also, these researchers indicated that birth tourism is practiced globally by pregnant women traveling to a developed or high-resource country expecting to give birth and obtain birthright citizenship for their infant.

Through a modeling analysis method, the authors showed findings that globalization, in the context of birth tourism, is driven by international trade, aided by information technology, and possess affluent effects on the environment, culture, political systems, economic development prosperity as well as on human well-being from societies around the world. The study reported no statistical measurements; though, other findings revealed that from the chosen 38 countries, new global estimates of 10.6% of all live births were preterm births in 2014. This research suggested that globalization significantly improves maternal and infant health in both rich and developing countries. Although maternal and infant mortality remain high in developing countries because of the remaining health challenges, such as accessing essential preventive and life-saving

medical care. The study suggested further research investigating the practice of birth tourism and how it may help diminish the number of health disparities worldwide.

The study by Grant (2015) suggested that countries like Taiwan, China, and the United States must further explore the trend of birth tourism because it is a growing market that can produce wealth. Similarly, Cheng (2016) implies further research to examine Hong Kong and the United States' privileged birth tourism circumstances. However, the study promotes a focus on pregnant women seeking healthcare internationally that support high-quality, safe birthing procedures and provides birthright citizenship. None of these studies offered the quality of care as affluence of birth tourism. Although the studies of Chawanpaiboon et al. (2019) and Ji and Bates (2017) shed light on the wealth that birth tourism brings to the receiving countries, these studies recommended further exploration of the practice of birth tourism, specifically the health disparities as well as open dialogues on birth tourism patients. Despite the affluence of birth tourism, healthcare is the bottom line of this practice, which guarantees mother and infant well-being.

### **Birth Tourism and Healthcare**

Yan and Chen (2014) utilized qualitative research to explore the influential Chinese practice of birth tourism merging into healthcare by involving the tradition of the one-month postnatal sequestration of new mothers termed “doing the month” (DM). This research offered no sample size. Hence, it provided data on postpartum nursing centers serving the Chinese birth tourism market in the United States while keeping their traditions. This study aimed to explain birth tourism landing in healthcare facilities in the United States through this traditional Chinese society practice of 1-month confinement

for post-partum women. Furthermore, the purpose of this descriptive study was to (a) explain the establishment of postpartum nursing centers as an entrepreneurial activity by focusing on the transaction cost perspective; (b) depict the practice of DM and how it can evolve into a profitable enterprise in ethnic Chinese communities; (c) explicate the theory of transaction cost entrepreneurship; (d) analyze the burgeoning success of postpartum nursing centers and birth tourism and the strategies used to persuade expectant mothers in using the service of DM; and (e) describe the postpartum center as a consumer-centric service from the perspective of the transaction cost entrepreneurship. Using the transaction cost entrepreneurship theory, the researchers analyzed and explained the burgeoning business of birth tourism in DM's new business.

Data collection included a descriptive interpretation of examined reports and narrative analyses. Although the qualitative data did not yield any themes, the study presented descriptive summaries with numerous content areas. The emergence of the Chinese postpartum nursing center included sub-content areas elaborating on DM's practice as a burgeoning Chinese nursing enterprise through birth tourism in the United States and the transaction cost entrepreneurship and burgeoning Chinese postpartum DM nursing centers. The findings revealed that the practice of DM, related to damage-prevention behaviors (such that of not washing hair to prevent a headache later) and damage-recovery behaviors (such that of eating more tonic foods to compensate for the blood loss during labor) promote the physical and psychological health of postpartum mothers and the healthy development of their infant as well as having social effects in the family relationships. Although DM promises many benefits for postpartum mothers, the

researchers also found a tremendous number of complicated and tedious procedures that occur when the 1-month stay is at home.

Further findings presented reasons for pregnant women practicing DM, which included increased costs and family tension affecting postpartum mothers during their stay if completed at home. The study also reported that among the reasons which contributed to the popularity of birth tourism for Chinese women, that DM was found to be popular and was the burgeoning of postpartum nursing centers in the United States (U.S.). The results demonstrated how entrepreneurs take advantage of institutional arbitrage and persuade expectant mothers to practice birth tourism and utilize DMs and postpartum nursing centers in the U.S. rather than at home. The study recommended that future research explore the transaction cost entrepreneurship theory's application to explain the emerging healthcare services offered to Chinese mothers who choose to deliver a child through birth tourism.

Subsumed into the emerging concept of healthcare tourism, Singh (2014) explored the concept of traveling for medical care using qualitative research, which included birth tourism as a stand-alone category of special interest tourism. There was no sample size provided, but the purpose of this descriptive study was to examine the alternate forms of tourism in India's tourism industry and their impact on healthcare and how healthcare tourism is becoming a new and emerging international business. Any individual who travels overseas for a particular purpose conceptually meets the definition of a traveler practicing tourism (Singh, 2014). According to Singh (2014), medical tourism refers to the act of traveling to another country for the best leisure and high cures against diseases, specialized treatments, and better medical costs. This study did not

provide emergent themes. However, several descriptive interpretations offered data clarifying the phenomenon of traveling to other countries explicitly for medical treatment. The Definition of “health tourism” and the definition of a “tourist” emerged as well as categories explaining medical tourists, treatment of illness, enhancement procedure, wellness tourism, reproduction treatment, birth tourism, and low-cost treatment for healthcare tourism patients. The categories addressed India's tourism services spectrum, such as spa-wellness services and birth tourism services. These are frequently prevalent from countries not offering the needed maternal healthcare services or healthcare services found only in the host country.

The findings of this study are evident in linking healthcare and tourism as emerging healthcare businesses. The research confirmed that more than 130 countries worldwide are competing in the global business of healthcare tourism. Some of this success is assumed by certain countries placing healthcare within the tourism industry. In India, healthcare tourism generated in 2006 a revenue of over \$600 million U.S. dollars. Furthermore, other reasons for healthcare tourism specifically yielded pregnant mothers practicing birth tourism not only for the advantage of receiving quality medical care not available in their home country but also to have the child gain citizenship from the new country. As disposable income increases, people are inclined to travel to some countries to get better quality healthcare services. Findings also revealed that the offering of qualified medical specialists the various hi-tech services and low-cost treatments play an essential role in developing healthcare and tourism. The study implied that future research should explore factors about developing the individual forms of healthcare tourism for the various tourism branches to develop, such as birth tourism.

Mikheal et al. (2016) conducted a quantitative retrospective study to examine the characteristics of birth tourism neonates admitted into the neonatal intensive care unit (NICU). Through a longitudinal descriptive design over three years (February 2012 to January 2015), these researchers identified and collected birth tourism cases relevant to perinatal, medical, social, and financial data. The data collected compared with a sample size of 100 randomly selected non-birth tourism neonates admitted in the NICU for that period, and a total of 46 birth tourism neonates were identified. The data analysis performed was using statistical comparisons between the birth tourism and the controlled non-birth tourism groups. Using the nonparametric Wilcoxon-Mann-Whitney test for continuous variables and the chi-square test for differences in categorical variables in these two groups, the researchers produced a formal statistical comparison  $p$ -value, unless the number of events was inadequate for analysis. Birth tourism neonates were more likely to be born to older women (34 vs. 29 years;  $p < 0.001$ ) via cesarean delivery (72 vs. 48%;  $p = 0.007$ ) and at a referral facility (80 vs. 32%;  $p < 0.001$ ). Further findings revealed that the birth tourism group had longer hospital stay (15 days vs. 7 days;  $p = 0.02$ ), more surgical interventions (50 vs. 21%;  $p < 0.001$ ), and higher hospital charges (median \$287,501 vs. \$103,105;  $p = 0.003$ ). One-third of the birth tourism neonates enrolled were in public health insurance programs, and four birth tourism neonates (10%) were adopted.

Other findings from this study's statistical analysis, comparing the birth tourism group and the controlled non-birth tourism group showing demographic characteristics, revealed no significant differences in gestational age, birth weight, sex, Apgar score, or delivery room management of these infants. Regarding race, the majority of birth tourism

neonates were of Asian mothers from China and Taiwan (89%), and non-birth tourism neonates were predominantly White (51%) or Hispanic (40%). Measurable differences between groups in this study and families of birth tourism neonates admitted to the NICU face significant challenges. Subsequently, these researchers encouraged future work to quantify and address the distress and anxiety apparent in birth tourism families. These scholars also suggested an increase in birth tourism NICU admissions in the region of Southern California. Future epidemiological studies on the birth tourism population targeting a geographical location, state, county, or large metropolitan area are recommended from this study to examine the NICU admission rate. Extensive studies to benefit from elaborating on birth tourism families impact healthcare systems and societies warranted from this study.

Another qualitative study by Cesario (2018) explored the driving factors and the challenges and opportunities birth tourism incorporated in medical tourism presents in healthcare. In this descriptive study, no mention of sample size; however, a description of birth tourism, the controversial activities concerning this form of reproductive tourism, and the various healthcare provisions surrounding birth tourism were given. Findings reveal that individuals who travel internationally to seek healthcare need to prepare to endure extended stays and face financial burdens. The findings pointed to solutions for language and communication barriers, cultural barriers, including tools that provided for these resources. Implications from this study revealed that birth tourism fueled by electronic communication and international travel ease is a rapidly growing market. The most cited reasons for this practice are affordability, accessibility, and acceptable quality. This study implied that nurses should play a key role in shaping policies and laws

associated with the industry of birth tourism. The study recommended that companies servicing traveling patients need to hire nurse case managers to help patients seeking healthcare services abroad.

In a qualitative study, Jaramillo, Goyal, and Lung (2019) explored reasons Chinese women practice birth tourism by traveling to the United States on a tourist visa, specifically seeking maternal healthcare to give birth. This experimental design revealed a sample size of 12 participants, and the researchers used convenience and snowball sampling to recruit Chinese women from waiting rooms of obstetricians' offices known to care for birth tourism patients. In a demographic questionnaire and answering interview questions, participants provided answers about their reasons for traveling to give birth and birth experience while in the United States (U.S.). A qualitative analysis method utilized was to extract themes from the participant's narratives. Results revealed that 12 married, college-educated women, aged between 26 and 39 years, self-identifying as birth tourists from China, took part in this study. Furthermore, the content analysis presented two themes: (a) positive perceptions of childbirth in the United States and (b) securing a future for their child.

These findings exposed that approximately one-third of women who come to the United States to give birth travel on a tourist visa are from China. Results also included descriptions of birth tourists from China experiencing the United States' healthcare system and their reasons for choosing this path. Highlighted reasons included setting up American citizenship for their baby, securing a better future for their newborn, utilizing better quality healthcare from the U.S., and having painless childbirth. Clinical implications suggested that Chinese birth tourists come to the United States to better

childbirth experience and secure future opportunities for their children. According to the study's themes, researchers share that nurses should be aware of the current political climate on immigration and birth tourism to promote a safe and judgment-free environment when providing care to women's unique populations. The study recommended that research is necessary on international patients' care, especially during the stringent political climate.

Mikhael et al.'s (2016) research affirmed an increase in birth tourism admissions and recommended that extensive studies are needed to elaborate on the impact of birth tourism families on the healthcare systems and societies. Additionally, Ya and Chen (2014) also explained birth tourism as a burgeoning business using transaction cost entrepreneurship theory. Both pieces of research support the notion that birth tourism is an emerging business that offers healthcare services to pregnant women who travel internationally to deliver a child. These researchers collaboratively recommend future research to focus on the medical services offered to this population. Similarly, the emerging business of birth tourism, often subsumed in medical tourism, not only offers affluence such as birthright citizenship to the newborns, but it also offers various specialized healthcare services which may not have been available in the departing country of these pregnant women (Singh, 2014; Jaramillo et al., 2019). As birth tourism families choose to travel abroad with a plan to deliver their infant to a United States hospital, these families utilize numerous specialized services when their newborns are admitted into the NICU (Mikheal et al., 2016). Mikheal et al. (2016) reported that admissions into the NICU poses several risks and are due to numerous factors as well as causes negative impacts to the admitted infant and birth tourism families. What is not

known is the quality of care services given to birth tourism in the NICU. Therefore, this study illustrated the care provided to birth tourism families who admit an infant into the NICU. Although they travel abroad to give birth before returning home, expectant birth tourism families face more complex medical challenges when faced with admission into the NICU (Mikhael et al., 2016).

### **Studies Addressing Admissions into Neonatal Intensive Care Units**

Harrison and Goodman (2015) conducted a quantitative, retrospective study from 2007 to 2012 to examine the risks of neonatal intensive care units (NICU) admission for the United States (U.S.) newborns. The purpose of this research was to describe the characteristics of infants admitted to the NICU and observe risks across the range of birth weight and how these risks changed during the 6-year study period. This epidemiologic time-trend analysis utilized national vital statistics data from the Birth Public Use Data Files (BPUDF), representing live births to the U.S. and District of Columbia residents. The sample size of 17,896,048 newborns from 38 states, including the District of Columbia, represented 72.9% of the total birth cohort. Statistical analysis for this population-based study utilized Stat, version 13.1 (StataCorp) to measure two outcomes.

The primary outcome was the admission to the NICU according to four levels of neonatal care recommended by the American Academy of Pediatrics. Level 1 unit – well newborn nursery provides care for stable term infants; Level 2 unit – special care nursery provides comprehensive care to moderately ill or preterm infants; Level 3 unit – NICU provides care for high-risk infants; and Level 4 unit – NICU provides the full range of respiratory support, including surgical care. The secondary outcome measured birth weight and gestational age composition, as well as the trends in the NICU of infants who

used assisted ventilation for more than 6 hours during their admission period. Time-trend statistical analysis of crude stratified (by birth weight) and adjusted admission rates by year and Modified Poisson regression with error variance determined adjusted relative rates. The covariates for adjustment included: (a) infant characteristics of gestational age, plurality, delivery mode, sex, and (b) mother characteristics of parity, race/ethnicity, age, and educational level. This method was adapted from a Centers for Disease Control and Prevention model to describe infants' admission rates. Similar to conducting a Chi-square test of the trend, a simple linear regression used in this study was to decrease the potential of type 1 error.

Regression with robust error variance was to determine adjusted relative admission rates in this study. The results yielded an overall increase of 23% in NICU admissions during the six years of the study and indicated that compared to the total U.S. birth cohort of almost 4 million in 2007, approximately 58,000 additional NICU admissions occurred in 2012. The research culminated that both the admission rates for very low-birth-weight infants and regular-birth-weight infants were on the rise out of the study populations. Although very low-birth-weight infants benefit from neonatal intensive care and experience better outcomes in a level III NICU, the researchers suggested that it may be concerning normal-birth-weight infants and less critically ill in this similar setting to intensive and costly care. Therefore, the study recommended researching this aspect of admissions of newborns and the services they receive.

Furthermore, this research proposed that a NICU admission can contribute to family distress related to altered parental roles, higher costs, and the increased medicalization of a healthy birth. Consequently, the researchers recommended further

studies about potential overuse and the appropriate, efficient, and effective use of the different levels of care across the spectrum of infants admitted into the NICU. This study also examined neonatal intensive care rendered to the full spectrum of U.S. newborns and advised further research on potential causes and consequences of the trends noted in this study using additional data on patients, health systems, and NICU outcomes in the context of costs and length of stay.

Al-Wassia and Saber's (2017), in quantitative research, aimed to assess the prevalence, describe the patterns, and examine the risk factors for NICU admission of term infants, and identify areas for quality improvement. This study utilized a cross-sectional analytical design to perform a retrospective longitudinal chart review from January 1 to December 31, 2015. Although the study's sample size was not disclosed, cases and controls were from all term infants ( $\geq 37$  weeks gestation age) selected from 36 beds, level III NICU admitted at King Abdulaziz University hospital in Saudi Arabia, which receives up to 400 admissions per year. Data collected were from the NICU admission records and the nursery, including maternal age, nationality, parity, history of diabetes or hypertension, premature rupture of membrane before 37 weeks of gestation, mode of delivery, and whether the delivery was spontaneous or elective. Associated pregnancy complications and fetal anomalies for which postnatal admission to the NICU and mothers' data (referred to as unbooked mothers) who did not attend the prenatal clinic in the hospital or any other healthcare facilities were also information collected from the maternal charts.

Statistical analysis compared groups to calculate admission prevalence utilizing IBM SPSS Statistics for Windows, version 21.0 (IBM Corp., Armonk NY, USA) where

variables compared were with the *t*-test Mann-Whitney U-tests and Fisher's exact tests. Multivariate logistic regression used was to determine potential risk factors for infants' admission into the NICU. The expected results revealed that 16% of the term infant admissions to the NICU and the prevalence was 4.1% less than that reported in other NICUs. Infants admitted to the NICU were often the newborns of non-Saudi nationals ( $p = .001$ ) and unbooked mothers ( $p < .001$ ). Non-Saudi national mothers were unbooked mothers primarily, and their infants constituted more than half of those admitted to the NICU.

The most common reasons for admission were respiratory distress with a frequency of 36% (52/142) of all admitted term infants, followed by hypoglycemia at 16% (23/142), and hyperbilirubinemia at 7% (11/142). Premature rupture of membrane occurred significantly more frequently; however, mothers had a higher elective cesarean section during this study period. The study's findings also posed a concern that there was limited access to information about the unbooked mothers, and the researchers could not ascertain whether these mothers received antenatal care in another center to understand how their status affected the risk of admission of infants to the NICU. Moreover, details about the neonatal hospital stay and types of interventions received from unbooked mothers were not during the study, hindering identifying vital areas to focus on when planning quality improvement. The study results identified the following areas recommended for improving care, including more effective and efficient NICU resource usage as follows: (a) population of non-nationals and unbooked mothers to be embraced by health care system that can accommodate them and afford appropriated maternal care

for better outcomes (b) NICUs to review all admissions and audit potentially avoidable admissions to reduce associated costs.

Williams et al. (2018) conducted qualitative data analysis to explain protective factors and environmental deficits associated with the NICU. The research investigated the inherently vulnerable NICU mothers who admitted an infant into a level III NICU in the Midwestern United States between February 2015 and June 2016. The purpose of this research was to explore, through thematic analysis, the experiences of these mothers who responded to an open-ended question focused on elucidating prominent environmental supports and stressors of the NICU. Although this study was from a parent study, the researchers led a secondary analysis from a convenient sampling of 146 participants fitting the inclusion criteria of (a) mothers aged 18 years and older; (b) of single births; (c) who was discharged from the hospital but left behind a hospitalized infant in the NICU for six or more calendar days; (d) English speaking, and (e) mothers who signed the consent and completed the surveys before own discharge.

From the parent research, the completed primary data collection utilizing the following tools were: (a) a sociodemographic survey; (b) the Barkin Index of Maternal Functioning-Neonatal intensive Care unit; (c) the Edinburg Postnatal Depression Scale; and (d) the Parental Stressor Scale: neonatal intensive care unit (PSS: NICU). Of the 146 participants surveyed, the study used another convenience sample consisting of 46 mothers who responded to an open-ended question on the NICU survey. The question was specific and stated: “You are welcome to write any comments about other situations that you found stressful or what was helpful to you during the time that your infant was in the neonatal intensive care unit.” Only the qualitative data provided by the 46 mothers

who completed the narrative section of the PSS: NICU questionnaire included were in the thematic analysis of this study.

Five themes emerged from analyzing these responses: (a) amount and quality of communication with medical staff; (b) bedside manner of medical staff; (c) feeling alienated from infant's care; (d) support from other NICU mothers and families; and (e) NICU physical environment and regulations. The findings of this study highlighted the significance of the NICU environment as it relates to family health. Indications are such that communication was an identified theme in this study. As the core of mothers' experiences in the NICU, whether positive or negative, this theme leads the researchers to suggest that interventions that help the NICU staff increase their availability and communication with parents should focus on staff education and training. Regarding the theme addressing bedside manner, which detailed the interactions that medical staff have with families in the NICU, the researchers recommended future research to focus on clinical interventions that would raise providers' awareness about this complex term.

Moreover, this analysis resulted in a theme of "feeling alienated from infant's care and implicated the need for nurses to play more prominent roles in encouraging mothers to participate in the care of their infants as much as possible during their admission. Additionally, social support gleaned from this study and potential clinical implications of this finding advised by the researchers may include programs that facilitate peer support for mothers and families of babies in the NICU. The NICU physical environment and regulation's theme provided strong evidence through participants' comments that there is a need for improvement. This study suggested NICU facilities need to clarify their mission amongst NICU staff and the families and revise the

rules to assure that they are current, necessary, and in concordance with the mission. This study also suggested a need for NICU staff to become more aware of the mothers' needs and feelings and make a viable effort to decrease maternal stress levels. Future research imposed by the researchers should focus on factors impacting maternal stress in the NICU environment, create interventions for the themes mentioned in this study, and work-related to improving the NICU environment for these families.

Hagen, Iversen, Nessel, Orner, and Svindseth (2019) conducted a descriptive cross-sectional study to investigate associations between parental satisfaction and their socio-demographic status and associations between parental satisfaction standards of neonatal intensive care (NICU) services. The sample included 568 randomly selected parents of infants less than 37-week gestation receiving neonatal intensive care services who completed the questionnaire. The survey instrument was the Neonatal Satisfaction Survey (NSS-8), which covered family-centered care principles to measure parental satisfaction with care services provided within NICUs. This questionnaire contained 51 items covering aspects related to care and treatment, doctors, the conditions of the visit, NICU facility, facilitating for siblings, demographic information (age, education level, work status, income, marital status, language spoken, travel time to the hospital, sole provider, family support), parent anxiety, discharge, and two satisfaction questions. A Likert scale measured various items on the questionnaire with five possible choices. Descriptive statistics and Chi-square tests used were to analyze associations between variables and Spearman's rank correlations coefficient to investigate relationships among the factors from the data.

The results yielded small to moderate significant correlations between seven out of 13 independent areas (gender, education level, duration of stay, support, infants' health, gestational age, and single/ multiple births) and the eight NSS-8 factors. Parents' age, language, primary income, travel time, civil status, and sole providers not statistically correlated were with any of the eight NSS-8 factors. Support from families and friends and NICU care services (continuity of care, staff treatment, decision making for own infant) were the most critical sociodemographic areas associated with parental satisfaction levels reported. Parents were least satisfied with how the NICU facilitated infants' and parents' care during the later stages of their hospital stay and reported the need for more guidance and training in meeting their newborn needs. This study recommended that health personnel address all family members' needs in all phases of their hospital stay. Also suggested were elements such as being aware of parents who lack a support network, be more attentive to parents with longer NICU stays, provide support to siblings, and give greater attention to the continuity of care. This completed research was in a Scandinavian setting; thus, further research needed to compare satisfaction between units and other countries, including monitoring changes over time.

Patients' and parents' satisfaction is a significant indicator for evaluating healthcare systems' quality of care. Yılmaz, Atay, Arıkan, and Tekeli Güler (2016) conducted a quantitative descriptive study to evaluate mothers' satisfaction with infants admitted in the neonatal intensive care unit (NICU) regarding the quality of care. Furthermore, this research intended to examine the effect of sociodemographic characteristics on the parents of newborns' satisfaction. The convenient sample of 113 mothers of neonates admitted in the NICU located in Turkey was on the following

inclusion criteria: (a) NICU admission for at least 72 hours; (b) age of 0-28 days at the time of admission; (c) birth weight of 1500grams; (d) gestational age of 30 weeks; and (e) parents stay with the infant for at least 72 hours in the NICU. The researchers prepared and used a sociodemographic questionnaire consisting of parental age, the gender of newborn, gestational age, history of NICU admission, parental education level, employment status, and parents' health insurance status.

Pediatric Quality of Life Inventory (PedsQL) measurement model for healthcare satisfaction scale, developed by Dr. James W. Varni and associates and translated in the Turkish language with reliability and validity confirmation in previous studies, consists of six subscales of information (family participation, communication, technical skills, emotional support, general satisfaction) was utilized (Varni et al., 1999). This questionnaire contained 25 items with a five-point Likert scale score of 1 representing *never satisfied* to 4 representing *always satisfied*. Also, an alternative answer of “not applicable” was utilized to elicit the level of satisfaction regarding the quality of medical services and psychosocial satisfaction of parents. The scores achieved were calculated for 23 items, and Cronbach’s alpha coefficient met all measured sub-scales of the PedsQL composite.

Data analysis performed input in SPSS V. 16 with a significance set at  $p < 0.05$ , using descriptive statistics to measure the variables, *t*-test for continuous variables, Mann Whitney U-test, and Kruskal-Wallis test for comparison of the study groups. The results revealed no statistically significant difference between sociodemographic and mean scores of family participation, communication, general, and total satisfaction. Additionally, the highest mean was obtained in information dissemination, while the

lowest scores were in the subscales of emotional support and communication. This research recommended that healthcare professionals in the NICU receive training on developing the required skills to increase the quality of care by gaining the families' satisfaction with their admitted infant. Furthermore, the research suggested a need to improve the quality of care when admitted into the NICU. Future studies conducted are to examine the effect of parents' other sociodemographic characteristics on the level of satisfaction with medical services within this setting. This study led to improved quality of care in different populations and sections of the healthcare system.

The qualitative inquiry by Harrison and Goodman (2015) confirmed an overall increase in NICU admissions, and the researchers suggested that it may be concerning that normal-birth-weight infant and less critically ill in this similar setting are exposed to intensive and costly care. Subsequently, Al-Wassia and Saber's (2017) descriptive research recommended a more effective and efficient NICU resource usage by reviewing all admissions and audit potentially avoidable admissions to reduce associated costs. Furthermore, in this aspect of admissions of newborns and the services they receive involve NICU staff and the families, Williams et al. (2018) suggested the need for NICU facilities to clarify their mission amongst NICU staff and that future research should focus on factors impacting maternal stress in the NICU environment. Accordingly, this will support the study from Hagen et al. (2019), who suggested further research to compare satisfaction between units and countries, including monitoring changes in the NICU environment. The study by Ylmaz et al. (2016) recommended that healthcare professionals in the NICU receive training on developing the required skills to increase the quality of care by gaining the families' satisfaction with their admitted infant.

Building on these insights, a phenomenological study on neonatal nurses' lived experiences caring for birth tourism admitted into the NICU is desirable.

### **Experiential Context**

This study's experiential context section addressed the nurse researcher's knowledge or awareness about the topic of interest. Van Manen (1984) asserted that it is feasible for the researcher to have similar experiences and perceptions to those of the participants or may have experienced the same phenomenon. Understanding this context provides the researcher with personal orientation through this step of the research process which will help in cognitive ability to reflect and develop new ideas with their real-world experience (Munhall, 1994). The researcher acknowledged awareness of the topic being studied by reflecting on past experiences of being a newcomer in the United States, giving birth to a baby who had to be admitted into a specialty unit for treatment several days after her birth, and past experiences of providing nursing care to diverse families in a neonatal intensive care setting. From those experiences, the need arose for a nursing inquiry about the nursing care neonatal nurses provide to birth tourism families in the NICU.

Among the many influential factors, such as: being in a new country, having a language barrier, not understanding nurses and doctors at the bedside during delivery, and being away from family support; not being able to see, hold, and welcome the newborn was most significant. These, along with the social worker requesting hospital forms to be completed, produced fear and anxiety, which left a lasting negative impact. As a patient in the labor ward, no forewarnings to help with the confusion and the strange events that followed. Following a painful delivery, the newborn obtained hyperbilirubinemia

treatments for two days, which required her admission to the nursery under a fluorescent light. Emotions, such as fear, sadness, worry, and a sense of failure, surrounded this critical life event. Having a firstborn is supposed to be the most beautiful day; instead, it felt like delivering in a twilight zone.

Subsequently, struggling through this experience left some lingering questions concerning how this situation would have been different if the surroundings were familiar or better understood the spoken language. This experience resulted in posing the question: “What could have helped for a better birthing experience”? Questions at this stage in the evolution of this nursing inquiry became: What could improve the care for families who are newcomers during the arrival of their newborn? Working professionally as a neonatal nurse since 2005 in South Florida allowed further experiences with the topic of interest. As a neonatal nurse, when admitted families are spending more extended time than planned into the NICU, there is a familiarity with certain families with their newborns. Working in the NICU not only provided ample opportunities to serve a diverse patient population but also sparked interest in finding out how the body of neonatal nurses delivers care for families who are newcomers, such as birth tourism families.

Coming into the study with preconceived ideas regarding the topic required planning, self-reflection, and journaling on the phenomenon. As Munhall (2012) explained, personal experiences are not distant from the researcher but integrated into self-being, which makes this novice researcher cognizant of personal experiences and utilizes them in such ways to improve the study—being cognizant aids the researcher in seeking further understanding of this phenomenon (Munhall, 1994). Van Manen (1990) proposed that phenomenological inquiry stems from our own experience or exposure to

the phenomenon. A subjective notion and personal experience projected in this study helped illustrate some of the everyday phenomenological concepts. Although the researcher projected personal experience into the study, van Manen (1990) uttered that being aware of the potential effects of unconsciousness, assumptions, and presuppositions is critical in understanding human behavior. As part of the research activities, it is necessary to practice reflexivity and an inevitable reduction level (van Manen, 1990).

Reflexivity in phenomenological writing means that the researcher will engage in unambiguous, and self-awareness of any critical views formed during the study (Munhall, 2012). Van Manen (1990) emphasized that in a phenomenological study, the researcher must understand something's essential structure by reflecting on it and practicing reduction. The reduction process is related to partial bracketing. The goal is not to isolate the researcher's understanding and feelings in the research, instead to journal to facilitate an understanding of factors relevant to how the information is processed and interpreted (Van Manen, 1990). Journaling concerning reflexivity in a reflective journal where the researcher made notes to scrutinize the data and find relationships within the transcribed interviews. Throughout the study, the researcher kept a diary and engaged in an ongoing dialogue with herself through journal writing. Subsequently, assumptions were recognized throughout the study and placed in that journal to reveal biases in this study.

Van Manen (1990) cautioned that bracketing is related to reduction, and this term borrowed from Husserl will push the researcher toward suspending biases or various beliefs in the reality of the world. Recognizing one's own biases and addressing them through reflexivity is of the phenomenon's essence, and this novice nurse researcher was the instrument of the research process. Reflexivity allowed the researcher to bracket

personal assumptions and reduce bias (Berg & Lune, 2017). In this hermeneutic phenomenological inquiry, the researcher maintained reflexivity. The researcher was better determined about the phenomenon and how they came to know (Watt, 2007). It is only through an introspective record from journaling that one may view and control biases, feelings, and thoughts, so there will be an understanding of how these may be influencing the study (Watt, 2007).

Munhall (1994) emphasized that further exploration through reflections is necessary from the situated context in terms of space and time, rationality, and embodiment which completes the phenomenological text. In this situated context, participants will have a voice as well, and the researcher was aware that she may have altruistic as well as personal motives for this study, but the researcher was also aware that the experiences of others relating to the phenomenon are individualized (Denzin & Lincoln, 2018). Reflexivity in the context of interpreting the data, according to Creswell (2014), doing qualitative studies requires the researcher to recognize the different facets of interpreting meanings developed within the researcher's perceptions related to the phenomenon. The phenomenon of interest was seen through the participants' fresh eyes, perceptions, and lived experiences. Reflexivity during the study process provided self-awareness, including awareness of how one has participated in developing meaning. Therefore, being intersubjective with the phenomenon of interest helped the researcher find meaning.

### **Chapter Summary**

Chapter Two presented a review of the literature to include the historical context of birth tourism, birth tourism and birthright citizenship, studies addressing the benefits

of birth tourism, birth tourism and healthcare, and studies addressing admissions into neonatal intensive care units. Moreover, a synthesis of the literature confirmed the significant gap in the literature. This chapter closed with a discussion of the researcher's experiential context acknowledging any presuppositions about the phenomenon. Chapter Three presents a discussion of the method and design of the study.

## **CHAPTER THREE**

### **METHODS**

The purpose of this hermeneutic phenomenological study using van Manen's (1990) methodology was to understand the lived experience of neonatal nurses caring for birth tourism families who admit a newborn into South Florida's neonatal intensive care units (NICUs). This research aimed to give neonatal nurses a voice to express their individual experience in caring for birth tourism families, inductively interpret their everyday experience in their lifeworld, and understand the essence of caring for this unique population. This chapter presented the research method, provided an overview of the research design, and described the study sample and setting. Detailed plans highlighting access and recruitment of the sample, inclusion criteria, exclusion criteria, ethical considerations, data collection procedures, interview questions, demographic data, data analysis plans, and research rigor will be delineated. Guided by van Manen's (1990) approach to hermeneutic phenomenology, in the methods section, the researcher organized the study's writing and situated themselves as the investigator in the participants' world of experience. Additionally, van Manen's (1990) six research activities and Miles, Huberman, and Saldaña (2014) data analysis illuminated the nurse researcher as she sought to interpret (hermeneutic) the data, as well as grasp the essence of the lived experience of neonatal nurses caring for birth tourism families in South Florida's NICU.

#### **Research Design**

A research design is an approach followed by the nurse researcher intended to organizationally drive the research question, purpose, and study method of the inquiry

(Creswell, 2013). In qualitative research, the design using Max van Manen's (1990) approach to hermeneutic phenomenology is to engage the nurse researcher in this human science research and understand nurses caring for birth tourism families in the neonatal intensive care units (NICU). Phenomenology is both a philosophical viewpoint and a research design (Schutz & Luckmann, 1973; van Manen, 1990). As a research design, phenomenology seeks the fullness of living, the ways one can experience the world as he or she is, and for what it is to be as him or herself (Husserl, 1970; Van Manen, 1990). Focused on the phenomenon, the researcher met participants in their unique way of experiencing the phenomenon. The researcher utilized phenomenology as the research approach to pursue understanding the lived experience in the neonatal nurses' lifeworld known as the world as they immediately experience it.

In doing phenomenological research, van Manen (1990) ascertains that a researcher must understand the following characteristics and apply them as such:

1. Phenomenology is descriptive in nature and deeply interested in experiences to obtain a deeper understanding of the nature or meaning of everyday experiences. The researcher asked the participants to talk about their experiences and creatively capture the specific phenomenon of life in linguistic description.
2. Phenomenology thrives from anecdotal data to develop an understanding that remains focused on human experiences' uniqueness. Therefore, the researcher did not show or prove, nor produce law-like statements, or establish functional relationships; instead explained the individual's experiences, resulting in a uniquely deep understanding of each participant's phenomenon.

3. Phenomenological research takes a Western method of aiming to acquire understandings about concrete lived experiences through language. The researcher was attentive, practiced thoughtfulness, and utilized the language of a lived experience by narrating every experience accurately.

4. Phenomenology is interested in concreteness, differences, and what is unique and interested in the essential and in the difference that makes a difference. It consisted of the researcher mediating in a personal way the antinomy of particularity and universality.

5. Phenomenology poses the research question that seeks the meaning or significance of the phenomenon. The researcher structured questions with meanings appropriated to the subject matter in a conversational style related to lived life and created insights only to the subject matter described (p. 23).

According to van Manen (1990), these qualities enlightened the researcher interested in doing sound phenomenological human science research to humanize human life.

The integration of van Manen's (1990) method evolved into hermeneutic phenomenology. According to van Manen (2016), hermeneutic or interpretive-descriptive phenomenology is a method or attitude of approaching a phenomenon as the researcher reflects on the lived experience. Van Manen's (1990) hermeneutic phenomenology is about the phenomenon manifesting in an individual's lifeworld the way it is lived. The nurse researcher understood the phenomenon's experiences from interpreting the life stories of participants and how they perceive it. To do hermeneutic phenomenology, giving, through van Manen's (1990) lens, attempts to accomplish the impossible as it requires to construct a full interpretive description of some aspect of the lifeworld. The

researcher remained aware that lived life is always more complex than any explication of meaning can reveal (van Manen, 1990). In this interpretive approach, the process of doing hermeneutic phenomenology required the text's writing and language to be in the lifeworld to reflect a study in the lifeworld. Therefore, the researcher interpreted and described meanings from the lived experience of the participants through reflective writings.

The hermeneutic phenomenological method is best to explicate neonatal nurses' life-world experiences caring for birth tourism families in the NICU. Hence, to van Manen (1990), the study of the lifeworld is the world as it is immediately experienced, pre-reflectively rather than the conceptualized way to categorize or reflect on it (p. 37). Understanding the lifeworld helped to frame this novice researcher's mind to use the lifeworld to guide participants, and the studied phenomenon lived experience. The nurse researcher gave hermeneutic significance, and reflectively assigned meaning to lived experiences in the lifeworld through interpretive acts such as meditations, conversations, daydreams, and inspirations (van Manen, 1990). Van Manen (1990) explained that hermeneutic research is not a prescribed mechanistic set of procedures, but it brings creativity alive and stimulates insight. This insight guided the researcher to understand how to be in the lifeworld as the actor and emerge.

Van Manen's (1990) hermeneutic phenomenological inquiry method does not offer a step-by-step approach to the procedural system of data analysis. Instead, six procedural research activities helped the nurse researcher arrive at a deeper understanding of nature's everyday experiences (van Manen, 1990). Although these activities do not allow the analysis of qualitative data, van Manen's hermeneutic phenomenology guided

the researcher to pilot the process in exploring the phenomenon. These six procedural research activities included: (a) Turning to the nature of the lived experience; (b) Investigating experience as it is lived; (c) Reflecting on essential themes constituting of the nature of this lived experience; (d) Advancing self to the art of writing and rewriting about the lived experience; (e) Maintaining an oriented and robust relation to the topic of inquiry, and (f) Balancing the parts of the writing to the whole (van Manen, 1990). This process required the researcher to be reflective, insightful, sensitive to language, and continuously open to experience (van Manen, 1990). The nurse researcher adopted Van Manen's (1990) six procedural activities to answer the research question: "What is the lived experience of nurses caring for birth tourism families who admit their newborn into South Florida's NICUs?"

The first procedural research activity, *Turning to Nature of the Lived Experience*, required that the nurse researcher involve thoughtfulness and questioning of the phenomenon of interest (van Manen, 1990). The researcher "committed to a single thought" and deeply practiced the fullness of thinking to achieve the fullness or wholeness (van Manen, 1990, p. 32). The researcher returned to the question to make sense of a particular aspect of human existence with more detailed and more profound descriptions. In this study, the researcher turned to one single question on neonatal nurses' lived experience caring for birth tourism families in neonatal intensive care units while committing to full, deep thoughts of the phenomenon as it is experienced.

The second procedural activity, *investigating experience as it is lived*, calling for the researcher to explore the lived experience as it is lived. This activity required the researcher to stand in the fullness of life and shared situations during the world of living

relations. The lived experience is like an existential investigation where the researcher asked for meanings or examples during the data gathering and data generation stage. The goal of gathering other people's experiences was to obtain an experiential description of caring for birth tourism families in NICUs and allowed the researcher to become more experienced about the phenomenon. According to Munhall (1994), open-ended questions and personal journaling should be embraced to gather information about the lived experience to facilitate this activity. The researcher explicated any presuppositions, assumptions, and any preunderstanding about the phenomenon (Munhall, 1994).

Max van Manen (1990) proposed four stages during data collection to investigate the experience as it is lived. The first stage involved the nurse researcher reflecting on neonatal nurses' personal experiences caring for birth tourism families in NICUs at the beginning and during the inquiry process. This stage was followed closely and permitted the researcher to put aside biases during the interview and analysis process. In the second stage, the researcher used sources to present the etymology of words or the origin of words and how their meanings changed throughout history, such as in the word caring. The third stage during data collection is to gather descriptions of neonatal nurses caring for birth tourism families in NICUs. The researcher interviewed the volunteered participants using open-ended questions to describe their personal experiences with caring for birth tourism families in NICUs. The fourth stage guided the nurse researcher to connect the experiential description in literature and art. This was asking the participants to share artistic examples, such as poems or drawings, of the experience of caring for birth tourism families in South Florida's NICUs.

The third procedural activity, *reflecting on essential themes*, consisted of reflectively bringing into proximity what has not been revealed or hidden from routine everyday life. As explained by van Manen (1990), “understanding a lived experience takes a true reflection, a thoughtfulness, or a reflective grasping of what it is that renders this experience its special significance” (p. 32). Therefore, the nurse researcher reflectively asked what constitutes the nature of the lived experience of caring for birth tourism families in South Florida’s NICUs. Themes that often emerge from phenomenological studies are referred to as (a) the theme of uniqueness, which demands a turn to the lifeworld and requires approaching the experience in a manner that is unbiased; (b) the theme of essences ask for certain qualities or properties of the phenomenon that would make one experience it as the phenomenon; (c) the theme of commensurability relates to culture and phenomenology in the sense that hermeneutic phenomenology is amenable to forms of knowing, inquiring, and writing; (d) the theme of language in hermeneutic phenomenology refers to the use of words to describe the experience and words used to make understandable what seems to lie beyond language. Understanding these possible emerging themes will help bring to light what is in the dark and evade the intelligibility of everyday life's natural attitude (van Manen, 1990). This guided the nurse researcher reflectively about the experience of caring to constitute the nature of this lived experience.

The fourth hermeneutic procedural activity, *advancing self to the art of writing and rewriting*, is the phenomenological writing of the lived experience through the description of verbatim words from the participants. Max van Manen (1990) established that phenomenological writing is a writing activity involving “bringing thoughts to

speech” (p. 32). The nurse researcher comprehended this process if the root of phenomenology is understood. Phenomenology is the “application of language and thoughtfulness (*logos*)” to the lived experience, “to let that which surfaces,” such as the meaning, “shows itself precisely from itself” (Munhall, 1994, p. 33). This writing and rewriting art illustrated in this study as the researcher utilized the art of writing and rewriting to reflect, describe, and interpret the lived experience of neonatal nurses caring for birth tourism families in South Florida’s NICUs (van Manen, 1990). The researcher analyzed journals, interview transcripts, and member checking with the participants, interpreted the data, wrote and rewrite the findings, and related the literature findings. This phenomenological art of writing revealed the phenomenon.

The fifth hermeneutic procedural activity, *maintaining a strong and oriented relation*, involves maintaining a strong and oriented relation to the studied phenomenon. Max van Manen (1990) instructs the researcher to adopt an attitude of profound interest, be oriented or animated to the phenomenon in a total and human sense and be strong by avoiding superficialities and falsities. The nurse researcher avoided distractions, avoided preconceived opinions and prior knowledge, nor included abstract concepts or theories during this fifth stage (van Manen, 1990). The nurse researcher also demonstrated this procedural activity throughout the study process by being committed to the study. Accordingly, it is imperative to avoid the inclusion of the researcher’s biases and preconceived ideas. Avoiding these inclusions facilitated the maintenance of a solid and oriented relation to the phenomenon to explicate deeper, richer meanings from the interpreted texts of the lived experience of neonatal nurses caring for birth tourism families in South Florida’s NICUs.

The sixth hermeneutic procedural activity, *balancing the parts of the writing to the whole*, requires the nurse researcher to balance the parts or research context by considering parts and whole. Max van Manen (1990) concurs that “one needs to constantly measure the overall design of the study against the significance that the parts must play in the total textual structure” (p. 33). Throughout the inquiry process, the researcher focused on the study design, paid constant attention to the context of the study, and remembered, as the primary instrument, took a holistic approach to exploring the lived experience of neonatal nurses caring for birth tourism families in South Florida’s NICUs. The nurse researcher utilized these procedural activities to guide a phenomenological reflection in two significant steps: conducting thematic analysis and determining essential themes (van Manen, 1990). Although worded as “thematic analysis,” some researchers may not utilize this process to analyze the data from this study. Van Manen’s (1990) thematic analysis begins with (a) the nurse researcher describing the participants’ experiences; (b) reflecting on the lived experiences; (c) understanding the meaning of the experience as a whole; (d) evolving themes; (e) developing the essential themes; ending with, (f) determining meanings from the data obtained from the participant. Van Manen (1990) listed six hermeneutic phenomenological research activities that permitted the researcher a methodical structure and a means to seek an understanding of the essence of the lived experience of neonatal nurses caring for birth tourism families in South Florida’s NICU.

### **Sample and Setting**

The sample in a research study refers to a portion of a population that will best represent the population under study (Miles et al., 2014). The purpose of sampling is to

decide which participants to observe or interview who have the best knowledge of the phenomenon. There are two major types of sampling. Probability sampling includes random, stratified, and cluster sampling characterized by every participant in the population having an equal chance of being included in the sample. Non-probability sampling comprises convenience, purposive, snowball, and quota, where the selection is clear about what larger population the sample may reflect. This qualitative hermeneutic phenomenological inquiry utilized purposive and snowball sampling to recruit participants from many populations who will accurately represent a target population.

Purposive sampling is a form of non-random sampling selected with prior knowledge of the participants' description of who would represent the sampling criteria. In some cases, purposive samples are selected after visits to individuals' locations to ensure that specific inclusions of individuals are in the study. This study's purposive sample included neonatal nurses working in South Florida's neonatal intensive care units. Snowball sampling is the availability or the chain referral sampling (Lune & Berg, 2012). This form of sampling is when the existing study participants recruit future participants from among their acquaintances with the same experience. Snowball sampling is when it is difficult to identify participants for a study.

The sample size in qualitative research comprised a small sample of people nested in the context of the phenomenon and studied in-depth (Miles et al., 2014). According to Creswell (2013), the sample size and how many sites to recruit from do not contain a specific number. This hermeneutic phenomenological study's estimated sample size was a maximum of 25 neonatal nurses or when the researcher achieved saturation. Polkinghorne's (1989) sample size recommendations of five to 25 individuals who have

all experienced the phenomenon influenced the sample size of 25 participants of this study. Inclined by Charmaz's (2006) writings, the idea of saturation is that a phenomenologist researcher should stop collecting data when the categories or themes are saturated. In this study, while gathering new data, the information no longer triggered fresh insights or revealed novel properties or information. The setting in research refers to the particular site where data collection will take place. In this study, the setting referred to where the recruited participants will be from, including skill and familiarity with the study's location. The level of skill and familiarities of the recruited participants utilized was to characterize the setting. The recruited participants of this study were neonatal nurses working in South Florida's neonatal intensive care units. The South Florida region included Monroe, Miami-Dade, Broward, Palm Beach, Glades, Hendry, and Collier counties; however, only participants recruited were from Miami-Dade, Broward, and Collier counties.

### **Access and Recruitment of the Sample**

The sample's access and recruitment began upon obtaining the Barry University's Institutional Review Board (IRB) approval letter (see Appendix A) for this hermeneutic phenomenological inquiry. The nurse researcher sought recruitment of the sample from her professional network of nurses specialized in Neonatal Nursing. The flyer for recruitment of sample (see Appendix D) was distributed via electronic mail to the researcher's professional network of nurses and posted on the researcher's professional social media end-to-end encrypted websites such as Facebook Messenger, WhatsApp, and LinkedIn. Permission was sought by sending a letter of request for access (see Appendix C) to the presidents or representatives of the Florida Nurses Association

(FNA), the National Association for Neonatal Nurses (NANN), Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), and the South-East Florida Association for Neonatal Nurses (SEFANN) and by distributing the flyers for recruitment of sample to their members during members' meetings. Subsequently, permission for the flyer for recruitment to be posted on their websites was to obtain their members' list of electronic mailing addresses from FNAs, NANNs, AWHONN, and SEFANN organizations to forward the flyer to the members directly. Also, in keeping with the snowball sampling technique used in this study, each volunteered participant were encouraged to ask other neonatal nurses if they would be interested in participating in the study.

The flyer for recruitment of sample included the purpose of the study, inclusion criteria, researcher's contact information, telephone number, and electronic mail address that allowed participants who will be interested in volunteering in the study to contact the researcher for information. It also included the contact information for the Barry University faculty sponsor and IRB point of contact. Notification of a token of appreciation of the U.S. \$25.00 Visa gift card included in the flyer was provided for each volunteered participant and given at the beginning of the first interview and for them to keep whether they complete the study or not.

### **Inclusion Criteria**

Once contacted by interested participants, the nurse researcher determined if the participant met the inclusion criteria in this study. The inclusion criteria to participate in the study involved the following:

- Self-report as an active Florida licensed registered nurse

- Must have worked for a minimum of 6 months in a South Florida hospital with a level I to a level IV newborn, neonatal services (neonatal intensive care unit)
- Must have cared for birth tourism families who admitted an infant into a level I to a level IV newborn and neonatal services (neonatal intensive care unit)
- Able to read, write, and speak English
- Agree to participate via face-to-face or Skype interview, lasting a maximum of 60 minutes at a mutually agreed place and time
- Have access to the telephone, computer, electronic mail, and the Internet (Skype). If using Skype, must have video conferencing capability
- Be willing to meet for a review of the transcript via telephone for a maximum of 30 minutes
- Be willing to discuss experiences of providing care for birth tourism families who admit an infant into a NICU
- Be willing to have the interview digitally audio-recorded and transcribed by the researcher or a third party transcriptionist

### **Exclusion Criteria**

The exclusion criteria were anyone who did not meet the inclusion criteria, such as:

- Not self-reporting as an active Florida licensed registered nurse
- Have not worked for a minimum of 6 months in a South Florida hospital with a level I to a level IV newborn and neonatal services (neonatal intensive care unit)

- Have not cared for birth tourism families who admitted an infant into a level I to a level IV newborn and neonatal services (neonatal intensive care unit)
- Not able to read, write, and speak English
- Not agreeing to participate via face-to-face or Skype interview, lasting a maximum of 60 minutes at a mutually agreed place and time
- Not able to access a telephone, computer, electronic mail, and the Internet (Skype)
- Unwilling or not able to meet for a review of the transcript via telephone for a maximum of 30 minutes
- Unwilling or unable to express or verbalize their experience of providing care for birth tourism families
- Unwilling to have the interview digitally audio-recorded and transcribed by a third party transcriptionist

### **Ethical Considerations**

The nurse researcher provided procedures to protect all participants' confidentiality to the extent of the laws that pertain to the protection of human participants. After receiving the Barry University Institutional Review Board (IRB) approval letter (see Appendix A), the study commenced. To ensure ethical considerations and protection of human rights, the nurse researcher adhered and complied with all necessary steps and core principles set forth by the Collaborative Institutional Training Initiative (CITI) program to protect human subjects, maintained throughout the research process. The researcher contacted the participants who responded to the recruitment flyer by telephone or electronic mail. Once the participant showed interest, the researcher sent

an electronic mail to each participant informing about the study and the informed consent (see Appendix B). The researcher informed the participants that there are no known risks and that there were no benefits associated with this study. Participation in the study was voluntary. The participants were also informed that they had the right to withdraw at any time without penalty, stop the interview, refuse to answer any questions, and ask to turn off or pause audio-recorders at any point in the interview. The researcher assured all participants in this study that all information provided kept in confidence was to the law's full extent.

As this study conducted only one face-to-face interview with one of the participants, and Skype video conferencing with others, there were no anonymity; however, the researcher maintained confidentiality. The nurse researcher explained and maintained the confidentiality process throughout each interview. No name identifier in any reported findings and the use of no actual names were in the disseminated study. Each participant had the opportunity and provided a pseudonym (name identifier) to protect their identity. Each participant chose a pseudonym used in the demographic questionnaires, interview notes, digital audio-recordings, as well as written notes to maintain participant confidentiality. Documents included the participants' real names and pseudonyms stored and separated from the other hard copy data and the consent. Before each interview, signed informed consent was obtained and stored separately for other hard copy data (transcribed interviews, demographic questionnaires, and field notes). The reported results of the study displayed pseudonyms and in aggregated form to protect the participants' identities.

Moreover, the researcher established permission before recording and using digital audio-recording devices for all interviews and transcribed the data after each interview. Although plans were made to utilize a transcriptionist required to provide a signed third-party confidentiality agreement form (see Appendix G), before transcribing the digital audio-recordings containing information regarding the study's confidential nature, the researcher elected to complete the data transcription. Once the researcher obtained the signed consent, each participant received a \$25.00 Visa gift card as a token of appreciation. The researcher informed each participant that it is theirs to keep even if they refuse to answer any questions or withdraw from the study. All data stored were in a locked file cabinet in the nurse researcher's home office. The recorded interviews were by using two digitally audio-recording devices. After transcribing the interviews and member checking, the researcher destroyed the digital audio-recordings.

All electronic data that included all transcribed interviews and field notes were stored in separate files in a locked file cabinet in the nurse researcher's home office and later scanned and stored in the researcher's secured password-protected personal computer to keep in the researcher's home office. All data will be kept for a minimum of five years from completion of the research and, indefinitely, in an external digital password-protected storage port, locked in a file cabinet in the researcher's home office. Furthermore, participants were made aware that the data collected will be utilized for the study unless they choose to withdraw from the study, and if they choose not to continue the study, any information obtained would be destroyed immediately by the researcher. The study participants also received information on how to access the reported findings from this study if they should choose to do so.

Skype interviews with video conferencing for participants who may not meet face-to-face took place in the researcher's home office, allowing the researcher to see the monitor and hear the participant in a private setting. To assure participants' protection and confidentiality who elected Skype, only the audio portion of the interview was recorded using two digital audio recorders, including the backup recording placed near the nurse researcher's personal computer. Next, information regarding the study's purpose, the study's protocol, informed consent, and interview recording process were discussed and answered questions and provided clarifications regarding confidentiality before the start of the Skype interview. The informed consent was sent to each participant via DocuSign (password-protected secure electronic signature technology compliant with the US E-SIGN act) and obtained before the start of the interview. Precautionary confidentiality measures were followed by storing the signed consents and demographic questionnaires in separate files on the nurse researcher's password-protected personal computer and locked in a locked file cabinet in the nurse researcher's home office. Ensuing, all electronic mail with demographic questionnaires received from participants were saved in a file kept separately from DocuSign informed consents, digital audio-recordings, and transcribed data labeled with participants' pseudonym, which included saving the data in individual files. Subsequently, once the transcribed data were verified through member check, all audio-recording data and electronic mail were deleted.

### **Data Collection Procedures**

The data collection procedure unfolded to cover the following: the collection of data through timed face-to-face or Skype interviews using digitally audio-recorded conversations; planning for informed consent forms (see Appendix B), and demographic

questionnaires (see Appendix F); planning of transcription of raw data from audio-recording interviews and artistic expressions; and recording of field notes, memos, and journal entries. Data collection began when the researcher received the Barry University's Institutional Review Board (IRB) approval letter (see Appendix A) for this qualitative hermeneutic phenomenological nursing inquiry. Participants who volunteered for this study contacted the researcher via telephone or electronic mail utilizing the nurse researcher's contact information listed on the recruitment flyer. The researcher utilized a personal cell phone and Barry University email address to communicate with study participants. To proceed, the researcher identified and confirmed participants who met the inclusion criteria, who then received details of what will occur in the study. Neonatal nurses who met the inclusion criteria and were interested were scheduled for an interview, either via face-to-face or Skype, in a mutually suitable safe place and preferable time, and the informed consent was mailed electronically for their review. The researcher then proceeded with all study communications, including the review and completion of any written forms.

The interviews occurred amid a COVID-19 local and global coronavirus pandemic, and only one face-to-face interview was completed, and all other interviews were set up via Skype video conferencing. The face-to-face interview with the first volunteered participant occurred in a well-lit, private, and safe site with an atmosphere conducive to the interview process. The Centers for Disease Control and Prevention recommended researcher and participant practiced infection prevention and control by wearing a mask and sitting six feet apart in an agreed-upon site. This semi-structured interview began with "welcome" and "thank you" to the participant for volunteering to be

a part of this study, as well as information about the informed consent form. The research informed consent form included the following details provided to the participant prior to starting the interview: (a) the purpose of the study; (b) that there are no risks or benefits associated with this study; (c) the right to choose to withdraw from the study at any time without any penalty; (d) the total time commitment required (time for both interviews of 90 minutes, which included 60 minutes for the first interview, inclusive of 5 minutes for demographic questionnaire [see Appendix F] and sign informed consent form, and 30 minutes for the second interview or member check); (e) the role of each participant; (f) the manner in which data collection will be completed including awareness that the interviews will be with two digital audio recordings (guarding against equipment failure) and permission to be audio-recorded will be explained; (g) the way the study will be disseminated and all data storage; and (h) the maintenance of strict confidentiality details including to include the choice of a pseudonym, the transcriptionist who will be employed to transcribe the digital audio-recordings, and that the transcriptionist will provide a signed third-party Confidentiality Agreement form (see Appendix G) before transcribing the audio-recorded data; (i) the notice of participant's right to withdraw from the study at any time and that data collected will be utilized for this study unless the participant demands withdrawal from the study; and (j) to refuse to answer any questions as well as the right to request that digitally audio-recording be suspended or turned off entirely at any point during the interview.

After gaining assurance of the participant's understanding of informed consent, the researcher asked participants to sign the informed consent which the researcher collected after addressing all questions and concerns regarding the study. After signing

the informed consent, U.S. \$25.00 Visa gift card was given to the participant as a token of appreciation for their participation in the study and reminded the participant to keep the token whether the interview reaches its completion. The researcher then paused for the participant to ask the question(s) or share concern(s) regarding the information given before proceeding with the study. Subsequently, the researcher assisted the participant in filling out any study-related forms or demographic forms when necessary.

Next, the researcher asked the participant to select a pseudonym to be used throughout the study for identification purposes instead of the participant's name. If the participant did not choose a pseudonym, the nurse researcher suggested one for him or her. The researcher then asked the participant to place the identified pseudonym on the demographic questionnaire (see Appendix F) during its completion. The participant completed the demographic questionnaire using the pseudonym; thus, the researcher assured that pseudonym was not recorded on the informed consent. The demographic questionnaire and signing of the informed consent took a maximum time of 5 minutes to complete, including a maximum of 60 minutes for the interview. The signed informed consent and demographic questionnaire stored in separate files were then locked in a file cabinet in the nurse researcher's home office and later scanned and stored in the researcher's secured, password-protected personal computer.

Data recording devices were placed in the participant's view, and permission to be recorded was established before commencing interview questions. The researcher and participant engaged in an in-depth semi-structured conversation for a maximum of 60 minutes using a guide of open-ended interview questions (see Appendix E) developed by the nurse researcher. The researcher posed the overarching phenomenological question

and several probing as well as prompting questions. These questions aided in collecting conversations geared toward understanding the lived experience of neonatal nurses caring for birth tourism families in South Florida's NICUs. At the end of the interview questions, the researcher stopped the digital audio recorders. A maximum of 10 minutes (inclusive of the 60 minutes) allotted to the participant to reflect and give shape to their experience of caring for birth tourism families in a NICU through an artistic expression (personally created or chosen of poetry, song, picture art). The participant also had the option of turning in their artistic expression during the member-check meeting.

Next, the participant's contact information was verified, and arrangements made were for the date, and time of the second meeting, via telephone, for a maximum of 30 minutes for member checks or review of the transcribed data. After setting up the meeting, the researcher expressed gratitude toward the participant, thanked her, and reminded the participant that all information provided will be held in confidence and how the data will be stored, transcribed, and used. Immediately following the interview, the researcher labeled the digital audio recordings with the pseudonym. The total time commitment for participation in the study was a maximum of 90 minutes.

At the end of each interview, the nurse researcher journaled all observations and noted any nonverbal and verbal communication and the participant's body language. Likewise, the nurse researcher engaged in self-reflection, capturing an impression, emotional interaction, and observation of the interview process. Next, the participant's digital audio-recorded interview marked with their pseudonym was imported onto the researcher's password-protected personal computer. The researcher then transcribed the data before moving to the following interview. Once the transcripts were completed, the

researcher reviewed the transcribed data against each participant's digitally audio-recorded interview. The transcribed data was available for participant's review within two weeks post the researcher's verbatim transcription and was electronically mailed to the participant. The participant was then contacted at the scheduled date and time for the 30-minute follow-up interview for member check via telephone. The second meeting was not audio-taped, and according to Lincoln and Guba (1994), the setting for member-check is to review the data, interpretations, and conclusions by the researcher with the participant in a study to ensure that the information represents the neonatal nurses' reality. After the member check, the researcher thanked the participant for contributing to the study.

All subsequent interviews were completed via Skype with video conferencing for all participants' safety during the COVID-19 pandemic. For semi-structured interviews via Skype with video conferencing, the researcher opened with a welcome and thanked the participant. Information regarding the informed consent, study protocol, and interview recording process discussions was before commencing. The study's purpose, the digital audio-recording devices that included the backup recorder placed near the researcher's personal computer, and any pertinent question(s) from the participants were addressed before starting the Skype interview. Next, the informed consent was sent electronically via DocuSign.com and obtained once signed by the participant. Once the researcher received the signed consent via DocuSign, the participant's electronic mailing address was obtained, and the researcher provided a token of appreciation of the U.S. \$25 Visa gift card. Participants were informed that the Visa gift card would be theirs to keep, even if they decided to withdraw from the study. Once the researcher received the signed

consent, she mailed via the postal service or sent the \$25 Visa gift card by electronic mail to the participant not wanting to share their postal address.

Additionally, the researcher asked each participant to provide a pseudonym to protect their identity. The participants completed the demographic questionnaire using their pseudonyms and sent it back via electronic mail. The participant was allotted 5 minutes to complete the demographic questionnaire. Once the researcher received the demographic questionnaire via electronic mail, the researcher stored it in a separate computer file from the informed consent file. This data was kept in a separate file from the informed consent's file, which both were maintained in the researcher's password-protected personal computer securely located in the researcher's home office.

The Skype interview time was a maximum of 60 minutes. Permission to start the two digital audio-recorders established was before proceeding with interview questions. The researcher posed the overarching phenomenological question and several probing as well as the predetermined open-ended interview questions. At the end of the interview questions, the audio-recorders were turned off and allotted 10 minutes to engage in their artistic expression. Skype participants were informed to electronically mail the artistic expression labeled with each chosen pseudonym and uploaded in a computer file stored in the researcher's secured password-protected personal computer. At the end of the interview, the researcher expressed her gratitude for volunteering to participate in the study. Arrangements for a second meeting date and time were made for transcribed data to be reviewed by member check with the participant. The second meeting via telephone was a maximum of 30 minutes for Skype interviewers and not audio-taped. The transcribed data was available for participant's review within two weeks after the

researcher's verbatim transcription and electronically mailed to the participant. Once the completed member check, 90 days after completing all transcripts, audio recordings saved on the researcher's personal computer, the researcher destroyed the interviews' digital audio recordings.

Data collected was labeled with participants' pseudonyms and stored in separate files in the researcher's password-protected personal computer secured in the researcher's home office. Data were collected until the researcher reached saturation, which means the researcher heard similar conversations from different participants. Data kept will be as required by the United States regulations of research studies locked for a minimum of 5 years and indefinitely on a downloaded password-protected external drive locked in a file cabinet in the researcher's home office.

### **Interview Questions**

In hermeneutic phenomenology, the researcher's responsibility is to interview to enter the participants' life-worlds as they experienced the phenomenon. The nurse researcher used semi-structured, open-ended interview questions (see Appendix E) to understand the study's phenomenon. The structure of interviewing and questioning participants followed in-depth phenomenological-based interviewing with open-ended questions. This method combines lived experience interviewing with focused, in-depth interviewing informed by the phenomenological philosophy, which underpins the study (Seidman, 2013). The goal of interviews was to have the neonatal nurses participating in this study reconstruct their experience within the topic of caring for birth tourism families who admit their infant into the neonatal intensive care unit.

The grand tour or leading question is: "Tell me about your experience in caring for birth tourism families who have a newborn admitted into the NICU?" The researcher employed a conversational tone during the semi-structured interview to allow probing beyond answers to the prepared standard questions. To prompt and probe, follow-up questions used to get a deeper level of sharing about the phenomenon and guided the interview process to gather detailed information about the participants' experiences. In this qualitative hermeneutic phenomenological inquiry, interviewing is not to test hypotheses, neither to evaluate, but rather to have an in-depth discussion in understanding other people's lived experience and the meaning they make of that experience (van Manen, 1990). In this tradition, the researcher's actions indicated that the recorded experiences are the center of the world, the essential parts of the interview that required the researcher to keep his or her character contained (Seidman, 2013). Locke (1989) emphasized that the adequacy of the method of inquiry depends on the purpose of the inquiry and the questions asked. Therefore, how the researcher formulated the question drove the genre and method chosen for the nursing inquiry.

### **Demographic Data**

A researcher designed a demographic questionnaire (see Appendix F) used at the beginning of the study to obtain attributes about each participant in the study of the lived experience of neonatal nurses caring for birth tourism families in the neonatal intensive care units (NICU). Research participants were asked to provide the following demographic information: current age, gender, level of education, length of time as a registered nurse, length of time working in the NICU, and length of time working with

birth tourism families. The demographic questionnaire served as information concerning the participants' commonalities as well as differences in the study.

### **Data Analysis**

This nursing study utilized Miles et al.'s (2014) analytical method for qualitative data analysis. Prescriptive in nature, this approach was used along with van Manen's six research activities, and van Manen recommended three approaches to analyze data during this data analysis process. The process of data analysis in a qualitative inquiry starts with the data collection. This process ensured that the researcher assessed the data as it is collected. This phenomenological study appropriated with a phenomenological research question and collected experiential data that the researcher will conduct reflection upon will result in sound phenomenological analysis. This phenomenological method of data analysis also involved summarizing the large amounts of data collected, resulting in the presentation of essential features of the interviews leading to phenomenological insights. Qualitative researchers examine their data over and over to search for meaning and a deeper understanding. The data is then compared and connected to the interviews aiming to develop themes to create the essence for the phenomenon that is being investigated (Creswell, 2018).

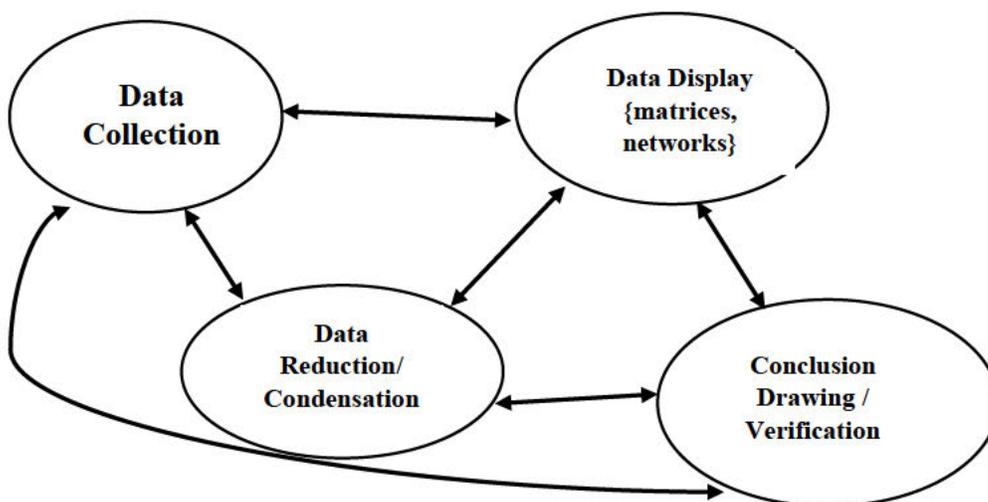
NVivo version 12 application is a qualitative data analysis software package utilized by the researcher to analyze data by associating codes with themes. Since analyzing in-depth interviews is labor-intensive, the researcher used this software program to create nodes and patterns, organize and analyze a large volume of data. This software's advertisers offered this tool to researchers to organize and manage the data faster and more efficiently to uncover more rigorous evidence. However, van Manen

(1990) suggested for hermeneutic interpretation, which the nurse researcher adopted, to execute line-by-line data analysis, read and reread the transcript several times, and make notes in the margins identifying categories or codes from the content of the transcript.

Van Manen (1990) did not offer a step-by-step analysis method for hermeneutic phenomenology; nevertheless, he spoke on three approaches to analyzing the data. First, the holistic or sententious approach guided the researcher to look at the text in its entirety and to find critical phrases that captured the meaning or central significance of the text as a whole. Second, the analysis of the data utilizing a detailed line-by-line approach. This step encouraged the researcher to sift through each sentence or sentence cluster to find sentences reflective of the experience. Third, the selective or highlighted approach entails that the researcher examined line-by-line of the transcripts for complete or partial sentences within the data that reflected the experience. The researcher then highlighted or circle or underlined after listening to and reading the texts several times. During the entire data analysis process, van Manen (1990) encouraged the researcher to remain engaged and continuously reflect on the data from transcripts and reflective journals. During the interpretation phase, the researcher assured hermeneutic handling of the data. The researcher formed an inventory of meaningful statements that are color-coded and make statements consisting of words or phrases that reflect the experience described (van Manen, 1990). After revising the data, the researcher created themes to capture the participants' experience's whole essence or meaning. Following the revision of the data and themes created, the second interview's function revealed itself at this stage. During this stage, the researcher revised the participant's themes to see if they were reflective of their experiences.

### Miles, Huberman, and Saldaña's Method of Data Analysis

Miles et al. (2014) lean toward the phenomenological process of extracting significant verbatim statements from the data, formulating meanings about the researcher's interpretations, clustering these meanings into series of organized themes, and elaborating on themes through detailed written descriptions. After collecting data through face-to-face and Skype interviews with all participants, this qualitative data analysis method was analyzed, which involved a series of flow analysis activities. This analysis method reduced the data into themes using coding to present the text's data and displayed by matrices and networks (Saldaña, 2015). The data analysis flowed into four activities: data collection, data reduction, data display by matrices and networks, and drawing conclusion and verification (see Figure 2).



*Figure 2.* Data analysis flow activities: (Lacroix, 2019 adapted from Miles, Huberman, & Saldaña, 2014).

Within these concurrent data analysis flow activities is the data collection flow activity, which entailed analyzing the data collected in different forms. This step presents

challenges when data is raw or non-transcribed (Miles et al., 2014). The data collection resembled the primary form in which data are. In other words, it included typed field notes turned into a formal write-up and audio recordings converted to a collection of words via transcription and artistic expressions (best analyzed through the memo process). Although these genres of qualitative data may have appeared simple to obtain during data collection, such as in the interview process, Miles et al. (2014) affirm that the data required care and self-awareness on the part of the researcher during data analysis because qualitative data mask of complexity.

Subsequently, after the data collection flow analysis activities occurred, the data reduction commenced. However, these flow activities took place simultaneously. The data reduction flow activity, also known as data condensation, was part of the analysis that the nurse researcher would continuously execute throughout the life of this qualitative study. This process involved selecting, focusing, simplifying, abstracting, and transforming raw data from field notes, journals, and interview transcripts to further data condensation episodes. Miles et al. (2014) emphasized the importance of themes during the data analysis. In the tradition of phenomenology, which aimed at gaining a deeper understanding of the nature or meaning of participants' everyday experiences, "theming the data" required comparable reflection on participant meanings and outcomes on the phenomenon (Miles et al., 2014). "Theming" the data was a form of analysis involving the researcher looking at data thematically to extract essences and essentials of participants' meanings from their lived experience (Miles et al., 2014).

Focusing on refined words and themes, the researcher assumed that the text was clear during the analysis. Moreover, Miles et al. (2014) recommended that the researcher

performed concurrent analysis with data collection while using themes that are the outcome of coding, categorization, or analytic reflection. This thematic analysis resembled a coding method that formed deriving more general themes through jottings and analytic memos (Saldaña, 2016). This way of analyzing the data was associated with taxonomies (hierarchical lists of different terms) treated in a cyclical act for generating categories, themes, and concepts while grasping meanings.

This study utilized the evolving method of Miles et al.'s (2014) analytic approach, and the researcher embraced the logical sequence containing special features or analytic moves recommended for the thematic analysis. Analytic moves involved the researcher moving from one inductive inference to another by collecting data, comparing this material while searching for patterns or regularities, seeking more data to support or qualify emerging clusters, and gradually drawing inferences from the new links data and cumulative set of concepts. Some shared features observed in this approach assisted the nurse researcher in moving analytically. These analytic moves were as follows:

- Assigning codes or themes to field notes, interview transcripts, or documents
- Sorting through the coded materials to identify similar phrases, relationships between patterns, themes, and familiar sequences
- Isolating the patterns and processes, commonalities and differences, and taking them to member checking participants
- Noting reflections or other remarks in jottings, journals, and analytic memos
- Gradually elaborating a small set of assertions, propositions, and generalizations found consistently in the data

- Comparing the generalizations found with the body of knowledge such as nursing literature pointing to constructs or forming themes

With these analytic moves, the researcher carefully noted the nature or kind of analyzed data. Further analysis occurred as the researcher wrote summaries, discarded, and organized the data so that conclusions can be drawn and verified (Miles et al., 2014). This data reduction flow made the data stronger, and through the researcher's decisions of all rational choices, the gathered data was continuously transformed until the completed final report.

Another flow of analysis activity was the data display, which the researcher created and used displays through analytic activities as part of the analysis (Miles et al., 2014). Analytic activities included designing good displays where the researcher decided which data and the form of the data were entered in the "matrix" (rows and columns of qualitative data). The researcher developed analytic displays during and after data collection by creating matrix templates to form data display networks. For example, during the analysis of a posed interview question and answer, the researcher created matrices with the emerging themes. Designing a data display by assembling organized information into an accessible and compact form facilitates the researcher to draw justified conclusions and move to the next step of analysis that the display suggested (Miles et al., 2014). From the matrices and networks of themes created, the last flow of analysis activity emerged.

The last flow of analysis activity is the conclusion drawing and verification. This flow was important in analyzing hermeneutic phenomenological data. It allowed the researcher to interpret meanings by determining the patterns, themes, making

comparisons, and clustering. This flow took place from the beginning of data collection until the conclusions. This activity included noting patterns, explanations, causal flows, and propositions until the coding, storage, and conclusions appear. Conclusion verification was lengthy to produce emerging meanings from the data that must be tested for rigor. Miles et al. (2014) guide researchers to a well-documented process with steps to qualitative analysis to reflect and refine this method of inquiry, which may make it more generally usable by other phenomenological nurse researchers.

### **Research Rigor**

Rigor is a concept applied to qualitative research and defined as how the researcher establishes the findings' trustworthiness (Morse, 2015). Research rigor in a qualitative inquiry is associated with inviting the data to others and carefully adhering to the chosen philosophical underpinning and the researcher's thoroughness in data collection (Krefting, 1991). According to Guba and Lincoln (1981), the concept of rigor refers to the criteria for determining the research's trustworthiness. Research rigor ensured that the study owns essential qualities in the context of being relevant, trustworthy, and free of bias. Lincoln and Guba (1985) proposed that the term trustworthiness rather than rigor is better to use in qualitative research, which is vital to evaluate the study's worth. Researchers seek believability based on trustworthiness to verify the study's truth (Lincoln & Guba, 1985).

Trustworthiness is a term coined by Lincoln and Guba (1985) to refer to a set of criteria for judging qualitative research's quality or goodness. This term is equivalent to the term's reliability and validity (Munhall, 2012). The nurse researcher is charged to ensure trustworthiness by reflecting the participants' truth. The researcher kept a

reflective journal to clarify the researcher's worldview and personal feelings about the phenomenon. Hadi & Closs (2016) suggested that researchers are encouraged to maintain a reflective journal to recognize and make explicit any personal biases. Accordingly, during this study, the nurse researcher maintained reflexivity and transparency by describing personal pre-suppositions and pre-conceptions. Lincoln and Guba (1985) expounded that trustworthiness criteria guide authenticity in a naturalistic inquiry. Lincoln and Guba (1985) provided the following criteria to achieve trustworthiness in qualitative research: credibility, dependability, confirmability, and transferability. Researchers maintained trustworthiness by debriefing with the research chair, including committee members, triangulation, prolonged engagement, member checks, audit trail, and reflexivity or reduction in this phenomenological study (Lincoln & Guba, 1981).

### **Credibility**

Schwandt (2007) asserted that credibility provides the research assurances of the fit between participants' views of their lifeways and the researcher's reconstruction and representation. Credibility means that results are credible or believable, and interpretations are accurate, and it is the quality of being believed or accepted as true, accurate, or honest (De Witt & Ploeg, 2006). Established by a series of techniques, the researcher executed tasks such as triangulation, member checks, researcher reflexivity, memoing, and interpreting with thick, rich descriptions to attain credibility (Lincoln & Guba, 1985). Member-checking is when participants were given a copy of their transcript to provide critical feedback regarding the data transcribed from the audiotape's truthfulness. Memoing allowed documentation of presuppositions, biases, feelings, assumptions, preconceived notions, and the investigator's ideas. Furthermore, to achieve

credibility, the researcher reported the data through the lens of the participants. In this study, the researcher ensured credibility by having participants verify the transcribed data; practiced reflexive journaling throughout the research process; invested time to establish trust with each participant; clarified misinformation from the researcher; or peer-reviewed the collected data by discussing the researcher's interpretation with other people.

### **Dependability**

Dependability focuses on the inquiry process and that the researcher is responsible for ensuring that the research process is logically and traceably documented (Schwandt, 2007). This dependability concept in qualitative research implied that the data is consistent under the same condition over time (Lincoln & Guba, 1985). By examining the raw data and interpreting it through thick, rich descriptions, the researcher affirmed the research's dependability. Furthermore, in the rigorous research process, the researcher's dependability was by adhering to a data collection systematically documented to verify and audit trailing furnishing an adequate amount of evidence (Lincoln & Guba, 1985). The researcher created an audit trail using a step-by-step approach to explain the methods applied during the data collection and data analysis processes. Another strategic way of dependability delineated through the research process was member checking, to which each participant was allowed to review the transcribed interview for accuracy. Consequently, the researcher ensured that the data and process were systematically and accurately documented so that other researchers interested in reconstructing the study may replicate it in the future.

**Confirmability**

Confirmability is concerned with establishing that the data and interpretations of research are not merely figments of the inquirer's imagination (Schwandt, 2007). It reflects the objectivity (neutrality) of the data collected and measures how well the study findings were supported by the data collected (Lincoln & Guba, 1985). The nurse researcher established confirmability by audit trail and control of research bias. Bias in qualitative research is an ever-present factor; unbiased interpretations emerged once the researcher recognized them in written self-reflection throughout the research process. The researcher's bias presented no bearing on the study's outcome. Therefore, the researcher laid aside all preconceived notions, ideas, presuppositions, and biases about the experiences of caring for birth tourism families in the neonatal intensive care unit.

**Transferability**

Transferability refers to how the findings of this study can be applied to another group or setting (Lincoln & Guba, 1985). The researcher provided enough information for readers to determine the data being transferable. Other strategies used to ensure transferability were as follows: 1) a well-written methodological approach; 2) thorough descriptions of participants; 3) thick descriptions of meanings; 4) most comprehensive possible range of information to allow judgment; 5) provided paper trail (Creswell, 2018). Furthermore, to achieve transferability, the researcher collaborated with the research committee of experts to assist and provide guidance throughout the dissertation process, enhancing this study's transferability.

### **Chapter Summary**

This chapter discussed the components underpinning the methods to guide this hermeneutic phenomenological study. These components included a thorough description of research design, description of the sample and setting characteristics, procedures involving access and recruitment of the sample, inclusion and exclusion criteria. This chapter also provided a detailed plan of ethical considerations and the process for data collection. Moreover, it covered interview questions, demographic data, and plans for data analysis. Research rigor and trustworthiness were addressed, including their application throughout the study.

## CHAPTER FOUR

### FINDINGS OF THE INQUIRY

The purpose of this hermeneutic, phenomenological study using van Manen's (1990) methodology was to understand the lived experience of neonatal nurses caring for birth tourism families who admit a newborn into South Florida's neonatal intensive care units (NICUs). This research aimed to give neonatal nurses a voice to express their individual experience of caring for birth tourism families, interpret their everyday experience inductively in their lifeworld, and understand the essence of caring for this population. Tasked to reveal the meaning of each participant's everyday experience, the phenomenological researcher immersed herself into the data to understand the phenomenon in detail through the phenomenological process influenced by van Manen's (1990) genre of researching lived experience. This study provided an increased understanding to help structure meanings on the nursing care rendered to birth tourism families and its quality and revealed some of these families' needs. Van Manen's six research activities served as a guide for the collection of the data from the 22 neonatal nurses along with the Miles et al. method of analysis, which directed the breakdown of the data through thematic analysis using coding to uncover meanings participants ascribe to the care given to birth tourism families who admit a newborn into the NICU. Findings in this qualitative hermeneutic study contribute to science and the body of nursing knowledge to improve birth families' health outcomes in the NICU.

Over the course of nine weeks, a maximum of 22 participants were interviewed, beginning on May 11, 2020, and ending on July 22, 2020. Although data saturation was achieved after interviewing 15 participants, the researcher conducted seven additional

interviews to ensure that no new information came from the data collected. These additional interviews assured qualitative rigor by increasing the study's credibility and substantiating and confirming the emerging themes (Denzin & Lincoln, 2018). This chapter includes the significant findings of the study summarized as follows: sample description, which provides the demographic information along with the characteristics of each participant; results of the data collection including themes; and reportage of the findings according to identified themes; and connection of the identified themes to a specific nursing theory.

### **Sample Description**

The researcher used the purposive sampling method was to select participants representing the sampling criteria listed in the flyer for recruitment. Snowball sampling technique, achieved by existing participants sharing the study's information, provided additional participants with first-hand experience with the phenomenon. The researcher sought recruitment of the sample from her professional network of nurses specialized in neonatal nursing. The Florida Nurses Association (FNA), National Association for Neonatal Nurses (NANN), South-East Florida Association for Neonatal Nurses (SEFANN), and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) relocated their services due to the pandemic, which resulted in displaying the flyer for recruitment on their website. This also prohibited the distribution of the flyer for recruitment in these respective communities of neonatal nurses during their monthly meetings which did not occur. Due to the COVID-19 pandemic, these suspended meetings forced the researcher to wait for participants from her professional network to volunteer for the study.

Participants who volunteered to participate in the study contacted the researcher via telephone. The selection of participants was inclusive of those who fit the inclusion criteria. The sample size included 22 neonatal nurses who self-reported as being active, licensed, Florida registered nurses whom 1) must have worked for a minimum of 6 months in a South Florida hospital with a Level I up to a Level IV newborn, neonatal intensive care unit; 2) agreed to participate via face-to-face or Skype interview, lasting a maximum of 60 minutes at a mutually agreed place and time; 3) able to read, write, and speak English; 4) had access to the telephone, computer, electronic mail, and the Internet using Skype video conferencing capability; 5) willing to meet for a review of the transcript via telephone for a maximum of 30 minutes; and 6) willing to have the interview digitally audio-recorded and transcribed by the researcher or a third party transcriptionist. All participants interviewed met the inclusion criteria and indicated an interest in the study. The sample included neonatal nurses who worked in neonatal intensive care units. Two of the participants worked in a stand-alone children's hospital holding a Level IV neonatal intensive care unit (NICU), and the remaining 20 worked in a Level II to a Level III NICU.

### **Demographic Representation**

The demographic representation in this study is inclusive of neonatal nurses from diverse ethnic backgrounds with numerous years of experience in the specialty of neonatal nursing. The sample size recruited was 22 neonatal nurses working in South Florida's neonatal intensive care units located within the counties of West Palm Beach, Broward, and Miami-Dade and who cared for infants of birth tourism families. Data saturation was achieved after interviewing a total of 15 participants; however, seven

additional interviews were conducted to ensure that no additional information would be revealed from study participants. All participants worked in a family-centered facility and cared for birth tourism families with an infant admitted into a Level I to a Level IV neonatal intensive care unit (NICU). The demographic data of the 22 neonatal nurses included ages ranging from 25 to 64 years old. The participants ages included 20-27 years (one participant), 28-34 years (one participant), 35-42 years (eight participants), 43-50 years (five participants), 51-58 years (three participants), and 58 years and more (four participants). All participants were of the female gender and various ethnic backgrounds. The ethnicities of participants included: Hispanic/Latino, African American, Asian/Pacific Islander, White American, American Indian, and others.

The participants' educational level ranged from diploma in nursing degree to a doctorate in nursing, displayed as diploma, associates, bachelor's, master's, and doctorate. Participants' years employed as a registered nurse included: 6 months to 4 years (one participant), 5 years to 9 years (two participants), 10 years to 14 years (three participants), 15 years to 20 years (seven participants), 21 years and more (nine participants). Participants shown by the number of years as a neonatal nurse included: 6 months to 4 years (one participant), 5 years to 9 years (two participants), 10 years to 14 years (four participants), 15 years to 20 years (10 participants), 21 years and more (five participants). The number of years in the participant's current NICU included: 6 months to 4 years (three participants), 5 years to 9 years (five participants), 10 years to 14 years (one participants), 15 years to 20 years (10 participants), 21 years and more (three participants). A majority of the participants worked in a family-centered care facility with a family-centered care policy; but two participants worked in a facility with no family-

centered care policy. The demographic information is demonstrated below in Tables 1, 2, and 3 discloses the collected data.

Table 1

*Demographic Representation of Participants*

Gender	Age	Ethnicity	Educational Level	Years as RN	Years as NN	Years in Current NICU	Family Training	FCC/ FCC Policy
F	58+	Hispanic/ Latino	Bachelor's	21+	15-20	15-20	Never	Yes/ Yes
F	43-50	Hispanic/ Latino	Master's	15-20	15-20	15-20	One time	Yes/ Yes
F	35-42	Hispanic/ Latino	Master's	15-20	15-20	15-20	Every year	Yes/ Yes
F	28-34	Other	Bachelor's	5-9	5-9	5-9	Never	Yes/ Yes
F	43-50	Hispanic/ Latino	Master's	21+	21+	15-20	One time	Yes/ Yes
F	35-42	Hispanic/ Latino	Bachelor's	15-20	15-20	15-20	One time	Yes/ Yes
F	35-42	Hispanic/ Latino	Master's	5-9	5-9	6mos-4	One time	Yes/ Yes
F	51-58	White American	Bachelor's	15-20	15-20	15-20	One time	Yes/ Yes
F	43-50	White American	Bachelor's	10-14	10-14	10-14	One time	Yes/ Yes
F	58+	African America	Associate	15-20	15-20	15-20	One time	Yes/ Yes
F	58+	Other	Master's	21+	21+	21+	Every 5years	Yes/ Yes

Gender	Age	Ethnicity	Educational Level	Years as RN	Years as NN	Years in Current NICU	Family Training	FCC/ FCC Policy
F	58+	Asian/Pacific	Diploma Nurse	21+	21+	21+	One time	Yes/ Yes
F	20-27	Asian/Pacific	Bachelor's	6mos -4yrs.	6mos -4yrs.	6mos -4yrs.	Every year	Yes/ Yes
F	43-50	Hispanic/Latino	Master's	20+	15-20	15-20	Every year	Yes/ Yes
F	35-42	African American	Bachelor's	10-14	10-14	5-9	One time	Yes/ Yes
F	35-42	Hispanic/Latino	Master's	21+	21+	21+	One time	Yes/ No
F	51-58	Hispanic/Latino	Bachelor's	21+	21+	15-20	Every year	Yes/ Yes
F	51-58	African American	Master's	21+	15-20	6mos -4	Never	Yes/ Yes
F	35-42	Hispanic/Latino	Master's	10-14	10-14	5-9	One time	Yes/ No
F	35-42	White American	Bachelor's	21+	10-14	5-9	Every 5years	Yes/ Yes
F	35-42	Asian/Pacific	Bachelor's	15-20	15-20	15-20	Every year	Yes/ Yes
F	43-50	Other	Bachelor's	15-20	15-20	15-20	Every year	Yes/ Yes

Table 2

*Demographic Representation of Participants by Age Group, Ethnicity, Level of Education, and the Number of Years Experienced as a Neonatal Nurse*

Variable	Category	N	%
<i>Participants Grouped by Age</i>			
Age Group	20-27	1	4
	28-34	1	4
	35-42	8	38
	43-50	5	23
	51-58	3	13
	58 +	4	18
<i>Participants Grouped by Ethnicity</i>			
Ethnicity	Hispanic/ Latino	10	48
	African American	3	13
	Asian/ Pacific	3	13
	American Indian	0	0
	White American	3	13
	Other	3	13
<i>Participants Grouped by Educational Level</i>			

Variable	Category	N	%
Level of Education	Diploma	1	5
	Associate	1	5
	Bachelor's	11	50
	Master's	9	40
	Doctorate	0	0
<i>Number of Years as a Registered Nurse</i>			
Years as a Registered Nurse	6 months – 4 years	1	4
	5 years – 9 years	2	9
	10 years – 14 years	3	14
	15 years – 20 years	7	32
	21 years or more	9	41

Table 2 presents neonatal nurses' demographic data by age, ethnicity, level of education, and the number of years as a neonatal nurse. The majority of the sample was between the ages of 35-42, reflecting 38% ( $n = 8$ ) of the participants. Twenty-three percent ( $n = 5$ ) were between the ages of 43-50, 18% ( $n = 4$ ) were 58 years old and older, and 13% ( $n=3$ ) of the population was between the ages of 51-58. Four percent (4 %) ( $n = 1$ ) of the sample represented each age group between 20-27 years and 28-34. None of the participants were American Indian, and 13% ( $n = 3$ ) of the sample elected others for ethnicity. The three participants who chose “Other” described their ethnicity as Haitian American, Haitian, and Caribbean American. Forty-eight percent 48% ( $n = 10$ ) were Hispanic/Latinos, and 13% ( $n = 3$ ) of the sample represented the category of African

American, Asian/Pacific, and White American. Besides choosing this category, numerous participants wrote out on their demographic questionnaire what each perceived to be their ethnic backgrounds, such as white non-Hispanic, Cuban American, Pakistani, and Portuguese. The remaining participants did not provide any additional information.

The participant's education levels included 5% ( $n = 1$ ) with a diploma degree and 5% ( $n = 1$ ) with an associate degree in nursing. Although none of the participants held a doctorate ( $n = 0$ ), however, 50% ( $n = 11$ ) practiced nursing with a bachelor's degree ( $n = 11$ ), and 40% ( $n = 9$ ) had a master's degree in nursing. Participants grouped by the number of years practicing as a registered nurse (RN) displayed in the highest category of 21 years and more, representing 41% ( $n = 9$ ) of the sample. Thirty-two percent ( $n = 7$ ) were RNs for 15 to 20 years, and 14% ( $n = 4$ ) were RNs for 10 to 14 years. Only 4% ( $n = 1$ ) were RNs for 6 months to 4 years, while 9% ( $n = 1$ ) were RNs for 5 to 9 years.

Table 3

*Demographics of Participants by Number of Years as a Neonatal Nurse, Number of Years in Current NICU, Additional Training on Care for the Family, Working in Family-Centered Care Facility, and Policy for Family-Centered Care*

Variable	Category	N	%
<i>Number of Years as a Neonatal Nurse</i>			
Years as a Neonatal Nurse	6 months – 4 years	1	4
	6 years – 9 years	2	9
	10 years –14 years	4	18
	15 years – 20 years	10	46
	21 years and more	5	23

Variable	Category	N	%
<i>Number of Years in Current NICU</i>			
Years in Current NICU	6 months – 4 years	3	14
	5 years – 9 years	5	23
	10 years – 14 years	1	4
	15 years – 20 years	10	45
	21 years and more	3	14
<i>Number of Years of Additional Family Care Training</i>			
Years of Family Care Training	One Time Class	11	50
	Every Year	5	23
	Every 5 Years	2	9
	Never	4	18
<i>Number of Neonatal Nurses Working in a Family-Centered Care Facility</i>			
Family-Centered Care Facility	Yes	22	100
	No	0	0
<i>Number of Neonatal Nurses Working in a Family-Centered Care Facility with a Policy</i>			
Family-Centered Care Policy	Yes	20	90
	No	2	10

Table 3 represents the demographics of participants by the number of years as a neonatal nurse, the number of years in their current neonatal care intensive care unit (NICU), the

additional training on caring for the family, the number of neonatal nurses working in a facility that provide Family-Centered Care (FCC), and the number of participants working in a facility with FCC. Participants grouped by the number of years as a neonatal nurse included: 4% ( $n = 1$ ) has been a neonatal nurse for 6 months to 4 years, 9% ( $n = 2$ ) has been a neonatal nurse for five to 9 years, 18% ( $n = 4$ ) has been a neonatal nurse for ten to 14 years, 46% ( $n = 10$ ) has been a neonatal nurse for 15 to 20 years, and 23% ( $n = 5$ ) has been a neonatal nurse for 21 years and more. The number of years in the current NICU comprised of 14% ( $n = 3$ ) of participants practicing in their current NICU for 6 months to 4 years, 23% ( $n = 5$ ) in current NICU for 5 to 9 years, 4% ( $n = 1$ ) in current NICU for 10 years to 14 years, 45% ( $n = 10$ ) in their current NICU for 15 years to 20 years, and 15% ( $n = 3$ ) of nurses were in their current NICU for 21 years and more. In the category of the number of years receiving training on providing care for the family encompassed: 50% ( $n = 11$ ) of the population had a one-time class, 23% ( $n = 5$ ) received additional training every year, 9% ( $n = 2$ ) had training every 5 years, and 18% ( $n = 4$ ) never received additional family care training. One hundred percent ( $n = 22$ ) of the participants claimed yes to work in a family-centered care facility. However, only 90% ( $n = 20$ ) of neonatal nurses working in an FCC facility affirmed having an FCC policy.

### **Characteristics of Participants**

Participants who met the inclusion criteria for this study volunteered their time and consented to share their experience in this study. Each participant signed a consent form before starting the audio-recorded interview. The researcher maintained confidentiality by inviting each participant to select a pseudonym to conceal their identity. A majority of the participants wrote their selected pseudonyms as instructed on

the demographic questionnaire; however, two of the participants asked the researcher to provide a pseudonym for them. To maintain their confidentiality, “NICU RN” and “NICU RN 2” were the pseudonyms chosen, and both participants confirmed that this suited their needs in disguising the different facets of identity during the discussion of their experience. During this sensitive task, the researcher took under consideration issues of ethnicity, age, and context of the participant’s life to select a pseudonym that does justice while assuring the protection of these participants' identities (Seidman, 2013).

Each interview revealed neonatal nurses' unique experience caring for birth tourism families with their admitted newborn into the NICU. Hermeneutic phenomenological interviews serve as a means for exploring experiential narrative to gain a richer understanding of this study’s phenomenon and to develop a conversation about the meaning of each participant’s experience. This section describes each participant’s demographic characteristics:

**Valeria** is in the age ranging between 51 and 58 years old. She is a Hispanic/Latino from Brazil and speaks Portuguese. Amid the start of the nation's new global pandemic, **Valeria** suggested meeting at the end of her shift. The meeting was in a mutually agreed place, where we could engage in this interview privately. We kept 6 feet distance between the two tables and wore our face mask to protect each other from the Coronavirus. The room was cleaned following CDC recommendations to protect against transmission of the COVID-19 and was well lit. Her hair was covered by a surgical cap and her face with a surgical mask, with only her eyes visible to the researcher. A bachelor-prepared RN, **Valeria** has been working as an experienced neonatal nurse for about 20 years, and in her current unit for now 18 years.

Living in Broward County with her husband and son, whom she delivered in her country 23 years ago, **Valeria** takes care of an array of very sick and premature infants in the NICU. However, she does not recall receiving additional training on caring for the family in the NICU. **Valeria** expounded that caring for the family is part of her job and includes teaching the mothers how to breastfeed their infant. Although her facility is a family-centered care NICU and has a family-centered care policy, she revealed that she is not so much involved in the family-centered care committee and is confident that the committee provides for every family. Birth tourism is not a familiar term to **Valeria**; thus, she affirmed caring for multiple international families who returned to their country after discharge from the NICU upon hearing the term's description by the researcher. **Valeria** explained that, “birth tourism families are frequently cared for in her unit and are often passed on to the social worker because these families need help.”

**Indigo Durand** provided her interview via Skype video conferencing to adhere to the now enforced amendments to protect against the COVID-19 pandemic. **Indigo Durand** is a 43-year-old Hispanic/Latino and has been a registered nurse for 19 years. She obtained her master's degree in the past year and works as a neonatal nurse in her current neonatal intensive care unit for the past 15 years. Migrating here with her parents from Colombia at the age of 16, **Indigo Durand** lived in Miami and delivered all her three children in the hospital where she is currently employed. **Indigo Durand** agreed to the Skype video conferencing at this time where social distancing is mandated across the Nation and not able to meet for a face-to-face interview. **Indigo Durand** wore her robe with her hair pulled back into a bun, and during the interview, she shared that all her children were homeschooling online due to the current pandemic of COVID-19 and

current lockdown and that may affect the Skype connection; however, there were no interruptions during the interview. Although all her children were born healthy and never required admission into the NICU, **Indigo Durand** expressed some familiarity with the term birth tourism. When queried about recalling about providing care for birth tourism families, however, to **Indigo Durand** voiced how the term sounds “discriminatory” and “sounds cold,” and she is “not used to hearing it from the nurses in the NICU.”

Due to the COVID-19 pandemic and homeschooling situation with her son, participant **AnnaV** scheduled a Skype video conferencing interview during her son’s naptime, because this was the only convenient way to participate in this study. **AnnaV** is a 39-year-old Hispanic/ Latino experienced registered nurse with a master’s degree. She has worked in this role for the past 20 years and started as a neonatal nurse in 2001 in South Florida at a free-standing children’s hospital. She is a single parent of an ex-premature adopted son who spent 65 days in a South Florida NICU. **AnnaV** has worked for the past 5 years in her current family-centered NICU, which holds a family-centered care policy, and she recalled receiving additional training on how to care for the family in the NICU every year. **AnnaV** is familiar with the term birth tourism and expressed how she “cared for infants of couples who came to Miami on vacation with no plans of delivering a baby; thus, unfortunately, the mother would suddenly go into early labor, warranting an admission into the NICU.”

**Gina Martin** is a 33-year-old Haitian-American registered nurse with a bachelor’s degree in nursing and experience in neonatal nursing for the past 8 years. **Gina Martin** has only been a nurse for 8 years and has worked in the NICU since graduation. She is single with no children, and agreed to a Skype audio-recorded

interview, and asked if her dog could take part in the call, as she held her white poodle while she discussed her experience in caring for birth tourism families. Although **Gina Martin** does not remember receiving any additional training on caring for the family, her current family-centered NICU has a policy on family-centered care. In caring for families in the NICU, **Gina Martin** disclosed that she has, “encountered birth tourism families, thus never referred them as birth tourism families.”

Skype video-conferencing for **Loana** was convenient to afford participation in this study because of COVID-19. **Loana** is a 43-year-old mother of three children with a teenage daughter who spent her first 3 weeks of life admitted into the NICU. This Hispanic/Latino registered nurse has been an experienced neonatal nurse for 21 years and received her master’s degree in 2018. Due to the pandemic, **Loana** expressed that she had to slow down traveling to different hospitals to see various patients and care for families in difficult situations. **Loana** remembers attending a one-time training on caring for the family in the NICU and practices in family-centered NICUs with a family-centered care policies. **Loana** has heard the concept of birth tourism, which is usually referred to in her unit as international patients. Birth tourism to **Loana** is “about the families, for whatever reason, it may be medical or any other different reasons, leave where they are from to come into this country to deliver their baby.”

**Nurse Nancy** affirmed that Skype video conferencing was the convenient way to interview for this study. **Nurse Nancy** is a 56-years-old White American registered nurse working as a neonatal nurse for the past 14 years in the first NICU that ever employed her. She is a single parent of three children who never required a NICU admission, and it has been 2 years since she attained a bachelor’s degree in nursing. A one-time seminar

offered was to introduce family-centered care in **Nurse Nancy's** unit, and a family-centered care policy is in place to guide nurses on how to care for the family in the NICU. **Nurse Nancy** recently took care of a birth tourism family in her unit and understands that “these families come to the United States with a birthing plan and having their child born in the United States to be a citizen.”

**Mari** agreed to Skype video conferencing and expressed her fear about the uncertainty of the COVID-19 pandemic and the nation's political state. **Mari** is a 35-year-old Hispanic/Latino and Bachelor prepared registered nurse who has been working as a neonatal nurse for the past 17 years. She is married with no children and migrated to South Florida from Honduras with her mother, who spent a month with her little sister admitted into a NICU in South America. **Mari** does not remember anything about her sister being in the hospital; however, growing up with a sickly sibling and hearing her mother's recollection of her NICU experience drove her to become a neonatal nurse. In **Mari's** current NICU, she has read a family-centered care policy and it is understood that family-centered care is practiced supporting all families and their newborns.

Nevertheless, **Mari** does not recall receiving any additional training on caring for the family in the NICU. **Mari** also expounded that she has not heard the word birth tourism; but, she has cared for international families. **Mari's** understanding of birth tourism is “a complicated thing to do, and sometimes plans are made by these families to go somewhere else to have a baby. It is a tough decision to make.”

**AM** shared that scheduling the interview via Skype video-conferencing was the safest amidst the global pandemic and convenient since she has a newborn at home. **AM** is a 34-year-old Hispanic/Latino and has been a registered nurse experienced in neonatal

nursing for 8 years. She recently received her master's degree and is working in her current NICU for the past four years. **AM** is a new mom with a six-month-old infant born at 37 weeks gestation who did not require admission into the NICU. Although she is a neonatal nurse, she was glad that her newborn was healthy and did not end up in the NICU. **AM** received a one-time additional training class on caring for the family in the NICU, and in her current NICU, a family-centered care policy guides her practice. She has worked in different family-centered facilities giving care to numerous families, including birth tourism families. **AM** is familiar with the term birth tourism and reported how she has, "come across many birth tourism families from the islands who come to this country because they do not have the facilities there."

**NICU RN** who chose Skype video conferencing is a 45-year-old White non-Hispanic American. Bachelor prepared a registered nurse for the past 18 years, and for 16 years, she has been working as a neonatal nurse. **NICU RN** is married with three children which two of her daughters were born in her present hospital. Practicing in a family-centered NICU, **NICU RN** affirmed a family-centered care policy to guides her practice. She also attended a one-time class training on how to care for the family in the NICU. Although the term birth tourism is not familiar to her, **NICU RN** is sure that over the past 18 years, she has taken care of birth tourism families in her current NICU. **NICU RN** does not use this term but is knowledgeable about these families who travel internationally to give birth in Miami. **NICU RN** asserted that, "as the name implies for tourism is a family from another country that is having a child here in the United States."

To be more comfortable speaking freely during the interview, **Mary** scheduled a Skype video-conferencing interview with audio-only because her while her daughter is

homeschooling and also to assure health and safety during this pandemic impacting our globe. **Mary** is a 55-year-old African- American, experienced registered nurse with a bachelor's degree in nursing. **Mary's** first nursing job has been in her current NICU, where she has been working as a neonatal nurse for the past 20 years. **Mary** works in a facility that uses a family-centered care policy and remembers receiving a one-time class on caring for the NICU family. **Mary** has never heard of the term birth tourism, and after understanding the context of the concept, she recalled caring for numerous international families in her NICU. **Mary** stated that "America is open to everybody from every country and every form of life," and being from Jamaica, **Mary** disagrees with how the concept is perceived. She believes that "these women who come from other countries to give birth are mainly to receive the care lacking in their own country."

**Peace**, who preferred Skype video conferencing, is 64 years old and described herself as a Caribbean American. **Peace** communicated that she is one of the registered nurses to open the first Level III NICU in the South Miami area in which she currently is employed. With more than 40 years of experience in neonatal care, she has a master's degree and works as a neonatal nurse in her current unit. **Peace** works in a family-centered care facility with a policy in place, and that family-centered care is a philosophy practiced in the NICU. Additional training on caring for the family in the NICU is not formally offered regularly, but **Peace** remembers that the staff will get educated if some issues arise regarding their care. **Peace** has taken care of many birth tourism families because her facility has an agreement with several of its insurance companies overseas. Not foreign to the term, **Peace** inferred that birth tourism involves, "families would

frequently travel to the U.S. on vacation, and some will come for the season and end up, not purposely, have their baby here.”

**Pina** agreed to Skype video conferencing; she is a 63-year-old Asian American working as a registered nurse for 31 years. Diploma prepared, she migrated to Miami and has been working in her current NICU for 23 years. Arranging for a Skype video-conferencing was ideal for the interview, which did not impose on **Pina** during the homeschooling of her grandson secondary to the COVID-19 pandemic forcing virtual school for all Miami-Dade public schools. **Pina** recalled receiving a one-time training class on caring for the NICU family and a refresher course that she completes online every 3 years. **Pina’s** NICU is family-centered, guided by a policy that she refers to, especially regarding who visits. Family being able to visit the infant in the NICU is essential to **Pina** since she experienced firsthand with her grandson spending 14 days in the NICU 7 years ago. **Pina** listens to the news and has heard of the term birth tourism on National Public Radio. She does not use this term in the unit, but she has cared for numerous birth tourism families. Birth tourism families to **Pina** are the “families who are not American citizens who want to come here to have an American baby.”

**Brianna Padilla** participated via Skype video conferencing. She is a 42-year-old Hispanic who has practiced as a registered nurse for the past 20 years. **Brianna Padilla** migrated here as an infant with her parents from Cuba and is now a mother of three children. She delivered her last baby 9 years ago in the hospital where she currently works. Master’s-prepared **Brianna Padilla** has been working as a neonatal nurse in her current NICU for 15 years. **Brianna Padilla’s** neonatal nursing practice is guided by a family-centered care policy, is kept up to date by a yearly additional training module on

caring for the NICU family. **Brianna Padilla** has heard the term birth tourism, but not referring to international mothers in the unit. However, she has cared for birth tourism families, “especially families that are from countries that are not able to provide a level three NICU care for their babies.”

When setting up to participate in this study, **DJ** was glad to have the option of a Skype video conferencing interview as this lessened the stress of keeping social distancing during the COVID-19 pandemic. **DJ** is 36-year-old African American bachelor’s-prepared registered nurse with 13 years of experience and currently has been working as a neonatal nurse for the past 4 years in the NICU. **DJ**’s current facility is family-centered, platformed by the policy; all neonatal nurses in her NICU receive training every year on caring for the family in the NICU. **DJ** has not too often heard of the term birth tourism. Nevertheless, she is knowledgeable and has cared for “several families that traveled and whether planned or sometimes just visiting from another country where the woman is pregnant and for different reasons, delivers here in the States.”

**NICU RN 2**, who elected Skype video conferencing for this interview, is a 38-year-old Cuban American registered nurse for the past 21 years and has worked as a neonatal nurse in her current NICU for 20 years. **NICU RN 2** has a family-centered care policy in the current unit and attended a one-time training class on caring for the family. Mother of four, **NICU RN 2** is glad that all of her children were born to term and did not require admission into the NICU. In her years of caring for families in the NICU, **NICU RN 2** heard of birth tourism families. She cared for several birth tourism families and

“because of distance from their country, a particular family from Kuwait required living in Miami temporarily during the admission of their infant into the NICU.”

Through Skype video conferencing, **Sandra** is a 26-year-old Asian Indian was able to complete the interview. **Sandra** appreciates the technology of Skype video conferencing on her iPhone, permitting her to participated in this study amid the pandemic. She is a registered nurse with a bachelor’s degree and has been working as a neonatal nurse for 3 years. Since graduation, NICU is the first Nursing position and according to **Sandra**, caring for the entire family is essential in the infant's care. **Sandra** never received additional training on caring for the family. In her family-centered NICU, she works with a policy that serves as a reference when giving care. “Birth tourism is not a commonly used term” she supposed; however, she has given care to “families who specifically come to this country in order to deliver their child whether that is intending to stay or not stay.”

**Bella**, who agreed to communicate via Skype video conferencing, is a 54-year-old Hispanic with 33 years of experience as a registered nurse. Bachelor prepared **Bella**, migrated to Miami with 27 years of neonatal experience, worked in her current NICU for 19 years. She is the mother of two adult children to whom she gave birth in Puerto Rico; thus, **Bella** can imagine the stress of having a baby in a foreign country. In her current NICU, **Bella** follows a family-centered care policy to guide the decisions made on handling visitation of the family in the NICU and only received one-time class training on caring for the family. **Bella** heard the terminology of “birth tourism as an official kind of terminology” in reading the flyer for this study. She cared for a plethora of

“international families and remembered of the anxiety these families had during their stay in the NICU.”

Through Skype audio/video conferencing, **Twiggy** is a 56-year-old African American registered nurse with a master’s degree and 31 years of nursing experience completed the interview. Interviewing via Skype is new to her and convenient due to the pandemic and her evening shift, not allowing much sleep. Although she only has a year in her current NICU, **Twiggy** has been practicing as a neonatal nurse for the past 15 years. Her current family-centered NICU withholds a policy, and every year, the staff receive additional training on how to care for the family. **Twiggy** is not familiar with the term birth tourism but has cared for women from the Caribbean area here in Florida on vacation, ending up giving birth to their baby. Some plan a nice vacation before having a baby but end up having the baby early during their vacation.

The mother of two school-aged children, Skype was ideal for **Jenny** to participate in this study as it facilitated her time with her children during virtual school and social distancing during the COVID-19 pandemic. **Jenny** is a 35-year-old Hispanic/Latino, experienced registered nurse for 12 years, and has been working in her current NICU for the past five years. **Jenny** is a neonatal nurse, and since graduation from nursing school, she has only worked in the NICU giving care to a plethora of sick and premature infants. Although **Jenny** works in a family-centered facility, she does not recall having a family-centered care policy in her current unit or receiving additional training on caring for the NICU family. The term birth tourism is unfamiliar to **Jenny** in the context of international families. However, **Jenny** has cared for international families, “who usually are cash-paying families and do not intend to stay in the NICU.”

**Ava** is a mother of three high school girls, and during the pandemic, having video-conferencing is the new way of life. Therefore, Skype worked well for interviewing her for this study. **Ava** is a 38-year-old White American registered nurse with a bachelor's degree for 22 years. With 12 years of experience as a neonatal nurse, **Ava** has been working in her current NICU for the past 6 years. **Ava's** current NICU holds a family-centered policy, and she received a one-time training class on how to care for the family. **Ava** is aware of the term birth tourism families; thus, she only knew these families as "tourism patients." **Ava** cared for multiple types of families, including birth tourism families, whom she has known to be "cash pay" for their "pre-planned deliveries and an amazing well-baby experience." **Ava** understands that an "amazing well-baby experience" means a "corner room and wraparound windows on the water in a South Florida hospital."

Interviewed via Skype video conferencing, **Chère** is a 38-year-old Asian registered nurse with a bachelor's degree in nursing and practicing as a neonatal nurse for the past 17 years. **Chère** migrated from Pakistan at 13 years old and worked in her current NICU for 15 years. In the hospital where she is employed, **Chère** gave birth to her three children. Additionally, 4 years ago, her newborn son was admitted into her current NICU, where they spent 3 weeks due to his prematurity. Guided by a family-centered care policy, **Chère** receives additional training on caring for the NICU family every 5 years. **Chère** is acquainted with the term birth tourism, and her recent experience was caring for a "birth tourism mother who was alone while visiting her sick infant because the father could not travel to South Florida."

**Jess** chose to participate using Skype video conference for the interview. She is a 44-years-old and a bachelor-prepared registered nurse from the Caribbean with 20 years of nursing experience. As a neonatal nurse, she currently works in a family-centered care NICU for the past 19 years. Underpinned and guided by a family-centered care philosophy, **Jess** refers to the policy when necessary in her unit and recalls receiving additional training every year to care for the NICU family effectively. Accustomed to the term birth tourism, **Jess** cared for numerous birth tourism families that come to America intending to seek the medical and perinatal care that they otherwise cannot receive in their country of origin.

### **Results**

Hermeneutic phenomenology was the preferred method in this study to help the researcher explore the lived experience of nurses caring for birth tourism families who admit an infant into the neonatal intensive care unit (NICU). This descriptive-interpretive inquiry method explored neonatal nurses' experience caring for this population from several different perspectives. By interpreting the neonatal nurses' lived experiences, the researcher recognized standard features and characteristics that helped to understand the phenomenon (van Manen, 1990). Before the data collection process began, the researcher received an approval letter (see Appendix A) from Barry University's Institutional Review Board (IRB). Recruitment procedures were to begin upon receipt of the letter. However, on February 11, 2020, the World Health Organization (WHO) announced a global pandemic known as the human novel coronavirus disease 2019 (COVID- 19), reaching the United States and forcing the researcher to delay and reschedule some of the participants' interviews.

Twenty-two participants volunteered and were interviewed. Once each participant contacted the researcher, an interview was arranged for those who met the inclusion criteria. Despite the pandemic, the options offered were face-to-face or Skype interviews. A majority of the participants chose Skype video-conferencing due to the need for social distance and fear of spreading the Coronavirus during the COVID-19 pandemic; but only Valeria's interview was via face-to-face. Amid the COVID-19 pandemic, only the first recruited participant was adamant in keeping a face-to-face meeting. Therefore, the researcher and participant met at a mutually agreed-upon place, which provided a clean, spacious room to allow 6 feet apart of distance, washing hands at a nearby sink, and wore face masks. Adhering to the World Health Organization recommendations such as standard, contact, and airborne precautions, these precautions were followed to protect against exposure and transmission of this novel Coronavirus.

Once the participant signed the informed consent via DocuSign.com, a \$25 Visa gift card forwarded to each participant was theirs to keep even if they decided not to complete the study. Twenty-one semi-structured Skype video conferencing interviews took place in the researcher's home office, which provided a private setting to protect participants' confidentiality. All audio-recorded interviews completed were after obtaining each participant's approval, and at the end of the questioning, appointments made for the follow-up were for member checks via a non-recorded telephone conversation. Immediately following each interview, the researcher journaled thoughts and feelings about the interview and reflected on observation of each participant's mannerisms and gestures and verbal and non-verbal behaviors. After each interview, the researcher personally transcribed each data set before moving on to the subsequent

interview. Although this task was time-consuming, this process, aligned with van Manen's recommendations to the hermeneutic, qualitative inquiry method, was a valuable part of data analysis.

Living in the text and continuously measuring how the interviews play significantly in the total textual structures within the context of the phenomenon helped the researcher find what was said and how it was said accurately. According to Max Van Manen's (1990) six procedural research activities, the researcher also followed the methodical structures, which dynamically interplayed in the transcripts' analysis. Furthermore, the researcher's regular reflective journaling helped capture any assumptions and biases that could affect the study's data and results. This suspension of one's various beliefs, also known as a reduction, helped the researcher understand the essential structure of caring for birth tourism families in the neonatal intensive care unit (van Manen, 1990). Along with van Manen's (1990) six research activities, the researcher adhered to three of van Manen's phenomenological approaches to generate this study's themes.

Within the holistic and sententious approach, the researcher looked at the text in its entirety to find critical phrases that captured the meaning or central significance of the text. The detailed line-by-line approach analyzed the data, which encouraged the researcher to scrutinize each sentence or sentence cluster to find words or meanings, reflecting the participants' individual experiences. Lastly, van Manen's (1990) selective approach entailed for the researcher to examine each transcript line-by-line for complete thematic statements emerging words representing the essence of the participants' experiences. Besides, reading and re-reading line by line to capture thematic statements

that emerged from each participant's experience continued scrutinizing the transcripts. Continuous and iterative, Miles et al.'s (2014) qualitative data analysis led the researcher to coding new ideas to what should go into the data display and illustrated by a matrix or charts. This analysis method was for the data reduction or condensation, data displaying with matrices and networks, and drawing and verifying conclusions. The researcher also used the NVivo 12-pro software to organize, and combine the participants' stories, which helped extract the themes for this study.

Themes in hermeneutic phenomenology refer to motifs (topics) that frequently occur in the text, and they are embodied and dramatized in the evolving meanings and imagery of the data collected (van Manen, 1990). The data analysis conveyed neonatal nurses' experiences of caring for birth tourism families who unexpectedly admit an infant into the neonatal intensive care unit (NICU). After engaging in the transcripts and immersing in the data, four significant themes emerged: *recognizing cultural interactions, acknowledging cultural consciousness, canalizing compassionate care, and bridging family-centeredness.*

The research question posed in this study was, "What is the lived experience of neonatal nurses caring for birth tourism families who admit their infant into a neonatal intensive care unit (NICU)?" Neonatal nurses' voices revealed themes from their lived experience of caring for birth tourism families in neonatal intensive care units, which elucidated Max Van Manen's hermeneutic four lifeworld's four existential themes. Unique to the hermeneutic phenomenological method of research, these four lifeworlds, spatiality (lived space), corporeality (lived body), temporality (lived time), and relationality (lived human relation), can be recognized in the data and are discussed in

light of the findings from this study (van Manen, 1990). The lifeworlds manifested a true reflection and essence of the phenomenon through reading and re-reading and forming meaning from the data obtained from the participants' lived experiences. The themes resulting from exploring the data met the research method's assumptions by bringing the neonatal nurses' natural attitude of their everyday life when caring for birth tourism families who admit an infant into the NICU into nearness.

Spatiality (lived space), according to van Manen (1990), is the physical space or the space in which participants are experiencing caring for birth tourism families. The lived space was impacted by the NICU environment's cultural norms, which implies that the nurses care for culturally diverse families in a culturally diverse environment. Therefore, the participants' nursing tasks point to recognizing the family and its culture to deliver cultural care tasks that are holistic using nursing skills to meet the infants' and their family's needs. Neonatal nurses recounted that their experiences of caring for families in the NICU involve caring for the premature and critically ill infants while incorporating nursing interventions, assisting, supporting, and enabling these unique families to care for their infants.

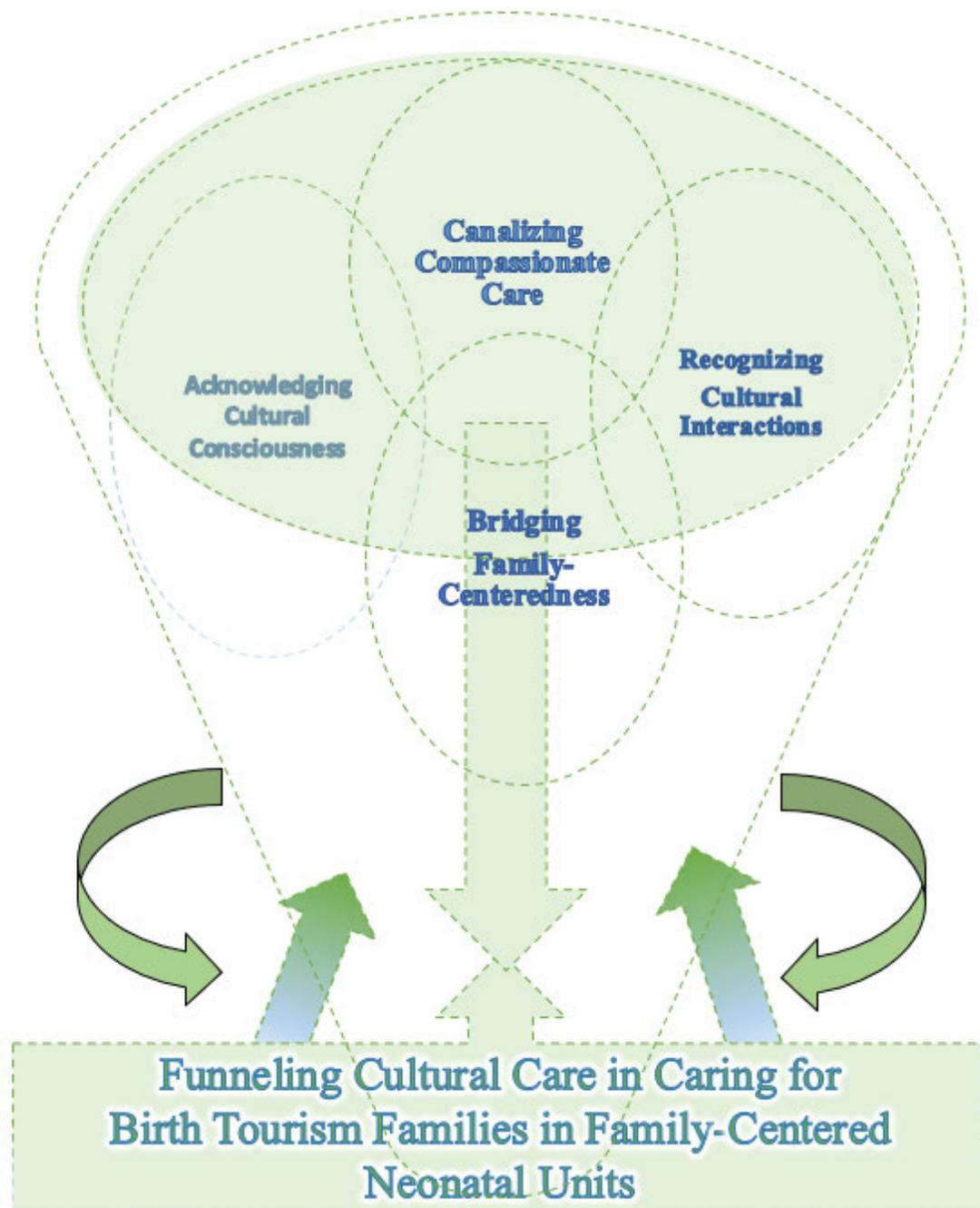
Corporeality (lived body) refers to the physical presence of one in the world (van Manen, 1990). In the context of corporeality, neonatal nurses are present in the world of caring for birth tourism families; an interaction occurs as they come to know each birth tourism family through an encounter. During every interaction, nurses recognize individual families with diverse nationalities in their world through a cultural engagement. Analyzing participants' data reveals that recognizing birth tourism families is not always easy. The stories collected implied a break in communication among the

neonatal team members which pointed to the need to bridge information between nurses providing the care, birth tourism families' constituents to make the nursing care culturally sound. Through this cultural interaction, the nurse recognizes the presence of birth tourism families in the unit to care for all family's needs.

Within each cultural interaction, nurses meet each birth tourism family in their lived space, lived body, and lived time. Temporality (lived time), according to van Manen (1990), denotes the subjective time inclusive of the past, present, and future, which makes up the scopes of the temporal way of being in the world. From the analyzed data, temporality in the participants' questions points to cultural consciousness relating to self-awareness and awareness of meanings and feelings while caring for birth tourism families. Lived time is not merely a matter of understanding or grasping the time in past, present, and future but also a conscious knowledge of one's feelings, motives, and desires, which in turn drives in a desire to distinguish one person from the other (Van Manen, 2016). Therefore, participants in their experience of caring for birth tourism families re-count each time spent with a birth tourism family by pulling from consciousness meanings past and present feelings. In the lived time, participants of this study acknowledged cultural consciousness when working directly with culturally diverse patients. They demonstrated some knowledge about who birth tourism families are as they cared for their infants in the unit and knew cultural preconceptions that raised alertness to biases about these patients' various cultures to deliver compassionate and competent care to them. Therefore, caring for birth tourism families while knowing cultural preconceptions helps nurses become aware of meanings and feelings predetermined at all times of the care, which improves the quality of care delivered.

Relationality (lived human relation) reflects that neonatal nurses working in family-centered care facilities must continually ensure cultural knowledge with every care encountered and bridge cultural disconnection among the many NICU team members. The concept of family-centered care underscores the differences in families' lifeways, language, norms, and cultural values (Little, 2018). Participants in this study expressed that giving care to diverse families involves a lived relation of knowing each family's culture, desiring to become culturally competent, and employing strategies with each encounter to deliver quality nursing care to birth tourism families. The researcher turned to the lifeworld, which required approaching the experience in an unbiased manner and yielded the themes that conveyed neonatal nurses' experiences caring for birth tourism families. To illustrate the emergent themes interpreted from participants' lived experiences, a schema in Figure 3 reflects the process of caring as a funnel, withholding active continuous phases that neonatal nurses incur during a cultural interaction with birth tourism families who admit a premature and ill newborn in the neonatal intensive care unit. The neonatal nurses from this study experience funneling culturally appropriate care when caring for birth tourism families to deliver quality, family-centered care successfully in the neonatal intensive care unit.

Denoted from participants' data are the four identifies emerging themes: *recognizing cultural interactions*, *acknowledging cultural consciousness*, *canalizing compassionate care*, and *bridging family-centeredness* (see Figure 3)



*Figure 3.* Conceptual representation of the lived experience of nurses caring for birth tourism families in South Florida’s neonatal intensive care units (LaCroix, 2020).

**Theme: Recognizing Cultural Interactions**

*Recognizing cultural interactions* emerged as a significant theme from the analysis of the collected data from this study. “Cultural” is the adjective of the word culture. The term “culture” contains many facets, and in the context of this study, it serves as an umbrella term encompassing multiple groups of individual’s beliefs, values, norms, and lifeways that can be shared, learned, and transmitted (Cai, 2016; Davidhizar & Giger, 2004; Leininger, 2002; Purnell, 2014) Culture is far more than some of its determinants such as gender, education, religion, socioeconomic status, and country of origin; it also involves race or ethnicity and influences people’s thinking and behaviors toward one another in the healthcare setting (Campinha-Bacote, 2002; Leininger & Reynolds, 1991). The term interaction, not clearly defined in the literature, is often interchangeably used with communication, and demarcated as an observable behavior during two persons’ encounters (Fleischer, Berg, Zimmermann, Wüste, & Behrens, 2009).

Researchers (Anderson, 1979; Shattell, 2004; Spiers, 2002) also used theoretical frameworks such as symbolic interactionism to describe interaction as a process of interpretation and construction of meaning to determine a subjective experience during an encounter. During a nurse-patient interaction, the nurse and patient (a member of different cultures) exchange some form of communication to deliver health information effectively (Campinha-Bacote, 2002). Accordingly, cultural interaction is a process that the nurse directly engages in a face-to-face exchange with patients from culturally diverse backgrounds to provide nursing care (Campinha-Bacote, 1998). Participants in this study revealed that while caring for premature or ill newborns admitted into the neonatal

intensive care unit (NICU), the cultural interaction with birth tourism parents is not always seamless and recognizable. Cultural interaction is continuous and denoted by contact, communication, and healthcare information exchanges among culturally diverse patients and healthcare team members (Campinha-Bacote, 2020; Sindyigaya, 2017). In *recognizing cultural interactions*, participants shared that there may be some challenges to knowing that the neonates they are caring for is of birth tourism families, making it difficult to provide for families' needs while in the NICU.

Participant **Mari** recounted her nurse-patient encounter, although recognizable, revealed some challenges. She said:

So hearing birth tourism, one family did come to mind from Dominican Republic. She wanted to learn. But I was not sure, so just by asking questions and talking, then she said that she was not from here and that they did not live in the United States. They lived in the Dominican Republic. And she wanted the baby to be born here in the United States. She did have health care in her country, that, she talked about. I think so, but not all the patients tell you these things.

Likewise, **Valeria** narrated about the familiarity that she sees during patient-nurse interaction. She expressed:

Because I am from another country and I have encountered families from where I am from. I am from Brazil and a lot of birth tourism from there. They talk with us; they talk, yeah. They said that they're not afraid to say that they do not live here. Oh, and some say where they are from and I know because some come from my country. They are not afraid; they say just like that. So, I am able to talk with them and take care of what they need.

**Indigo Durand** described how she interacted during encounters with birth tourism families in her unit and faced some obstacles in recognizing these families. She expounded:

They will mention it to you they will say, Oh no, we're not from here. We live, for example, in Venezuela, or we live in Haiti, or we live in Colombia. But they do not say that we are coming here in the U.S. to have our child here so he can become a natural born citizen. They do not say that. And have you known...the moms might just want the rights of a person born here but they just come and have their baby here. So, that's how I know because they talk about it, they say it themselves. But these poor moms can get lost in translation. When their baby is in the NICU they are very sad. They say that they are afraid because they are going to separate me from my child. I have had a parent mentioned that to me. Because the fact that you can actually see it and they talk about it as well.

**Mary** recounted how she perceives and recognizes birth tourism families and her interactions with them in the NICU. She said:

How we see them as they come in. Plus, they can tell you, they, they'll tell you when they are not from here. I've had parents that financially, they will admit that they're not able to provide for certain means like clothing for their tiny babies. Because of their status or financial status, they did not expect to stay in this country for so long and they cannot provide. But that shouldn't interfere with our care.

**Pina** elaborated:

But they do say that we were planning on going on vacation and then now baby. That's like an excuse ... Oh, we came from, for example, Argentina ... Or we came from Haiti and we came, or, you know, we were from the Bahamas or ...? Whatever. Oops. They have the baby. Okay, so you find yourself that you travel at eight months of gestational age and Oops, I had the baby.

**Peace** shared her contact with birth tourism families and the different perceptions of her cultural interactions while caring for them in the NICU. She stated that:

Um, Yeah, actually I do remember a family. They were from. Yeah, they were coming from Haiti and one of the well-to-do families. So I remember the dad spoke English, but the mom didn't. So what I remember about them is that I spent a lot of time with them, like talking to them and talking them through the whole process. I spent a lot of time with them. So they were super thankful, very nice. I had taken some special care of them in the beginning the first time, and they felt so comfortable here they came back to the hospital is and that sort of thing. So I remember them.

**AnnaV** expressed her experience in recognizing birth tourism families as well as her expectations of the challenges these families face when she mentioned:

At the freestanding Children's Hospital most parents don't plan to be admitted to the NICU. I have had families from Central and South America that have planned to come to United States, and some families that have gone into preterm labor, while vacationing and had their tourist visa for a certain amount of time or going through the United States on a stop overflight to the Caribbean and they've been transferred to have their baby all of a sudden and the baby end up in the NICU.

**Gina Martin** was very passionate in sharing her experience how she recognized and bonded with caring for the birth tourism family she cared. She said:

The parents they were from, they were from Haiti. And they were having twins. And well, unfortunately they spoke, they spoke a little English, but not much. They were here for like; I think they were here for almost three months in the hospital. So yeah, it was there you can see it was very stressful and the communication was a problem as well so there, Yeah, it was stressful.

**Loana** expressed the lack of a standard way to recognizing birth tourism families in the NICU. She said:

I remember this mom that, Yes, she came here to have her baby and she wanted to go back to her country. I remember like, for example, we had a famous person from one of his country and, you know, she came here, she doesn't live here, but she's very famous and you know, in the Hispanic world, the music world.

**NICU RN2** described:

They were here. They were living here temporarily but they were there and was to go back home after baby was discharge. Since wife had the baby, their plan was to go back home to Kuwait because they, you know, they wanted to be closer to the family. Obviously, culturally, it's very different from mine. The mom had to have her head cover. I can't remember what the guard was called. But you know, they're very big on that, like mom's head has to be covered before we entered the room. Because the dad, he would take it off when it was just her, but they were in the movie theater, when I took care of this baby. Baby was getting ready to go home. I discharged them actually.

Similarly, **Sandra** recalled a short cultural interaction, thus knowing that a birth tourism family was from another country who admitted their baby in the NICU. She stated:

I have before. Yes. It was a while ago, but it was. I believe a mother who was from Venezuela. And she had come, I don't remember the details of it, but she had come to deliver her baby and the baby was in the NICU for a short period of stay, was relatively stable not severely premature. So it was a quick thing.

**Bella** eloquently stated:

Yeah, I remember a few families not exactly by names, but I remembered some of the situations and they have families that there are traveling from out of country.

Yes, I remember some couple and others from the islands.

Reflecting on the overall experience of the neonatal nurses in this study, participants shared their insights on caring for birth tourism families and how they came to *recognizing cultural interactions* with these families. The participants exposed the differences in coming into direct engagement with birth tourism families from culturally diverse backgrounds. While assessing the neonates and interacting with the families, there remains a need for standardized care necessary to communicate and underscore the presence of families who traveled to South Florida to disseminate culturally appropriate care to birth tourism families in the NICU.

### **Theme: Acknowledging Cultural Consciousness**

*Acknowledging cultural consciousness* emerged as a strong theme in this study.

This theme stood as a significant element to the funneling for caring and interacting with birth tourism families in the intensive care unit from the participants' voices.

Transcultural nursing theorists (Leininger & Reynolds, 1991; Purnell 2021) defined consciousness when caring for a culturally diverse population as the development of awareness for cultures while creating an understanding of self and the other's culture. In the context of nursing, researchers (Campinha-Bacote, 2002; Giger & Davidhizar, 2008; Korten & Sahtouris, 2001; Leininger, 2002; Purnell, 2019) elucidates that consciousness in culture care, also referred to as cultural awareness or cultural sensitivity, is a significant part of healthcare delivery. Awakening and acknowledging cultural consciousness is essential to guide pedagogical and nursing practice and is one of the essential elements or cultural competence practices (Verdon, 2020).

Nursing culture care involves clinical knowledge, awareness (consciousness), compassion, and cultural understanding when caring for culturally diverse patients. Campinha-Bacote's (2002) model, "The Process of Cultural Competence in the Delivery of Healthcare Services," emphasized that cultural awareness, like cultural consciousness, is how healthcare professionals consciously acknowledge their own culture to understand others' cultures while avoiding biases. For this study, *acknowledging cultural consciousness* refers to how the participants recounted their experience of understanding birth tourism practice and the subtle opinion-forming, awakening of perceptions and biases forming toward birth tourism families' cultural backgrounds. The theme reflects the participants' feelings of birth tourism practice, their concerns, and the essentialness of giving the same care that birth tourism families seek. **Valeria** said:

Hum, I think that they come here just because they want the opportunity. Most of the time, yes, I think so ... I agree with birth tourism because they do not have so much in their country. For me, this has two sides. One side I think that it is good

because it can give them an opportunity, they know to give opportunity to be born in a different country, a different way to have a different language. But when you look on our perspective like a for a citizen working in this country, you pay for them, because they have no insurance, no nothing. And then in the end, we are they want us to pay for them. The hospital bill especially in the NICU is not cheap, it is very expensive. And in their country, it is the same. If they have to go to the hospital in their country, they have to pay cash and when they come here, we have better care for them, but they don't pay anything. So, for you as a citizen to receive the care, you pay the same or you can pay a lot of money, if you have no insurance and you don't have the choice of having free care as a citizen you will pay even if it's later. So I say something's like that it is not right.

**Indigo Durand** reflected:

When you think about it, it sounds like cold to me, when you think about those type of things. And I feel that not necessarily everybody comes with an intention and even if they come with that intention, at the end of the day, you're doing what's best for your child. Especially if during your pregnancy you are in a country where there is war, or there is hunger. You need to be better. You want to do what's best for your child. But then, if you have the opportunity to come in, you have the opportunity because you do have the means, you come and you decide to have the baby here in the United States, it's a rich country now. We know that our baby's going to have better chances.

**AnnaV** disclosed:

Like for example, my most recent one ... from Spain. So, I'm concerned because of the COVID ... from Spain ... they had the visa and had to leave the country and come back because they had expired, not expired, but he needs to check out of the country. And it was just in the beginning of COVID. So it's like, Why are you coming here, and you might have something traveling when COVID is going on. But that was circumstantial. So I think it's situational. So sometimes it's difficult when they travel internationally and come and they have these really sick babies that we save and after months and months and months, but then they don't pay. So, that affects the taxpayer not personally but just a principle. So there's many different aspects. Most of those families have prenatal diagnosis, with a complex issue that they feel can only be taken care of here, and for whatever reasons financially whether they work for an embassy or a conglomerate, or multinational or others that are able to get the health care in their country, and still come here, and they do it. They get to deliver their babies here, and they go home and it's not a burden on anyone. And we provide the best care we can.

**Gina Martin** narrated:

To me, to be honest, if I was in their case, I probably would have done it illegal or not, because I believe the majority of them that do it, they do it in the hope that they have their kid and then go back home. Not have the kid and the kid end up in the NICU and now it's, they have to stay longer, which is more like more money and usually don't budget for that. In that sense, I, don't think they pay, so I don't agree with it. But no, I don't think it should be illegal. Complicated ... Money wise because they have to stay longer. It becomes a problem. You know when

they have to stay longer. imagine now that you have a premature baby, and you have to stay for three months instead of you know, the four days or three days you expected to stay. Now it becomes a cost and majority of those people of course, they don't have insurance to cover that part here. I don't have much knowledge when it comes to cost and stuff, like hospital wise, but I feel like that's when it becomes a problem basically, after their babies get discharged, they leave, you know who's gonna pay the bill.

**Loana** divulged:

Birth tourism to me are these families that, you know, for whatever reason, it may be for medical reasons or any other different reasons that they might have, decide that where they live or where they're from is not the place where they want to have this child and they find people here or physicians, or places here where they can actually come into this country and deliver their baby here.

In their country, they know that they don't have the technology to save a baby that is going to have certain conditions, they have the means to come here and give a chance to their child. There are other people that they have some family here, they're planning later on to come here that they just want to have a kid here and they just, pay for whatever they need to pay or do whatever they have to do to come here and have their kids. I think some of them do come here some don't pay for the whole bill, they just come as a like visiting or vacation, whatever they want to call it and then they know that they're gonna end up delivering here. But there's also these other people that they do plan to deliver here, where the parents

knew they were having the baby here, but they paid to come here the father and the other kids stayed in their country.

**Nurse Nancy** explained:

So, I believe I understand it as being families that come to the United States with a birthing plan, and having their child born in the United States to be a US citizen.

Um, I probably don't think that it is illegal, birth tourism. I don't recall about the news. Well, I feel like if we can provide care and save the child's life, I think it should be allowed, so that the infant has a better chance. I agree with that. Um, I guess I have mixed feelings about the taxpayers paying for, um. If the infant could have received normal health care in their country, it does not make any sense.

I definitely feel like I understand if they need to come to the United States to provide a better chance for their child to have a better quality of life and quality of health care, to where we could possibly save the child's life. But if it's a healthy, well newborn and could have been born in their country, and not utilizing our taxpayer's money, I think I have mixed feelings.

**Mari** said:

Okay. So to me right now what birth tourism was, one family did come to mind automatically in she was from Dominican Republic. The mom, first time mom and a young mom. She had money but I remember her specifically saying that she wanted her baby to be born here. You know this is a family that I could tell with money, but it was just their plan just to have a baby here. The baby was in the NICU for like two months before she passed away, so I was able to bond with her with her that the dad very, very sweet people. So for right now, that's what I

mean. You know, and that It's kind of taking advantage of it. Like that So yeah, I kind of it's illegal. Because it's a complicated thing to do. It's a very critical, it's even the decision to do that you have to have a lot of thought into it. So it's a very, like fine line, I don't want to use the wrong word, but sometimes the responsibility is the parents. Like, as someone that's trying to have a baby, want to be able to plan to go somewhere else, to have a baby versus just for the sake of just being with a baby being in another country, for citizenship. I don't think that's ok. When, if I have to think about it, in my first reaction wasn't even illegal. I try not to think like that. My heart is not like that. You know, but I have to, Okay, stop and think. I really am stopping thinking.

**AM** acknowledged these families' presence in her unit. She shared:

So we got a few different facilities. We've had a few. That the babies, you know, they were planning on just going back home. But for whatever reason the baby had to be admitted in the NICU. We also have other babies that come into us from the islands to be just to be cared for because they don't have the facilities there. We have the Virgin Islands, the Cayman Islands, St. Croix. We also have had a few families that they know that in their country that baby will not be cared for, the baby would just be left as in palliative care and comfort measures and they want everything done. So then that influences our system. And you know, the taxpayers are the ones who pay for that for a baby that is a US citizen because they were born here but are just going to return to their country. So we will be left putting a million dollar bill I think it's a very big issue.

Participant **NICU RN** expressed her responsibility to give all families the same care. She said:

Um, well, I think what the name implies for birth tourism is a family that is having a child that wants to have their child here in the United States that is from a different country. You know, for whatever reasons they choose, they want to have their baby born in the United States, whether it be for the nursing care that we provide the medical care that we provide in the United States, the safety of birth, in United States or whether it's for citizenship, whatever it is their reasons. That's why they come in from a different country to have their child. So it's, um, I guess my answer would be that it's it is conflicted. I don't feel that it should be illegal. I don't think that our borders should be a closed borders for any reason, but I do think that there should be policies in protecting the economic part of it. Also because as a nurse, I'm not in the leadership role. So my job as a nurse is to care for that baby. No matter what if it came from Mars, it's my job to care for that baby he or she is a human being. I'm a firm believer in Love, and I think that goes along with care. And a person, whether they are from the United States or Japan or Mars, it doesn't matter. It's our responsibility.

Similarly, **Mary** said:

Well, I've never heard that concept, but I mean, that word birth tourism, I don't agree with it. A lot of these women are high risk moms that I know and cared for from Jamaica that it's especially if they're multiples, triplets or are twins. Sometimes they are not able to facilitate or care for them, especially if they're very high risk. Yes, they come here for the opportunity to seek that type of care.

That part is not that's not what should be on our first priority is giving the care in a safe environment. That needs to be considered.

**Peace** narrated her experiences and shared her views, although not familiar with the terminology; thus, she described the genre of birth tourism families encountered in her neonatal unit. She said:

No, I never heard that terminology, but they are those international patients they don't live here. They just come here to have a baby. I'm trying to remember. A lot of the families that I have taken care of were here because the hospital had an agreement with their insurance company. Others for example, had an agreement with the government. Well, okay, so first of all, you would have the ones that are not here on the government contracts, they pay for their package to give birth here. So are those considered birth tourism also. Yeah, I mean, and even before all of this, they'll always know that, you know, looked down upon certain people, you know, they come here and take our stuff or whatever, but I used to tell these nurses, your parents came here, so you could have a better life because everybody is an immigrant. You know what I mean? Right. But these birth tourism families are looking for a better life for their children and they're not just stealing anything from you.

**Pina** acknowledged not taking a left or right stand on the act of birth tourism practice, explaining how subtle prejudice may cross the mind. She said:

Birth tourism to me means that the families come here. Like they're not American citizens but they want to come here to have an American citizens so they come at a point where they could deliver here. You know, they go through lengths just to

come here. It's so happens, they're pregnant and gave birth here. I think, you know, I wouldn't take having a citizen away from them. They planned it and they knew that if they gave birth here, they could have an American citizen. I'm not totally against it. I'm sort of neutral. So as far if I think that it's an illegal act. Um, depending on the situation, I wouldn't judge. Nobody has really heard of people birth tourism it's not been mentioned in the unit. But biases? It could cross someone's mind, but I don't think we give less care because we know Oh, they just had the baby. Because, you know, they're, they want to have an American citizen. I don't think we give less care because of that; you know, I think the care is the same. Although, you know, it would cross someone's mind. Oh, you know, but we care for babies just the same.

**Brianna Padilla** said:

Yes, in a lot of the times, yes some families come over because they're in their country, they are not able to do certain things or they or they don't know how to care or have the means to care for the preemies or, or things like that.

I have seen and know that in other countries, if you have a baby with a defect, they are probably just gonna let the baby pass away. But when or if you come here sometimes, we're willing to be able to do a little bit more and stuff and have more care. The surgeons being able to be around and all that, like we don't just let them go because they have a thing. And I know a lot of the times people from like the DR or Venezuela as well, even the Caymans will come to deliver with us because they know that we can help their child out. I'm not very big into politics and all that so I don't know the whole thing behind birth tourism.

Participant **DJ** feels that besides influences by assumptions about birth tourism families, this patient population's choices should be respected. She noted:

I know what it is because I've had several families or patients that are taking care of where families have traveled up whether it was planned or sometimes two people could be visiting from other countries and then the woman could be pregnant and for different reasons, she delivered up here in the states.

Subsequently the baby had to go in the NICU, but they still plan to go back home.

So yeah, so a variety of different things. I don't see that as illegal at all. I think people have choices. I also still don't agree with what the media portrays. Because I think people have to understand. And I mean, again, I can look at it from different ways. There are people who live in certain countries, certain islands again, I can go back to Jamaica, I can go back, I can see Haiti, I can even use Cuba, I can even say Brazil, there's some people who live in these countries that cannot access care. Some of these moms don't care anything about the United States to come here and stay. All they want is to give birth and return home. I think the mere fact again, that they want to come here is to have their child, and just for our healthcare and also the quality of care, and the resources that we have available here.

**NICU RN2** exemplified her awareness of her own culture's influence to understand and give care to birth tourism families. She shared:

I've heard the word in several circumstances. Maybe, okay so they are international families who just have their babies here and go back home. No, I don't think that it is illegal like the news say. So I have mixed feelings about this.

Okay, because there's some people that have the means to be able to do this. Not everybody has the means to be able to leave their country to come to this country to receive with the hope or the aspiration of receiving better care, which most likely, they are because they're probably coming. For example, my family. Okay, most of my ancestors, my family are Cuban. Okay, so Cuba right now is a communist country. the healthcare system is broken. It is very, very bad. When you go to the hospital there, you need to take everything, even if that's okay, because of the lack of supplies and the lack of things for them to be able to care for their patients. So, if a family member of mine had the opportunity, not only financial, okay, the ability to get a visa, a passport, whatever it required, legally, right, let's say legally, to leave their country to come here. I would want them. No, but I just think it's also I guess, a contradiction or is that not fair. Because what about those people that cannot, that don't have the means to be able to leave their country to come here and get better care.

**Sandra** perceives birth tourism as, “People who specifically want to come to this country to deliver their child whether that is with the intention of like staying here or not staying.” She said:

Overall perhaps it is illegal for birth tourism families to do that. Yes, to a certain extent, I think public opinion it comes to the point of especially when it comes to payments. If it's coming from, you know, tax dollars of people who are citizens of the country. These babies are a high risk perhaps like there couldn't be a exception made but aside from that, in my opinion these babies have a lot of complications

in the future. And it might actually even like separate families. So perhaps, you know, it could be simplified and maybe it should be stopped.

**Bella** voiced:

Well, I feel that in these two cases was like an incidental situation because you know, I guess they got permission by the doctor to come. And basically, they were not that far, they were not ready to deliver. And some complications have come up with their pregnancy, in the end that needing to stay, you know, in the States. There was a mom, I remember her plan, she was on a vacation buying stuff or something and her plan was to go back home to have a baby there, not here. That was one of her biggest anxiety because her husband needed to go back to work and she had to do everything, and she was here by herself. But I feel that a lot of people come purposely just to have the babies here can impact us somehow, you know, in a negative way that baby has a lot of complication. I'm not sure if I will use the word illegal but birth tourism impact negatively our economy somehow the long terms who have complications then later on the care for that baby can financially and will have a negative impact. But with that, it does not change the care that I give to baby here. At least I don't think about that.

**Jenny** remembered and elaborated:

I think it's not very kind to be condescending with these families and not all our families don't stop here just because, whether it's from the Caribbean or Hispanic families, we like to bring everybody in. So we make sure they feel like they realize it's important to visit their baby. But I do remember one family that came for shopping purposes and then she went into labor. So I know that family there

were several of those members who came for shopping trips. Well, that family, which I honestly, I know sounds terrible, but I do remember them mentioning it in the report because the impression of this family was that they're very about possessions...all they care about is shopping here and making sure they get to the mall before they go back to their country. They even asked if they could take the baby to the mall whenever they got discharged.

The study findings affirmed that participants acknowledged and understood the the culture surrounding birth tourism's practice. The reported stories consistently echoed the participants' insights, feelings, and prejudices that may have been influenced by the negative implications on the term and practice of birth tourism. Participants subtly expressed *acknowledging cultural consciousness* by sharing their understanding of one's own culture, empathy, and recognizing the diverse cultures from birth tourism families. When encountering birth tourism families in the NICU, participants stated that regardless of clients' country of origin, remaining sensitive to their situation is sometimes difficult; but giving appropriate, culturally sensitive care is important.

### **Theme: Canalizing Compassionate Care**

*Canalizing compassionate care* emerged as a strong theme in this study, considering that compassion is a quality deemed a prerequisite and underpinning the nursing profession (Shantz, 2007). The term canalizing is to cause to move to a central point or the channeling of behavior (Enzman Hines & Gaughan, 2017; Gottlieb, 1991). Participants of this study verbalized the meaning of caring and caring for the family by directing and addressing birth tourism families' social and emotional needs channeling to giving holistic care (an approach of giving comprehensive care). Cultural desire involves

the concept of caring (Campinah-Bacote, 1999). Reid (2010) elucidated that “people do not care how much you know until they first know how much you care” (p. 48).

According to concept analysis, and within the context of this study, compassionate care carries the following prevalent characteristics: (a) a dimension of caring, (b) sympathetic consciousness of another’s distress, (c) sensitivity to the pain and brokenness of another, and (d) suffering alongside another (Schantz, 2007). The neonatal nurses in this phenomenological study describe the meaning of the word “caring” and “giving care” to their patient by not only explaining their everyday nursing tasks but also using terms such as: “care from the heart,” “empathy,” “support,” and “sympathy,” to name a few. These meanings permitted the insight of the theme *canalizing compassionate care* making sense to this text of life.

**Gina Martin** elucidated that caring is taking care of the physical; thus, caring is from the heart. She explained:

My day of caring in general is usually a very busy day ... especially if it's a very sick baby. You never know what's going to happen. Like, you can start a day, you can start your day with the baby being very stable to midday, your baby's not stable anymore. The word caring cannot define, I mean, taking care of the baby is with your heart. I will say, with, the knowledge you have and the compassion and ... I guess. Let's say, for example, if you were to do an IV, for example, you're going to use sucrose. And I feel like sucrose is part of caring because some nurses, maybe, some people might do the IV without giving it thinking that Oh, if I just give the pacifier that might help the baby. But the sucrose will help them as well. Before you do it, to me like a caring act will be, especially in the NICU,

when you care, you don't only care for the baby, so it's the parents as well. You have to teach the parents, you have to tell them exactly this is, what you're going to do. And by teaching the parent, let them know I'm giving the sucrose to help the baby a little bit with the pain and also swaddle the baby, also can help the baby. I feel like this not just the part of the physical care is an example of caring.

**AnnaV** said: "I try to empower the family to be able to care for that child as best they can, without being scared." **Loana** expounded that caring should be approached holistically, and incorporating the family is part of canalizing the infant's care. She disclosed:

Caring as a nurse. It means for me to not only take care of the medical part of the patient but looking at the patient in a holistic way where I can I also take care of the mom, the dad or whoever is that person that is going to be part of this kid's family. Paying attention to their needs, not only health and medical needs, but also social needs, emotional spiritual needs, knowing how to canalize everything to the right person that can actually take care of every single aspect of their life ... or being there for them when they're going through rough times trying to put myself in their shoes ... when they come with some situation, trying to evaluate if we can make exceptions to certain rules, let's say visitation rules or something like that for a kid that it's almost you know, that is dying, you know, with all these are the rules for visitation, but now something is happening out of the norm. Can we allow support family being here? Can we do more for the family? So any experiences that they are going through especially that they are away from their

country. You know, the best is that we can, treat them like human beings, not like a number.

**Nurse Nancy** affirmed that there is a culture of holistic care, and culture caring is doing NICU tasks and incorporating the family with visitation. She said:

I guess right now we're under a different circumstance. With COVID pandemic. So a lot of the families aren't there with visitation. But I would come in and proceed with my day with my care. Providing the needs of the patient medications, ventilation, whatever, hum, nutrition just all rounded. Because the families aren't there, and the infants are not able to care for themselves. So this is a culture, I mean, a community where we do everything for the patient. Neonates. In the neonatal intensive care.

**Mari** sensitively highlighted the emotions that she observed when interacting with birth tourism families in the NICU. She passionately said:

Caring for the family is being empathetic to the mom. I can't even imagine it, you know, because I've never experienced or been in her shoes but trying to be as attentive to her feelings to her needs at that moment. You know, just if they look sad or of course if I see them crying, I try to care for them. I'm a baby nurse but I want to be there for the mom too and give her the hug. That's what I would feel like she would need at that moment. So I try to always be there for the mom too and being sweet and kind and caring for the for the mom. That's what caring for me is being there being attentive to her feelings, her emotions at that moment just trying to put as best as I can myself in her shoes. But it's a difficult thing to do, but just trying to show that with emotions.

For **AM**, caring is doing a lot for the baby and the family. However, there are some difficulties in the caring aspect overall. She said:

Well, I work in a level three NICU, so our babies are micro-neonates, and we have chronic babies with tracheostomies and gastrostomies that have been there for months and will be there for a little bit longer. And then we have our little transient babies that just come for hyper bilirubin or with or without sepsis or for surgery. So we do a lot for those babies. A lot can be anything from caring for the for the family, as they arrive giving support, you have lactation services. As a nurse, you try to explain to them everything that's going to be happening, everything that's going on, everything that they see in the unit, like they leave to go back to their country with the baby. So they are stressed. Then we always work together to try to create the plan of care for the baby, keep you, know their feelings, and keep them in mind because it's a very difficult time for them. And then obviously with the babies, we care for the babies in the sense that we follow orders obviously, but you know we do everything to the best of our ability, and we love them like our own.

**NICU RN** elaborated:

I think that care is difficult because we know what it is, and we do it feeling in our heart but, to verbalize what it is, it's probably a little more difficult. Our patients are human beings. Nurses have a responsibility for providing the support and the needs of the patient and the family members and since family members are an extension of the babies, really, we're caring for the whole family. It's just not the

baby specifically. It's the support that we give to our patient particularly the mother and the father.

**Peace** said:

Well, caring is basically taking care of the whole person or the whole baby and the family you know, to take care of their physical needs as far as the patient is concerned, and then for the family will take care of their psychological needs and whatever else you may need while they're here at the hospital. Okay. Like I know personally because I help with those Haitian families that come here sometimes knows that the baby need surgery. Part of the care is putting them in Uber for transportation back and forth from the hotel. Or that they can call them a taxi. We have given them bus tickets so they can get on the bus as if their family that they are staying with live far away or whatever so they're coming on the bus. Okay, then we have a lot of resources. So that is part of caring. Because, yes, that is a shock to be in another country. So yes and having surgery. Yes.

**DJ** said:

I, um, the way I would define caring is the same how I feel about, you know, showing compassion to, you know, families, the patients, I'm just providing good care, being a good listener, you know, meeting their needs. And, you know, as far as the, you know, the daily care of the newborn is just, you know, meeting the daily needs of the baby and certain tasks that you know, allows the baby to grow and developmentally get better every day until discharge.

**NICU RN2** explained:

Caring is a big word, and it encompasses every aspect of, you know, baby and mom and showing empathy and compassion to the mom and what she's going through as well as to our direct patient, which is the baby. As we know, you know, the moms become our patients to kind of, we help them, we advise them, we give them counseling at times, so that what we need to call in for more support, social work or pastoral care, whatever lactation, whatever they may need, that's more specific. But we kind of look at the whole picture and caring I feel both into that. And in not just being liquid blinders on and just like, okay, the baby is not my only problem, you know, right, kind of looking at the whole picture and being caring. I don't know if that helped you say holistic and caring and all that kind of goes hand in hand for me.

**Sandra** precisely eluded that, “Caring to me means that that you are taking care of somebody and you're putting their needs first whatever that maybe you're putting their needs first”. **Bella** recounted:

Well, caring means like involve the parents and the baby itself. You know, we have to deal with a lot of situation that the parents go through, the NICU that is already like a very difficult time. Thinking about what you're bringing in, like the light. So, caring, for me, it is like looking for the baby's needs and the care of the baby and reassuring the parents as well as looking for some of the parent needs and see how I can help them. Kind of like that. That is caring to me.

**Indigo Durand** has her passionate ways of relating to her patients when she expressed this. She said:

Now within the whole caring thing. If there are parents there, I will, you know, I have to incorporate the parents in the care. And then I teach them how to do a diaper then I teach them how to give a bath to their baby, how to hold them and how to wrap them. And then if the baby is able to come out of the incubator for them to have kangaroo time. Many of the parents are usually first time parents, and they have no clue how to take care of the baby, plus the fact that they are so anxious and worried about why the baby's there, They don't have that natural course of when you have a baby and the baby stays with you and your instinct kicks in, they go through this broken It's kind of like a broken instinct that these parents go through especially the mother, because the baby has been taken away from her and now, she's like, lost because she cannot really express her motherhood. Now imagine that in a totally foreign country. It's broken and so it's difficult what these parents go through. We're kind of like the ones that incorporate what the parent need. I mean if a parent needs social service for them to be able to attain what they are anxious about because they're not only anxious about the fact that they cannot be 24/seven with their child and the child is sick. They are also anxious about so many unknown things especially passport for the baby, Social Security's, monetary insurance goes, as simple as, why, like sometimes the father cannot travel and the mother is alone going through the NICU alone. Caring is supporting her and letting her know that she is not alone.

Participant **Mary** added:

To me, caring is providing a service. But most important, it is providing the basic needs that we would need to provide for babies staying in the NICU would set up

the plan for that just your basic needs. I hope it really gets you know, makes a statement out there to know that caring is the most important thing no matter what form of walk of life that people come from. It is giving holistic care.

**Pina** indicated that: “How do I define care, making sure that babies are stable. That's the primary one and making sure we teach the families how to care for the babies when they are discharged.” **Brianna Padilla** suggested:

Caring. Meaning being able to care for the baby as far as all the needs, it needs to mean as far as respiratory eating and then being able to provide mental you know, and just family care to the family and itself as well as not just the patients, it is to everybody.

**Twiggy** mentioned:

Taking care of the baby, but also the parents as well as their parents, their most emotional pain. Well, it starts out at like 7am in the morning, it's a 12 hour shift so I work to 7pm. And I'm usually providing care. Physical care for the baby. And the parents, you know they visit often on and whenever they visit, I give updates to the family, answer whatever questions they may have and provide whatever resources they may need, it could be bottles and clothing for their baby. I can answer questions for them, if they have questions about their babies and give them emotional support.

The study participants consistently verbalized words that describe caring for birth tourism families and illustrated acts of caring with words reflecting compassionate care.

Participants, additionally, emphasized the need to care to the infant as well as the family, and providing for all their needs. The study participants voices reflected that they channel

their nursing care along with their emotions to provide for the needs of the infant and family. It is through canalizing support, empathy, care from the heart and sympathy that neonatal nurses give compassionate care to birth tourism families in the NICU.

**Theme: Bridging Family-Centeredness**

*Bridging family-centeredness* arose as an essential theme from this study. It denotes the process which neonatal nurses would utilize during their cultural interactions with birth tourism families to connect other healthcare team members, resources, and strategies to incorporate the family-centered care philosophy for a seamless delivery of holistic nursing care that is culturally congruent. Viewed as a philosophy, “family-centeredness” is defined under the pretext of different labels, including family-centered care, family-centered practice, family-centered approach, patient-centered care, and relationship-centered care (Panes, 2020). Family-centeredness as a process includes utilizing various tools such as communication, family-centered strategies, and organizational resources combined when caring for birth tourism infants and their families.

Family-centeredness in the NICU is an approach to promoting parental participation in the planning and delivery of care of their infant, and thus when servicing a culturally diverse group, nurses must incorporate a culturally sensitive approach (Soni & Tscherning, 2020). According to Campinha-Bacote (2010), in a nurse-patient interaction, cultures disconnect when information is distorted. This causes a lack of cultural knowledge, lack of understanding patients’ worldviews and their needs, and lack of communication between the healthcare team members (Ionio et al., 2016; Jeffreys, 2015). Participants in this study, were faced with working in a very stressful

environment, and they also expressed that there is a distortion of information, lack of cultural knowledge, lack of understanding patient's worldviews and their needs, lack of communication, and inconsistency in obtaining resources when caring for birth tourism families and their infants. The following are supportive statements from the participants on the necessities for *bridging family-centeredness* when caring for birth tourism families:

**Valeria** shared her challenges in communication and family culture disconnection:

You know sometimes there is the issue that some of the parents are very weak about the language. Okay. Now, I remember I have like Indian people like the language and communication was so hard for us, and even the culture. See it's hard because you have some difficult families that we deal with and some kind of parents because they don't know why they act like in ways that it may be normal in their cultures or have expectations end maybe in their country it's like respect but from our culture here it is not viewed as a respected thing. Sometimes they, family centered group have an hour long meeting every month. They will say something about family centered care, but I don't participate in the meetings. I don't know completely all the things they do. But I know that they are involved with the care and care about the need too of the families and care about the NICU. The families they get together they help each other, made of parents, like parents who have premature babies or had experience from before. So they get together and talk with each other. Because for them to go through all this drama that you have when you have the preemie baby or a sick baby in the NICU.

**Indigo Durand** expressed the difficulties during her interactions with birth tourism families and feels that her hospital organization should offer better communication and language services. She said:

Well, the thing is that we do offer those translators, and they are there, okay when we've done for many, families are that so many of us speak different languages. I'm not sure how many different nurses who knows these different languages, but we have a pretty extensive list that we look up and call that nurse to speak to the families. I know like the doctors use that list and it is all over the hospital its offered. That is part of family centered care. But its not constant.

Participant **Nurse Nancy** echoed her sentiments:

Um, I think that every patient in the hospital in our NICU is open to family centered care. I don't think that there's any distinct difference like, oh, they're from out of the country. So let's make sure they have family centered care, like everybody is open to family centered care. And for birth tourism, Um, International services? Yes. I am not sure what the department offers, but I have heard of them coming in checking on parents that are from another country. Yes. I think they help them find housing or just kind of facilitate their stay I would imagine. Hum, their living arrangements, you know. Like somewhere to stay and probably assist them with insurance.

**AnnaV** shared her perspective on difficulties obtaining seamless information. She said:

Sometimes a social worker has to update us on what's going on. It's a multidisciplinary approach to find out for these international families. Or we find that it's an international family in our admission history, the nursing admission

history. There're criteria that says do you have transportation issues for you to getting home? Do you own your home? Do you feel safe in your home? Hum! In some special situations, it usually comes up right on admission, but we don't know before admission. From the way they answer these questions we know. That information of the patients is with the bedside nurse, or the admitting nurse or any nurse taking care of the patient.

**Gina Martin** also disclosed:

As family center care help every mom that comes to the NICU doesn't matter what, you know, their circumstances. There is a group of Mom and come and talk to the new mom, it is called ICU babies. They give the random stuff. They help them. They have all of them they are family centered. But No, not really familiar with the international department in this hospital. No, I've got to be honest, because we're never like ask them if there are any international families coming. When stuff starts happening as usual and the mom has a problem or ask for you, know social security or some resources I don't know how to answer, I guess social worker, like they usually step in and then I guess, you know they will share that with us. But no, no, actually, not always.

**Gina Martin** also recounted on cultural understanding which is not done by all the staff. She said:

So, the culture in Haiti is where they have their babies close to them, but now the culture in the NICU, which is telling them, no you cannot hold your baby, or put your baby on your breast instead you have to, learn how to hold the baby away from you to feed. Only because I am from there that I know.

**Loana** also discussed the lack of seamless communication. She revealed:

The family centered, it doesn't really matter if you are an international patient, it's like, a universal thing that we do with everybody. We start we start talking to social workers through their interviews and then we meet as a multidisciplinary team and we discuss these cases. In some hospitals we do that like every week and some hospitals we do it daily, it depends. Because, you know, because as you go back on the history of the patient, like social family history, Pregnancy history and all of that you can put the business together a little by little and you're like, okay, this one just didn't mean to these two happen here, but it just happened. These one came because I needed these services that these persons thought was not going to be able to get anywhere else.

Participant **AM** explained the relayed information given to the nursing team which makes it family-centeredness. She added:

We communicate usually what they do is that whenever the baby gets admitted, I mean, we always speak with a parent, we have a welcome package that explains everything about the rules. So they we have a global like a department that's called Global. They pretty much are the liaison between the families, the International families, and then our unit and daily cater to them to the point where they'll even like make their doctor's appointments or follow ups. If they need to stay here a little bit longer before they can return home. Just, you know, do whatever they can to try to facilitate everything for them. So we have an actual Department for International babies.

**NICU RN** recalled a similar experience and emphasized how the healthcare team practice family-centeredness by addressing cultural barriers that may be presented:

Again, we do have family centered care with the international services if there is any kind of cultural barriers, we try to you know, assess these families in the NICU, we try to learn and understand those and respect those. If there is a language barrier, we will get, translation services. You know we'll get a translator. But then other than that, so we try to support the needs from the other country to incorporate them in the care of the baby. Again, we do have the, the international services if there is any kind of cultural barriers, we try to you know, assess as in NICU. We don't change. But, because of COVID we don't have visiting hours, but we still support them with breast-pumping over the phone. So, every, so we try to support the interaction aspects.

**Mary** admitted that birth tourism families face some caveats and suggested inter-department communication to ameliorate the holistic care for family-centered care. She explained:

It's harder I guess for the parents, like I said, if they don't have the family unit there to help them get through it. It could be a little difficult but, that's where we're trying to get a feel of understanding for them, and we become their family. Again, I think some of the family some caveats, I think we did refer them over to the International department which helped them to get shelter. And because they are not living here, while they're staying here because the baby is in the NICU, they also need to find resources for that family if they don't have family here. They can also help for resources to go back home in their own country, and when

they do go back home, they can help them facilitate to find some type of care. But it's not just international department, they need to work with social work, us nursing and whoever the liaison is in the island where they are from. So I, again, several different departments that can combine to help.

**Peace** affirmed that the international department communication is part of family-centered care and explained the philosophy of her unit. She enlightened:

It is supposed to be part of our philosophy statement. That's a family centered care team where everybody is supposed to participate in family centered care. Yes, international department communicates. For the preemies that end up in the NICU, so those family are expecting to pay for a normal delivery. So, when they come into the NICU, you, they have to work with social work and, they have to pay that NICU bill. So again, when you have rounds or whatever, not the one we do at the bedside but big rounds the one on Mondays. The staff taking care of the baby don't attend that one. That's when the social worker would present, you know, what these families and all these different nuances...Like, you have some that are cash paying families. They too are Internationals and they do pay. Well, as I said, the ones that are here and go through the international department have the contract with the hospital, they have a certain expectation that they will be well taken care of. Okay. And then I think the staff doesn't always know but if they do find out they already have that perception that, Okay, these international patient, they're coming with a contract, we're going to take good care of them.

**Pina** disclosed a disconnection in communication when they forewarn physicians about international patients' admissions, and the nursing staff is not aware. She said:

The family centered care is the same. Whether you are birth tourism, or you're a regular citizen, we, you know, we include the parents of the care of the baby so they could give self-care. They could care for debate, they are just the same at home, whether you're a tourist or you're an American citizen, it doesn't matter. We have an international department, but they are not really geared on for all the families they help families who are from abroad, who are I guess who are, you know, high risk moms who are air-lifted here to the US. There is communication between the international department and the NICU. There's communication between nursing and the International Health Department after the birth, but that's why, you know, that doctors are forewarned. To prepare, like, for example, on this date, we will have an international patient airlifted and then, and then the charge nurse will know. Or the supervisors, but we don't know those things until before they come.

Participant **DJ** shared her bridging cultural disconnection experience:

For me, I mean the only way I tend to find out that it's a, you know, a birth tourism family is during the report there, there really isn't anything in the unit like displayed or on the chart to say that this patient is from, you know, a specific country or Island or anything is just, you know, passed down from nurse-to-nurse through the report. I don't really think there's been too much difficulty in terms of families, you know, being from another country and, you know, I don't think there's any different treatment in terms of whether they're from another country or whether they're actually in the same boat. And then as far as ways for these families or family centered care is that families are always allowed in the unit.

There's, you know, there's really no timeframe that they're, you know, certain changes with you know, Coronavirus has. You know, I'm not going to get into that. But family centered care is as you know, allowing the parent to be there at the bedside with their child, you know, mom or dad or mom with a visitor dad with a visitor. At any time of the day, 24 hours a day. Because I mean, it doesn't matter where the patient is from, we still, you know, provide the same family centered care to everyone.

**Jenny** shared:

We are family centered, which, ideally it means, at least from my perspective, it means making sure that the families that are involved in the care of the patient, making sure that they feel like they're part of the decision making of their baby's care. It's also making sure that they're at they have access to the babies. You know, we have 24-hour access to their babies, they were allowed to visit they were allowed to bring visitors I mean, limited, we didn't limit how many per day especially families from the Caribbean and Hispanic families, we like to bring everybody in.

Unfortunately, **Brianna Padilla** feels that birth tourism families may not benefit the fullness of family centeredness philosophy. She shared: "I feel that the mere fact, that birth tourism families are not from here that they are able to benefit the family-centered care because they don't have family here."

*Bridging family-centeredness* to neonatal nurses is vital to provide holistic care to birth tourism families. Most of the study participants had their perspectives about family-centered care and voiced numerous interventions that make their unit a family-centered

NICU. Nurses' knowledge deficit regarding integrating all aspects of family-centered care is evident and does not include birth tourism families. While some participants lack knowledge about the admission process of birth tourism families and the unidentified core processes of communication, collectively, participants' voices pointed to the need to develop the ability to conduct a cultural assessment to provide culturally congruent nursing care for families of other cultures. Even though a few neonatal nurses did not recall having frequent training on family-centeredness, their strategies revealed disunity in practice, need for educational intervention baseline, and cultural connectedness when caring for birth tourism families in the NICU. Consequently, *bridging family-centeredness* strategies will assure that neonatal nurses are competent to deliver culturally congruent care to infants and their families in the NICU.

### **Connection to a Theory**

In doing this research, one of the primary goals was to identify a nursing theory that would contribute to understanding the study's findings of the lived experience of nurses caring for birth tourism families in the neonatal intensive care unit (NICU). Among the theories considered were: Madeleine Leininger's transcultural nursing theory, Leininger sunrise model; Purnell's model for cultural competence; Giger and Davidhizar's transcultural assessment model; as well as Campinha-Bacote's model, "the process of cultural competency in the delivery of healthcare service." The researcher's careful reflection and considerable examination of each participant's demographic information helped choose the appropriate framework to support this study's findings. Furthermore, scrutinizing the numerous demographic categories such as the participants' number of years in the neonatal intensive care unit and their place of origin helped the

researcher relate the themes to a theoretical framework. Additionally, recounting participants' encounters, interactions, and rich stories shared about caring for birth tourism families in the NICU were supported evidence integral in selecting and connecting the constructs of Campinha-Bacote's 2018 model to the themes that emerged. *The process of cultural competency in the delivery of healthcare services model*, created by Dr. Josepha Campinha-Bacote, is an ongoing process in which healthcare providers continuously strive to deliver care to a diverse population effectively. Within this process's core is the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Through the compilation of these constructs, the model's essence drives nurses to recognize their ability, know their limitations in providing cultural care, and become culturally competent to deliver appropriate care to patients of multiple cultural backgrounds.

### **Chapter Summary**

This chapter discussed the study participants' sample description, and the data collection results, including the themes that emerged for the analyzed data. Explicated data obtained from the formulated phenomenological question were analyzed using Max van Manen's six research activities and the Miles et al. analysis method, which guided the phenomenon of nurses caring for birth tourism families. The strong themes of *recognizing cultural interactions*, *acknowledging cultural consciousness*, *canalizing compassionate care*, and *bridging family-centeredness* were reported and supported with participants verbatim accounts. The researcher also presented the connection of a theory to the findings of this study. Chapter Five explores the study's meaning and interpreted

the findings, detailed explication of connection to the theory, significance of the study to nursing, strengths and limitations, and recommendations for future research.

## **CHAPTER FIVE**

### **DISCUSSION AND CONCLUSION OF THE INQUIRY**

The purpose of this hermeneutic, phenomenological study using van Manen's (1990) methodology was to understand the lived experience of neonatal nurses caring for birth tourism families who admit a newborn into South Florida's neonatal intensive care units (NICUs). This research aimed to give neonatal nurses a voice to express their individual experience of caring for birth tourism families, interpret their everyday experience inductively in their lifeworld, and understand the essence of caring for this population. This chapter presents the exploration of the meaning of the study, discusses the interpretive analysis of the findings, and explains how the themes connect to Campinha-Bacote's 2018 cultural competence model: "The Process of Cultural Competemility in the Delivery of Healthcare Services." Additionally, this chapter also presents the study's significance and implications for nursing education, nursing practice, nursing research, and health and public policy. Finally, the nurse researcher discusses the study's strengths and limitations and provides recommendations for future research.

#### **Exploration of the Meaning of the Study**

The overarching question, "What is the lived experience of nurses caring for birth tourism families in the neonatal intensive care unit?" guided this study. The topic of birth tourism is highly politicized in the media and thus overlooked in the healthcare industry, meaning it has not been evident in nursing research. Although the subject of "caring for families" is amply found in the literature, no studies were found that explored the phenomenon of nurses caring for birth tourism families in a United States NICU. Studies (Arredondo, 2019; Cole & Gunther, 2019; Penn & Watermeyer, 2018) exploring nurses

caring for families of various cultural backgrounds in numerous hospital settings concluded that there are many preconceived biases of these populations resulting in cultural misunderstanding, mistrust, and adverse health outcomes. However, a lack in this inquiry area justified studying the lived experience of nurses caring for birth tourism families in the NICU.

The data collection was from interviewing 22 participants who met the study's inclusion criteria. Numerous data from participants' demographic such as the number of participants working in a family-centered care facility, the number of years working in the NICU, and the number of participants receiving family-centered care training provided in-depth information during each interview. Through semi-structured interviews tailored by the established protocol of by Barry University's Institutional Review Board, the researcher met the aim of giving neonatal nurses a voice to express their individual experience of caring for birth tourism families in the NICU. Expressing their thoughts, feelings, reflections, emotions, and desires, the participants provided the meaning of their experiences.

Moreover, influenced by Max van Manen's six hermeneutic phenomenological research activities, the researcher analyzed the data using the Miles et al. research method of analysis. These chosen analysis methods were to allow the researcher: to interpret the data through one's unique analytic lens and filter, to appropriate a phenomenological structure creating a sense of organizational form, that allowed the researcher to create subsuming themes of this study. Simultaneously, the researcher engaged in numerous activities, including journaling, reflecting, living with, immersing, rereading the data, coding, and reviewing the artworks and descriptions to search for the meaning of

participants' experiences. These activities helped the researcher interpret the data to gain a deeper meaning and understanding of the phenomenon's essence.

Inductively interpreting the study participants' everyday experience in their lifeworld led the researcher to uncover the emotions, compassion, strengths, and challenges of neonatal nurses encountered when caring for birth tourism families who unexpectedly admit sick or premature newborns into the NICU. Four overarching themes revealing neonatal nurses experience interpreted as funneling cultural care for birth tourism families in family-centered NICUs through continuous phases of: *recognizing cultural interactions*, *acknowledging cultural consciousness*, *canalizing compassionate care*, and *bridging family-centeredness* emerged from the data. The researcher then connected the themes to a theoretical framework, the Campinha-Bacote's 2018 cultural competence model: "The Process of Cultural Competemility in the Delivery of Healthcare Services", which connected the ongoing process in which nurses effectively care for families of diverse cultures.

To ensure the trustworthiness of this phenomenological study results, the researcher implemented rigor throughout its analytical process. Van Manen's (1990) hermeneutic attitude during writing phenomenologically requires going back and forth among the various level of questioning, doing justice to the fullness and ambiguity of the lifeworld experience, re-thinking, reflecting, and recognizing aiming to create in-depth writing. Trustworthiness aims to support the argument of the inquiry's findings (Lincoln & Guba, 1985). Lincoln and Guba (1985) proposed four alternatives for assessing trustworthiness in qualitative research: (a) credibility, (b) dependability, (c) conformability, and (d) transferability. *Credibility* established through the researcher's

extended tasks was complete through triangulation, member-check, reflexivity, memoing, and following van Manen's recommended hermeneutic activities to yield thick, rich descriptions from the data. The researcher also ensured *credibility* following the protocol established by Barry University's IRB during recruitment, data collection, and analysis. Practicing reflexive journaling throughout the study, also verifying the transcribed data with participants, investing time and clarifying misinformation with participants, and consulting research chair and committee members for feedback on interpretation of the data ensured *credibility* in this study.

The researcher recorded all interviews and adhered to the rigorous systematic process of qualitative research to ensure *dependability*. *Dependability* was achieved by the researcher's examination of the raw data, creating an audit trail using a step-by-step approach, explaining the method used and analysis completed, and having participants review the transcribed interviews. This researcher then engaged in confirmability. *Confirmability* refers to controlling biases and was accomplished by the researcher setting aside all preconceived notions, ideas, and presuppositions in reflective journaling. Reflective journaling to record personal assumptions and use of insights to control biases. Maintaining an audit trail, also transcribing interviews verbatim, and rechecking for errors were used for *confirmability*. According to Lincoln and Guba (1985), *transferability* is the ability for this study's findings to be applied to another population or setting. The nurse researcher adhered to Creswell's (2018) strategies, which were: a well-written methodological approach; a thorough description of participants; thick and rich descriptions of meanings; the broadest possible range of information to allow judgment; provision of a paper trail, thereby furnishing opportunities for replication of results to

ensure *transferability*. Moreover, to accomplish *transferability*, the researcher collaborated with the experts' research committee to guide the dissertation process.

### **Interpretive Analysis of the Findings**

In qualitative research, interpretive analysis of the findings means digging into the findings to understand what lies beneath them in the sense of looking at the information at hand and creating meanings. This study's participants collectively expressed various experiences of caring for birth tourism families and their infants in the NICU. Through data analysis, the researcher made sense of the large amounts of the collected data by reducing the raw data, identifying what is significant, and constructing a framework for communicating what the data exposed. The revealed themes of *recognizing cultural interactions*, *acknowledging cultural consciousness*, *canalizing compassionate care*, and *bridging family-centeredness* not only informed the posed research question in this study but also summarized the discourses of neonatal nurses into finding the essence and lived meaning of the experience.

#### **Theme: Recognizing Cultural Interactions**

In the nursing literature, *recognizing cultural interactions* refers to the process of identifying an engagement with or a direct nurse-patient encounter involving patients from culturally diverse backgrounds (Campinha-Bacote, 2002; Giger & Davidhizar, 2002; Leininger & McFarland, 2002; Otuata, 2019; Purnell, 2021). Denoted by contact, communication, and healthcare information exchange, cultural interaction happens continuously when neonatal nurses care for infants and their families in the neonatal intensive care unit (NICU). According to Campinha-Bacote (2002), cultural interaction is an ongoing process of cross-cultural communication that is verbal and nonverbal between

individuals or groups with a mutual understanding and respect of each other's values, beliefs, preferences, and culture to promote equity in healthcare. In this study, participants of diverse cultures caring for premature and sick newborns encounter, interact with, and incorporate the families of diverse cultural backgrounds. These actions are funneled throughout the essence of caring and reflected in the theme of *recognizing cultural interactions*. The findings of this study supported by prior research (Beirne, Bradshaw, & Barry, 2020; Butrin, 1992; Gallagher, Shaw, Aladangady, & Marlow, 2018; Tavallali, Jirwe, & Kabir, 2017) indicated that cultural interactions made is exclusive of nurses caring for infants with families of culturally diverse backgrounds. However, unrecognized cultural interactions cause miscommunication, impacting the infants' health outcomes and well-being (Beirne et al., 2020; Butrin, 1992; Gallagher et al., 2018; Tavallali et al., 2017).

Participant **Indigo Durand** disclosed that recognizing birth tourism families is grim at times. She said:

I think that I know, like it's sometimes difficult but, I'm able to identify the ones that are coming from another country when they show that they have the means to, you know, like, the well off from other countries. Their country may have some economic situation, or the people there are really, really, really, poor. But I will say, because, they have the means... they are not afraid to say, Okay, so I'm in this country because I'm gonna have my baby.

**Mary** also recounted:

For me, personally, I guess their background and their culture is what you really should be looking at, but you can tell how they perceive the difference in our

healthcare and the way we carry around with them. The way we give their baby care. Also what their needs are, what they have and can't have or provide. That's where we would try and step in and help. But I think it's usually how they come in, what they ask for.

Similarly, **Nurse Nancy** added:

I don't think there's a specific way to identify them. We don't point anybody out. I think we treat everybody the same. So I don't think they are identified. Talking with the parents and communicating with them, then we find out that they are not from here.

**Mari** reacted to a nurse-patient encounter as a cultural interaction yielding to a cultural bonding with birth tourism families in the unit. She said:

So hearing birth tourism, one family did come to mind automatically in she was from Dominican Republic. We ended up talking and I ended up bonding with that mom. I asked her if she was a first-time mom because she will need more teaching and help to take care of the baby.

A qualitative study by Butrin (1992) examined nurse-patient encounters and determined that there is cultural diversity during the interaction between nurses and patients of diverse cultural backgrounds. However, nurses and patients expressed mutual satisfaction in caring; thus, there is incongruency in the perceptions of the encounter due to nurses lacking knowledge of cultural differences and a mutual dissatisfaction due to expressions of language difficulties. Participant **Pina** elaborated, "I don't really know until the parents themselves tell me. Like they don't tell you that... actually, they say (Oh, I just came) or (Oh, we came from), for example, (Argentina...)."

**Valeria** also echoed:

You know sometimes there is the issue that some of the parents are very weak about the language if they are from somewhere else, so they don't talk. Okay. See it's hard because you have some difficult families that we deal with and some kind of parents because they don't know why they act like in ways that it may be normal in their cultures or have expectations end maybe in their country it's like respect but from our culture here it is not viewed as a respected thing. And then it's hard is hard is like multiple cultures so it's, it's not easy for the nurse to deal with all this stuff.

Another qualitative study by Beirne et al. (2020) exploring nurses' perspective of caring for infants born of parents belonging to the traveler's community, recognized that the culture, specifically culture of the traveler's group, has a significant influence on interactions and decision making while in the neonatal unit. In the context of this current study, **Bella** stated:

Yes, I remember a couple from Argentina I have to say that maybe the biggest issue for them was like the anxiety or how they're gonna deal like with the different emotions, the finances, the complications of the babies because remember, these babies were born prematurely while they were traveling on occasions for a vacation.

**Peace** shared:

The experience I've had with those families that came with the Baptist agreement, were that those families were pretty well to do in their countries. They traveled frequently to the US on vacation, for example...they kind of had an idea of what

the healthcare was supposed to look like. And they were very distraught. Because they were telling them, you know how the spinal bifida is really bad. And eventually the baby left and actually left, to go for surgery at another children's hospital and then came back to this hospital finish his course of treatment before they went home. And then like three years later, they came back to have another baby and the baby ended up in the NICU. And then, at that time, they came in they asked specifically for me to pick up the baby. Yeah. Well, I think I was able to appease them to, you know, not make them have a smooth transition, but kind of let them know that yes, I understand what's happening. They told you this, and this may happen, this may not happen and actually the baby ended up doing very well.

In a qualitative inquiry, Gallagher et al. (2018) explored parents' experiences toward nurse-patient interactions when their admitted infants are in the NICU. Numerous issues emerged from the data, such as infant's admission impacting parenting transition; consistency of care and dissemination of information, hindering parental perceptions of respect and humane touches, as well as communication, including hindering parental autonomy, trust, parental expectations, and interactions on the neonatal unit. Participant **Loana** expressed how the pieces are put together during nurse-patient interactions with birth tourism families. She stated:

Um, let me see. It depends. Sometimes, you start finding out information and putting all the pieces together...Sometimes, you end up saying...Oh, okay, so... I don't really think this person came here on vacation...I really think this person did come here to get this done for this baby. Because...as you go back on the

history of the patient, like social family history, pregnancy history and all of that...you can put the story together...little by little.

**AnnaV** expressed:

For these parents with a premature infant, they are typically frazzled because not only that they are not home, but they are in a scary situation. And even for a family that chose to go down this path. They are still anxious because they are not home. So they are anxious with the finances. So, it is self-pay because they don't have a package with the tourism, then the NICU stay is usually not included in that package, and the amount of money that they face to be responsible for or they worry about is a substantial amount.

Researchers Tavallali et al. (2017) described the expectations and experiences of cross-cultural care encounters among minority ethnic parents, which involved three categories: fundamentals in nursing, cultural sensitivity and understanding, and influencing conditions. The data yielded that language skills and bilingual nurses' availability in a multi-ethnic society can facilitate communication and increase parents' satisfaction in cross-cultural care encounters. Similarly, in this study, participant **Valeria** narrated her encounter with a birth tourism family from her country of origin. She said:

One of them, I remember I clear tried to talk to them to try at least. I am from Brazil and speak Portuguese, and to remember the name, but I could not remember the name of the patient and, you know, in all, nobody remembers all their patients' name. But I remember them it was like a woman from Venezuela. She had twins like a couple of twins, and one of the babies went home fast, but the other one ended up staying in the NICU. Because the baby had some issues.

They were skin issues. This forced the babies to stay longer than the others in the NICU. But the problem is, they only spoke Spanish. Because they were rich, and so the father gave her the support with the finance, and they even had a nanny. And she had the nanny come into the unit to take care or learn to take care of the baby. The nanny needed to learn how to take care of the dressings for the baby and everything else for the baby. So that part is important to be able to understand the teaching.

Interestingly, **Gina Martin** shared:

But me since I speak Creole, so it was a little better. So whenever they see me like I had their baby, it was different because they were able to communicate with me. I was able to communicate with them, give them updates better. Tell them what is going on with their baby. And whenever if I do not have them, I was able to, to speak for them. You can see they were a little more like okay, oof! at least somebody can tell me what is going on with my baby. So the stress level for sure was higher, was high. And in the NICU, of course, communication is a big deal. Because they, they need that. They need to be able to understand what's going on with their kids. And be able, they were able to communicate with me not only as their nurse, but I, my God I was like, I understand that, you know, I understand them. Whenever they come in a different mood, I can understand the. It is different than someone from a different place who does not even understand nor not able to even communicate with them, you know, in their own language as well.

**NICU RN2** recognized that the family's culture was very different from hers. She said:

There were some challenges there ... like with the male position, you know, when I spoke to them, the mom kind of had to have not only her head covered, she kind of also like took a step back and dad was kind of the primary speaker. So also language barrier, right. So dad's English was much better than mom. You know, "ella puede hablar" ("She can talk") but not as good. So the dad was the primary talker. Again, this was totally difficult because of language, and as part of their culture, the women just kind of take a step back.

In summary, the researcher found that the essence of caring is reflected in the theme of *recognizing cultural interactions*. Participants' actions of caring were revealed that by contact and communication with birth tourism families, cultural interactions occur and are continuous. Neonatal nurses caring for birth tourism families in the NICU require the funneling of *recognizing cultural interactions* as an ongoing process to promote cross-cultural communication with a mutual understanding and respect of the other's culture to promote equity in the delivery of healthcare.

### **Theme: Acknowledging Cultural Consciousness**

The American Nurses Association (2001) posited that nurses must acknowledge differences in attitudes, beliefs, thoughts, and priorities in different patient populations' health-seeking behaviors. This acknowledgment postulates diversity awareness to reflect the nursing profession's contract and responsibility to act according to the nursing code of ethics, which demands to be aware of one's attitudes, beliefs, thoughts, and priorities in providing care to individual patients, families, communities, and populations of diverse cultural backgrounds (American Nurses Association, 2001). Literature suggested comprehensive studies (Campinha-Bacote, 2002; Giger & Davidhizar, 2008; Korten &

Sahtouris, 2001; Leininger, 2002; Purnell, 2005) that addressed the delivery of nursing care to groups of patients with culturally diverse backgrounds. These studies explored the nursing care delivered and revealed that the care was framed under concepts, theories, and models of transcultural nursing, as well as culturally competent nursing, cultural diversity in order to deliver culturally congruent healthcare to patients of diverse culture. Among the few models, Campinha-Bacote's (2002) cultural competence model in delivering healthcare services holds a construct known as cultural awareness, which encompasses the concept of cultural consciousness, asking nurses to consciously acknowledge their own culture and avoid biases toward other cultures to be able to work in a culturally diverse environment.

In this study, *acknowledging cultural consciousness* in connecting with the model refers to the participants telling their experience of understanding the concept of birth tourism and their sensitivity, the subtle opinion-forming, their awakening of perceptions, and the biases toward birth tourism families. Cultural consciousness is a central element of healthcare delivery that integrates clinical knowledge, sensitivity, and cultural understanding and is necessary to deliver not the same care for all families in the neonatal intensive care unit (NICU), but culturally appropriate care to birth tourism families (Alexander-Ruff & Kinion, 2018). Prior research (Alexander-Ruff & Kinion, 2018) evaluated 30 future nurses' cultural consciousness perceptions when caring for a Native American community by using an intrinsic case study in situ of clinical experiences' reflections. These researchers' tacit assumptions did not match the results of the study. Although at the end of the study, participants improved their clinical assessment, nursing skills, and intercultural communication, two-thirds integrated their preconceptions with

this population into caring for Native Americans. In this current study, participants expressed their worldviews, feelings, concerns, and the importance of giving care to birth tourism families who travel internationally to deliver a well newborn.

**Pina** acknowledged not taking a left or right stand on the act of birth tourism practice, nevertheless, subtle prejudice may cross the mind. However, the care she gives is the same. She said:

For example, I think we have had a parent from a South American country come here, because she's high risk pregnancy, but she wants to come here on a dual motivation to have the baby here and also to be well taken care of and also to have an American citizen, I'm not against that. Yeah, some nurses said, Oh, they just want to have an American citizen. They do talk about it once they know. Okay, I do think it's the discrimination to the parents but not the baby. I don't think they've been labeled as birth tourism. I think we know them more like the families who, they just want the baby to have an American citizenship. Nobody has really heard of people birth tourism it's not been mentioned in the unit. But biases? It could cross someone's mind, but I don't think we give less care because we know Oh, they just had the baby. Because, you know, they're, they want to have an American citizen. I don't think we give less care because of that; you know, I think the care is the same. Although, you know, it would cross someone's mind. Oh, you know, but we care for babies just the same.

**Peace** narrated:

They are those international patients they don't live here. They just come here to have a baby. I have cared for them. Yes. I don't think that birth tourism should be

treated as an illegal act. Around...the staff would feel that, okay, they're here taking advantage of the US, Medicaid and the US food stamps and they're just here to take advantage of what the US have to offer. As opposed to the family who we know are paying for the hospital. You know, I need to treat everybody the same way. Yeah, I mean, yeah, some of the staff would treat them like, really bad. We know by like, comments, {they don't even have a car here and they come and have a baby, how are they going to get on the bus to go to the airport with a baby. We have to pay for that too?} Those types of comments. You know: {have a baby when you can feed baby} Or, all these types of comments that they make. Similarly, **Mary** verbalized:

But I think it's a plus if they become citizens, but I don't think that's what their game plan is. They're just looking for care for healthy birth. America is open to everybody from every country, every form of life. If you have the opportunity and you're able to come here to have a safe delivery, then I don't think you should make it an illegal act. No, I mean, at the end of the day, it's the birth of a child. Everyone is treated the same, no matter if you have coverage or you don't have coverage, our oath as nurses, are to provide the care that is needed, regardless of where that family, they come from, or degree that they can pay or not pay.

**Loana** unveiled that:

All that care, like this kid had a syndrome. He had a tracheostomy, he was a kid that was going to need home care, medication, all of these things for life, for as long as he lives, and from what I remember, everything was approved through Medicaid and here he is. His status is that he is one of the best paid baseball

players back in the Dominican Republic. I mean, I always go back to what my duty here which is to save lives treat the person as a human being regardless of whatever however they can pay and however they get here and however you know you're not gonna let somebody just die in your face and not give them the exact same medical care just because you in your eyes is not right the way they came here.

Not *acknowledging cultural consciousness* regarding providing culturally knowledgeable care hinders nurses' competence to provide excellent and effective nursing care to culturally diverse patients. A study by Markey, Tilki, and Taylor (2017) revealed feelings of uncertainty and ambiguity of how to act when faced with a lack of cultural consciousness. In this grounded theory approach, the researchers explored the experiences of nurses caring for patients from diverse cultural, ethnic, and linguistic backgrounds. The findings added new perspectives to understanding enablers and barriers to culturally sensitive care. Similar experiences were found from participants of this current study. **Valeria** vividly painted her understanding and views:

Okay, because some definitely are rich, maybe they pay the bill, I don't know if they pay or not, but most of them, they take their child, go back to their country. And then, these babies grow and these individuals, in the future they come back. You know, because the kids already are citizens, they have the birth certificates and then they come. These citizens when they are born, they are born here, and the parents plan to come, and they are not going to pay. They're not going to say that. But they don't pay. Because then, you know, they come and manipulate the system. And because, of course, you cannot neglect them, you cannot say that you

can't travel to another country if you want to have a baby. We have an EMTALA. So, they need, they come here, and you treat them good, and they have their rights. So, and they know that. They come. They're here and you cannot say no. I think about the negative things they say about that. Because I'm Brazilian and I think the settling of it all they are right to come to have a better life so I'm not the one who is going to say something to them or to even treat them different. No.

**Indigo Durand** expressed:

Hum, honestly, I feel that the title itself, to me, sounds a little like its discriminatory, because...I'm a mom. Because when you say birth tourism it's like okay, I'm pregnant and then I travel to another country to have a baby. So what? Because first of all, maybe in the other country my baby will be able to have a better chance in life. I don't think that it's just because if the babies are born here, they're going to be able to have that nationality of that particular country...also, in most of the ones that I have had, are people that are actually well off in their countries. And even though they are well not in their countries, they have the opportunity to come, which, their countries are complicated and problematic from political standpoints violence and poverty. Because sometimes it is worth, to express what you think about that, and say what your opinions about negative perspective on birth tourism. I guess because I'm an immigrant and I came from. I came when I was 12 from Colombia. To me, a lot of people are ignorant about the situation of some mothers, ignorant, and lack of empathy and lack of understanding.

Participant **Sandra** explained:

Initially, they were hesitant. It took a lot of... it took a lot of time, you know, time and getting adjusted to the routine. Getting familiar with people, so it took time but, in the end, yes Well, I didn't tell these parents where I was from. They sensed they had some comfort, because I'm Indian as well. However, I don't speak the language, just different culture. I was born here. So I think they'd be that little sense of familiar, familiar, familiarity helped them. But also, I, just spending time and having the staff come and talk to them and creating a family in the NICU itself, you know, making that the new norm that helped them a lot. So With time, it just became their norm. They were very hesitant. They were like really hesitant, very scared. Um, and I, you know, they wanted to also have a more holistic approach when it came to the baby which we were able to incorporate them into the care. But in comparison to an American family, I just think, that they were very hesitant because sometimes they don't want to ask but perhaps even feel comfortable to ask. So with time it got better though.

Participant **Jess** expounded that biases exist already. She explained:

Yes, absolutely. Think about what you just said, there's a bias already predetermine. Why am I going to form any relationship with anybody in Baptist Hospital? I don't think if I was the patient, and I came here as international tourist that I would actually have anybody know that I came here for that purpose. I think it would just be, a oops! I wouldn't reveal to people that I came here for that purpose. I think people do that. I do because the biases have already been made. Like I said, why would I want anybody to take care of my baby who's looking at me with inferiority. And where any thought process would be that, "oh, she just

came here for the purpose of having an American baby and return to her country. She wanted to have an American kid. She wanted our resources. I would not reveal that to anybody.

Markey et al.'s (2017) research raised questions unanswered in the existing literature. This study explored why nurses feel that it is acceptable to choose to do nothing about their lack of *acknowledging cultural consciousness*. This inquiry emphasized that identifying the nature and implications of nurses' feelings about a particular culture or of the uncertainty or lack of cultural knowledge when providing care for patients from diverse cultural backgrounds is an essential contributing factor to improving cultural sensitivity and quality care. This current study's findings consistently describe attitude, knowledge, and perceived understanding of birth tourism families in the NICU. **Mari** said:

That's the memory that came that comes to mind that's very specific, like she came from the Dominican Republic to have the baby here. Someone like this, that is pregnant and one's the baby to be born in another country, where is better, where they have better resources, better care better, everything. But other people, You know, it's, I don't know what the word is taking advantage, you know, because if you're not from here, if you don't live here, you're using the other country's resources I don't want to use the word responsible because, I don't want to sound like it's a judgment, but it's a very difficult thing to do, difficult decision to make. I don't know if I 100% agree with birth tourism.

**AM** elaborated on *acknowledging cultural awareness* regarding the practice of birth tourism. She described:

So they come to have the baby here with a diagnosis already at hand. I don't really agree with it, because I do believe that a lot of people do it in order to get a US citizenship for their baby. So then that they can come legally later when their kid can file for papers for them. And they pay like, you know, whatever from ten thousand to fifteen thousand dollars with a maternity package purchased with an OBGYN, and they stay at the hospital, but then, they come to our facility. Now that baby is a Medicaid baby.

**Brianna Padilla** said:

And I know a lot of the times people from like the Dominican Republic or Venezuela as well, even the Caymans will come to deliver with us because they know that we can help their child out. I'm not very big into politics and all that so I don't know the whole thing behind birth tourism. No I don't think that it is illegal. Yeah. I think that some nurses just think that these international moms want to have their child they want their child to be an American citizen. So they just, you know, create the means to be able to have the child here. So, some nurses tend to be a little bit biased about that, because these families they want the benefits or perks from here. Um, I mean, I tend to ignore them and because everybody has their own bias and things, so I tend to ignore it unless they're being rude or something and, but generally, I just tend to leave it be and let them think whatever they want to think and keep going.

**NICU RN** expanded on her conflicted emotions in her consciousness. She said:

I guess I have, probably, mixed emotions. I don't think that it should be illegal. I think that, ultimately, it is, basically, beneficial because it can help the economy

because they purchase a package for the birth care. So, in that it stimulates the economy. Where I'm conflicted is that this might be very difficult for policies and how do you define what could be and what couldn't be in the financial legal part. I do have a concern about is when there is a required need, more need for the baby and the baby is, in the NICU and once the baby is in the NICU then then a lot of times These parents don't have the insurance to cover the new costs. And then they now, need Medicaid for the baby which now starts draining from our economy.

**Loana** expounded:

The mother came here alone. She delivered her kid here with problems. A surgical problem and in the baby were taking care of here in our NICU. And then when we asked, you know, are you planning to go back for the follow up and all of that. And she's like, absolutely, I came here to deliver the baby, to give the baby a chance to live and, I'm going back to my country. So, you know, we've seen it all, from one extreme to the other. I wouldn't call it an illegal act because at the end of the day, the kid was born here was ...was sick enough to be here long enough, it's an American birth. It's a kid that was born here. So I mean, what are you going to do these kids need, we're not going to let them die or give them less of medical attention just because for parents decided to come here. I just think it's more like That part is more like political than anything. I think it's unfair that there are other kids that are born here that their parents are from here, they cannot get Medicaid because their parents, they don't qualify because the parents make money.

The findings in this current study are consistent with the literature (Hart & Mareno, 2016; Marshall et al., 2017), reporting that health care professionals, including nurses' perceptions of *acknowledging cultural consciousness* to be at a moderate level of cultural awareness and unconscious bias, a low level of cultural knowledge and preparedness, and comfort in delivering cross-cultural care, therefore posing challenges when caring for patients and families from diverse culture. Participant **DJ** proposed that although they choose to remain silent when faced with co-worker negative comments about birth tourism families, she knows the biases. Participant **DJ** said:

I again try not to judge. I just think it's just a choice. I do think of biases. And it's unfortunate. Because like I said, again, people have choices. And what's even crazier to me about that is that some of the nurses who themselves have these biases were either immigrants or migrated here themselves or maybe even have family that migrated here and even though they were born here....to have those biases in my particular work environment is I just don't get it. You know, there are certain things you wish or would want to stand up for. And also, I guess there's times that you should know when to kind of pick a battle or pick a fight, and that you just remain silent. I would I think most of the time, I kind of fall into that latter scenario knowing when to pick up battle and most of the time just kind of staying silent.

**Gina Martin** narrated:

But yeah, to be honest like that, I don't really have any negative feelings towards it. I feel like some people they need it, because that's the way for them because, the majority of them that do it, they have a visa here. And their kids now going to

be a citizen here, so they can give them the opportunity to have their residency as well you know. So that's how. Maybe it's an island thing. Other situations, No, I don't think it's illegal. As long as the person come with a plan of having their baby, and then three days, four days they leave the hospital and spend a couple days here and then go back to the country if that's their plan and pay for it, I don't think it should be illegal. And I feel like the mom that comes, have the money plan for that. It becomes a problem when the NICU part comes in, I think that's when it becomes a little like a problem.

**Sandra** also expressed her feelings and said:

I think maybe, that might be, or perhaps the perception. I don't think ultimately it changes the care though I think that there's like a stigma but when it comes to the care of the of the baby itself I, I'd like to think it doesn't. Yes, if it's a high risk pregnancy, that they will be allowed to come here and give birth. I feel like or if a baby is to be born here and actually, they get citizenship. I feel like perhaps it is to be stopped or dependent on like, what kind of quality of care these babies need.

**AnnaV** disclosed:

So to me birth tourism means a family that has either planned or inadvertently had a baby in a location that was not their home. I have had families from Central and South America that have planned to come to United States, and some families that have gone into preterm labor, while vacationing and had their tourist visa for a certain amount of time or going through the United States on a stop overflight to the Caribbean and they've been transferred to have their baby all of a sudden and the baby end up in the NICU. The whole thing in general, I think, that it is illegal.

So I have mixed feelings. Some people come just to have a delivery. and then they go home. And that's okay, you know, they don't incur any issues. But some people.

In brief, participants' experiences revealed that *acknowledging cultural consciousness* when caring for birth tourism families in neonatal intensive care units demand to be aware of knowledge, feelings, attitudes, and preconceived perceptions during cultural interactions with families of diverse cultural backgrounds. The participants voices yielding the interpreted theme of *acknowledging cultural consciousness* is viewed as a pragmatic approach whilst addressing the needs of neonatal nurses to provide nursing care from a sensitive and humanistic perspective. This awareness ensures equality of care delivery across all patient populations and cultures.

### **Theme: Canalizing Compassionate Care**

The feeling of compassion lies at the intersection of caring with empathy or sympathy, which, when combined, produces a response of caring for others' distress and a desire to alleviate that distress (Altimier, 2015). Compassionate care is embedded in nurses' professional standards and codes of practice is fundamental to nursing manifested through the vital skill of caring (Benner, Tanner, & Chesla, 2009). Caring and compassion are often synonymously utilized to illustrate or describe the feelings or actions of giving care. According to nursing theorist Jean Watson (2008), caring is an individual of three dimensions of mind, body, and soul, who is a being, and whose wholeness is valuable and deserves respect, assistance, and care, seeing and giving to another of the same being and wholeness and dimensions. Nurses caring, therefore, provides compassionate care. All 22 participants of this study explained their actions of

*canalizing compassionate care* through their stories of caring for infants and the birth tourism families. In the nursing literature (Campinha-Bacote, 2002; Davidhizar, Giger, & Hannenpluf, 2006; Leininger, 1991; Purnell, 2002;) characterized compassionate care associated with caring and culture in numerous theories, models, and frameworks delineating intercultural and transcultural caring where nurses create compassionate partnerships with families of diverse cultural backgrounds. The emergence of this theme *canalizing compassionate care* was significant as participants described caring for infants and birth tourism families with words such as “empathy,” “caring from the heart,” “support,” and “sympathy.”

In a study conducted by Molala and Downing (2020), the researchers revealed that although nurses experienced an overwhelmingly stressful environment and uncaring relationships, participants shared their compassion, their humanity, and transpersonal caring with patients and parents and perceived the need for knowledge, skills, and the essential human virtues of compassion and humanity to offer holistic care. The literature findings are in sync with participant **Valeria** who describes her caring as follows:

I take care of the babies some are very sick and when families come, we have to talk to them, and we teach them. Breastfeeding and feed the baby and change the diaper. I wouldn't say, it's special because like I treat one better than the other. I always treat everybody the same. I don't care if they don't speak the language, or some are angry at time. So for me, they are the same and I am a nurse, so I treat everyone one of my patients every one of them equal.

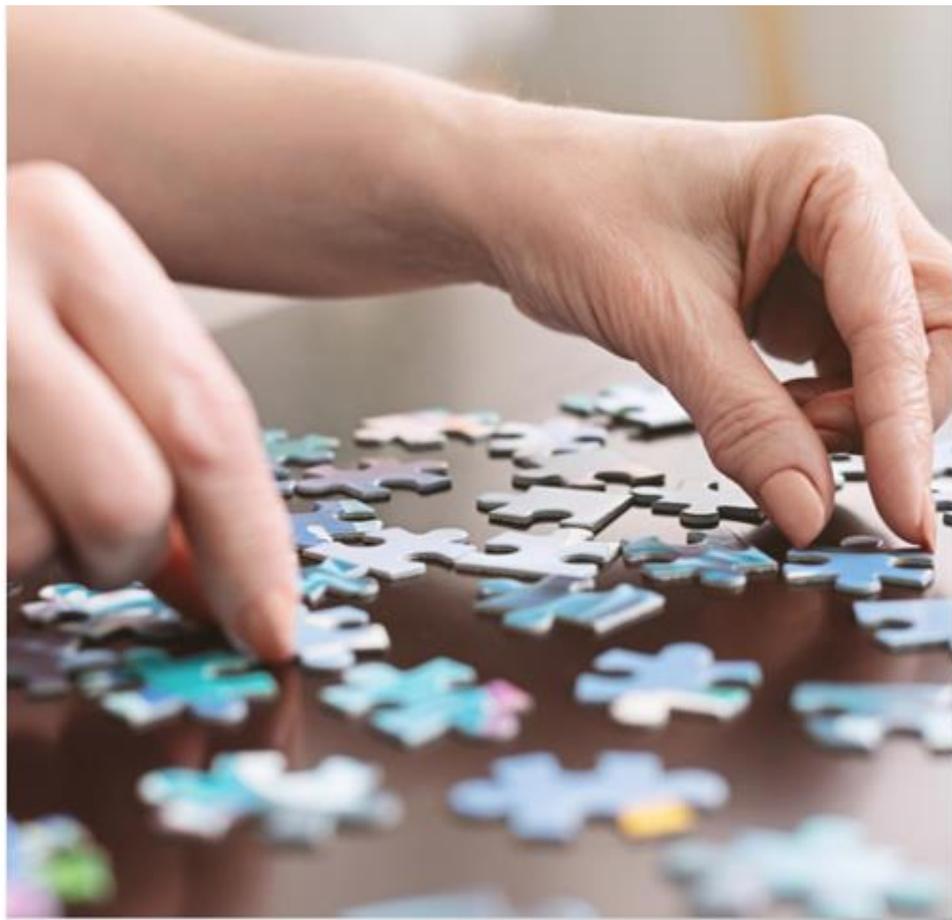
**Participant Jess** explained:

The quality of care is standardized across in the NICU. Everybody received the same compassion and the empathy that they should receive and that is built in the NICU. We try to make sure to parent's needs are met, the parent involved the infant, or the family while they are with their infant. And I really don't think there's a difference between the patient that is there for birth tourism versus the average person who is an American has a kid in the NICU, I really don't think there's a difference in the quality of care.

**Indigo Durand** stated:

Now within the whole caring thing. If there are parents there, I will, you know, I have to incorporate the parents in the care. And then I teach them how to do a diaper, then I teach them how to give a bath to their baby, how to hold them and how to wrap them. And then if the baby is able to come out of the incubator for them to have kangaroo time. Many of the parents are usually first time parents, and they have no clue how to take care of the baby, plus the fact that they are so anxious and worried about why the baby's there, They don't have that natural course of when you have a baby and the baby stays with you and your instinct kicks in, they go through this broken interaction. So it's a puzzle. Because these moms, not only that they come from another country, but they are also in a country that they are not from. Pregnant. You already know that when you are pregnant...you have so many needs. Emotional and spiritual needs and they are coming of another country to have their baby and boom their baby needs to be in the NICU for whatever reason, prematurity or that the baby needs some type of breathing help. I wish that we could understand, all of us, that the first connection

that the mom has with her baby we all go through that and the mom comes in for the first time and she sees her baby and you know. Either if it's a c-section or a vaginal delivery. Figure 4 is a conceptual representation adopted by Indigo Durand illustrating her experience of caring for birth tourism families in the NICU.



*Figure 4.* A puzzle. (Conceptual representation adopted by Indigo Durand, 2020 from Goss, 2020)

**Anna V** made her contribution by voicing her ways of caring with compassion through achieving nursing tasks and helping the family:

Um, first things first, you know, check your stuff to make sure your orders are all right, make sure your data is correct, get to know the families. And depending on what the babies need to whatever's next for them on their schedule, their

predetermined schedule. I try to keep it, You know, for what their baby schedule is, you know not to rock the boat, work with the families. Caring means, carrying the doctor's orders, helping the families all care for their baby and care for themselves, helping me lead the multidisciplinary team, they should know that at best. Um we try to do minimal touch for the little ones we're trying to do as normal as possible to routine at home with the bigger ones, so that they transition well. And caring for birth tourism families, Okay well, because it's been difficult for them, you know, it's so varied. But I think with compassion it will have to be a kaleidoscope. A kaleidoscope of hope. They all just come with hope. Yeah, yeah. At the end, that's a pretty thing. Hope, I think that everyone who comes here want the same thing.

Figure 5, “*A kaleidoscope of hope*” drawn by participant **AnnaV** depicts her experience of caring for birth tourism families in the neonatal intensive care unit.



Figure 5. A kaleidoscope of hope. (AnaV, 2020)

Babaei, Taleghani, and Kawanara (2016) in an ethnographic study involving 20 Iranian nurses and 12 patients explored the compassionate behaviors in different cultures. The data collected from this study described nurses' compassionate behaviors closely related to cultural issues formed by communication between nurses and patients and nurses and patients' families during nursing care. The research recommended that to improve compassionate behaviors, nurses need to train on holistic and patient-centered approaches, and implied considering compassionate care to make changes in culture caring environment. In this study, the participants' responses pointed to the same descriptions. **Loana** desired not to provide art to illustrate rather explain her illustration of the care provided to birth tourism newborns and their families. She expounded:

Caring as a nurse. It means for me to not only take care of the medical part of the patient, but looking at the patient in a holistic way, not only health and medical needs, but also social needs, emotional spiritual needs, knowing how to canalize everything to the right person that can actually take care of every single aspect of their life...to illustrate the care I give, it would look like moms from different cultures, from different family compositions, with different kids in the NICU with some able to grow and thrive and others having a hard time with no follow through. So some kids in difficult situations. So what well, I think that we need, we need to be more culturally competent. And try to, you know, to have more available resources to you know, to deal with language barriers.

**Nurse Nancy** affirmed that there she pays attention to the different cultures to give holistic care. She said:

I think recently, I had a family who came from Haiti, and had their baby here. I, actually, I think they came here because the care would have been better for their baby here versus in Haiti because, it was pre-determined that the baby was going to have some health issues. So, I believe they came to the United States for better health care. Um, they're a very caring loving couple, very appreciative. I do feel like we did provide the care that we could. In the long run, the baby was transferred to another hospital here in Miami and passed away. So. Okay, caring for these families. I mean, I guess maybe a broken heart, you know, like, the sad emoji you know. You know, you feel like you're giving 100% and you just feel like you could do more. I would say a crying sad emoji. That....is compassionate care.

Figure 6 depicts Nurse Nancy's conceptual representation of her experience of caring for birth tourism family.



*Figure 6.* The sad emoji (Conceptual representation adopted by Nurse Nancy, 2020).

**Gina Martin** stated:

The word caring cannot define, I mean, taking care of the baby is with your heart. I will say, with, the knowledge you have and the compassion and ... I guess. Let's say, for example, if you were to do an IV, for example, you're going to use

sucrose. And I feel like sucrose is part of caring...I remember...the parents they were from, they were from Haiti. Umm, you know, I was very happy actually to be able to take care of them. Whenever I went to work, I always wanted to take care of them. Why because of the language issues you know, these, I feel like as a parent when you have your kids in the NICU, every day is a different thing every day you come you're giving you different updates and, and if there's a big procedure happening, and if you, if you don't understand what you're telling you, it become more stressful. And so, I remember I as a primary, and because we have something we call, primary, primary nurses. So whenever you are work really You are the one who takes care of the same baby every time. That they may have the same nurse every time until that Baby gets home. So I was able to do that for them. And you have a, like, I said the communication part was a big thing. And in the NICU, of course, communication is a big deal. Because they, they need that.

A group of researchers, Papadopoulos et al. (2017), conducted an international online survey involving 15 countries exploring understanding and demonstrating compassion in nursing practice. The research revealed the impact of sociopolitical influences on perceptions of compassion and the importance of compassion and rendering compassionate care. Subsequently, the findings from this study results connected to Papadopoulos et al. (2017)'s results in the context of the common perceptions of the attributes of compassionate care and the importance of *canalizing compassionate care* in the delivery of nursing care.

**Peace** admitted:

Well, caring is basically, taking care of the whole person or the whole baby and the family you know, to take care of their physical needs as far as the patient is concerned, and then for the family will take care of their psychological needs and whatever else you may need while they're here at the hospital. Okay. For the family that I have taken care of we're here because my hospital had an agreement with their insurance company. So those are considered birth tourism also. They don't live here. They just came here to have a baby. The challenges that they have, because they came here to pay cash, not acquire another bill. So then, you know, we have to find them all these resources give them ways to see if they can get Medicaid for the baby. Once the bill gets to a certain point. The baby will be on Medicaid as a US citizen. So yeah, so they do have resources for them also.

Um, I think, you know, too I don't know the kind of help they get but people say things like, why these people will come to this country. It is to have the babies is just to look for something better. And a lot of them come here, not to steal anything not to take anything from your Social Security or your Medicaid or something and somebody said something like that. You're going to take my Medicare. So ridiculousness. They came to actually get better care. And those people, the ones that end up here, that permanently stay, they are very hard workers. They push their kids to go to school and be hard workers. So they're, you know, giving something to the society not actually taking stuff from us.

Participant **AM** recollected:

So we do a lot for those babies. A lot, can be anything from caring for the for the

family, as they arrive giving support, you have lactation services. As a nurse, you try to explain to them everything that's going to be happening, everything that's going on everything that they see in the unit like the like the leaves on the baby. Just so that kind of like to ease a little bit of their, their stress. Then we always work together to try to create the plan of care for the baby, trying to keep you know, their feelings and try to keep them in mind as well because, it's a very difficult time for them. I remember the grandmother and the mom came from St. Thomas. The mom, she had to buy like a poly-visol for like \$9. And she's like, Oh, isn't that covered by baby's insurance. And I said, well, it's over the counter. So you know, she couldn't pay for that, right. And she told me I didn't have any money. So the nurse practitioners like gave her the money so she can buy it before she goes to St. Thomas. This mom had to go. She had to take this one flight there leaving for St. Thomas on at around 1230 in the afternoon. So that was definitely a challenge to get somebody out of the hospital quickly.

**Pina** supposed:

Uh, yeah, they're very concerned. You notice that they're self-paid because they're concerned on the price. And each day the baby gets delayed is stressful for them because then it could cost thousands of dollars a day. And so we tried to work with them to discharge the baby as soon as you know, the baby's stable, and the doctors have done that too. Because their birth tourism mom and their self-pay, the doctors work with them to make sure that they don't get delayed in their leaving and that the baby is okay before leaving the nicu. Yes, I think so.

**Twiggy** passionately said:

So, I think what I'm trying to say is that, because she had difficulty trying to have a child. She had to go through invitro fertilization, and she carried the babies up until like 23 to 24 weeks gestation. She came here to vacation and then she went into labor. Okay, so, two little boys, you know, they were twins, and ended up staying in the hospital well over three months. I do not think that it should be viewed as an illegal act to have a child, no matter where a child is born. No, I think it's every human is right to have access to health care, no matter where they give birth what city, state, place they give birth as they are right it's our humans rights. I don't like to see anybody suffer, so which to me I feel, like as a nurse I'm called to be a nurse. And I feel like when a patient family or client is suffering, I'm suffering.

Participant **DJ** elaborated:

While the baby was in the unit, of course, you know, there was a little bit of frustration that you could tell from the parents, both mom and dad because they wanted the baby to go home. I think there might have been some challenges towards the end with the discharge process in terms of trying to figure out all of the follow-ups and everything that would have to take place, and I'm not sure exactly how it all ended up in the end because that was not a part of the actual discharge. I took care of the patient several times. Well, you know, all of that was going on, but I believe I'm, you know, trying to find out the resources for the mom while she stayed on stateside, have those follow-up appointments with the baby before she takes the baby back home. I do believe that there are some

resources available in Jamaica. I think certain specialties would still have to be seen here in the United States.

When caring for the newborns of birth tourism families in the NICU, the participants from this study perceived that compassion is the principal element in their provision of nursing care. Their experiences corroborated in the nursing literature listed above and these findings interpreted to the theme of *canalizing compassionate care*. The results of this study yielded that, in their practice, neonatal nurses identified that their nursing acts, skills, feelings, and emotions are platformed by compassion to provide quality nursing care.

### **Theme: Bridging Family-Centeredness**

Bridging is described as an act of extending across by putting a bridge over. In the unique sense of caring, the term bridging means incorporating all caring team members to care for and support infants and their families in the neonatal intensive care unit. The concept “family centeredness” is defined under the pretext of different labels, including family-centered care, family-centered practice, family-centered approach, patient-centered care, and relationship-centered care (Panes, 2020). According to Cooper et al. (2007), family-centered care in the NICU is a standard of care and a philosophy that incorporates respect, communication of information, choice flexibility, empowerment, collaboration, organizational resources, and support delivery. Nurses utilized strategies to incorporate the infant’s family through collaboration characterized by trust, connection, mutual caring, mutual knowledge, guidance, positive rapport building, and a mutual understanding of roles and responsibilities (Scholl, Zill, Härter, & Dirmaier, 2014). Participants in this study collectively expressed the way of caring for the family in a

family-centered unit as they funnel the care provided to birth tourism families by *bridging family-centeredness*. Expressed by the participants, *bridging family centeredness* means to involve and encourage the family in caring for the infant; incorporate the family-centered approach; and engage and connect multidisciplinary team to provide resources for the family.

**Indigo Durand** expanded on this:

We do have family-centered care, but do they have per say a family-centered care. To me, okay, now parents are part of the baby's care, meaning that the parent needs to be able to involve themselves in the baby's care, meaning that they, it's important for them to be present in rounds and participate in rounds. Well, now with COVID19, things are different. But before COVID they were allowed to be in the unit 24/7 for them to be able to be part of every baby's touch time and bonding and learning. So by the time that they will go home they will feel 100% comfortable taking care of their baby.

**Nurse Nancy** recounted:

Family-centered care, we want to incorporate the families with caring for their infant, when possible, we want them to interact in change diapers be there for touch times. Be there for rounding when we discuss the patient's plan for the day, we try and incorporate the parents in all of the care. So, they feel welcome, and they feel like they're actually caring for their baby.

Participant **Peace** explained:

It is supposed to be part of our philosophy statement. That's a family centered care team where everybody is supposed to participate in family centered care. Our

policy will be updated soon. It's going to change and it's going to be the piece that says about the extended family for example, well, for birth tourism families let's say that they say, I'm coming from Haiti, I think I can use that as an example, to have a baby here. And I'm staying with my aunt. I came with my husband and I'm staying with my aunt. And I have cousins in the household, my aunt and my cousins can be one of the favorite fives. So, if the mom doesn't feel good and the aunt can go to the hospital, they can go visit the baby and go and tell the mom how the baby is. Remember, we have to treat everyone equally. And whatever the birth parents want to call family is what we should honor as family.

Participants in this study practice in family-centered care units and perceive to bridge family-centeredness with families. However, this study's findings of providing family-centered care among study participants seemed to depend on the neonatal nurses' perceptions and not a standardized or ideal family-centered care approach. Consistent with the literature, Coats et al. (2018) descriptive qualitative study, described nurses' perceptions of the benefits and challenges of providing family-centered care in pediatric intensive care units. Ten participants were interviewed through semi-structured interviews. The questions were of four categories: the environment and its relationship to care delivery, nurses and families' stressors, communication, and family involvement and decision-making. It was revealed that nurses described providing quality family-centered care as a "balancing act" characterized by the interaction between (a) intensive care unit policies related to visitation hours and family presence at the bedside and (b) physical transformations in the intensive care unit from shared open space to individual private rooms. However, the study concluded that although there were benefits to FCC, nurses

also met challenges in implementing FCC in pediatric intensive care units. Participants in this current study shared their similar experiences. **Valeria** said:

So, I will be honest, I don't like getting completely involved for the family centered care and they probably have a policy there and the papers and everything, but I just know that it's there. We have like different committees. And then it's hard is hard is like multiple cultures so it's, it's not easy for the nurse to deal with all this stuff. Most of the time when they need help, we involve social work to help them or help with the insurance, a place where they will stay for the day, and as they arrived with their suitcases, they need a place to keep their stuff and also help them to get things together for when they are discharged from the hospital. Social worker help find a place for them to stay, and the social worker know a lot of places that can help them. Sometimes there are places offered for free, like the Ronald MacDonald house or other places offered by some associations that help them, but I am not sure about those things.

Participant **Gina Martin** expressed:

In the unit, family centered care for us, is the parent, that the parents are allowed they can spend 24 seven in the NICU. And they also can they have a lot of say. When they are doing rounds, they are part of the rounds. They usually, we usually encourage them to come, to be here, when the doctors do rounds. So, their voice you know, count a lot and also let me see if I can think of something from my head. Um, family centered care policy or training? To me, um, I don't remember we have papers around like they have policies, but I don't remember a class on family centered care.

**AnnaV** shared:

Really family centered care for me is caring which everyone on the team has a voice for the baby. And the goal is to help the baby grow and get well. The parents are invited to participate in rounds. They have a voice during rounds and the nurse have a voice, and the multi-disciplinary OT, PT speech as well.

Sometimes a social worker has to update us on what's going on. It's for all families across, I am not sure if that will be considered under this. But they do have complex needs.

Participant **Nurse Nancy** added:

Um, I feel like I mean, I don't think I'll ever forget that patient. I care for her a lot. I feel like I am honored to have been able to care for their baby because they were so appreciative. I don't think that the social worker is attached to the International department. I think social work provides a service for all of the patients. I don't believe they work directly with international services. I could be wrong. It's a good question.

Furthermore, researchers Ghorbani et al. (2018) explored NICU nurses' perceptions about implementing the FCC model. The data resulted in significant themes such as: *walking on an insecure foundation, inappropriate base, a pathway with no lines, and unequal encounter*. The findings signified that nurses felt a lack of facilities, inadequate space, and staff's specific instruction in encouraging parents' engagement and high work pressure hindering their ability to provide an ideal FCC. This qualitative study found that despite an FCC model in place, there was a lack of essential substructures and the absence of a systematic program to engage parents in caring for their infants,

resulting in FCC operating differently by nurses, causing a discontinuity FCC implementation in NICUs. These findings connected to the current study as evidenced by the multiple perceptions of the participants pointing to the need of bridging resources and services for birth tourism families to deliver a family-centered care to the newborns and families.

**Mari** reflected on employing family-centeredness:

We are a family-centered care hospital. We are open, you know, of course to the parents 24 hours 7days, they can visit their baby as much they can. Now for birth tourism moms. I remember the mom was alone and the dad was not in the picture. We wanted to give the best scenario for the NICU experience at the moment, so we try to be accommodating so that she doesn't feel alone and allowed grandma who travelled with her or I think the grandma lived here and the mom didn't, the grandma to visit the baby without the mom being there. What I remember they needed translations services. I think we had to translate or maybe a few times because she I don't think she spoke, hum she spoke English maybe the dad did a little bit, but I don't think the mom did so like, you know, the language barrier was there so we had to translate.

Participant **Jess** honest divulgence of her experience in caring for birth tourism families in a family-centered care unit. She said:

It can't really say that birth tourism meshes with family-centered care because most of the time is a mom or a support person coming and not the entire family. So again, most of the time that parent is here alone by themselves. And they don't

have any extended family members or any other family members to come to meet us. So at that level it's just the mom and the dad or some other support person.

Participant **DJ** remembered and shared her experience:

In terms of the NICU, I've always, you know, enjoyed working at Family-Centered NICUs, where, you want the mom to be around, you want the dad to be around, you want to help educate the families, so that they can provide the best care for their baby and also feel comfortable taking their baby home and also at times, you know, making other members of the family also feeling included, maybe like the grandmother or siblings or aunts, uncles. It's more like a philosophy in terms of family-centered care. The nurses receive I believe, I know that every three, four months we get education in the NICU. I think the family-centered care part must be at least once a year. I'm not sure if it's more but in the NICU and in my particular unit we get our education quarterly. There's also aside from the NICU policy and know that there's also some other new education that we received from the organization itself in terms of international families, um, and I think it might just go over, you know, some of the stuff that we've already talked about in terms of, you know, resources and meeting the patient's needs.

Similarly, **NICU RN** elaborated on her views:

Family-centered care in other words, I define as very pro parent involvement we consider the parents, members of our team...also we, do not have visiting hours per se for the parents. In our units, considers the parents being not visitors, so we don't have visitors we don't have visitation hours for the parents. We as nurses really start from day one. Teaching them how to care for their baby whether is a

micro preemie. And then again, we're very supportive of you know, you know, we have we have a breastfeeding committee that teaches them you know, the breastfeeding. So, every aspect of caring for their baby, we try to involve so I that, I guess really is the definition of family-centered care.

In a quantitative study conducted by Feeg et al. (2016), the researchers aimed to describe and compare how healthcare providers from the three countries, United States, Australia, and Turkey, perceived family-centered care (FCC). The findings showed that working with children was significantly more positive in attitudes than with the families. These results added to the understanding of influences on practice from the three different countries and helped determine baseline beliefs and ascertain interventions to improve FCC implementation. These findings are linked to the current study findings because the majority of participants expressed the multiple interventions that they apply to caring for the families while caring for the infants in the NICU.

Boztepe and Kerimoglu-Yildiz (2017) explored the views of nurses regarding FCC practice. This qualitative study indicated that nurses had positive views of FCC activities and recognized the need for the family's continuing presence during the child's admission. However, the data yielded that families' cultural characteristics were an obstacle. Therefore, the researchers recommended implementing an FCC model better and that nurses should understand the model conceptually and understand the rights, roles, and responsibilities of parents. Additionally, a recommendation was also made for nurses to have sufficient resources, appropriate education, and support from their managers to practice FCC appropriately.

Participant **Valeria** illustrated her sentiments resembling these researchers' findings:

The only other thing I can point to, is that sometimes it is so overwhelmed. And they can't even come to check on the baby. The parents they can't come because they don't have cars and it's hard for them, so they can't come every single day. And some are from poor countries and don't plan for all the extra money they need to spend. And that a problem. Also they are now worried when are they going to leave the NICU, so they ask a lot of time when they are going to leave. And then they get super busy getting things quick for their baby before they leave the country that's the reason, they cannot come here every single day. So I know that they have some travel problems, because now they need to be ready like, when are you going to leave to go back home.

Albougami et al. (2019), in a cross-sectional correlational study, aimed to examine the perceptions of non-Muslim expatriate nurses working in Saudi Arabia regarding the relationship between cultural competence and patient-centered care. Pearson's correlation analysis indicated that total cultural competence was significantly related to total individualized nursing care ( $r = 0.255, p < .01$ ). Results yielded findings suggesting a statistically significant positive correlation between having cultural competence and providing individualized patient-centered care. This study concluded that Filipino nurses have greater perceived cultural awareness and sensitivity and perceive more culturally competent behaviors than Indian nurses. The researchers recommended developing educational programs on cultural competence and patient-centered care skills for expatriate nurses to deliver effective culturally competent nursing care.

In the context of culturally congruent care, barriers such as language and communication, making decisions, and differing norms and beliefs embedded in the care of families are also affecting the patient-nurse interactions. Participants of this study echoed the numerous strategies to involve the parents in their infants' care regardless of the family. However, birth tourism families may not receive culturally appropriate family-centered care if nurses lack competency in being culturally sensitive to birth tourism families.

**AnnaV** shared her thoughts:

Sometimes it's difficult, because let's say it's a wealthy family, for example, and they're going to have nannies, or nurses. So we worry about whether we're going to have to train that staff or not to take care of the baby in the appropriate method that the baby needs. We worry about, you know, how many flights, they have to take to get home, the logistics part, we discuss at length. What else do we do? We try to always, try to train the parents for their complex baby they are going home with, their medically complex kids. And in that kind of situation we might just have the mom, because the father always goes back to work in their country. We might not have grandma coming because she's in another country, she doesn't have a visa to come visit or what not, or she already came and left, and the baby has been there for five months and she was there for a month. You know that they can become lengthy admissions for us. That is of the essence of family-centered care.

**Participant Peace** explained:

Oh, it's not a yearly class we take to learn about family-centered. I think it's brought up every couple of years, or if we had some type of issue, then, you know, they'll talk about it to the staff. But that's kind of reviewed every single year because, I think it's supposed to be whatever your philosophy, once you work in the unit. Well, if a family feels that the nurse is not taking care of the baby like they're supposed to, because of, you know, because they're different from countries or whatever, then you know, they will report that to the supervisor or whatever. And then you know that nurse will be spoken to about how we are to treat the family and things like that. That's why we have like the favorite fives, favorite fives that can come when the parents are not there, that sort of thing. So, they can designate them as family and family-centered care is to basically take care of the whole person.

**Mary** expounded:

Family-centered care and our unit is basically that we center on the family's needs, we get the family involved from day one. It's not just having the patient there and we're the only gear one providing care. It is more hands on with respect of their culture, we respect their wishes. We try to make it more like we're all a family to help them. So in a whole family unit way. I believe that it was a one-time class we took on family-centered care. I don't recall them talking much about international patients. The Family Center Care was basically geared on families here in the United States. It really didn't talk about other cultures, or faiths or anything, it was just treating on a whole the families that we interact mostly here with.

Participant **AM** said:

They don't really let us know that they're coming. I mean, we just know that an admission is coming, or it's coming from and all that but not that it's an international unless they fly here. Like from the Caymans, we will know that ahead of time. Once the babies arrive, and we get more of like the admission history and everything, that's when we start figuring out what's going on. Like, most of them are moms that came to shop, quote, unquote, to shop and they just happen to have the baby. We even had once they're actually American Lawyers, but they were based out of London with British passports. And she came back to Naples to visit her mom and she had preterm labor. So she had the baby here. So that ended up being born as a US citizen.

Participant **Chère** tells her experience:

So right now we are not practicing our policy of family-centered carefully because of the current COVID-19 situation. But, prior to this pandemic. We had a favorite five, this so that allowed the parents of the child to select up to five other members of their family and or friends or whoever they deem to participate in visiting the child and being present during touch time. And it basically involved in the first early days of the child's life. And, because of COVID, we had a change in the hospital routine to where the babies can now be transitioned with the mom in the recovery room versus transitioning in the nursery and that is whether she is a C-section or vaginal birth, and as long as the infant is stable enough. And if not stable the infant is rushed to the NICU. That was also part of the family-centered care. It is linked still, actually because just because they're international patients

doesn't mean they're not allowed to have five, doesn't mean they're not allowed to have their baby present as they're transitioning even though, in this circumstance over interview, we're talking about nice patients so that wouldn't be the same because they wouldn't be able to volunteer to manage from doing whatever we provide for our families across the board, international or not.

Participant **Ava** explained:

I remember one particular patient just because of the devastation of that baby and ended up being with us for a little while, I don't know how long that situation went through. The issue that I have with caring for that family is that they only speak Spanish, and I don't. So the bond between me and the family was not there.

Whereas other families, I know able to show them you know, and really participate and really educate them and the problem that I've had with international patients is, you know, here in Miami and we've had international patients and some patients are calm. Never had an issue with that, but I don't remember a scenario. But, with the family I know that our unit has a family centered care committee got involved. They help with all their concerns. I'm not on that committee to be able to know more specifics, but I know that they meet periodically and discuss difficult moms. You know, how we can incorporate the families more into bedside care, including, you know, using hospital iPads to communicate with moms.

Outlined in the literature was the essence of participants' stories reflecting the theme of *bridging family-centeredness* interpreted by the researcher. Participants in this study communally conveyed that they provide care to birth tourism families in a family-

centered unit guided by family centered care policy or philosophy. Participants' caring actions encompasses *bridging family-centeredness* involving a funneling phase of connecting the infants with their birth tourism parents, whoever the parents designated the family to be, and the healthcare team providing care for the infant admitted into the NICU.

### **Connection of Themes to The Process of Cultural Competemility in the Delivery of Healthcare Services Model**

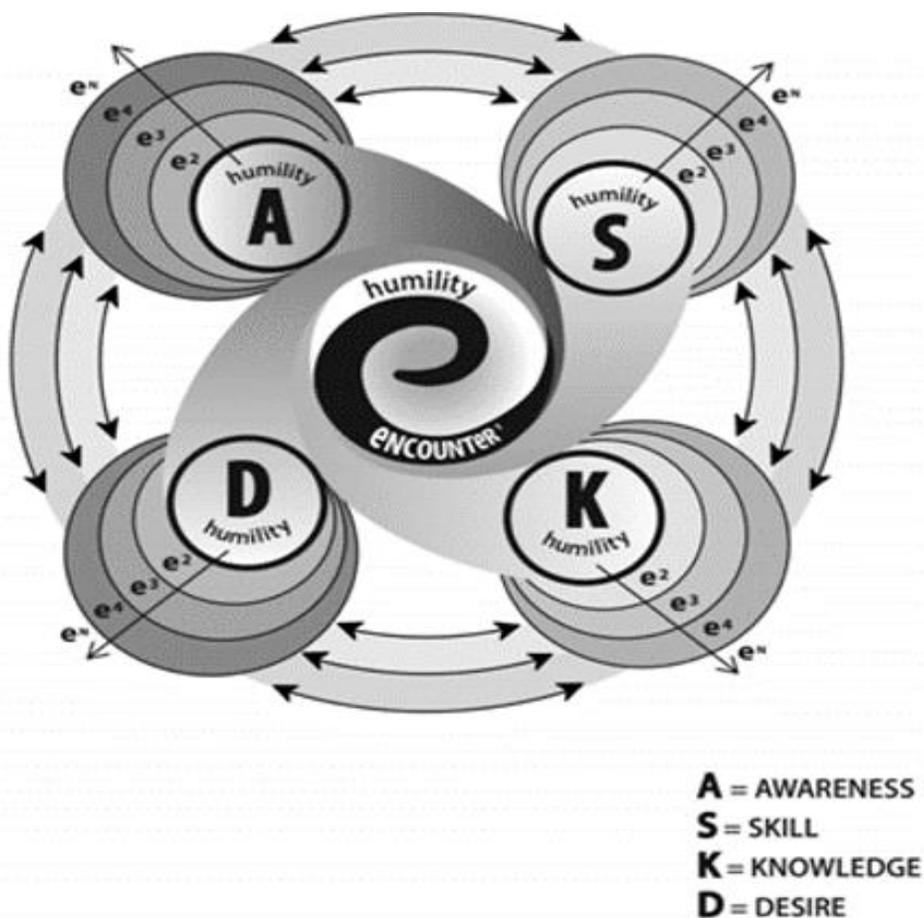
In conjunction with this current study's findings, Campinha-Bacote's (2018) model, the Process of Cultural Competemility in the Delivery of Healthcare Services model connects to the significant themes of *recognizing cultural interactions*, *acknowledging cultural consciousness*, *canalizing compassionate care*, and *bridging family-centeredness* which foster the funneling of cultural care for birth tourism families in the neonatal intensive care unit (NICU). Twenty-two nurses who participated in this study described their lived experience of caring for birth tourism families. The participants described their meanings ascribed to caring for these families who travel with the plan to deliver a well newborn, and, unfortunately, admit a premature or sick infant into the NICU. Their willingness to share their experiences allowed the researcher to understand the meaning of neonatal nurses caring for infants and their birth tourism families. The researcher linked the findings of this study with the constructs of Doctor Josefa Campinha-Bacote's 2018 model, the process of cultural competemility in the delivery of healthcare services.

According to Campinha-Bacote (2018), this process proposes a model with a theoretical coactive relationship between two concepts: cultural humility and cultural

competence. The following constructs permeate the blending of these terms: cultural humility, cultural encounter, cultural awareness, cultural knowledge, cultural skill, and cultural desire (Campinha-Bacote, 2018). Campinha-Bacote first developed stages of the model beginning in 1969. Influenced by the works of Nursing theorist Madeleine Leininger's (1978) on transcultural nursing and the work of Professor of Counselor Education, Paul Pederson (1988) on multicultural development and through the pursuit of her baccalaureate, master's, and doctoral degree in Nursing, Campinha-Bacote in 1998 developed the model of "cultural competence in the delivery of healthcare services." Through multiple revisions in 2002, 2010, and 2018, the final revision of the process of cultural competence in the delivery of healthcare services model evolved by the terms "competence" and "humility" merging to coin the term "cultural competemility" in which the concept of humility, used as a construct, changed the model into the process of cultural competemility in the delivery of healthcare services (Campinha-Bacote, 2018).

Campinha-Bacote (2018) asserted that professionals providing healthcare services must engage in the process of becoming culturally competent while being engaged in the process of cultural humility. Her model of cultural competence is used as a framework is for developing and implementing culturally responsive healthcare services. In the context of this model, competence is a quality or state of being proficient, and humility is a quality or state of being humble (Campinha-Bacote, 2018). Therefore, "cultural competemility" is the ongoing process in which nurses continuously strive to achieve to be able to work within the cultural context of individuals, families, and communities effectively, while being and becoming humble (Campinha-Bacote, 2002, 2019).

See Figure 7 for The Process of Cultural Competemility in the Delivery of Healthcare Services Model Copyrighted in 2018 by Campinha-Bacote.



*Figure 7.* The Process of Cultural Competemility in the Delivery of Healthcare Services Model Copyrighted in 2018 by Campinha-Bacote

### **Assumptions of the Model**

In a synergistic process between cultural humility and cultural competence in which cultural humility infuses all the constructs of the model. According to Campinha-Bacote (2018), the process of cultural competemility in the delivery of healthcare services holds the following assumptions:

1. Cultural competence is a process and not an event.

2. Cultural competence consists of six constructs: cultural humility, cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire.
3. There is more variation within ethnic groups than across ethnic groups (intra-ethnic variation).
4. There is a direct relationship between the level of competence of health care providers and their ability to provide culturally responsive health care services.
5. Cultural competence is essential in rendering effective and culturally responsive services to culturally and ethnically diverse patients.

### **Constructs of the Model: The Process of Cultural Competemility in the Delivery of Healthcare Services**

This care model includes six essential constructs that help understand cultural competemility and consist of the following: (a) cultural humility, (b) cultural awareness, (c) cultural knowledge, (d) cultural skill, (e) cultural encounters, and (f) cultural desire (Campinha-Bacote, 2018).

**Cultural humility.** Campinha-Bacote (2018) thought that cultural humility is often seen as an alternative approach to cultural competence and is viewed, according to Tervalon and Murray-Garcia (1998), as a dynamic and lifelong process focusing on self-reflection and personal critique. In a concept analysis, Foronda et al. (2016) defined the concept of cultural humility as a process of being open, raising self-awareness, being egoless, self-reflect, and critique during an interaction with individuals of diverse cultural backgrounds. It is through cultural humility that nurses realize that worldviews they hold

about patients and their everyday interactions can contribute to socially just actions (Campinha-Bacote, 2018).

**Cultural awareness.** Campinha-Bacote (2018) defined this as self-examination and in-depth exploration of one's own cultural and professional background. This process involves recognition of one's biases, prejudices, and assumptions about individuals who are different, as well as being aware of influences of one's own cultural or professional values to avoid the risk of imposing own beliefs, values, and patterns of behavior on another (Campinha-Bacote, 2016; Leininger, 1978)

**Cultural knowledge.** Campinha-Bacote (2018) addressed cultural knowledge as a process of seeking and obtaining education about patients' health beliefs and values from diverse cultural and ethnic backgrounds, including gaining knowledge on patients' worldviews. Gaining knowledge on patients' worldviews helps nurses understand their illness interpretation, disease incidence, decision making, and treatment efficacy.

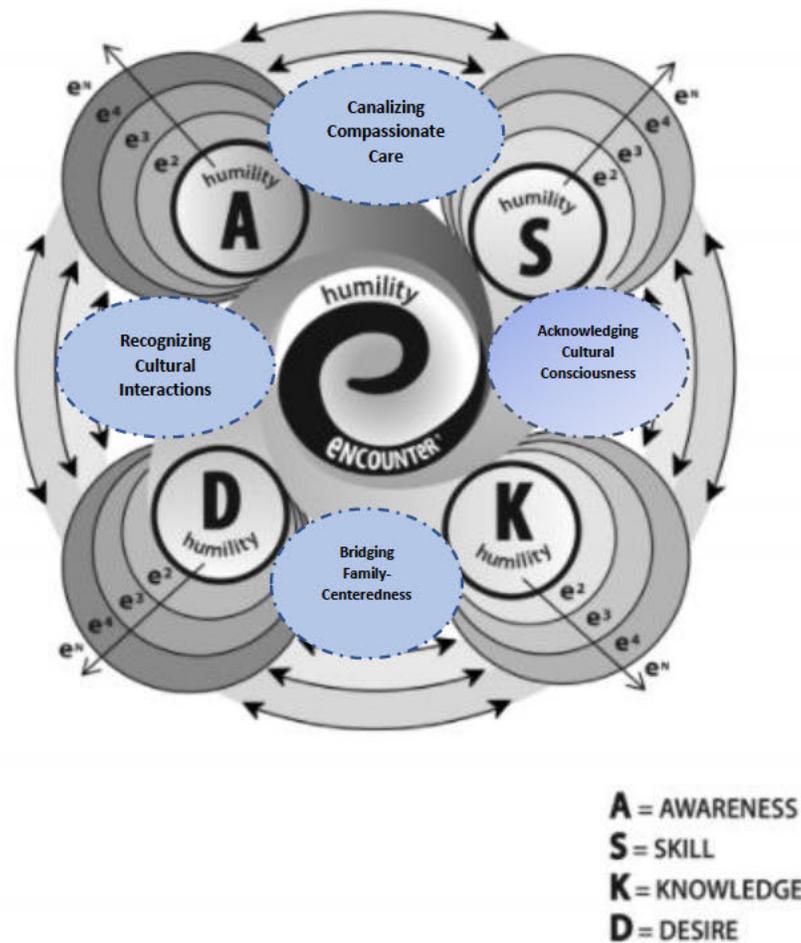
**Cultural skill.** Campinha-Bacote (2018) explained that it is the ability to accurately perform a culturally-based physical assessment and collect relevant cultural data regarding patients' presenting diagnosis.

**Cultural encounter.** Campinha-Bacote (2018) communicated that cultural encounters encourage the nurse to directly engage in cross-cultural interactions with the patient from culturally diverse backgrounds. Accordingly, a cultural encounter is a process that the nurse directly engages in a face-to-face exchange with patients from culturally diverse backgrounds to provide nursing care. It also involves the nursing assessment of patients' linguistic needs and providing interpreters to facilitate communication during the encounter. This directly interacting process helps preconceive

notions of one's existing beliefs about the individual's culture, by preventing possible stereotyping that may occur.

**Cultural desire.** Campinha-Bacote (2018) disclosed that this process involves caring and being motivated to *want* to, rather than, to *become* culturally aware, culturally knowledgeable, culturally skillful, and familiar with every patient during a cultural encounter. In this process, nurses are not merely saying that they respect the patient's values, beliefs, and practices. However, within this construct, nurses are charged with providing interventions that are effective with a particular ethnic group. Cultural desire includes a genuine passion for being flexible and open with others, accepting differences, and learning from others (Campinha-Bacote, 2015).

These constructs derived from Campinha-Bacote's two previous models of the biblically based model and the culturally competent model, combined to arrive at the conceptual framework of cultural competemility. To fully comprehend the model, Campinha-Bacote (2018) explained that through the synergistic process between cultural humility and cultural competence, cultural humility permeates each of the constructs, cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire achieving a process of being and becoming culturally competent. Nurses who "engage in the process of becoming culturally competent" concurrently "engage in the process of cultural humility," as they are involved in a "cultural encounter to obtain cultural knowledge, and demonstrate cultural skills, by conducting a culturally sensitive assessment," and while becoming culturally aware of their own biases and presence of "isms" (racism, sexism, classism, colorism, ethnocentrism, anti-Semitism, ageism, ableism) (Campinha-Bacote, 2018).



*Figure 8.* Conceptual representation of constructs from The Process of Cultural Competemility in the Delivery of Healthcare Services connecting to the themes from Funneling Cultural Care for Birth Tourism Families in Family-Centered Neonatal Units (LaCroix, 2021, adapted from Campinha-Bacote, 2018)

The constructs of Campinha-Bacote’s (2018) model, the process of cultural competemility in the delivery of healthcare services was chosen to connect with the themes which emerged from the study: *recognizing cultural interactions, acknowledging cultural consciousness, canalizing compassionate care, and bridging family-*

*centeredness*. See Figure 8 which depicts the connection of the themes of this study with the model. Six constructs were connected to the themes. Out of the six, one construct, cultural humility serves as a conduit and saturates all other the five constructs forming cultural competemility. This relationship is in a continuous process combining cultural humility with the constructs comprising cultural competence (cultural awareness, cultural knowledge, cultural skill, cultural encounters, cultural desire) amounting to cultural competemility (Campinha-Bacote, 2018). The theme of *recognizing cultural interactions* was connected to cultural encounter, cultural skill, and also tied to the construct of cultural humility. In this study, majority of the participants shared that they had a direct engagement, face-to-face communication, with some form of exchange to receive and give health information with birth tourism families who traveled internationally, from numerous destinations, and these families unfortunately admitted an infant into the neonatal intensive care unit. Subsequently, cultural skill was connected as well because the participants meet and assess the newborns and their families, collect the necessary data to provide for their needs. In addition, participants expressed the meaning of caring and the majority of voices expresses perceptions which connected to the construct of cultural humility. Accordingly, this study's participants revealed caring for the infants as their primary patients and recognizing birth tourism families as they assessed to see where the family is from, to provide for their needs while in the NICU.

Participant **Mari** indicated that she remembered one family from the Dominican Republic and that she bonded with the first-time young mother and the dad. **Valeria** expressed that she encountered families from her country Brazil, that many birth tourism families are from there, and that she cared for their babies born in her hospital. **Valeria**

also added that some families face issues related to being “weak about the language” and illustrated by recalling the Indian family with language and communication challenges and the obstacles faced with their culture. **Indigo Durand** recounted one of the many times that she encountered birth tourism families whom she described as being “well off” in their countries, meaning they chose to come and have their baby here in the United States because they have the opportunity to come.

The theme of *acknowledging cultural consciousness* was connected to cultural awareness as well as cultural humility. Majority of participants acknowledged relating their own culture and background, including their personal experiences, understanding birth tourism families, and the situation presented of admitting a sick infant into the NICU. Many participants shared their pre-conceived ideas, which included subtle opinions formed toward birth tourism families. Participant **Loana** stated, “...the best-paid baseball players back in the Dominican Republic... it is a kid that was born here...I just think that part is like political...everything was approved through Medicaid.” **Nurse Nancy** shared that although she has mixed feelings regarding caring for birth tourism families and that she understands that “they need to come to the United States to provide a better chance for their child to have a better quality of life and quality of health care.” In this clinical encounter, cultural humility is exhibited by the participant by maintaining a humble attitude to understand the patient. However, she feels that “the well newborn could have been born and not utilizing our taxpayers’ money.” **Peace** indicated that she knows that the birth tourism families she cared for traveled with a contract and paid for their hospital stay. Thus, she feels that the staff expresses different sentiments. Additionally, **Peace** said, “the staff would feel that, okay, they are here taking advantage

of the U.S., Medicaid and the U.S. food stamps, and they are just here to take advantage.”

The theme of *canalizing compassionate care* was connected to cultural awareness, cultural desire, cultural encounter and also linked to cultural humility. All the participants of this study described their feelings and meanings ascribed to the word “caring” and “giving care” to birth tourism families. Cultural humility was infused into the care provided to the infants and families as evidenced by the acts of compassion described by the participants. Nurses from this study utilized the following terms to express the compassionate care they provide to birth tourism families such as: “care from the heart,” “empathy,” “support,” and “sympathy” as well as incorporating the family, which is all part of canalizing compassionate care. **Gina Martin** said, “The word caring cannot define, I mean, taking care of the baby is with your heart. I will say, with, the knowledge you have and the compassion and, I guess.” **AnnaV** mentioned: “I try to empower the family to be able to care for that child as best they can, without being scared.” **Loana** expounded that caring for birth tourism families is to give care holistically, and “where I can, I also take care of the mom, the dad or whoever is that person that is going to be part of this kid’s family.”

The theme of *bridging family-centeredness* was connected to cultural knowledge, cultural skill, cultural desire, cultural encounter, and cultural humility. All participants were faced with working in a very stressful environment and expressed that during a cultural encounter there is a distortion of information, a lack of cultural knowledge, a lack of understanding patients’ worldviews and their needs, a lack of communication, and inconsistency in obtaining resources when caring for birth tourism families and their infants. Furthermore, participants voiced that they employed the same numerous

strategies or skills to involve the parents in their infants' care regardless of the family by utilizing their perceptions of family-centered care. Some of the participants understand the importance of family and desire to provide quality care as their nursing practice is underpinned by the family-centered philosophy. However, birth tourism families may not receive culturally appropriate family-centered care if nurses lack competency in being culturally sensitive to birth tourism families.

**Pina** disclosed a disconnection in communication when they forewarn physicians about international patients' admissions, and the nursing staff is not aware. She said, "We have an international department, but they're not really geared on for all the families they help families who are from abroad." **Peace** affirmed that the international department manages the communication. Thus, there is a lack of understanding and communication among the staff to different birth tourism families. **Mary** admitted that birth tourism families face some caveats and suggested inter-department communication to ameliorate the holistic care for these patients. **Indigo Durand** expanded with rich information and narrated, "We do have family-centered care, but do they have per se family-centered care. To me, okay, now parents are part of the baby's care." **AnnaV** elaborated on her perception, and she said, "Really family-centered care for me is caring which everyone on the team has a voice for the baby, and the goal is to help the baby grow and get well." **Participant Peace** explained how she obtains knowledge:

"It is supposed to be part of our philosophy statement. That's a family-centered care team where everybody is supposed to participate in family-centered care. Oh, it's not a yearly class we take to learn about family-centered. I think it's brought up every couple of years or if we had some type of issue".

She also expounded on plans to include birth tourism families in family-centeredness. She said, “Our policy will be updated soon. It's going to change and it's going to be the piece that says about the extended family for example, well, for birth tourism families let’s say.” *Bridging family-centeredness* according to the neonatal nurses occurred in compartments of different actions and interactions with birth tourism families, such as language and communication, and employing numerous strategies to involve the parents in their infants' care regardless of the family.

### **Significance of the Study**

The significance of this hermeneutic phenomenological study using van Manen’s (1990) methodology was to understand the lived experience of neonatal nurses caring for birth tourism families who admit a newborn into South Florida’s neonatal intensive care units. This research gave neonatal nurses a voice to express their individual experience of caring for birth tourism families, inductively interpreting their everyday experience in their lifeworld, and understanding the essence of caring for this unique population. A review of the literature revealed a scarcity of research concerning the phenomenon of interest. Knowledge and understanding of the study's emerging themes supported the how and the what of nurses' experiences of caring for birth tourism families. The four overarching themes identified were: (a) *recognizing cultural interactions*; (b) *acknowledging cultural consciousness*; (c) *canalizing compassionate care*; and (d) *bridging family-centeredness*. These themes interpreted from the experiences of neonatal nurses caring for birth tourism families in continuous phases of funneling cultural care to deliver quality, family-centered, and culturally competent care. The essence of the study is the funneling of cultural care that the participants experience when caring for birth

tourism families with a sick or premature newborn admitted in the NICU by recognizing cultural interactions, acknowledging cultural consciousness, canalizing compassionate care and bridging family-centeredness to deliver quality, family-centered, and culturally competent care. The data obtained from this study added to the body of nursing knowledge and have implications for nursing education, nursing practice, nursing research, health and public policy.

### **Significance of the Study to Nursing**

This study on the lived experience of neonatal nurses caring for birth tourism families in the neonatal intensive care units (NICU) advances nursing science where it provided a better understanding of caring for this patient population. Neonatal nurses who provide care to birth tourism families voiced their caring experiences through their interviews collectively. The study's findings raised awareness of the lack of evidence in the nursing literature on this topic. Significantly, it was revealed through this study that birth tourism families travel internationally from developing countries seeking better quality healthcare in the United States and being cared for by neonatal nurses when their admitted infants faced some challenges. Furthermore, this nursing inquiry demonstrated how these neonatal nurses gave meaning to the care they render, how they viewed families, specifically birth tourism families, their worldviews surrounding the practice of birth tourism, and their perceptions of providing family-centered care. Significantly to nursing, the phenomenological data revealed a funneling approach to caring for birth tourism families.

Neonatal nurses may view their encounter once acquainted with birth tourism families as *recognizing a cultural interactions* which throughout the interaction, nurses

are *acknowledging cultural consciousness* while *canalizing compassionate care* and *bridging family-centeredness* for the delivery of culturally competent care. Moreover, despite the former Trump administration targeting birth tourism with new visa restrictions by the U.S. State Department planning to deny tourist visas to pregnant women traveling to deliver a child in the U.S., the National Center for Health Statistics reported a total of about 3.8 million registered births in 2018 (Maldonado, 2020; Scott, Meizin, Taba, & Witz, 2019). Therefore, birth tourism families are adding to the ethnic and cultural composition of hospitals' population. This increase in patient populations encourages neonatal nurses to incorporate culturally sensitive care for their patients' needs to ensure quality nursing care. This study is significant to nursing to meet a culturally diverse population's demands and needs in this aspect.

Additionally, considerable attention has been directed toward developed models and theories to help neonatal nurses recognize and respect transcultural diversity in ethnic, cultural, and socioeconomic groups while providing families' needs. This study fills a gap in nursing literature concerning the care provided to birth tourism families in U.S. hospitals. This study provided evidence on neonatal nurses caring for birth tourism families, halting further health disparities in South Florida NICUs. This study's findings elaborated on the neonatal nurses' stress and anxiety and described some of the caveats of the birth tourism families and their unanticipated medical, social, and financial challenges when they unexpectedly admit a newborn. Significant to mental health nursing, the knowledge obtained from this nursing study forewarned nurses of the expectations when caring for this population in the NICU. This information set forth may de-escalate some

nurses' barriers when caring for infants of birth tourism families to create positive health outcomes for the entire family in the NICU.

### **Implications for Nursing Education**

The American Association of Colleges of Nursing's (AACN) vision for nursing education for professional practice, provides elements and a framework for building nursing curricula that include cultural competencies. The expected competencies will assure nurses' qualification from the baccalaureate level to Doctor of Nursing practice programs to proficiently provide culturally competent care. Nurse educators are charged with preparing nursing students to provide culturally diverse healthcare to the diverse population admitted into the hospitals. This study's findings inferred understanding on the essence of neonatal nurses caring for birth tourism families, therefore contributing to the general knowledge of nursing students in the United States and around the globe. This study may also guide the education of current and future nurses who choose to specialize in neonatology about the specific healthcare needs of birth tourism families in the neonatal intensive care unit (NICU). The themes from this study may guide neonatal nurses in the development of sensitive, anticipatory guidance that may be produced online and distributed through travel agencies for pregnant patients wanting to engage in the practice of birth tourism. The information learned in this study sheds light on the aspect of family-centered care. The findings may educate practicing health professionals on effective strategies to meet the needs of birth tourism families and standardize the care surrounding the concept or philosophy of cultural care and family-centered care. This study increased the knowledge base in nursing regarding culturally congruent care in the NICU. Accordingly, findings from this study are useful in developing curricula that

increase cultural competence in nursing education among pre-licensed and post-licensed nurses to improve the nursing services rendered to birth tourism families and families of diverse cultural backgrounds. Besides, nurses are to be culturally competent when delivering holistic quality care to all patient populations.

### **Implications for Nursing Practice**

Nursing practice requires nurses to have a knowledge base of culture to deliver culturally sensitive and inclusive nursing care to patients with diverse backgrounds. The findings of this study addressed issues related to the current healthcare needs of birth tourism families when their admitted newborn is in the neonatal intensive care unit (NICU). In nursing practice, the findings have implications for providing culturally sensitive nursing care and cost-effective ways that promote positive patient outcomes. The findings derived from this study may provide empowerment to neonatal nurses to understand the meanings and experiences of caring for birth tourism families. This study gives a clearer understanding of the care given to birth tourism families instead of relying on anecdotal evidence from the news media about this population. Anecdotal evidence may influence change in neonatal nurses' worldviews on diverse patient populations or may influence their stance; however, this study findings produced new perspectives regarding caring for a patient population underscored as a burden to the American healthcare system. The alertness of acknowledging cultural consciousness may help nurses control one's awareness and seek to ameliorate the self when providing care to diverse patient populations. The study's testimonials may challenge nurses in practice to be aware and embrace cultural differences presented when caring for birth tourism

families and nurse-to-patient interactions aiming to bridging and lessening societal injustices by minimizing biases when caring for these families in the NICU.

Furthermore, these research findings may support evidence-based practice to promote cultural awareness and improve culturally competent care when caring for birth tourism families.

### **Implications for Nursing Research**

There is a need for qualitative research to deeply understand neonatal nurses' lived experience caring for neonates and birth tourism families. This research advances knowledge on birth tourism and may contribute to developing a quantitative perspective where scientists may want to look at the impact of birth tourism on NICU admission rates. This study's themes also added to the limited research exploring the perspectives of neonatal nurses delivering care to birth tourism families when facing a sick or premature newborn in the NICU. This hermeneutic phenomenological study on this population may contribute to scientific discussions about the phenomenon and encourage other scientists to explore other method genres to examine this topic. This study created a paradigm shift in seeking an interpretivist worldview regarding neonatal nurses caring for birth tourism families in the NICU, consequently understanding nursing's cultural care dispersed to these families. The findings of this study strengthened the knowledge base on quality, safety, and liability of nursing care rendered to sick newborns and their birth tourism families. Therefore, this study is projected to be the first of many studies, serves as a platform for other nurse researchers to build on, explore, and understand the lived experience of nurses caring for other populations of patients of diverse cultural backgrounds. This research is an important step forward, and it is in hopes that the

evidence generated from this study will help inform the development of future research on policy and practice in neonatal nursing.

### **Implications for Health and Public Policy**

Neonatal nurses are responsible for providing quality, family-centered, and culturally congruent care to families who travel internationally utilizing U.S. healthcare systems. Prior research (Mikheal et al., 2016) underscored that American communities are influenced by discourses highlighting that the birth tourism practice causes burdens and negatively affects U.S. healthcare systems socially, politically, and financially. This study's findings implied that neonatal nurses *acknowledging cultural consciousness* provide clarity for healthcare providers to deliver nursing care free from biases and stigmatizations. When developing inclusive policies, this research's results may support healthcare and migration efforts grounded in respect for human rights. Furthermore, this study's implications may provide insights for sound health policies that are needed globally to protect pregnant women seeking maternity care abroad.

From a nursing perspective, emerging needs of birth tourism families will ring the alarm to constituents and create conversations at the International Council of Nurses' (ICN) table, which usually presents to the national nurses' associations in more than 130 countries. The poignant needs of ensuring health and public policy that protect the interest of birth tourism families precisely when they end up admitting an infant into the neonatal intensive care unit (NICU) will evolve and become the focus of nurse advocates as they take a place at the table to shift the social, political, and cultural views of this population. This study's implications may also explain the quality of care birth tourism

families receives and include policies that would apply to birth tourism's different social aspects.

Despite the uproar from the recent Trump administration regarding birth tourism practices, this study provides education to diverse stakeholders who serve pregnant women who desire to travel internationally to receive maternity healthcare. Findings can enlighten the diaspora who share information worldwide to attract families to engage in birth tourism and safeguard this population against xenophobia. Departments of tourism, travel agencies and health care systems' international departments may benefit from this study's results. It may help start the conversation on visible regulatory policies assuring the delivery of quality and culturally congruent nursing care. Vis-à-vis hospital policies and management of the many healthcare systems operating in South Florida may initiate family-centered care and culturally competent care policies inclusive of birth tourism families.

### **Strengths and Limitations of the Study**

Literature is absent in exploring the lived experience of nurses caring for birth tourism families in South Florida's neonatal intensive care units. Accordingly, the shared experiences from this study added to the body of nursing knowledge. This study relied on the thick, rich descriptions of the phenomenon from the volunteered participants who provided a better understanding of the experience's essence. The data collected was based on the stories and perceptions of the participants. The sample utilized provided strength to this study's credibility by interviewing 22 neonatal nurses with an array of educational training and numerous years of expertise in the neonatal intensive care unit. Another strength of this study was the choice in the approach and method that guided the

investigation of this nursing inquiry; Max van Manen's (1990) hermeneutic phenomenological approach, and the Miles et al. (2014) method of inquiry offering a step-by-step and systematic approach that directed the novice researcher to explore, conduct, and develop an objective essence through subjective experiences.

Trustworthiness and rigor were maintained throughout the study. Nevertheless, potential limitations in the study exist.

Van Manen's approach consisted of six research activities requiring familiarization and understanding of the complex concepts; thus, the researcher needed to understand how to apply them to the study. Another limitation of this study included participants fitting the inclusion criteria, neonatal nurses from South Florida NICUs, limiting the findings' transferability to other populations settings or countries. The inclusion criteria included English-speaking participants; therefore, non-English speaking neonatal nurses were not included. However, all participants completed the interview process and committed to the necessary time to complete the interview. During the study's interview process, one of the limitations was that participants might have said what they believed the researcher wanted to hear. The participants may also not be wholly truthful or have divulged in their experiences out of embarrassment.

Furthermore, as a novice researcher and inexperienced, limitations of this study were related to design, setting, transferability, and data collection. Consistent with van Manen's hermeneutic phenomenology, the process of reflexivity requiring reduction to permit the discovery of spontaneous surge of the lifeworld was challenging to achieve as a novice researcher. Another key component to limitations of the research process was influenced by the researcher's nursing background which was made known to

participants of this study. Lastly, the researcher's limited personal experience with the topic may have affected the data analysis process. The researcher was also a novice at conducting phenomenological research.

### **Recommendations for Future Study**

This study provides a base for understanding the lived experiences of nurses caring for birth tourism families who unexpectedly admit a sick or premature newborn into the neonatal intensive care unit. With no previous research exploring the neonatal nurses' voices on caring experiences, a qualitative phenomenological study was the best method to acquire knowledge on caring for this population. Numerous implications for nursing research amounted from this study. This hermeneutic study's findings created avenues for other researchers to pursue inquiries in other research genres, such as quantitative to produce quantifiable findings or grounded theory to generate a theory.

The American Nurses Association (ANA) in the Nursing Scope and Standards of Practice, Standard 8 of culturally congruent practice, describes that nursing care is agreeable with the patients' preferred values, beliefs, worldview, and cultural practices. The study's findings focused on neonatal nurses' caring practices in the NICU, and the study's findings provided rich information, which is well supported by the associated cultural competencies for developing new knowledge to guide culturally congruent nursing care. Therefore, examining the critical factors affecting providing culturally competent care in population of diverse cultural backgrounds. Research conducted on nurses and healthcare professionals caring for birth tourism families remains limited, and there is a need for further studies on this population and family-centered care settings. Future investigations may explore the use of cultural competence instruments within

neonatal nurses and their response using these necessary tools while caring for the birth tourism population and other population of diverse cultural backgrounds.

### Conclusions

This chapter explored the study's meaning, discussed the interpretive analysis of the findings, and explained how the themes connected to Campinha-Bacote's conceptual model: the process of cultural competency in the delivery of healthcare services. The study's findings, the significance of nursing, and the implications for nursing education, nursing practice, nursing research, and public and health policy were also discussed. The study's strengths and limitations were also conferred, and recommendations for future research were proposed.

Neonatal nurses provide quality care for birth tourism families who unexpectedly find themselves with their newborn admitted into the neonatal intensive care unit (NICU) (Mikhael et al., 2016). Quality care is pertinent in delivering nursing care to help birth tourism families feel comfortable receiving nursing services while their infant is in the NICU (Giger, 2016; Purnell, 2013; Rose, 2012). The narratives of 22 participants were explored using Max van Manen's (1990) hermeneutic phenomenology. Data collected were via face-to-face and Skype video conferencing interviews and then transcribed by the researcher and authenticated by the participants. Data were analyzed using the researcher's line-by-line coding and van Manen's (1990) six research activities along with Miles et al. analysis method. Saturation was achieved and four themes emerged: *recognizing cultural interactions*; *acknowledging cultural consciousness*; *canalizing compassionate care*; and *bridging family-centeredness*. These themes conveyed and reflected the process of caring as a funnel withholding active continuous phases that

neonatal nurses incur during a cultural interaction with birth tourism families who admit a premature and ill newborn in the neonatal intensive care unit. The neonatal nurses from this study experience funneling caring when they recognized a cultural interaction with birth tourism families to deliver quality, family-centered, and culturally congruent care in the NICU.

Participants in this study revealed that while caring for a premature or ill newborn, the cultural interactions which happens when they meet the birth tourism family is not always recognizable. Once nurses funnel through the phases of *recognizing cultural interactions*, *acknowledging cultural consciousness* is necessary for *canalizing compassionate care* that is holistic to meet infants and families' needs by *bridging family-centeredness* to provide culturally congruent care to birth tourism families in the NICU. Nursing literature was scarce concerning the delivery of nursing care that is compassionate, culturally congruent, family-centered and appropriate for patients of diverse cultural backgrounds. Among the few models available giving care to a culturally diverse patient population, Campinha-Bacote's model: the process of cultural competemility in delivering healthcare services provided a connection with the themes that emerged from this study. This connection gave further meaning to the stories and experiences of neonatal nurses. This model connected similar synergistic process between culturally appropriate (competent) and compassionate (humility) care, which neonatal nurses through their stories, can render nursing care to birth tourism families in the NICU. Nursing knowledge gained through this study, the understanding of the lived experience of neonatal nurses caring for the birth tourism population. Funneling of cultural care is of essence through *recognizing cultural interactions*, *acknowledging*

*cultural consciousness, canalizing compassionate care and bridging family-centeredness*  
to deliver compassionate, culturally congruent, family-centered quality nursing care to  
birth tourism families who admit a sick or ill newborn in the NICU.

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*Appendix A***BARRY UNIVERSITY****OFFICIAL INSTITUTIONAL REVIEW BOARD APPROVAL LETTER****Barry University**

Division of Academic Affairs

Institutional Review Board  
 11300 NE 2nd Avenue, Miami, FL 33161  
 P: 305.899.3020 or 1.800.756.6000, ext. 3020  
 F: 305.899.3026  
[www.barry.edu](http://www.barry.edu)

**Research with Human Subjects  
 Protocol Review**

**LETTER OF APPROVAL AS EXEMPT**

Date: 03/20/2020  
 Expiration Date: 03/19/2021  
 Protocol Number: 1581368  
 Study Title: Nurses Caring for Birth Tourism Families in Neonatal Intensive Care  
 Units: A Phenomenological Inquiry  
 Principal Investigator: Tamara LaCroix  
 Faculty Sponsor: Jessie M. Colin, Ph.D., RN, FRE, FAAN

Dear Researcher:

On behalf of the Barry University Institutional Review Board (IRB), I have granted final approval for this study as exempt from further review.

As principal investigator of this protocol, it is your responsibility to make sure that this study is conducted as approved by the IRB. Any modifications to the protocol or consent form, initiated by you or by the sponsor, will require prior approval, which you may request by completing a protocol modification form.

It is a condition of this approval that you report promptly to the IRB any serious, unanticipated adverse events experienced by participants in the course of this research, whether or not they are directly related to the study protocol.

Should you wish to maintain this protocol in an active status beyond the expiration date noted above, you must submit an annual report, checking the box to request a deadline extension for an additional year.

If you have questions about these procedures, or need any additional assistance from the IRB, please contact the IRB point of contact, Ms. Jasmine Trana (305-899-3020 or [jtrana@barry.edu](mailto:jtrana@barry.edu)). Finally, if you are required to carry professional liability insurance, please review your policy to make sure your coverage includes the activities in this study.

Sincerely,

Tan Fung Ivan Chan, EdD, OTD, OTR/L  
 Co-Chair, Institutional Review Board (IRB)  
 Barry University  
 College of Nursing and Health Sciences (CNHS)

\*\*\*\*\*  
*Note: The investigator will be solely responsible and strictly accountable for any deviation from or failure to follow the research protocol as approved. Barry University has no liability related to claims arising from said deviation or failure.*



## *Appendix B*

### **BARRY UNIVERSITY**

#### **INFORMED CONSENT FORM**

Your participation in a research project is requested. My name is [REDACTED] and I am a Barry University College of Nursing and Health Sciences (CNHS) student working on a Doctorate in Nursing Degree. I am conducting a Nursing study titled **“Nurses Caring for Birth Tourism Families in Neonatal Intensive Care Units: A Phenomenological Inquiry”**, and I am seeking information that will be useful in the field of Nursing for practice in neonatology and research.

The purpose of this study is to understand the experience of neonatal nurses caring for birth tourism families who admit a newborn into South Florida’s neonatal intensive care units. This research aims to give neonatal nurses a voice to express their individual experience of caring for birth tourism families, to inductively interpret their everyday experience in their lifeworld, and to understand the essence of caring for this unique population.

In accordance with this aim, the following procedures will be used: The interview will be conducted via face-to-face, or Skype video conferencing method, using open-ended questions related to the topic of neonatal nurses' lived experiences in caring for birth tourism families who admit an infant to South Florida NICUs. The semi-structured interview that will last a maximum of 60 minutes at a mutually agreed place and the time will include the completion of a demographic questionnaire lasting a maximum of 5 minutes (inclusive of the 60 minutes), open-ended questions for the interview and reflection time to translate their experience of caring for birth tourism in the NICU into an artistic expression (poetry, song, picture art) lasting a maximum of 10 minutes (inclusive of the 60 minutes). Participants will have the option of turning in their artistic expression via electronic mail for participants who have chosen the Skype video conferencing method.

A maximum of 30 minutes for the second follow-up member check meeting involving a review of the transcript and option to turn in artistic expression via electronic mail. The second follow-up member-check meeting will be conducted via telephone to make sure that the interview transcription notes are correct and to clarify any question (s). This will be scheduled at the end of each interview for a later date and time agreed upon between participant and researcher. The total participation time is a maximum of 90 minutes for the documentation forms completion by the participant, interview questions,

the artistic expression, and the second follow-up member-check meeting. We anticipate that the number of participants to be a maximum of 25 neonatal nurses.

Your consent to be a study participant is strictly voluntary and should you decline to participate, or should you choose to drop out at any time during the study, there will be no adverse effects on your employment as a neonatal nurse.

There are no risks to you for your involvement in this study. Although there are no direct benefits to you for participating in this study, your participation in this study may help our understanding of providing care to birth tourism families in the NICU.

If you decide to participate in the study, you must meet the following criteria:

- Self-report as an active Florida licensed registered nurse
- Must have worked for a minimum of six months in a South Florida hospital with a level I to a level IV newborn neonatal services (neonatal intensive care unit)
- Must have cared for birth tourism families who admitted an infant into a level I to a level IV newborn and neonatal services (neonatal intensive care unit)
- Able to read, write, and speak English
- Agree to participate via face-to-face or Skype interview, lasting a maximum of 60 minutes at a mutually agreed place and time
- Have access to the telephone, computer, electronic mail, and the Internet using Skype video conferencing capability
- Be willing to meet for a review of the transcript via telephone for a maximum of 30 minutes
- Be willing to have the interview digitally audio-recorded and transcribed by the researcher or a third party transcriptionist

**If you decide to participate via Skype.** As this project involves the use of Skype, measures will be taken to prevent others from eavesdropping on communications and to prevent impersonation or loss of personal information. Skype issues everyone a "digital certificate" which is an electronic credential that can be used to establish the identity of a Skype user, wherever that user may be located. Further, Skype uses well-known standards-based encryption algorithms to protect Skype users' communications from falling into the hands of hackers and criminals. In so doing, Skype helps ensure user's privacy as well as the integrity of the data being sent from one user to another. If you have further concerns regarding Skype privacy, please consult the Skype privacy policy. To ensure confidentiality, the researcher will establish a separate Skype account for this research project only. After each communication, the researcher will delete the conversation history. Once this is done, the conversation cannot be recovered. The audio portion of the Skype communication will be recorded using a separate digital audio-recorded device.

No identities will be revealed. Each participant will be asked to choose a pseudonym that will only be known by the participant and the nurse researcher. A pseudonym will be used on a demographic questionnaire to keep personal information confidential. In the

event of the participant's withdraw from the nursing inquiry, the data obtained from them will be destroyed and not included in the study.

An informed consent form will be sent via DocuSign (password protected secured electronic signature technology compliant with the US E-SIGN act) for participants who are not able to meet for face-to-face interviews and accessing Skype. Participants interviewing via Skype will be guided to how to securely sign in and to resend documents via nurse researcher's electronic mail. Precautionary measures will be taken to access these DocuSign forms on nurse researcher's password-protected personal computer.

All digitally audio-recorded data will be transcribed by the researcher or a transcriptionist. The transcriptionist will provide signed third-party Confidentiality. Data from digital audio-recordings will be destroyed after the researcher verifies that the interview transcripts are correct and clarifies any questions with the participant during the second follow-up meeting (member checking). All data will be kept separate in a locked file in the researcher's office. Data received from the transcriptionist will be stored on the nurse researcher's password-protected computer, and later scanned and destroyed. Upon completion of this study, the researcher will maintain all data from this nursing inquiry, as required by United States regulation for five years and indefinitely thereafter in a password-protected external hard drive locked in the researcher's home office.

The nurse researcher will give a \$25 Visa gift card to the participant after they sign the informed consent or receipt of the DocuSign consent as a token of appreciation for participating in the study. This token will be kept by the participant whether the interview reaches its completion or refuse to answer any questions. If you have any questions or concerns regarding the study or your participation in the study, you may contact me at [REDACTED] my faculty advisor and Chair, [REDACTED], or the Institutional Review Board point of contact, Jasmine Trana, at (305)899-3020 and/or .

If you are satisfied with the information provided and are willing to participate in this study, please signify your consent by signing this consent form.

### **Voluntary Consent**

I acknowledge that I have been informed of the nature and purposes of this nursing study by Tamara LaCroix and that I have read and understood the information presented above, and that I have received a copy of this form for my records. I give my voluntary consent to participate in this experiment.

By signing this form, you agree that you understand the nature of the study, the possible risks to you as a participant, and how your identity will be kept confidential. When you sign this form, this means that you give your permission to volunteer as a participant in the study that is described here.

\_\_\_\_\_ Face-to-face Interview      \_\_\_\_\_ Skype Interview

\_\_\_\_\_ Yes, I would like to submit creative artistic piece      \_\_\_\_\_ No, I will not submit a creative artistic piece

(Please choose the method of participation and indicate whether you would like to submit a creative artistic piece)

\_\_\_\_\_  
*Signature of Participant*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Researcher*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Witness*

\_\_\_\_\_  
*Date*

(Witness signature is required only if research involves pregnant women, children, other vulnerable populations, or if more than minimal risk is present.)

*Appendix C***BARRY UNIVERSITY****LETTER OF REQUEST FOR ACCESS**

[REDACTED]  
 Ph.D. Student Barry University, College of Nursing and Health Sciences  
 [REDACTED]  
 [REDACTED]

**SUBJECT: A Nursing Study of Neonatal Nurses Providing Care to Birth Tourism Families in South Florida's Family-Centered Neonatal Intensive Care Units**

Dear Sir/Madam:

I am a doctoral student at Barry University, College of Nursing and Health Sciences. I am conducting a study on the experience of neonatal nurses who are currently working in South Florida's NICUs. Participants should be registered nurses who hold an Associate, Bachelors, Master of Science in Nursing, or a Doctorate in Nursing and who have worked with birth tourism families for at least 6 months. I plan to collect data from the participants using audiotaped recorded interviews and 2 meetings (meeting 1 is max 60 minutes interview; meeting 2 is max of 30 minutes member check for review of transcript) via face-to-face at a mutually agreed upon place, or via Skype, lasting a maximum of 90 minutes for both meetings. I anticipate a maximum of 25 neonatal nurses to briefly discuss my study. There will be no link to your organization and the study. They may contact me by phone and/or email provide on the recruitment flyer. Participation in this study is voluntary for neonatal nurses who are willing to share their experiences as to providing care for birth tourism families. Volunteers will be given a \$25.00 Visa Gift card as a token of appreciation.

If you agree, may you please draft a letter of approval to access your members and post the flyer of recruitment on your website, to be place on a letterhead and return a scanned copy to [REDACTED]

Thank you for your consideration in allowing me access to recruit volunteers for the study. If you have any questions, you may please contact me at [REDACTED]. You may also contact my faculty sponsor, [REDACTED]. The IRB contact is Jasmin Trana at (305) 899-3020 or via email at [REDACTED]. I look forward to your response at your earliest convenience.

Sincerely,  
 [REDACTED]

Barry University Doctorate in Nursing Philosophy Student, CNHS

*Appendix D*

**BARRY UNIVERSITY**

**FLYER FOR RECRUITMENT OF SAMPLE**



COLLEGE OF  
**NURSING &  
HEALTH SCIENCES**  
**Barry University**



**NEONATAL NURSES NEEDED  
VOLUNTEER TO PARTICIPATE**

Have You Cared For **BIRTH TOURISM FAMILIES**  
**Who Admitted an Infant in the NICU?**

**PURPOSE OF THIS STUDY:**

**-TO SHARE YOUR EXPERIENCE OF CARING FOR BIRTH TOURISM FAMILIES**

**YOU MUST BE:**

1. Self-identify as a Florida licensed registered nurse specializing in neonatal nursing
2. Working in a South Florida neonatal intensive care unit
3. Have cared for birth tourism families
4. Be able to read, write, and speak English fluently
5. Agree to participate via face-to-face or via Skype interview- Maximum of 60 minutes
6. Have access to the telephone, computer, email, and the Internet (Skype, video conferencing)
7. Be willing to meet for a review of the transcript via telephone for a maximum 30 minutes
8. Be willing to have the interview digitally audio-recorded and transcribed by a third party transcriptionist

**BE AVAILABLE FOR MAXIMUM of 90 minutes**

Maximum **60-minutes** - Face-to-face or Skype **INTERVIEW**

Maximum **30-minutes Conversation** to confirm the transcribed interview

**RECEIVE \$25.00 Visa gift card AS AN APPRECIATION**

**NEED MORE INFORMATION: Please Contact-**

Researcher: **Tamara LaCroix** at Barry University – Cell [REDACTED]

E-Mail Address: [REDACTED]

Dissertation Chair: Dr. Jessie M. Colin at [REDACTED]

E-Mail Address: [REDACTED]

Barry University Institutional Review Board: Jasmine Trana at-305-899-3020

E-Mail Address:

*Appendix E***BARRY UNIVERSITY****INTERVIEW QUESTIONS****The Grand Tour Interview Question**

What is your experience of providing care for birth tourism families who admit their infant unexpectedly into a neonatal intensive care unit?

**Follow-up Questions**

- What does “birth tourism” mean to you?
- Have you had any experience in caring for birth tourism families?
- Tell me more about your experience.....?
- Give me an example of a situation.....?
- How do you feel about the act birth tourism?
- Do you believe that birth tourism is an illegal act?
- How will you address negativity regarding birth tourism?
- What does “caring for the family” means to you...?
- What does, providing care to birth tourism families means...?
- What does the care for the infant means...?
- Tell me what your day in the neonatal intensive care looks like?
- Tell me about family-centered care in your NICU?
- Using silence to prompt participants to recall their experience.
- Is there anything else you would like to add?

*Appendix F***BARRY UNIVERSITY****DEMOGRAPHIC QUESTIONNAIRE**

**Thank you for participating in this Nursing Study. This will take you 10 minutes to complete.**

**Please complete the following questionnaire by selecting and providing the most appropriate answer for you.**

**Pseudonym:** \_\_\_\_\_

**(Select a single name of your choice that will be used in the study)**

**(Please circle your answer or fill in the blank)**

**Age:** 20 – 27    28 – 34    35 – 42    43 – 50    51 – 58    58+

**Gender:** Male    Female

**Ethnicity:** Hispanic/Latino    African-American    Asian/Pacific Islander  
American Indian    Other: \_\_\_\_\_

**Educational level:** Associates    Bachelor's    Master's    Doctorate

**Marital status:** Married    Common-law    Single    Divorced    Separated

**The number of years of experience as a registered nurse:**

6 months – 4 years    5 – 9 years    10 – 14 years    15 – 20 years    20 years +

**The number of years of experience as a neonatal nurse:**

6 months – 4 years    5 – 9 years    10 – 14 years    15 – 20 years    20 years +

**The number of years in the current unit:**

6 months – 4 years    5 – 9 years    10 – 14 years    15 – 20 years    20 years +

**Have you ever received training on how to care for the family or families from a foreign country?**

One-time class    Every year    Every five years    Every 10 years    Every 15 years +

**Is your facility family-centered? Yes No Is there a Policy for family-centered care? Yes No**

*Appendix G***BARRY UNIVERSITY****THIRD-PARTY CONFIDENTIALITY FORM**

## Confidentiality Agreement

As a member of the research team investigating \_\_\_\_\_, I understand that I will have access to confidential information about study participants. By signing this statement, I am indicating my understanding of my obligation to maintain confidentiality and agree to the following:

- I understand that names and any other identifying information about study participants are completely confidential.
- I agree not to divulge, publish, or otherwise make known to unauthorized persons or to the public any information obtained in the course of this research project that could identify the persons who participated in the study.
- I understand that all information about study participants obtained or accessed by me in the course of my work is confidential. I agree not to divulge or otherwise make known to unauthorized persons any of this information unless specifically authorized to do so by office protocol or by a supervisor acting in response to the application protocol or court order, or otherwise, as required by law.
- I understand that I am not to read information and records concerning study participants, or any other confidential documents, nor ask questions of study participants for my own personal information but only to the extent and for the purpose of performing my assigned duties on this research project.
- I understand that a breach of confidentiality may be grounds for disciplinary action and may include termination of employment.
- I agree to notify my supervisor immediately should I become aware of an actual breach of confidentiality or situation which could potentially result in a breach, whether this is on my part or on the part of another person.

Signature: .....Printed Name..... Date.....

Signature: .....Printed Name..... Date.....

*Appendix H***BARRY UNIVERSITY**

Barbie Carpenter, Editor/Owner  
Carpenter Document Consulting  
[barbie@carpenterdoc.com](mailto:barbie@carpenterdoc.com)

April 14, 2021

Dear Barry University Dissertation Committee:

This letter certifies that I completed a comprehensive edit of Tamara LaCroix's dissertation, entitled *Nurses Caring for Birth Tourism Families in Neonatal Intensive Care Units: A Phenomenological Inquiry*. The manuscript was edited for grammar and style; no content was changed or rewritten. The document was returned with revisions, including tracked changes to accept and comments to address, on April 13, 2021.

Sincerely,

Barbie Carpenter

*Appendix I*

**BARRY UNIVERSITY**



Clinical, Administrative, Research  
& Educational Consultation  
in Transcultural Health Care

**J. Campinha-Bacote,**  
PhD, MAR, PMHCNS-BC, CTN-A, FAAN  
Transcultural Healthcare Consultant

☎ 513-469-1664  
☎ 513-469-1764  
✉ meddir@aol.com

www.transculturalcare.net

11108 Huntwicke Place  
Cincinnati, Ohio 45241

April 14, 2021

To: Ms. Tamara LaCroix  
From: Dr. Josepha Campinha-Bacote  
President, Transcultural C.A.R.E. Associates

RE: **Contractual Agreement for Limited Use of Campinha-Bacote's  
Model of Cultural Competemility**

This letter grants one-time permission to Ms. Tamara LaCroix to copy my 2018 model of cultural competemility as it appears on my website at in <http://transculturalcare.net/the-process-of-cultural-competence-in-the-delivery-of-healthcare-services/>, in her academic paper to be submitted in her doctoral proposal and final paper in 2021.

**TIME FRAME:** Permission to use my model is a one-time use as stated above when she submits it to her professor in an academic paper by May 30, 2021.

**RESTRICTIONS OF COPYING:** This permission only allows the copying/ of my model in this paper and Ms. Tamara LaCroix agrees that my model cannot be copied for any other reason outside of this paper. This includes, but not limited to, not being copied in another formal or informal publication or academic paper, handouts, Power Point presentations, presentations to her faculty, students or colleagues, Poster presentations or in any hard copy or electronic formats for presentations or for any other purpose.

Ms. Tamara LaCroix will use the following citation when citing my model in her paper:

**The Process of Cultural Competemility in the  
Delivery of Healthcare Services  
Copyrighted in 2018 by Campinha-Bacote**

**GOVERNING LAW:** All parties acknowledge that this Contractual Agreement for Limited Use of Campinha-Bacote's Models of Cultural Competence and Competemility are a valid contract. This contract shall be governed and construed under the laws of the State of Ohio, except as governed by Federal law. Jurisdiction and venue of any dispute or court action arising from or related to this contract shall lie exclusively in or be transferred to Hamilton County Municipal Court, Hamilton County Court of Common Pleas, or the Federal Court situated in the County of Hamilton, Ohio.

**ATTORNEY'S FEES AND COSTS:** In any action to enforce any provision of this Agreement, the prevailing party will be awarded reasonable attorney's fees and costs.

Dr. Josepha Campinha-Bacote

Ms. Tamara LaCroix

4/14/21  
Date  
4/15/2021  
Date

*Appendix R*

**Dissertation Correction Sheet  
Barry University College of Health Sciences  
College of Nursing and Health Sciences**

Candidate's Name: Tamara LaCroix \_\_\_\_\_

Telephone Home: 786-597-2970 Work: N/A

Date to Candidate: 4/28/2021 Date returned to Chair: 4/29/2021

Page	Paragraph	Line	Correction	Checked
Page 269	1	17, 18,19, 20	Elaborated on connection to cultural skill and cultural humility	
Page 272	1	8,9,10	Added clarity to added constructs' connections cultural skill, desire, encounter and humility.	
Page 263	2	5	Added funneling of cultural care	
Page 269	1	Figure 8	Added the conceptual representation of constructs	
Page 176	Figure 3	Figure 3	Lines showing fluidity and solid lines were replaced by fluidity	
Page 274	2	14	Added funneling cultural care	

See corrections listed on attached sheet(s).

Other \_\_\_\_\_

Corrections have been made and approved:

Dissertation Committee Chair \_\_\_\_\_ Date 6/28/2021

Program Director \_\_\_\_\_ Date 6/28/2021

**VITA****ACADEMIC DEGREES**

	<b>DATE</b>	<b>MAJOR</b>	<b>FIELD</b>
Barry University	2016-2021	PhD	Nursing
Barry University	2009-2012	MSN-Ed	Nursing
Barry University	2006-2008	BSN	Nursing
Miami Dade College	2001	AS	Nursing
Lindsay Hopkins Technical Center	1993	LPN	Nursing

**PROFESSIONAL EXPERIENCE**

Barry University	2014-present	Nursing Faculty
Baptist Children Hospital	2005-present	Registered Nurse
NOVA South Eastern University	2016-2018	Nursing Faculty
Education Affiliates/ Fortis College	2013-2014	Nursing Faculty
Baptist Hospital of Miami	2006-2012	BLS Instructor
Baptist Hospital of Miami	2001-2005	Registered Nurse
Integrated Health Services at Greenbriar	2000-2001	LPN-Wound Care
Coral Reef Nursing and Rehabilitation Center	1998-2000	LPN
Integrated Health Service at West Gables	1997-1999	LPN-Wound Care
Villa Maria Nursing and Rehabilitation Center	1995-1997	LPN
Saint Anne's Nursing and Rehabilitation Center	1993-1995	LPN

**CERTIFICATIONS/LICENSURE**

BLS, NRP, ACLS, PALS Certifications

CITI Certification

Florida Board of Nursing Registered Licensure

## **HONORS AND AWARDS**

- 2018 Florida Blue Poster Award from Lambda Chi Chapter-Sigma
- 2009 Sigma Alpha Pi, National Society of Leadership and Success Award

## **SCHOLARLY ACTIVITIES**

- NIELP Collaborative- Barry University 2019  
Co-bedding research study- South Miami Hospital 2012

Pet Therapy research study- Homestead Hospital 2010

## **MEMBERSHIPS IN COMMUNITY ORGANIZATIONS**

- 2019- - NIELP- Nursing International and Education Learning  
Program- Barry University Team

## **PROFESSIONAL SERVICES**

### **Service to the Community**

- January 2019 - NIELP- Nursing International and Education Learning Program-  
Barry University Team- Project Port-de- Paix, Haiti
- April 2014  
and 2016 - Dr Herbert and Nicole Wertheim Community Healthcare Conference  
“The Essence of a Registered Nurse in the NICU”
- November 2013- Baptist Children Hospital “Annual NICU Reunion”
- April 2013 - Dr Herbert and Nicole Wertheim Community Healthcare Conference  
“How to become a Health Professional.”

## **POSTER PRESENTATIONS**

- 2020- SEFANN Hot Topics in the Tropics XXV “Perceptions of Neonatal Nurses  
Providing Cultural Competent Care To Traveling Women in the NICU”
- 2019- Barry University Annual Conference “Optimizing Healthcare Internationally with  
Interdisciplinary Partnerships: Nursing and Education Collaborative Experience in the  
North-West Department of Haiti
- 2018- Sigma Theta Tau Lambda Chi Chapter Nursing Conference Poster Presentation  
“Access to Maternal Health Care for Undocumented Pregnant Women in South- Florida”  
Florida Blue Nurse Leadership Development Program
- 2013- Co-Bedding Study- 2<sup>nd</sup> Annual Research Conference Baptist Health of South  
Florida- Podium Presenter