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Globalization: Migrant nurses' acculturation and their healthcare encounters as consumers of healthcare

Cheryl Zlotnick[1] | Harshida Patel[2] | Parveen Azam Ali[3,4] | Temitayo Odewusi[5] | Marie-Louise Luiking[6]

[1]Cheryl Spencer Department of Nursing, University of Haifa, Haifa, Mount Carmel, Israel

[2]Institute of Health Care and Sciences, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden

[3]Health Sciences School, Doncaster and Bassetlaw Teaching Hospitals, University of Sheffield, Sheffield, England, UK

[4]International Nursing Review, Sheffield, England, UK

[5]Department of Nursing, Queen Margaret University, Edinburgh, Scotland, UK

[6]Anaesthesiology, Leiden University Medical Centre, Leiden, The Netherlands

Correspondence
Cheryl Zlotnick, Cheryl Spencer Department of Nursing, University of Haifa, 199 Abba Khushi Ave, Haifa, Mt Carmel 3498838, Israel.
Email: czlotnick@univ.haifa.ac.il

Abstract

Globally, one of every eight nurses is a migrant, but few studies have focused on the healthcare experiences of migrant nurses (MNs) as consumers or recipients of healthcare. We address this gap by examining MNs and their acculturation, barriers to healthcare access, and perceptions of healthcare encounters as consumers. For this mixed-methods study, a convenience sample of MNs working in Europe and Israel was recruited. The quantitative component's methods included testing the reliability of scales contained within the questionnaire and using Hayes Process Model #4 to test for mediation. The qualitative component's methods included analyzing interviews with iterative inductive thematic analysis. Quantitative findings on MNs ($n = 73$) indicated that the association between acculturation and perception of the healthcare encounter, which MNs experienced as healthcare consumers, was mediated by barriers to healthcare access, even after adjusting for age and gender ($p = 0.03$). Qualitative interviews with MNs ($n = 13$) provided possible explanations for the quantitative findings. Even after working in the host country's healthcare system for several years, MNs reported difficulties with their healthcare encounters as healthcare consumers, not only due to their limited knowledge about the culture and healthcare resources but also due to the biased responses they received.

KEYWORDS

acculturation, foreign nurses, globalization, healthcare experiences, migrants, workforce diversity

1 | INTRODUCTION

Many countries' healthcare systems struggle to address the healthcare needs of the increasing numbers of migrants, defined as individuals who move to and reside in a country that is outside their country of birth without regard for the intended duration of residence (International Organization for Migration [IOM], 2019a, p. 132). Of the approximately 272 million migrants enumerated in 2019, many were skilled healthcare workers including nurses, who comprise the largest professional group of healthcare workers in the world (IOM, 2019b). Globally, 13% of nurses meet the definition of being a "migrant" (Buchan & Catton, 2020). Within the Organisation for Economic Co-operation and Development (OECD) countries, an even higher percent (about 16%) of nurses were migrant nurses

(MNs); of these, a third originated from OECD countries, a quarter from upper-middle-income non-OECD countries, a third from lower-middle-income countries, and 6% from low-income countries (Socha-Dietrich & Dumont, 2021).

MNs add greater cultural diversity to the nursing workforce and contribute to better staffing, and better staffing promotes patient satisfaction, which, in turn, improves healthcare outcomes (Haddad et al., 2022). Understandably, the benefits of employing MNs are realized only if the MNs are healthy themselves. MNs who have a satisfactory perception of their healthcare encounters as consumers and recipients of healthcare are more likely to use healthcare services when needed. This study explores the experiences of MNs as healthcare consumers by examining the relationships among acculturation, barriers to healthcare access, and perceptions of the healthcare encounter in the host country.

2 | BACKGROUND

The umbrella term of migrants contains several diverse groups. Among the vulnerable migrant groups are refugees or asylum-seekers who cross international borders through irregular means as they flee from poverty or war. Included in the less vulnerable migrant groups are regular migrants who possess citizenship or work visas and seek better economic opportunities and different lifestyles. Many MNs fall within this latter category.

Owing to nursing shortages, MNs with education and experience have been recruited from their country of origin to work in another country (host country), which most frequently has been a high-income country. The result is that disproportionately, MNs comprise 15.2% of nurses in high-income countries versus less than 2% of nurses in middle- or low-income countries (World Health Organization [WHO], 2020).

Many MNs lack an understanding of several aspects of their host country's culture. They report issues with communication, both verbal and nonverbal, problems adapting to the host country's work procedures and routines, and other difficulties adjusting to the new culture and society (Brunton et al., 2019; Yu et al., 2018). MNs who are culturally and linguistically diverse from the native population are at particular risk for these stresses and difficulties (Schilgen et al., 2019). Unequal wages, unfair promotion practices, racism, and discrimination have been reported by MNs from Australia (Smith et al., 2022), Germany (Roth et al., 2021), the Netherlands (Cottingham & Andringa, 2020), the United Kingdom (Lin et al., 2018), the United States (Connor, 2016), and several other countries (Balante et al., 2021). MNs, therefore, have health risks due to psychological and social stresses (Goh & Lopez, 2016; Pung & Goh, 2017). Country differences and misunderstandings regarding safety and the use of protective equipment add to these health risks (Qureshi et al., 2022).

Acculturation refers to the process whereby migrants undergo social, psychological, and cultural changes so they understand and can adapt to a different culture, typically the host country's dominant culture (Berry et al., 1989). Acculturation includes recognizing the lifestyle and unique features of the host country's culture, possessing knowledge of the country's resources and systems, having the ability to access these resources and systems, and undergoing psychosocial changes that enable migrants to balance the host country's culture with their own; the result is that acculturation alters the migrants' self-identity such as Korean–Canadian (Berry et al., 1989).

Although many studies have reported a link between duration in the host country and acculturation, more recent studies have noted that duration in the host country does not always correlate either with life satisfaction in the host country or with acculturation. Instead, investigators showed that an important part of acculturation and life satisfaction is arriving in the host country with realistic expectations for economic and social integration (Hendriks & Burger, 2020; Zlotnick et al., 2020). Therefore, it is no surprise that MNs with greater acculturation, regardless of years in the host country, have greater physical, psychological, and social quality of life (Goh & Lopez, 2016).

Still, migrants' acculturation is not solely under their control. Acculturation is a bidirectional process and includes the transformation of the society as it absorbs and interacts with migrants and their values, culture, and behaviors as well as the transformation of migrants as they experience the values, culture, and behaviors of the host country society. The transformation phase in which individuals are in the midst of changing from one status to another is the core concept of the theory of liminality (Higgott & Nossal, 1997). The liminal space is filled with the ambiguity of the transition, which is distorted further by geographical, sociopolitical, and other influences (Willis & Xiao, 2014). The theory of liminality has been used to describe the transitional phase of MNs as they work in the host country (Choi et al., 2019). For MNs, the process includes blending values and beliefs obtained from their country of origin with those obtained from the host country. This process of merging two cultures includes absorbing and integrating the reactions and interactions that they have with others including nonmigrants in the host country. For migrants, this period of transformation called the liminal state is characterized by uncertainty, fear of failure, and being unclear about their societal role or status (Willis & Xiao, 2014). It is a period of vulnerability and stress.

It is less common to think about nurses, even MNs, as being vulnerable, particularly within the realm of healthcare. Due to their work experience and healthcare background, we might assume that it would be easier for MNs to overcome barriers to healthcare access compared to other migrants. This assumption makes MNs an interesting population group and might explain the few studies exploring the topic of MNs' acculturation and healthcare encounters or access as consumers of healthcare.

Among studies that examined MNs' acculturation, most were qualitative with very small samples (Balante et al., 2021; Buttigieg et al., 2018; Connor, 2016). The relatively few that were quantitative studies measured MN acculturation using either theoretically based scales, instruments specific to unique target populations, or scales targeting only language and communication difficulties, which

omitted information such as sample questions or levels of internal consistency (Alexis, 2015; Goh & Lopez, 2016; Hall et al., 2015). The result is a dearth of information on reliable measures of MN acculturation.

We also searched for peer-reviewed literature on the topic of MNs' healthcare encounters in which the MNs were consumers but found none. Nevertheless, we did find a meta-ethnographic review that presented a theoretical model suggesting that migrants' perception of their own healthcare encounters in the host country (as healthcare consumers) was linked to migrants' acculturation and migrants' perceptions of their ability to overcome barriers to healthcare access (Luiking et al., 2019). However, this meta-ethnographic review was based on studies with diverse samples including regular migrants as well as vulnerable migrant groups, such as asylum-seekers and refugees (Luiking et al., 2019). Since MNs usually are in the less vulnerable group of regular migrants and have the added advantage of working in the healthcare system, it is possible that they would experience much fewer barriers to healthcare access than other migrants, even well-educated ones.

3 | AIM AND HYPOTHESIS OF STUDY

The aim of this study was to focus on MNs as consumers of healthcare services and examine the associations among the three major constructs from the meta-ethnographic model (acculturation, barriers to healthcare access, and perception of the healthcare encounter).

4 | METHODS

4.1 | Research design and data collection (EQUATOR checklist)

This study used a mixed-methods design and adhered to the reporting standards of the EQUATOR—quality of mixed methods studies in health services research (O'Cathain et al., 2008). The quantitative component, using a cross-sectional design, was comprised of a questionnaire that enabled the examination of associations among the three constructs (i.e., acculturation, barriers to healthcare access, and perception of the healthcare encounter). The qualitative component included in-depth interviews designed to provide a deeper understanding of these three constructs and the relationships among them.

4.2 | Data collection

For the quantitative component, working MNs were recruited through an online invitation from March 2021 through June 2022 via social media outlets targeting nurses in Europe, Israel, and elsewhere. Among the social media sites used were: European Region of Sigma's Facebook, Linked-In, and Twitter. The link included the study purpose, study description, and the online questionnaire.

For the qualitative component, one method of recruitment was via an invitation placed at the end of the online questionnaire. Additional recruitment methods included networking and word-of-mouth. These efforts were mostly implemented by the second through fifth authors who identified MNs within their social networks.

4.3 | Sample and setting

For this mixed-methods study, migrant was defined as being born in one country (country of origin) and working in another (the host country), thus MNs were defined as being registered nurses who were born in another country (country of origin) and worked in the host country. All MNs participating in this study were recruited from Europe and Israel.

Using G-Power version 3.1, we found that to achieve at least 85% statistical power to detect a moderate effect of 25%, given five predictors, and a $p < 5\%$, a minimum sample size of 64 was needed. A total of 75 MNs entered the online site and filled out the questionnaire. Two questionnaires, however, were incomplete, so the quantitative component contained a sample of 73 (97%). For the qualitative component, a total of 13 MNs completed online interviews.

4.4 | The instruments

The quantitative questionnaire, developed by the research team, was an anonymous, online English-language questionnaire that required 10–15 min to complete. The questionnaire contained basic demographic questions (e.g., gender, year of birth, country of birth, current country of residence, years lived in the host country), and scales to measure the three constructs (i.e., acculturation, barriers to healthcare access, and perception of the healthcare encounter).

- MN acculturation. This construct, measured by nine questions on a 5-point Likert scale, achieved an internal consistency of 0.726. An example of the items in this measure includes: "It was easy for me to adapt to living in my host country."
- Barriers to healthcare access. This construct, measured by eight questions on a 5-point Likert scale, achieved an internal consistency of 0.823. An example of the items in this measure includes: "Seeking professional health care in my host country is difficult for me due to a lack of knowledge about available services."
- Perception of the healthcare encounter (as consumers of healthcare). This construct, measured by six questions on a 5-point Likert scale, achieved an internal consistency of 0.956. An example of the items in this measure includes: "How do you personally feel about the last visits with the health care professionals in your host country? [I felt] Respected."

The qualitative interviews lasted 40–90 min and began with the general open question: "What is crucial for you while seeking medical care?" Probes were used to elicit examples of cultural aspects, beliefs, and perspectives about acculturation, barriers to healthcare access, and perceptions of the healthcare encounter. The interviews were tape-recorded (with permission), anonymized, and transcribed verbatim. Interviews were collected until saturation was reached.

4.5 | Ethical considerations

Investigators from three countries obtained ethics committee approval for administering the mixed-methods study (from three countries: Israel—University of Haifa #040/21; Sweden—Gothenburg University #2020-02873; UK—University of Sheffield #032809). Accordingly, the study was carried out in accordance with the principles of the Declaration of Helsinki.

4.6 | Data analysis

For the quantitative component, analyses were conducted using SPSS version 27 and Hayes Process Model #4 to test mediation (Hayes & Scharkow, 2013). Variable frequencies were examined. Bivariate analyses included examining associations using Pearson's correlation coefficients and assessing internal consistency using Cronbach's α. Multivariable analysis included linear regression models using Hayes Process Model #4 to examine whether barriers to healthcare access mediated the relationship between MN acculturation (independent variable) and the perception of the health encounter (dependent variable).

For the qualitative component, the iterative inductive thematic analysis was conducted by at least two researchers using the following steps (Denzin & Lincoln, 2018). Researchers individually read all interviews to gain a sense of the whole (de-contextualization phase); next they reread each interview separately, coding text for categories and themes; and then ensured that all content was reviewed with respect to the aim (recontextualization phase). Once researchers completed their coding individually, they reviewed codes together until a consensus was reached. Next, they conducted thematic coding based on MN acculturation, barriers to healthcare access, and perception of the healthcare encounter as a consumer of healthcare.

5 | RESULTS

5.1 | Quantitative component

In the sample of MNs ($n = 73$), the majority were females, married, educated at the graduate level, and employed full-time (see Table 1). The region of the country of birth varied: about a third were born in Europe, about a half in Asia (including the Middle East), and the remainder in Africa and the Americas. The region of the host country, however, was less varied as most MNs lived in Europe, and only about a 10th or fewer lived elsewhere. Approximately a 10th did not report their current region of residence. Table 1 also shows demographic characteristics. MNs' ages varied between 24 and 74 years, with an average of 41 years; their duration of residence in the host country ranged between 1 and 53 years, with an average of 13 years; and their nursing experience averaged about 9 years.

Associations of continuous variables measured by Pearson's correlation coefficients indicated the following associations: age and years in the host country ($p < 0.01$), age and years of nursing experience ($p < 0.01$), years in the host country and perceptions of the healthcare encounter ($p < 0.05$), MN acculturation and barriers to healthcare access ($p < 0.01$), MN acculturation and perception of the healthcare encounter ($p < 0.01$), and barriers to healthcare access and perception of the healthcare encounter ($p < 0.01$) (see Table 2).

Multivariable analyses tested whether barriers to healthcare access mediated the relationship between MN acculturation and their perception of the healthcare encounter (as a consumer of healthcare), adjusting for gender and age in years (years in the host country and years of nursing experience were not entered into the regression due to their strong correlations with age in years, see Table 2). A significant indirect effect was found between MN acculturation and perception of healthcare encounter, which was mediated by barriers to healthcare access ($b = 0.01051$, $t = -2.2255$, $p = 0.030$) (see Figure 1). As such, these findings indicated a causal chain that began with better acculturation, led to fewer barriers to healthcare access and resulted in more positive perceptions of their health encounter. The finding that the direct effect between the MN acculturation and perception of the healthcare encounter as a consumer of healthcare was not significant ($b = 0.1589$, $t = 1.0823$, $p = 0.284$), supported the hypothesis of full mediation (i.e., the existence of *only* the indirect causal chain).

5.2 | Qualitative component

MNs ($n = 13$) participating in the qualitative interviews were in the age group 27–64, came from 12 different countries of origin, and were living in six different host countries across Europe and Israel (see Table 3). Approximately half worked in academia while the others worked in clinical areas. The majority (69%) had advanced education. From interviews, we identified quotations that referred to the three main thematic areas of the quantitative findings: MN acculturation, barriers to healthcare access, and perceptions of the healthcare encounter in the host country (as a consumer of healthcare). Quotations are presented for different MNs.

5.2.1 | Acculturation

Several MNs mentioned acculturation issues. Some were related to the social environment and others to the work environment. Others were endemic.

TABLE 1 Quantitative component: Demographic and other characteristics of migrant nurses ($n = 73$).

Variables	n	%
Gender		
Female	51	69.9
Male	22	30.1
Marital status		
Married	44	60.3
Not married	29	39.7
Education		
Undergraduate degree or nursing school	35	47.9
Graduate degree	38	52.1
Employed		
Full-time	54	74.0
Part-time	19	26.0
Region: Country of birth		
Africa	4	5.5
Americas	8	11.0
Asia	21	28.8
Europe	28	38.4
Middle East (Asia)	12	16.4
Oceana	0	0
Region: Host country		
Africa	0	0
North, Central, or South America	8	11.0
Asia	0	0
Europe	47	64.4
Middle East (Asia)	7	9.6
Oceana	2	2.7
Not reported	9	12.3

	Mean	Standard deviation	Range	Number of scale items	Cronbach's α
Age (years)[a]	41.3	12.84	24–74		
Residence in the host country (years)	12.6	10.76	1–53		
Nursing experience (years)	8.9	8.39	0–40		
Migrant nurse acculturation	32.6	5.07	19–44	9	0.73
Barriers to healthcare access	17.3	6.62	5–34	8	0.83
Perception of healthcare encounter	23.3	5.57	6–30	6	0.96

[a]Missing data for eight respondents.

Social environment

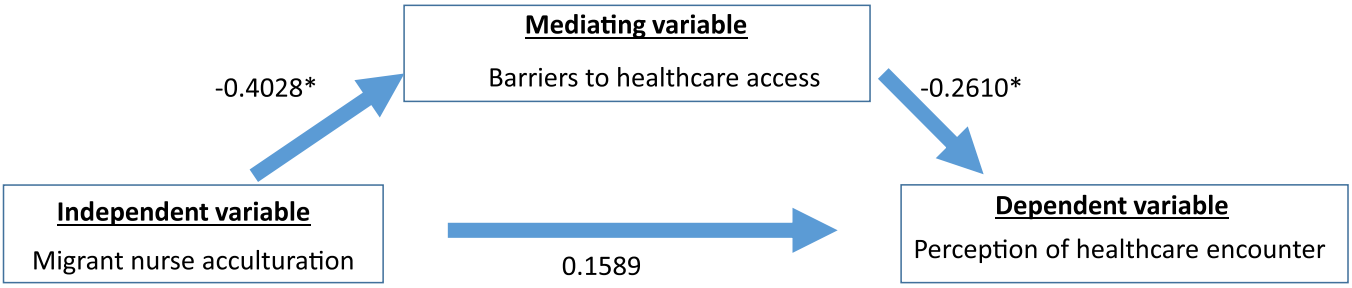
Several MNs reported that after living decades in the host country, they felt "very much at home" (MN-14, MN-15). However, one MN added a caveat to the statement: "I feel very much at home here, but of course I will never feel as if I was born here. Does that even matter? If you are happy in life, it's your mind set that matters" (MN-15).

Another MN also added a qualifier on their status in the host country.

	1	2	3	4	5	6
1. Age (years)	1					
2. Residence in the host country (years)	0.699**	1				
3. Nursing experience (years)	0.365**	−0.190	1			
4. Migrant nurse acculturation	0.181	0.147	−0.021	1		
5. Barriers to healthcare access	−0.121	−0.155	0.000	−0.353**	1	
6. Perception of healthcare encounter	0.205	0.262*	0.036	0.323**	−0.348**	1

*$p < 0.05$; **$p < 0.01$.

TABLE 2 Quantitative component: Pearson's correlations coefficients of continuous variables for migrant nurses ($n = 73$).



Relationship	Total Effect	Direct Effect	Indirect Effect	95% Confidence Interval		t-statistic	Conclusion
				Upper bound	Lower bound		
Independent variable (Migrant nurse acculturation) on Mediator (Barriers to healthcare access) on Dependent variable (Perception of healthcare encounter)	0.2640		0.1051	0.0016	0.2783	-2.2255*	Full Mediation
Independent variable (Migrant nurse acculturation) on Dependent variable (Perception of healthcare encounter)		0.1589		-0.1349	0.4527	1.0823	

*$p<0.05$: Using Hayes Process Model #4 Mediating Model (included covariates gender and age in years, which were not significant)

FIGURE 1 Mediating influence of barriers to healthcare access on the relationship between migrant nurse acculturation and perception of healthcare encounter ($n = 73$).

> I suppose my accent is not native and never will sound like a native. There are tensions at times when I have to repeat myself as I am not understood the first time. I try to be as helpful as possible in these situations and show that I am trying to accommodate the situation… Even thought I am here for over 30 years I still don't feel totally comfortable as a native might. My thick accent, which I am proud of, still shows that I am not from here. People are polite about it, to a point, but [they] do consistently remind me that I am not from here. (MN-10)

When MNs spoke about acculturation, they compared their own status to those of native-born residents. In these comparisons, even if they had resided in the host country for decades, their status or situation was lesser than the native-born residents.

Work environment

Acculturation to the work environment of the host country was discussed in very different terms than the social environment. MNs discussed their roles as nurses, as most of them were experienced professionals.

> It has taken some time to get used to the healthcare system approach here. Healthcare in the UK back in the 80's was about the concept "caring" and showing that towards patients. Much of the [nursing] care here in the healthcare system is about task orientated protocols. I felt at times discrimination [from other nurses] about the way I approached nursing and patients in a more person-centered approach. I was told we don't do that [type of healthcare] here, you have to pay attention to the collective way we do things on this unit. (MN-15)

TABLE 3 Qualitative component: Demographic profile of migrant nurses (n = 13).

Country of origin	Host country	Residence in the host country	Age	Position of employment	Highest degree
Iceland	The Netherlands	32 years	64	Senior lecturer	PhD
Italy	UK	2 years	45	Professor	PhD
Kurdistan	Sweden	17 years	35	Nurse, primary care	Masters/APN
Lebanon	Ireland	9 years	35	Senior lecturer	PhD
Macedonia	UK	32 years	56	Senior lecturer	PhD
Pakistan	UK	18 years 11 months	48	Nurse	MSc
Pakistan	UK	21 years	45	Research nurse	MSc
Philippines	Ireland	21 years	52	Nurse, critical care	BSc/critical care diploma
Serbia	Sweden	6 years	34	Nurse, geriatrics	RN/bachelor
Somalia	Sweden	15 years	40	Nurse, trauma	RN/bachelor
Syria	Sweden	7.5 years	27	Nurse, thorax	RN/bachelor
Ukraine	Israel	32 years	49	Professor	PhD
UK	Belgium	32 years	56	Professor	PhD

Integrating both the practice in the country of origin with those of the host country required conscious effort as expressed by one MN:

> In the beginning I might have felt pressured to assimilate into the dominant culture to avoid discrimination. Especially in the way I felt about caring for patients, what I had been taught as a student nurse in my home country. This pressure could have led me to a loss of cultural nursing identity and a sense of not belonging, but I pursued my stance and am glad of that. (MN-9)

Acculturation in the work environment was frustrating and anxiety-provoking. They felt conflicted between the need to fit in with the nurses of their host country and the need to retain the professional nursing standards acquired in their country of origin. Again, MNs made comparisons between the nursing practice and healthcare systems in their countries of origin and their host country, and perceived that when their clinical practice reflected the caring standards of their countries of origin rather than the task-oriented standards of the host country, their nursing activities were deemed as being poorer quality.

Another issue was disrespect; not accepting MNs as equal to non-MNs. A MN gave an example:

> Especially when it is you, when you're working in the healthcare settings and you know you're surrounded by the sisters [nurses] and the in-charge on top, you feel like they don't respect you sometimes. They just put the burden, burden, burden on you. Because I worked as a Band 5 nurse [salary ranking of a newly qualified nurse] for the past 15 years and you feel like you want to talk with somebody about it but with who? Because on the top, they are all sitting together. I don't even feel like anything [a person]. You have been disrespected; you know they have not listened to you. (MN-16)

This MN reported many levels of disrespect: as an individual who was ignored, as a team member who was assigned more work than others, and as a nurse with professional education and experience who had been overlooked for promotion. The comment illustrated the anguish and helplessness of being surrounded by nonmigrant healthcare professionals who perpetuated the inequity.

Racism

Acculturation was difficult due to the disrespect and inequities in the social and work environments. MNs whose skin color was darker and distinctive from the majority of individuals comprising the native population (MNs of color), however, reported that the addition of pervasive racism permeated both environments and completely eliminated the possibility of acculturating into the host country's society.

For instance, one MN stated: "I feel like Swede but the fact is you can never be a Swede because of your skin color" (MN-1). Another

said: that due to skin color "… you will never be cared for as a Swedish patient" (MN-5).

These quotations showed that MNs felt that racism toward their skin color precluded them from ever attaining "full" membership status in both the social and work environments. Racism also interfered with obtaining healthcare at the same level as white individuals, whether they were healthcare professionals or not. For example, one MN stated:

> Needs are met, but you notice the shortage of staff and you can see that many individuals in the staff cannot deal with the migrants because they lack cultural competence, hence I have noticed that a migrant nurse often treats a migrant patient better than a Swedish nurse. (MN-1)

Racism based on skin color prevented acculturation. The lack of diversity in the workforce was reflected by the absence of cultural awareness, and racism was so endemic that MNs concluded that the only way that they would receive appropriate healthcare would be through a fellow migrant.

5.2.2 | Access to healthcare

Cultural and communication misunderstandings

MNs encountered barriers when trying to gain access to healthcare due to poor communication, which was increased by a lack of face-to-face contact (MN-16, MN-17). While knowledge about the healthcare system facilitated gaining access to healthcare for one nurse (MN-14), others faced cultural obstacles and misunderstandings: "As a patient, you want quick solutions and relief from problems, but it seems that they don't understand your problem" (MN-2). Cultural misunderstandings added a barrier to healthcare access and to the frustration and helplessness of being in the role of a consumer who could not negotiate the healthcare system.

Even after having lived and worked in their host country's healthcare system for several decades, many MNs indicated that to obtain healthcare services as consumers, they needed help navigating the system (MN-7; MN-8; MN-13; MN-15; MN-17) or assistance with communication in the host country's language (MN-10). One MN stated:

> I came as a student and had access to healthcare via the university. But after my student access was not applicable any more, I had a hard time finding a GP. Some were rude, some were polite. It took quite some time and effort. (MN-9)

Another noted that access to healthcare was facilitated by knowing someone locally and "having connections" (MN-9). An additional perspective offered was:

> Now I am much more comfortable accessing services and navigating systems but that is only after working in various parts of the system and having good networks with colleagues who work in different parts of the system and I can tap into their knowledge about how to approach things. (MN-16)

Duration in the host country contributes to having a better status (student to working person). Still, MNs experienced difficulty with navigating the healthcare system to meet their needs (e.g., finding a general practitioner) and many obtained assistance from friends and colleagues.

Being ignored

Frustration was common among MNs who were trying to gain access to healthcare. One MN said:

> It's just so hard to get an appointment or to be seen by GP unless you ae dying! You have to cross so many hurdles before you are even able to speak to someone. In my GP surgery, sometimes it can take more than an hour to get the call answered by the receptionist, who then asks you so many questions, to basically tell you that no appointments are available for the day, and you have to go through the whole process again tomorrow. It just puts you off and you don't want to contact GP unless you are dying! (MN-16)

Many MNs are caring for their families. This additional role adds responsibility and highlights other obstacles to healthcare access. As described by one MN:

> I have had one serious encounter when my husband was really badly ill and that was a few years ago. It was really difficult to get access to appropriate services earlier on as the doctors would not take us seriously or listen to the problems that my husband was having. He ended up collapsing and was transported to A & E in ambulance, but then it was ok and services were provided nicely. (MN-17)

The MNs relayed their stress of being ignored and deterred by healthcare gatekeepers and other healthcare professionals. They noted that they only were able to obtain the needed healthcare when the situation became dire.

System-wide obstacles

Other barriers to accessing healthcare were due to shiftwork (MN-13) or staff shortages (MN-4). As a result, some decided to delay obtaining needed healthcare:

> Sometimes I just ignored the problem [and decided] that it will settle itself rather than going to GP,

> because especially if you're working nine till five, and there is no access because recently our practice said that there is no face to face appointments available and you cannot come to the surgery to make an appointment. (MN-17)

Another MN remarked: "There are long waiting times in the healthcare system here for all of us, which means that it can be difficult to get an appointment [for myself and my family] while I am teaching" (MN-10).

Being a MN and living alone added other obstacles as detailed by one MN:

> I know personally that I wait far too long before I make a conscious decision to make an appointment with a healthcare professional. Because I am here alone, I keep myself very busy with work and don't always have the time. Then sometimes it is hard to make the appointment [due to work commitments]. (MN-8)

Barriers to healthcare access stemmed from the MNs' perceptions of a lack of cultural competence, such as being ignored, and system-wide issues such as hours of operation. Such behaviors encouraged them to delay seeking healthcare.

5.2.3 | Healthcare encounter (from the perspective of a consumer of healthcare)

Respect

The healthcare encounter experiences varied. Some MNs reported feeling respected (MN-17) and treated well (MN-13). Others felt differently. "I don't understand the doctors. The doctors use that [patronizing] tone" (MN-3). Some reported that the physician did not listen to them. As one MN said:

> I was putting on weight as a side effect of a medication, but they kept on saying that weight gain was related to my eating habits. The only thing my physician cared about was that I continue taking my prescribed medication. (MN-1)

Responses from MNs varied; however, several MNs felt ignored by their providers. There was little dialogue or effort to understand or to communicate with the MNs effectively.

Required preparation for a healthcare visit

Conversely, MNs relayed their understanding that healthcare providers had a short period of time to dispense treatment. As one MN indicated:

> During general practitioner appointments time in the healthcare system is very short and it is not favorable to come with more than one problem [otherwise] this puts the 10 min or so they have into jeopardy and you can feel the stress in the way that your appointment finishes. (MN-10)

Several MNs indicated that they prepared themselves before the healthcare encounter: "I always do my homework before I go to an appointment, just to be safe and clear about what I am asking for." (MN-10). This MN felt the need to prepare for the healthcare visit. Without this "homework" or preparation for the visit, the MN would not receive the needed care.

Avoidance of the regular healthcare system

Due to the difficulties in their healthcare encounter, one MN remarked: "the healthcare guarantee doesn't exist although it is a legal mandate, it's [healthcare] only for the rich" (MN-5). Another noted:

> [Rather than use the regular healthcare system,] I go private and pay the fees, it's a bit of peace of mind when you know that you will be treated in a timely manner. I have come from a country with a socialist background, but if I need the best healthcare I will pay for it. (MN-10)

An even more extreme approach was mentioned by another MN who obtained healthcare in: "my country of origin … [where the healthcare is better] and the medications are cheaper" (MN-9).

These quotations indicated problematic experiences with both their healthcare provider and the healthcare system overall. Some MNs were not taken seriously. Others reported the need to prepare for the healthcare visit to ensure that their healthcare questions were answered and healthcare needs addressed in a timely manner. In some extreme cases, MNs had avoided the healthcare system of their host country completely, either by paying for private healthcare, or in one circumstance, by obtaining the needed healthcare in the country of origin.

6 | DISCUSSION

Both the quantitative and qualitative components of this mixed-methods study indicated that the MNs who had better perceptions of their healthcare encounters as consumers of healthcare possessed better acculturation and experienced fewer barriers to healthcare access. Possessing barriers to healthcare access (i.e., the mediator) was the crux of the causal chain between acculturation and perception of healthcare encounters. Moreover, in the quantitative study, the fully mediated model was adjusted for gender and age (which was highly correlated to years in the host country), indicating that these covariates did not influence the associations found in the model. Qualitative findings with MNs supported quantitative findings, showing that difficulties with acculturation and overcoming barriers to healthcare access often preceded reports of having a poorer healthcare encounter as a consumer of healthcare.

6.1 | Healthcare encounter

We found no studies that used a quantitative scale to measure MNs' perceptions of their healthcare encounters as consumers of healthcare. Scale scores from this study's quantitative component indicated that MNs ranked their perceptions of most healthcare encounters as better than average. Since the participants of this study were MNs, this assessment seemed reasonable.

Yet, despite this assessment, some MNs reported in qualitative interviews that they were treated disrespectfully during their healthcare encounters. Several MNs noted that as consumers of healthcare, their healthcare practitioners did not listen to them or take them seriously despite knowing that the migrants themselves worked in healthcare. Due to the difficulties in their healthcare encounters, some felt compelled to prepare for their healthcare encounters or ask native-born residents to accompany them to their healthcare appointments or even to obtain their healthcare in their country of origin. The apprehension, hesitancy, and avoidance about obtaining healthcare in the host country, which was expressed by several MNs, was even more unexpected given that many of the MNs in both the quantitative and qualitative components of this study worked full-time and lived in the host country on average for more than a decade.

6.2 | Barriers to healthcare access

The quantitative component's findings indicated that possessing (or not) barriers to healthcare access was the mediator in the causal chain, linking the independent variable (i.e., acculturation) and the dependent variable (i.e., perceptions of healthcare encounters). The qualitative interviews provided explanations about the barriers to healthcare access, which included difficulties with the language and culture of the host country, feeling ignored by healthcare professionals, and system-wide barriers that impeded making healthcare appointments.

Being ignored by healthcare professionals blocked MNs' access to healthcare until the situation became dire. There are repercussions to ignoring MNs. When MNs were ignored repeatedly, they experienced self-doubt about their knowledge and professional abilities (Choi et al., 2019). Our findings suggested that these behaviors not only added stress and frustration but also dissuaded MNs from obtaining healthcare.

These behaviors have ramifications that extend beyond the MNs' access to healthcare. Since nursing is a women-dominated profession, MNs often are the healthcare resources for their spouses/partners and children. Placing barriers to healthcare for MNs also places barriers to healthcare for their families, as was found in this study and by others (Zhong et al., 2017).

Other barriers to healthcare access were system-wide issues such as making appointments through the receptionist and the limited hours of the healthcare provider. MNs, like other nurses, work different shifts and scheduling healthcare visits can be difficult. As a result of the problems with timing, MNs avoided obtaining needed healthcare. These delays in healthcare could cause further physical harm.

Measurement of barriers to healthcare access is challenging, and our study did not measure or rank each barrier to healthcare access; however, our univariate results suggested that MNs ranked their barriers to healthcare access as about average. No other studies were found with which we could compare the results obtained from this scale. Studies are needed to design and test the validity of scales measuring perceptions of barriers to healthcare access among healthcare professionals.

6.3 | Acculturation

Quantitative findings indicated that the perception of the healthcare encounter began with acculturation; and both quantitative and qualitative findings indicated that MNs struggled with acculturation, consistent with other studies (Brunton et al., 2019; Goh & Lopez, 2016; Pung & Goh, 2017; Yu et al., 2018). Our qualitative findings further elucidated acculturation difficulties that extended to both the social and work environments. In their social environments, many MNs were not accepted as native-born residents due to their accents and language problems. Experiences in their work environments were no better. Many MNs were treated as less qualified than their native-born counterparts and were overlooked for promotion. These acculturation difficulties in both environments occurred even after MNs lived and worked in the host countries for more than a decade.

As several MNs said, they would never be accepted in the same way as native-born residents, stating that their status was unequal and lesser compared to native-born residents. They would never achieve that same status and would remain in the transitional state of being a migrant no matter how long they lived in the host country. Such beliefs are consistent with the liminal state of ambiguity (Choi et al., 2019). These reports of remaining in the state of transition were so prevalent that one study concluded that MNs needed to have realistic expectations for acculturation and embrace this ambiguity in their new host country (Brunton et al., 2019).

For MNs of color, it became clear that racism ensured that they would never be accepted. The pervasiveness of racism toward MNs of color has been noted in many other studies across the globe (Alexis, 2015; Balante et al., 2021; Buttigieg et al., 2018; Cottingham & Andringa, 2020; Dahl et al., 2017; Lin et al., 2018; Roth et al., 2021; Smith et al., 2022) and was identified as interfering with acculturation in our qualitative interviews. MNs reported racism at work in their roles as healthcare professionals and while undergoing treatment in their roles as consumers of healthcare. Levels of whiteness or color may contribute to racism (Narkowicz, 2023). Racism also may have contributed to the quantitative finding that the MNs' duration in the country (a covariate) was inconsequential and unrelated to barriers to healthcare access or perceptions of their healthcare encounters as consumers.

A framework categorizing racism and discrimination that supported our findings contained the following parameters: (1) civic discrimination determining whether a population is deserving or not based on host country perceptions and policies; (2) migratory discrimination reflecting language ability, accent, place of education, and profession; and (3) ethno-racial discrimination based on ethnicity, race, language, or religion (Safi, 2023). The tenets of this framework were consistent with our study findings. For example, civic discrimination was demonstrated when MNs reported difficulties acculturating to the host country's task-oriented philosophy versus their caring-based philosophy of nursing practice. Quotes by the MNs showed that their healthcare knowledge and practice were not respected by nurses in the host country. Migratory discrimination was demonstrated by MNs' comments about the challenges that they faced due to their accents and difficulties with the language, which resulted in reduced acculturation and increased barriers to accessing healthcare. Finally, ethno-racial discrimination was apparent as many MNs of color reported discrimination since their skin color was darker than most individuals comprising the native-born population. The levels of discrimination and racism not only reflect societal ills but also contribute to increases in the physical, social, and psychological illness of persons of color (Phelan & Link, 2015).

6.4 | Strengths and limitations

This study's strengths include the focus on the under-researched topic of MNs' healthcare encounters as consumers; employing a mixed-methods study design; using and conducting reliability testing on measures of acculturation, barriers to healthcare access, and the perception of their healthcare encounter; and recruiting an international sample of MNs from Europe and Israel for the quantitative and qualitative study components. Study limitations included employing a relatively short questionnaire that omitted questions on important barriers such as discrimination, disseminating the questionnaire via social media, possessing a small sample of qualitative interviews, and using a small convenience sample of English-language surveys for an international group of MNs. This mixed-methods study used a cross-sectional study design thus causal inferences cannot be made. English-language surveys might have been the reason for the large number of nurses with graduate degrees, which also could limit generalizability. Moreover, the decision to participate in either the quantitative questionnaire or the qualitative interview might have been influenced by the nature of the MNs' healthcare experiences. Some researchers have recommended comparing the results of MNs based on their countries of origin and host countries, as each country has a different national culture and health system (Balante et al., 2021); however, these quantitative comparisons were not possible due to our small sample size. Lastly, the study was conducted during the COVID-19 pandemic, which also may have influenced the results.

Owing to these limitations, generalizability of results must be made with caution. Still, based on our literature, this study is among the first to examine the relationship between MN acculturation and barriers to healthcare access on the perception of their healthcare encounters as consumers of healthcare.

7 | CONCLUSIONS AND RECOMMENDATIONS

This study highlights the issues of MNs as consumers of healthcare. We found that despite having lived in their host country for decades, MNs repeatedly stated that they believed that several aspects of their lives as residents, healthcare professionals, and consumers of healthcare were less positive compared to those of native-born residents. Since many MNs in this study also worked as healthcare professionals in their host countries, it was surprising to hear that this lower status even extended to the MNs' experiences as healthcare consumers. Thus, MNs lived in a perpetual situation of transition (i.e., a liminal state), not completely fitting into their host country either as residents in the social environment or as healthcare providers in the work environment.

One situation that was replete in the literature and also in this study's findings was the added burden placed on MNs of color. Racism interfered with all aspects of life. Future mixed-methods studies would benefit from using a community-based participatory research approach that would engage MNs of color to participate in the investigative team, so they could provide insights on the creation and implementation of interventions that would target healthcare professionals, both as colleagues and as caregivers, with the goal of reducing racism, increasing cultural sensitivity, and promoting workforce diversity. Such studies are particularly important as nursing shortages in high-income countries continue, and so, we can anticipate an increasing number of MNs worldwide.

AUTHOR CONTRIBUTIONS

Study design: Cheryl Zlotnick, Harshida Patel, Marie-Louise Luiking, and Parveen Azam Ali. *Data collection*: Cheryl Zlotnick, Harshida Patel, Marie-Louise Luiking, Parveen Azam Ali, Temitayo Odewusi. *Data management*: Harshida Patel, Marie-Louise Luiking, Parveen Azam Ali. *Data analysis*: Cheryl Zlotnick, Harshida Patel, Marie-Louise Luiking, Temitayo Odewusi. *Study supervision*: Cheryl Zlotnick. *Manuscript writing*: Cheryl Zlotnick, Harshida Patel, Marie-Louise Luiking, Parveen Azam Ali, Temitayo Odewusi.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Data is not available due to ethics committee restrictions.

ORCID

Cheryl Zlotnick http://orcid.org/0000-0002-3327-2155
Harshida Patel http://orcid.org/0000-0002-6038-1031
Parveen Azam Ali http://orcid.org/0000-0002-7839-8130
Temitayo Odewusi http://orcid.org/0000-0002-1746-6080
Marie-Louise Luiking http://orcid.org/0000-0001-9108-5844

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