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A case study of English Language Learners who have successfully completed a healthcare education program

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**A case study of English Language Learners who have successfully completed
a healthcare education program**

by

Theresa Ann McCloud Smith

A dissertation submitted to the graduate faculty
in partial fulfillment of the requirements for the degree of
DOCTOR OF PHILOSOPHY

Major: Education (Educational Leadership)

Program of Study Committee:
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Iowa State University

Ames, Iowa

2013

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DEDICATION

I dedicate this dissertation to my wonderful family.

The love of my life, my husband Adam,
whose belief in me and unending support made this journey possible.

My children, Katherine, Abbigail, Nicholas, and Zachary;
who each supported and cheered me on in their unique and dynamic ways.

My mother Joyce, the strongest woman I know;
her love for me knows no end.

My sissy Jennifer, who has been by my side through life's ups and downs;
your trust in me is inspiring.

My brother-in-law John, niece Elizabeth, and nephew Jackson,
who always provided a sense of relief and humor when the journey seemed overwhelming.

And finally, to my beloved Grandpa Bill and Grandma B
whose loving embrace has shown down upon me as a guiding light.

We did it!!

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ABSTRACT

The purpose of this study was to determine if English Language Learners (ELLs), who had successfully completed a healthcare education program, identified support services as having an impact on their academic success, and to identify what support services were critical to their successful completion of the healthcare education program. The researcher was interested in learning how higher education institutions, that offer healthcare education programs, could better support ELLs to be successful in their chosen program.

A qualitative case study methodology was used for this study. Five ELLs who successfully completed a healthcare education program at a small, private, health sciences college in the Midwest were interviewed. The case study methodology provided the opportunity for participants to share their perceptions and wisdom from first-hand accounts of their knowledge and engagement in the subject matter.

All five participants indicated support services did have an impact on their success as an ELL in a healthcare education program. Six support services were identified as critical to their successful completion of a healthcare education program as an ELL. The first five services: (a) additional time for learning, (b) tutoring, (c) build confidence, (d) assign mentor, and (e) additional time for practice were each unanimously identified by all five participants as critical to their success as an ELL in a healthcare education program. The sixth service, integrate ELLs and English as First Language (EFL) students in the same classroom, was viewed as a positive experience and would support the learning experience of the ELLs by three of the five total participants in this study. Two of the participants did not feel this would be supportive of learning by the ELL.

CHAPTER 1. INTRODUCTION

Background of the Study

The United States is becoming more ethnically and culturally diverse. 2008 U.S. Census Bureau statistics, as reported by Hansen and Beaver (2012) cite “nearly 37 percent of the U.S. population identified themselves as minority and greater than 55 million households have a first language other than English” (p. 166). Dass-Brailsford (2007) cite U.S. Department of Health and Human Services statistics (2005) “since 1975, the U.S. has resettled 2.4 million refugees. Since the enactment of the Refugee Act of 1980, the average number of refugees admitted annually is 98,000” (p. 226). Passel and Cohn (2008) indicate:

The U.S. population is projected to grow by 117 million people between the years 2005-2050 due to the result of immigration. Of this increase, 67 million will be the product of direct immigration and 50 million will be their descendents (p. 1).

Dass-Brailsford (2007) defines “refugee” according to the United Nations (U.N.) protocol “people outside their country of nationality who are unable or unwilling to return to their country because of persecution or a well-founded fear of persecution due to race, religion, nationality, or membership in a particular social or political group” (p. 226). Fairbairn and Jones-Vo (2010) define “immigrant” as “an individual who has permanently moved to a new country of their own accord” (p. 10).

The magnitude of the changing demographics of the U.S. population is critically important to the healthcare industry from both a cost containment and a human respect perspective. “Cultural incompetence by healthcare providers can contribute to the additional difficulties endured by politically traumatized clients” (Dass-Brailsford, 2007, p. 230). In

2006, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recognized the importance of cultural competent care and added it to their guidelines as a standard expectation of care (as cited by Gilchrist & Rector, 2007). People from diverse backgrounds are more likely to seek healthcare from a provider of a similar race or ethnicity (Smedley, Stith, & Nelson, 2003). Byrd and Clayton (as cited by Gilchrist & Rector, 2007) stated “when diverse providers are available, patients are more likely to use health care services more appropriately and costs are better maintained” (p. 277). Research by Cooper and Powe (2004) indicated patients are more compliant with treatment regimens and express increased fulfillment with their care when their healthcare provider is of a similar race and ethnicity. An interpretation of the literature would certainly support it is wise to provide healthcare for culturally and ethnically diverse people by culturally and ethnically diverse healthcare providers. If considered from the perspectives of reverence, integrity, and compassion for all of mankind, perhaps it would also be viewed as not only a wise thing to do, but the right thing to do.

In analyzing the literature on the need for a diverse healthcare workforce, there is extensive writing about the critical importance for increased diversity among the nursing profession; however, minimal research has focused on the need for increased diversity of allied health (non-nursing, non-physician) care providers. Brown (2008) articulates “improving the nation’s diversified workforce is a challenge for all health professions” (p. 184). As a result of these research findings, the majority of the literature identified in this study comes from nursing sources. The information from the literature is applicable and impacts the entire healthcare industry, across all touch points of the patient-care continuum, and the entire healthcare team. The Sullivan Commission (2004) reported a vision for the

entire U.S. healthcare system focusing on excellence, access, and quality for all people. The commission identified the need to augment diversity in the healthcare professions by constructing creative career pathways and transforming the culture of health professions schools.

Immigrants and refugees coming to the United States face challenging cultural adjustments. These individuals have overcome significant barriers to arrive in the U.S. and once here, continue to face extreme challenges in cultural adjustment. Dass-Brailsford (2007) cite the following cultural adjustment concerns:

- Relocation to another country and a loss of original home means that all that was considered familiar instantly changes. From the outset, adjustment is traumatic. Connections are disrupted with significance contexts that include land, language, customs, families, and social networks (Marsella, 1994; Rechtman, 1992).
- Loss of employment and dwindling financial resources increase refugees' socio-economic stressors (Boehnlein & Kinzie, 1995).
- Language and cultural challenges are inevitable during the process of adjusting to a new country (Pope & Garcia-Peltoniemi, 1991, p. 228).

Giger and Davidhizar (2004) developed a transcultural assessment model to evaluate cultural differences among people. This model is based on six interrelated factors that influence a person's cultural norms including:

- Communication (ingrained early in life);
- Space (personal space expectations);
- Time (passage of time, points of time, and duration of time);
- Social organization (patterns of learned cultural behavior);

- Environmental control (perception of capacity to direct the environment);
- Biological variations (physical, psychological, and health characteristics (p. 6-16).

A person's level of awareness of these factors, their acceptance of these differences, and their interest to learn about these unique differences all influence their cultural acceptance of others. It is imperative for the healthcare industry to expand the level of cultural competence among their providers. By preparing more culturally and ethnically diverse individuals in healthcare careers, the cultural awareness of the healthcare team increases and as a result, the care provided originates from a more culturally competent paradigm. This heightened cultural awareness better serves the increasingly diverse populace of the U.S.

For the purpose of this study, the researcher utilized certain terminology interchangeably. The following terms were used in reference to a person(s) for whom English is not their first language: (a) Immigrant, (b) Refugee, (c) English Language Learner (ELL), (d) English as Second Language (ESL), and (e) English as Additional Language (EAL).

ELLs face noteworthy barriers to higher education. Yoder (1996) classified the barriers of ELLs in higher education as: (a) personal, (b) academic, (c) language, and (d) cultural (p. 8). Malu and Figlear (1998) identified similar areas of concern for ELLs: (a) language development, (b) different expectations of nursing education, (c) fear of failure, and (d) the participatory learning model (p. 44). ELLs are learning English and the language of healthcare as well as the language specific to their chosen profession. There is an adaptation occurring to the American culture, as well as the culture of their chosen profession. From an academic perspective, often ELLs have to adjust to a completely foreign instructional style with different learning expectations from which they are accustomed. While all of this is occurring, the ELLs are enduring personal adjustments ranging from a change in their social

relationships and support system, to internal feelings of fear of loneliness and alienation (Gardner, 2005b).

An extreme obstacle to higher education for immigrants and refugees is the language barrier. Language acquisition poses a significant barrier for ELLs. Reading, writing, and speaking in English, as well as listening to the English language is challenging for ELLs. Research conducted by Sanner (2004) identified students were reluctant to speak in class and experienced intimidation and discrimination because of their accents. As a result, ELLs can be labeled as non-participatory.

Caputi, Engelmann, and Stasinopoulos (2006) cited Krashen's work on second language acquisition:

Fluency in the second language is the result of acquiring the language, not just learning it. Acquisition refers to the subconscious process of 'picking up' the language through exposure and [learning refers] to the conscious process of studying. Both processes are necessary for successful mastery of a second language (p. 108).

The Cummins model of language acquisition (as cited by Abriam-Yago, Yoder, and Kataoka-Yahiro, 1999, p. 144-145) identifies two continuums upon which language acquisition occurs. The first continuum is context embedded (facial expressions, gestures, feedback) and context reduced (more complex communication dependent on the student's knowledge of the language such as in a textbook or lecture). The second continuum is cognitively undemanding (subconscious occurrences of everyday life) and cognitively demanding (requires conscious focus of language and concepts). The Cummins model also identifies two categories of language proficiency: (a) Basic Interpersonal Communication

(BICS) and (b) Cognitive Academic Language Proficiency (CALP). Figure 1 is a simple graphic interpretation of the cummins model.

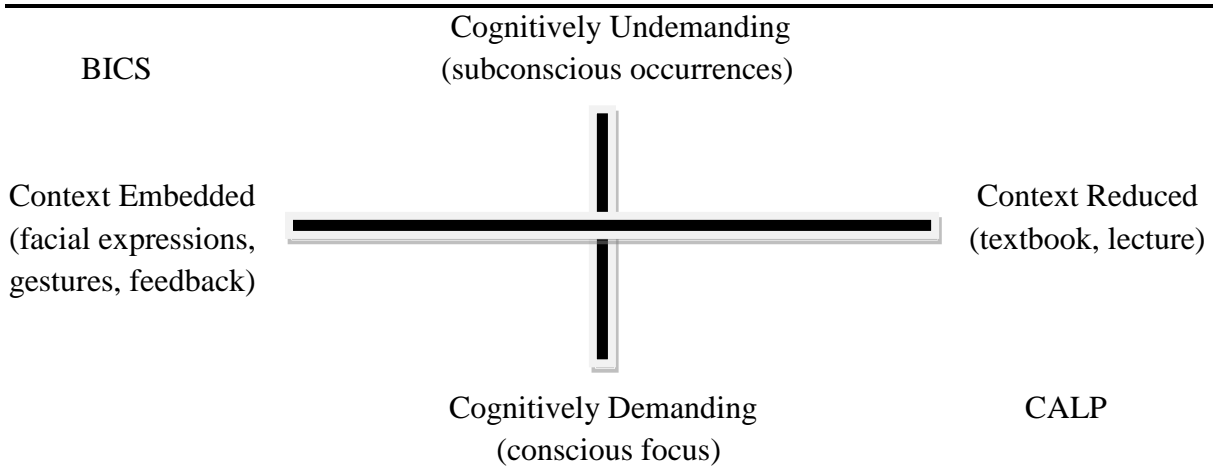


Figure 1.1. cummins model (Abriam-Yago et al., 1999)

The goal of language acquisition with the cummins model is to move from cognitively demanding, context reduced content to a more cognitively undemanding, context embedded state of understanding. ELLs who have a working understanding of social language (context embedded and cognitively undemanding) may feel they would be successful in an academic program when in reality they do not have the language skills necessary to be successful (Malu & Figlear, 1998).

Problem

As the population of the United States becomes increasingly culturally and ethnically diverse, the impact on the healthcare system is significant. A magnitude of providers across the healthcare continuum is not prepared to provide cultural competent care. Immigrants and refugees who come to the United States are resistant to seek healthcare services from non-ethnically and culturally diverse healthcare providers (Smedley et al., 2003; Gilchrist & Rector, 2007; and Cooper & Powe, 2004). The significant change in the demographics of the

U.S. population is critically important to the healthcare industry from both cost containment and a human respect perspective.

Immigrants and refugees often have experienced significant trauma, and witnessed first-hand enormous pain and suffering of those around them. These ELLs often aspire to work in healthcare in hopes of giving back and helping others. For those who dare to dream of becoming a healthcare provider, they must overcome significant barriers (Gardner, 2005b; Giger & Davidhizar, 2004; Malu & Figlear, 1998; Sanner, 2004; and Yoder, 1996).

To meet the growing demand for culturally and ethnically diverse healthcare providers, the challenge for the healthcare industry is to attract more culturally and ethnically diverse individuals who aspire to careers in healthcare. As a result of this demand, healthcare higher education institutions face the challenge of offering effective support services to help ensure the success of culturally and ethnically diverse students (ELLs, EALs, and ESLs). These ELLs are highly valued students who, if given the proper support services, can go on to become excellent healthcare providers who actively demonstrate compassion while conveying a profound sense of reverence for all those entrusted in their care. The outcome of a more culturally and ethnically diverse healthcare provider workforce will be the provision of more culturally competent care.

Purpose

The purpose of this study was to determine if ELLs, who had successfully completed a healthcare education program, identified support services as having an impact on their academic success, and to identify what support services were critical to their successful completion of the healthcare education program.

Research Questions

Two research questions guided this study:

1. Do ELLs identify support services as having an impact on their academic success in a healthcare education program?
2. What support services do ELLs identify as critical to their successful completion of a healthcare education program?

Significance of the Study

The United States is becoming more ethnically and culturally diverse. ELLs often encounter language and cultural barriers when seeking medical care. These barriers can create a sense of fear to the point of preventing many of these individuals from obtaining medical care until it becomes an emergency. This level of healthcare crisis manifests in a significantly compromised health status for the individual, affecting their quality of life, and generates a heightened burden on the healthcare system through increased emergency room visits.

As reported by Smedley et al. (2003) people from diverse backgrounds are more likely to seek healthcare from a provider of a similar race or ethnicity. The provision of culturally competent care is the standard expectation as mandated by JCAHO in 2006 (as cited by Gilchrist & Rector, 2007). By having healthcare providers who look different than the traditional Caucasian healthcare provider, a greater sense of connectedness for ELLs will be fostered and the opportunity to build trust with their healthcare provider will be enhanced. This will promote the utilization of healthcare services at a more health conscious appropriate time and cost effective level, prior to the situation becoming an emergency.

Institutions that provide healthcare education need to explore innovative models that embrace ELLs. Creative and meaningful support services need to be provided for ELLs to meet their unique challenges. These support services need to be congruent with the needs identified by ELLs, and not based on assumptions of what others think ELLs may need. Successful completion of their chosen program and transition into professional practice benefits the healthcare workforce and the increasing diverse population of the United States.

This study provides a voice for immigrants and refugees interested in pursuing a career in healthcare to clearly articulate what services would most help them as ELLs in a healthcare education program. As a population often silenced as a result of the magnitude of barriers they face, the opportunity to be heard allows meaningful insight into identifying resources to best meet their needs.

The findings of this study provide institutions of higher education, which offer healthcare programs, guidance into how to better serve these unique and highly valued learners. The outcomes are significant for all stakeholders involved in the education of healthcare providers, healthcare policy makers, and healthcare consumers.

Educators and administrators in higher education have a need to be better informed on how to best meet the needs of ELLs in higher education. The findings of this study contribute to the body of knowledge on supporting ELLs in higher education, with a focus on ELLs in healthcare education.

The findings of this study contribute to the body of knowledge on resiliency theory, specifically focused on adult immigrants and refugees' pursuit of higher education, with a focus on healthcare education.

Theoretical Framework

The theoretical framework chosen to guide this study was resiliency theory. This theory is based on the premise that individuals have the ability to overcome adversity. Turner, Norman and Zunz, (1993) defined resiliency as “the ability to bounce back, recover, or successfully adapt in the face of obstacles and adversity” (p. 170). Werner (as cited by Dass-Brailsford, 2007) identified “resiliency is the term applied to those individuals exposed to severe risk factors who nevertheless thrive and excel” (p. 29). Dumont and Provost (1999) indicated resilient people possess an attitude of adaptability. In the 1989 landmark longitudinal study by Werner, resilient individuals were described as having the ability to use protective coping mechanisms to assist in overcoming adversity. Dass-Brailsford (2005) added “cultural context” parameters to the definition by indicating resiliency is “a subjective concept that is not simple to define. What may be considered resilient in one context may not be so in another. Resiliency is a process that occurs within a cultural context” (p. 575-576). Richardson, Neiger, Jensen, and Kumpfer (1990) define resiliency as “the process of coping with disruptive, stressful, or challenging life events in a way that provides the individual with additional protective and coping skills than prior to the disruption that results from the event” (p. 34). Higgins (1994) delineates “resilient” from “survivor” in that “resilient emphasizes people do more than merely get through difficult emotional experiences...it’s an active process of self-righting and growth” (p. 1). Benard (1991), as cited by Henderson and Milstein (1996), identifies all individuals have an aptitude for resiliency. The extent to which resiliency is developed differs based on individual circumstances.

Wolin and Wolin (1993), as cited by Henderson & Milstein (1996), identify:

Seven internal characteristics “resiliencies” that develop as a result of dysfunctional environments. These resiliencies are initiative, independence, insight, relationship, humor, creativity, and morality. Even one of these characteristics...can be enough to propel that person to overcome challenges of dysfunction and stressful environments and that additional resiliencies often develop from an initial single strength (p. 10).

“The qualities that define individual resilience have been demonstrated in individuals from different ethnic groups, different socioeconomic strata, different cultural settings, and at different life stages,” (Werner, 1989, as cited by Richardson et al., 1990, p. 33).

The application of resiliency theory for this research study speaks to explain the foundational strength and aptitude that immigrants and refugees must possess in-order to cope, adapt, and survive the enormous challenges they face. Higgins (1994) identifies resilient people are “self-propelled, they operate with a firm belief that knowledge is power and that their futures will advance if they are active change-agents in their own lives” (p. 20).

The success of ELLs pivots on their ability to be resilient and persevere. Resiliency theory provides a theoretical explanation of where this strength originates. The participants in this study were immigrants and refugees who fled their homelands in hopes of building a new and better life in America.

Resilience, like growth itself, is a developmental phenomenon propelled by vision and stamina. It evolves over time. *Facilitating* resilience is more a matter of orientation than explicit intervention. It assumes that many of the maltreated are motivated to overcome hardship... (Higgins, 1994, p. 319).

A key factor in the immigrants and refugees' level of success is determinate upon their ability to secure gainful employment in this country. Providing a pathway for these individuals to successfully complete a healthcare education program and pursue a career in healthcare, meets the need for gainful employment, as well as the desire of many immigrants and refugees to give back and care for others. As resilient individuals build levels of success, they achieve "consistently higher self-esteem over time" (Higgins, 1994, p. 21).

In considering the concept of resiliency in schools, Henderson and Milstein (1996) identify:

Resiliency research offers hope based on scientific evidence that many, if not most, of those who experience stress, trauma, and "risks" in their lives can bounce back. It challenges educators to focus more on strengths instead of deficits, to look through the lens of strength in analyzing individual behaviors, and confirms the power of those strengths as a lifeline to resiliency (p. 3).

Richardson et al. (1990) developed the resiliency model. This model suggests challenges in life can result in different outcomes and even initial "dysfunction" can achieve a positive resolution. The outcome of what happens in a person's life is determinant by their reaction to the circumstance, which is dependent upon their available resources, both internal and external, to adjust and move forward. The more resilient a person is the more positive or successful their responses will be. Henderson and Milstein (1996) identify:

The environment is critical to an individual's resiliency in two ways. First, the internal protective factors that assist an individual in being resilient in the face of a stressor or challenge are often the result of environmental conditions that foster the development of these characteristics. Second, immediate environmental conditions

present, in addition to the stressor or challenge, contribute to shifting the balance of an individual's response from one of maladaptation or dysfunction to homeostasis or resiliency (p. 7).

Figure 1.2 is a simple graphic interpretation of the resiliency model.

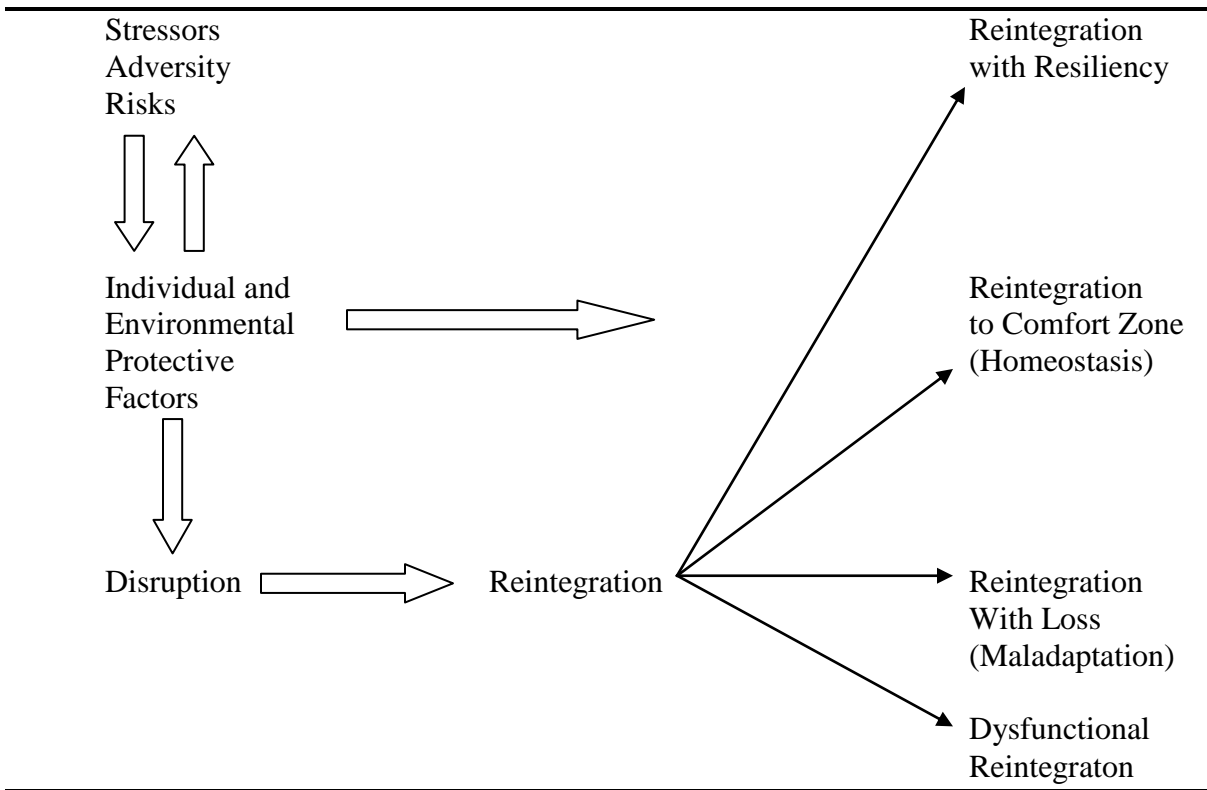


Figure 1.2. resiliency model (Henderson and Milstein, 1996)

Henderson and Milstein (1996) indicate “resilience is a characteristic that varies from person to person and can grow or decline over time; protective factors are characteristics within the person or within the environment that mitigate the negative impact of stressful situations and conditions” (p. 8). Table 1.1 is a listing of internal and external protective factors affecting resiliency taken from Richardson et al., 1990; Benard, 1991; Werner, and Smith, 1992; and Hawkins, Catalano, and Miller, 1992 (Henderson & Milstein, 1996, p. 9).

Table 1.1. Internal and Environmental Protective Factors (Henderson and Milstein, 1996)

 Internal Protective Factors:

 Individual Characteristics That Facilitate Resiliency

- Gives of self in service to others and/or a cause
 - Uses life skills, including good decision making, assertiveness, impulse control, and problem solving
 - Sociability; ability to be a friend; ability to form positive relationships
 - Sense of humor
 - Internal locus of control
 - Autonomy; independence
 - Positive view of personal future
 - Flexibility
 - Capacity for and connection to learning
 - Self-motivation
 - Is “good at something”; personal competence
 - Feelings of self-worth and self confidence
-

Environmental Protective Factors:

 Characteristics of Families, Schools, Communities, and Peer Groups That Foster Resiliency

- Promotes close bonds
 - Values and encourages education
 - Uses high-warmth, low-criticism style of interaction
 - Sets and enforces clear boundaries (rules, norms, and laws)
 - Encourages supportive relationships with many caring others
 - Promotes sharing of responsibilities, service to others, “required helpfulness”
 - Provides access to resources for meeting basic needs of housing, employment, healthcare, and recreation
 - Expresses high and realistic expectations for success
 - Encourages goal setting and mastery
 - Encourages prosocial development of values (such as altruism) and life skills (such as cooperation)
 - Provides leadership, decision making, and other opportunities for meaningful participation
 - Appreciates the unique talents of each individual
-

Internal and Environmental Protective Factors (Henderson and Milstein, 1996)

Through identification and increasing the awareness of these internal and environmental protective factors, those working with immigrants and refugees are better prepared to facilitate supportive measures to enhance their level of success.

Researcher's Positionality

The researcher first started working with immigrants and refugees through employment at a small, private, health sciences college in the Midwest. As part of their vision and mission, this institution reached out to immigrants and refugees in the community and provided an opportunity to pursue a healthcare education program to those interested in pursuing a career in healthcare.

The researcher's capstone project involved working with the data being collected from the co-horts of ELLs pursuing a healthcare education program and conducting a literature review of support services for ELLs. The researcher then compared the results of the literature review with what support services were being offered and made recommendations toward the consideration of offering additional support services based on data from the literature discovery. This process sparked additional interest in conducting a qualitative study to learn from the ELLs who successfully completed a healthcare education program. The researcher's intent was to compare what the college was already offering, what was identified in the literature, and what did ELLs who successfully completed a healthcare education program recommend regarding support services for ELLs.

Delimitations/Limitations of the Study

This study involved interviews of five participants who successfully completed a healthcare education program at a small, private, health sciences college in the Midwest. The

small sample size and purposeful sampling limits the generalizability of the research findings.

Definition of Terms

The following terms were defined for use in this study:

English as Additional Language (EAL): A person for who English is not their first language.

The term is used interchangeably with ELL and ESL.

English as First Language (EFL): A person for who English is their first language.

English Language Learner (ELL): A person for who English is not their first language. The term is used interchangeably with EAL and ESL.

English as Second Language (ESL): A person for who English is not their first language. The term is used interchangeably with EAL and ELL.

Immigrant: A person who comes to permanently live in another country.

Mother Language: A person's first language; language used in their home country. The term is used interchangeably with Native Language.

Native Language: A person's first language; language used in their home country. The term is used interchangeably with Mother Language.

Refugee: A person who flees their home country to permanently live in another country.

Resiliency: The ability to adapt and overcome challenges.

Summary

The purpose of this study was to determine if ELLs, who had successfully completed a healthcare education program, identified support services as having an impact on their academic success, and to identify what support services were critical to their successful completion of the healthcare education program. Two research questions guided this study

with a focus on whether ELLs identify support services as having an impact on their academic success in a healthcare education program, and what support services did ELLs identify as critical to their successful completion of a healthcare education program.

Chapter 2 examines a review of the literature pertaining to barriers and support services for ELLs in a healthcare education program.

Chapter 3 identifies the methodological approach for the study. This chapter reviews the epistemology, methodology, and methods used; as well as the criteria followed for data analysis and trustworthiness in qualitative research.

Chapter 4 presents the findings of the study identifying the support services critical to the success of ELLs in a healthcare education program and themes that emerged.

Chapter 5 includes a discussion of the results relevant to the literature, recommendations for future research, and conclusion.

CHAPTER 2. LITERATURE REVIEW

Introduction

This chapter reviews the literature relevant to ELLs in a healthcare education program. The findings are presented as barriers facing ELLs and support services for ELLs in a healthcare education program.

Barriers Facing ELLs

The United States is becoming more ethnically and culturally diverse. 2008 U.S. Census Bureau statistics, as reported by Hansen and Beaver (2012) cite “nearly 37 percent of the U.S. population identified themselves as minority and greater than 55 million households have a first language other than English” (p. 166). Dass-Brailsford (2007) cite U.S. Department of Health and Human Services statistics (2005) “since 1975, the U.S. has resettled 2.4 million refugees. Since the enactment of the Refugee Act of 1980, the average number of refugees admitted annually is 98,000” (p.226). Passel and Cohn (2008) indicate:

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The magnitude of the changing demographics of the U.S. population is critically important to the healthcare industry from both a cost containment and a human respect perspective. “Cultural incompetence by healthcare providers can contribute to the additional difficulties endured by politically traumatized clients” (Dass-Brailsford, 2007, p. 230). In 2006, the JCAHO recognized the importance for culturally competent care and added it to their guidelines as a standard expectation of care (as cited by Gilchrist & Rector, 2007).

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In analyzing the literature on the need for a diverse healthcare workforce, there is extensive writing about the critical importance for increased diversity among the nursing profession; however, minimal research has focused on the need for increased diversity of allied health care providers. Brown (2008) articulates “improving the nation’s diversified workforce is a challenge for all health professions” (p. 184). As a result of these research findings, the majority of the literature identified in this study comes from nursing sources. The information from the literature is applicable and impacts the entire healthcare industry, across all touch points of the patient-care continuum, and the entire healthcare team. In 2004, the Sullivan Commission reported a vision for the entire U.S. healthcare system focusing on excellence, access, and quality for all people. The commission identified the need to augment diversity in the health professions by constructing creative career pathways and transforming the culture of health professions schools.

Campinha-Bacote (2002) identifies cultural competence as a process involving five aspects:

- Cultural desire: the motivation to want to engage in the process of becoming culturally competent and learn from cultural exchanges.
- Cultural awareness: the self-examination and in-depth exploration of one's own cultural background.
- Cultural knowledge: the process of learning about other cultures.
- Cultural skill: the ability to collect relevant cultural data.
- Cultural encounter: the interaction with individuals from diverse cultures (p. 181).

Research by Sealey, Burnett, and Johnson (2006) supports the need for cultural competency training for faculty. In this study, 313 nursing faculty in the state of Louisiana were surveyed using Campinha-Bacote's model of cultural competence, the results indicate cultural competency training is lacking.

Giger and Davidhizar (2004) developed a transcultural assessment model to evaluate cultural differences among people. This model is based on six interrelated factors that influence a person's cultural norms including:

- Communication (ingrained early in life);
- Space (personal space expectations);
- Time (passage of time, points of time, and duration of time);
- Social organization (patterns of learned cultural behavior);
- Environmental control (perception of capacity to direct the environment);

- Biological variations (physical, psychological, and health characteristics) (p. 6-16).

A person's level of awareness of these factors, their acceptance of these differences, and their interest to learn about these unique differences all influence their cultural acceptance of others.

Yoder (1996) classified the barriers of ELLs in higher education as: (a) personal, (b) academic, (c) language, and (d) cultural (p. 8). Malu and Figlear (1998) identified similar areas of concern for ELLs: (a) language development, (b) different expectations of nursing education, (c) fear of failure, and (d) the participatory learning model (p. 44). ELLs are learning English and the language of healthcare as well as the language specific to their chosen profession. There is an adaptation occurring to the American culture, as well as the culture of their chosen profession. From an academic perspective, often ELLs have to adjust to a completely foreign instructional style with different learning expectations from which they are accustomed. While all of this is occurring, ELLs are enduring personal adjustments ranging from a change in their social relationships and support system, to internal feelings of fear of loneliness and alienation (Gardner, 2005b).

Caputi et al. (2006) cited Krashen's work on second language acquisition:

Fluency in the second language is the result of acquiring the language, not just learning it. Acquisition refers to the subconscious process of 'picking up' the language through exposure and [learning refers] to the conscious process of studying. Both processes are necessary for successful mastery of a second language (p. 108).

The Cummins model of language acquisition (as cited by Abriam-Yago et al., 1999, p. 144-145) identifies two continuums upon which language acquisition occurs. The first

continuum is context embedded (facial expressions, gestures, feedback) and context reduced (more complex communication dependent on the student's knowledge of the language such as in a textbook or lecture). The second continuum is cognitively undemanding (subconscious occurrences of everyday life) and cognitively demanding (requires conscious focus of language and concepts). The cummins model also identifies two categories of language proficiency: (a) Basic Interpersonal Communication (BICS) and (b) Cognitive Academic Language Proficiency (CALP). The goal of language acquisition with the cummins model is to move from cognitively demanding, context reduced content to a more cognitively undemanding, context embedded state of understanding. ELLs who have a working understanding of social language (context embedded and cognitively undemanding) may feel ready to begin an academic program, when in reality they do not have the language skills necessary to be successful (Malu & Figlear, 1998). Figure 2 is a simple graphic interpretation of the cummins model.

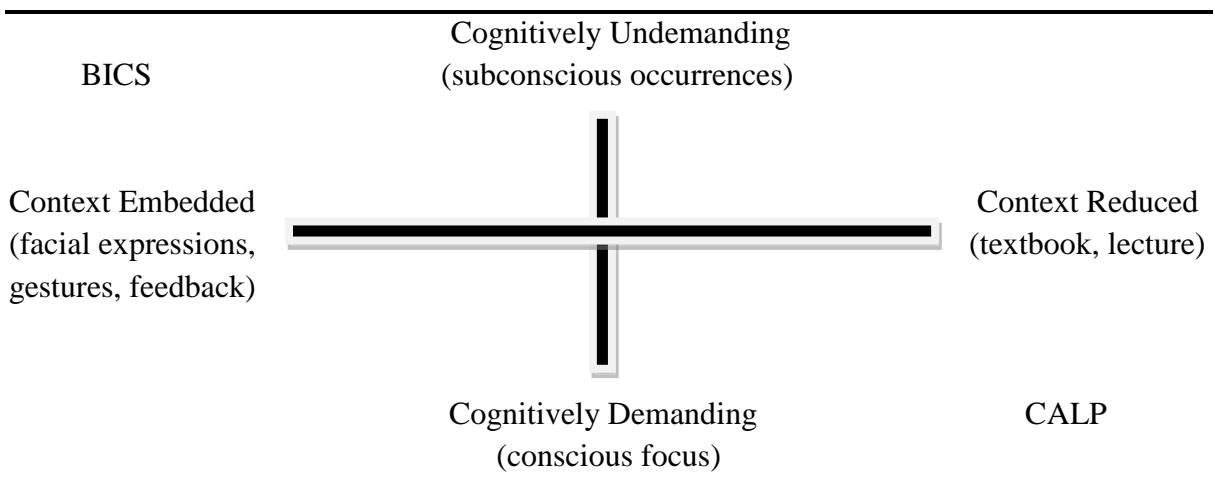


Figure 2.1. cummins model (Abriam-Yago et al., 1999)

Language acquisition poses a significant barrier for ELLs. Reading, writing, and speaking in English, as well as listening to the English language is challenging for these

students. Research conducted by Sanner (2004) identified students were reluctant to speak in class and experienced intimidation and discrimination because of their accents. As a result, ELLs can be labeled as non-participatory.

ELLs pursuing a healthcare education have the challenge of learning the English language, medical terminology, and the language, or professional jargon, of their chosen discipline. With all of these language considerations, communicating effectively in the clinical setting can be especially challenging. Just as English as the first language students can experience stress because of their fear of being misunderstood or not understanding the needs of a patient in a clinical setting, ELLs may experience a heightened sense of fear because of their accent and language skills.

In a study by Sanner et al. (2002) aspects of social isolation was experienced by all participants. As a result of the students not having confidence in their verbal language ability and concern about their accent, they withdrew verbally which led to a sense of isolation. Jalili-Grenier and Chase (1997) indicate ELLs in higher education are often isolated from their usual support system. This change in normalcy can be stressful for these students and places them at higher risk of having challenges to adjust and cope with their new environment. Kurz (1993) identifies students in these situations commonly experience cultural shock from the sudden change in their cultural environment.

Support Services for ELLs

In the 1991 study by Memmer and Worth, multiple support services for ELLs were identified:

- Placement tests
- Preadmission meeting to assist students with the application process

- Detailed orientation program including a social interaction
- Support courses: remedial, medical/profession terminology
- Workshops: study skills, writing, conversation lab for students to practice English
- Open house involving student families
- Financial aid
- Academic advising, counseling, retention coordinator to bridge between student, faculty/staff resources, early intervention system
- Mentor programs: alumni or professional/student, faculty/students, student/student
- Peer tutoring
- ESL/minority faculty
- Flexible classes: loads, times, ratio of students to teacher, clinical lab mix of ESL students and English as the first language students
- Decreased faculty-to-student ratio, additional time for skills learning (p. 391-395).

These services lend themselves to supporting and ensuring the ELL's success in their chosen program.

Malu and Figlear (1998) stressed the importance of orientation for ELLs. A strong and well-organized orientation program is critical for the success of these students. ELLs are new to the college setting and require clear explanation of expectations and identification of available resources, both in knowing what is available, as well as how to access the services. The college orientation program is an activity that can begin to create a sense of acceptance, connection, and belonging for these ELLs. When students are comfortable with their

surroundings, are knowledgeable regarding services available, know their advisor, and have an understanding of policies and expectations; they are more likely to be successful.

The literature identifies the importance of making connections through the orientation process. For example, Stewart (2005) identified the importance of including the family in the orientation activities to facilitate support for the ELL. Including a social component in the orientation program plays a key role in facilitating engagement by these students beginning with their very first interaction on campus. Connecting the students with the faculty and staff in a social setting provides a relaxed atmosphere for relationships to begin. Building social connections for the ELL is critical in supporting their engagement with the campus environment and building a sense of community. These efforts designed to engage ELLs in the campus community both academically and socially are supported by Tinto's Model of Student Attrition (Tinto, 1993).

Klisch (2000) discusses the importance of regular social events for bringing small groups of ELLs together. A good example of how this could work in practice would be for advisors to schedule social events for their advisees. The events could occur periodically throughout the academic year and be used to conduct advising business as well as time for relaxation and entertainment. Brown (2008) identifies the importance of "offering social activities that complement cultural customs" (p. 189). Participating in functions that are familiar can be comforting for ELLs. Social activities can also be a time to highlight different cultural groups, practices, and customs. These events can become a celebration shared with the larger group or campus community and can serve a dual purpose of celebration and support for the ELLs, as well as educational for individuals from different cultural groups.

Starr (2009) begins to recognize the complexity of the language and culture adjustments ELLs are undertaking. These students are learning two new languages, English and healthcare, and two new cultures, American and healthcare. While true, these levels of language and cultural learning do not seem to fully represent the accurate complexity of what the ELLs are enduring. From a language perspective, there are at least two levels of English being learned: social (conversational) and academic, as well as three levels of healthcare language: healthcare (medical), medical terminology, and professional jargon. From a cultural perspective, in addition to American and healthcare culture, the student is also learning about and adjusting to the culture of their academic institution as well as the culture of their chosen profession.

Klisch (2000) discusses the value of providing assertiveness training for ELLs. This training can promote the ELL's confidence and comfort level to speak in public, ask questions, and engage in leadership roles during their academic experience and beyond into their chosen career.

Shakya and Horsfall (2000) identified the need to ensure all students are included in a study group and not resolve this as the sole responsibility of each student to navigate. ELLs may lack the self-confidence to approach other students and engage in creating a study group. This research study also identified the importance of creating support groups and advocated the use of a buddy system to ensure each ELL felt a sense of connection and belonging. Peer support groups can provide academic support for participants, as well as a sense of social connection and engagement. Gardner (2005b) suggests including times for families to participate in support group activities as a way to further build the sense of

connection and provide opportunity for families to better appreciate the expectations and requirements of the ELL in their program of study.

Malu and Figlear (2001) indicate study groups should consist of “ESL and fluent English speaking students” (p. 204). This cross-cultural study group creates a sense of value and learning for both groups of students through the sharing of language, academic content, and culture. This intentional sharing works to build a sense of understanding and connection among the participants. Keane (1993) designated study groups comprised exclusively of ELLs as non-effective and may actually support academic failure. Identifying that without English as First Language (EFL) participants, the members of the study group do not have the skills to identify errors and offer correction. Klisch (2000) advocates pairing ELLs with EFL students who meet regularly for casual conversations. The impetus here is for a social relationship to develop as they get to know and support each other, as well providing a natural context for ELLs to improve their conversational English skills in a relaxed, non-threatening environment.

Conversation circles are identified as a support for ELLs by Caputi et al. (2006). This is when a faculty person meets with a group of ELLs on a periodic basis to discuss the following:

- Creating an opportunity for EAL students to share their thoughts and concerns,
- Determine learning needs,
- Share identified learning needs with other faculty,
- Identify areas for faculty development (p.110).

Through this activity, ELLs feel a sense of connection to the faculty and they (the faculty) care about the student. The faculty gain insight into the educational needs for these at risk

students, as well as an awareness of cultural competency, and other faculty development topics.

Holmes and Moulton (1997) support the provision of ELLs having a structured opportunity to practice their writing skills on relevant topics in a low consequence format. The written work is submitted to faculty for review; however, is not assigned a grade. This provides ELLs the opportunity to practice their writing skills, expressing their thoughts in an organized fashion, and receiving valuable feedback from faculty. ELLs may also use this activity to practice their speaking skills by reading their work out loud.

Guhde (2003, p. 114-115) developed a template for individual or group tutoring of ELLs based on the skills necessary for language mastery. The tutoring exercises consist of: (a) reading, (b) listening, (c) speaking, and (d) writing. Students are given a recorded tape based on current course content. They are expected to study the course material, listen to the tape, and write about the information they heard and read about. The student also receives a tape recording and written list of pertinent medical terminology. The student is expected to listen to the tape and read the words as they hear them on the tape recorder. At the tutoring session, the student reads his/her written note about the content covered in class and covered on the tape recording. The tutor provides feedback to both the written and spoken assignment. The student then reads from the list of medical terminology and receives feedback; the student works on mastery of pronunciation. The final segment of the tutoring session involves the student listening to a tape recording of content for the next class and tutoring session. The student is then asked to transcribe what they heard on the tape. The complete process is subsequently repeated in preparation for the next tutoring session. Any part or the entire tutoring template can be utilized to meet the needs of ELLs. The template

can also be modified as indicated per limitations to fit available time, financial, or other constraints.

Newman and Williams (2003) identifies the benefit of workshops where ELLs provide information to the faculty and advisors regarding barriers they encounter. The student panel responds to predetermined questions and shares their personal stories, as they feel comfortable in doing so, regarding challenges they have faced. The advisors reported a greatly enhanced appreciation of the challenges the ELLs have overcome and better understanding of the needs they have both inside and outside the classroom.

Memmer and Worth identified a wide variety of support services designed for ELL success in their 1991 study. An area of focus was to offer workshops organized around: (a) conversation labs, (b) study skills, (c) writing, and (d) cultural competency and sensitivity training for faculty. Conversation labs are opportunities for ELLs to practice their English skills (p. 391). Newman and Williams (2003) identified the need to provide ELLs a handout of “Strategies for Success” that include important topics and key information they could take with them after each workshop (p. 93). Workshops can offer ELL and EFL students and faculty opportunities to share information and learn from each other. The frequency of being offered and atmosphere of a workshop environment also supports the participants building a sense of connection and engagement.

Phillips and Hartley (1990) recommended assessing the learning styles of ELLs. In their “survey of 1,388 ESL students, in general, the students preferred kinesthetic and tactile learning styles” (p. 31). This information can be utilized to best advise an ELL as they are selecting a program of study and during their program for determination of how they best learn to increase retention and student success.

Walker and Click (2011) reported on the focused need to provide library orientation for ELLs. Due to their varied educational backgrounds and learning experiences, it should not be assumed ELLs know how to utilize the library. Librarians should determine the ELL's needs and provide an appropriate orientation with written information the students can take for future reference.

The literature identifies the need for cultural competency training. Gardner (2005a) identifies a need for cultural competency training by faculty, Caucasian students, and minority students. In order to improve student outcomes and promote success, educators need to have a better appreciation of ELL needs and challenges. Both Caucasian and minority students could benefit from better understanding other cultures. This cultural awareness will carry forth from the classroom to the clinical setting where the care of patients is provided. From the research conducted by Donnelly, McKiel, and Hwang (2009), the development of a cultural awareness course is recommended to educate participants about cultural diversity. "Ultimately, it could serve to reduce ethnocentrism, racism, stereotyping, and prejudice" (p. 147). The authors note the limited availability of resources may negate the development of a full course on cultural diversity. As an alternative, they suggest a series of guest speakers on a variety of cultural diversity topics partnered with group discussions to facilitate exploration of the topics and dialogue among participants.

The benefit of mentoring relationships is identified in the literature. Wilson, Andrews, and Leners (2006) provide a summative report of strategies that can be implemented through a mentoring program (p. 19). Table 2.1 lists these strategies.

Table 2.1. Strategies of a Mentoring Program (Wilson, Andrews, and Leners, 2006)

Communication
Provide forums with faculty/student representatives
Facilitate regular social contact
Foster effective study skills (i.e. tape recording lectures, note taking techniques, test taking strategies)
Model effective ways to cope with stress
Encourage non-directive counseling/listening
Provide academic advising/counseling
Professional Leadership
Examine effective strategies for interacting with authority figures
Involve students in professional groups
Teach assertiveness skill development
Support sharing of professional 'lived experiences'
Confidence Building Activities
Make judicious choice of clinical placements
Share lived experiences/stories of 'professional journey'; novice to expert
Include students in activities for fun and relaxation
Foster career development (i.e. resume assistance, interview coaching)
Support Seeking Strategies
Encourage involvement in support groups
Recognize and support connectivity to extended family relationships
Provide assistance in seeking sources of financial support
Enhance awareness and access to campus/community resources

Strategies of a Mentoring Program (Wilson, Andrews, and Leners, 2006)

Gardner (2005a) discusses the need for mentoring relationships to be established between faculty and students. "Educators must be approachable, sensitive, and nonthreatening so that *all* students feel comfortable asking for help" (p. 161). Abriam-Yago (2002) classified mentor relationships into three categories: (a) professional (role models in the field of study, alumni), (b) faculty, (c) peers. The mentor-mentee relationship can prove to be invaluable to

the success of the ELL as they navigate the complex challenges of their education program both inside and outside the classroom.

Designating an instructor as the ELL advisor can create an essential contact person for ELLs. This faculty member serves as a resource for both ELLs and faculty who teach ELLs. Klisch (2000) indicated:

Having a specific ESL Advisor has been a rich and mutually fulfilling experience... Students report that they benefitted from having one person, to whom they could relate, a person who cared about them, knew them well, and was familiar with their individual and common concerns. The advisor experienced immense personal satisfaction by assisting ESL students to achieve their goals, and learned a great deal about the culture and strengths, as well as the difficulties... (p. 24).

Research conducted by Donnelly et al. (2009) identified the phrase “partners in learning” as a classification for those individuals who provided support to the ELL. There was a sense of trust between the ELL and their partner that had been developed and as a result, the relationship was highly valued.

From their review of the literature on shame and the possible implications for ELLs, Colosimo and Xu (2006) identified four strategies to be used with ELLs:

- Teach ESL students to shift the locus of control from external to internal to reduce undue influence from others.
- Teach ESL students to put difficulties into perspective and see the big picture.
- Educate ESL students to set realistic personal goals and expectations, taking into account all the challenges associated with studying and living in a new culture.

- Inform ESL students that they have considerable control over their learning experiences (p. 74).

Providing guidance and support to the ELL experiencing shame is important; however, faculty and advisors should be cognizant of the professional resources available. Promptly identify a situation which may benefit from, or require, professional counseling is critical to the well being of the ELL. As a standard resource, professional counseling services should be available for ELLs. Brilliant (2000) identifies academic issues for ELLs are often based on the personal chaos they are experiencing stemming from their cultural change. Professionals trained in ELL counseling can be a valuable resource to ELLs and faculty. Using a team approach to addressing the varied needs of these students is preferred to better support positive outcomes with ELL success.

Summary

In this chapter, the researcher reviewed the literature relevant to barriers facing ELLs, and support services for ELLs in a healthcare education program. The literature identified a magnitude of challenges facing ELLs in pursuing higher education. These barriers are often the reasons ELLs do not consider higher education as an option for them. Multiple support services were identified in the literature.

CHAPTER 3. METHODOLOGY

Introduction

The purpose of this study was to determine if ELLs, who had successfully completed a healthcare education program, identified support services as having an impact on their academic success, and to identify what support services were critical to their successful completion of the healthcare education program.

Case Study

A case study is an intensive evaluation of a particular issue, process, group, organization, or social, political or related phenomenon (Creswell, 2003; Yin, 2009). The qualitative approach to research is favored when the research questions seek to “explore” the subject matter (Stake, 1995). Denzin and Lincoln (2000) identified “case study can be a disciplined force in public policy setting and reflection on human experience” (p. 448).

The research design used in this study was qualitative case study. This qualitative case study was conducted by means of answering the two research questions that guided the study:

1. Do ELLs identify support services as having an impact on their academic success in a healthcare education program?
2. What support services do ELLs identify as critical to their successful completion of a healthcare education program?

The case study methodology allowed this researcher to deeply explore the two questions guiding this study. The researcher was interested in learning how higher education institutions, that offer healthcare education programs, could better support ELLs to be

successful in their chosen program. Qualitative studies provide the opportunity for participants to share their perceptions and wisdom from first-hand accounts of their knowledge and engagement in the subject matter.

Denzin and Lincoln (2000) identified three types of case studies: (a) intrinsic, (b) instrumental, and (c) collective:

- Intrinsic: the case itself is of particular interest and the researcher wants a better understanding of that particular case.
- Instrumental: the case is examined by the researcher mainly to provide insight into an issue or to redraw a generalization; the case is of secondary interest and facilitates understanding of something else.
- Collective: the researcher jointly studies a number of cases in order to investigate a phenomenon, population, or general condition (p. 437).

This case study was instrumental because it focused on studying a particular issue, support services for ELLs in a healthcare education program, with the intent of understanding how to better support these students to be successful.

Philosophical Paradigm

The advocacy/participatory epistemology served as the basis for this qualitative case study. According to Creswell (2009) advocacy/participatory worldview seeks to “change the lives of the participants, the institutions in which individuals work or live, and the researcher’s life” (p. 9). The intent of this research was to identify support services that assist ELLs to be successful in a healthcare education program. By increasing the knowledge surrounding ELLs to successfully complete their chosen healthcare education program, their lives will change as will the lives of others they have the good fortune to care for. Creswell

(2009) also indicated “advocacy research provides a voice for these participants, raising their consciousness, or advancing an agenda for change to improve their lives” (p. 9). ELLs are a population typically silenced due to the language barrier; the design of this research study was intentional to provide the participants a voice to articulate their wisdom on support services for ELLs in a healthcare education program.

Kemmis and Wilkinson (1998), as cited by Creswell (2009), identified four key features of the advocacy/participatory forms of inquiry:

- Participatory action is recursive or dialectical and focused on bringing about change in practices. Thus, at the end of advocacy/participatory studies, researchers advance an action agenda for change.
- This form of inquiry is focused on helping individuals free themselves from constraints found in the media, in language, in work procedures, and in the relationships of power in educational settings. Advocacy/participatory studies often begin with an important issue or stance about the problems in society, such as the need for empowerment.
- It is emancipatory in that it helps unshackle people from the constraints of irrational and unjust structures that limit self-development and self-determination. The advocacy/participatory studies aim to create a political debate and discussion so that change will occur.
- It is practical and collaborative because it is inquiry completed with others rather than on or to others. In this spirit, advocacy/participatory authors engage the participants as active collaborators in their inquiries (p. 10).

This case study included each of these “key features”:

- Through intention to bring about a change in practice in higher education institutions that offer healthcare education programs so they offer the support services critical to the success of ELLs.
- By assisting ELLs to free themselves from the constraints found in language and in the relationships of power in healthcare educational settings.
- By increasing awareness of the needs of ELLs in a healthcare educational setting and creating a platform for discussion.
- Through the active engagement of the participants in this qualitative study in the provision and review of the data to ensure accuracy.

Research Site

The site for this study was a small, private, health sciences college in the Midwest. As part of their vision and mission, this institution reached out to immigrants and refugees in the community and provided an opportunity to pursue a healthcare education program to those interested in pursuing a career in healthcare. According to the United States Census Bureau, the 2010 population of the metropolitan community this college was situated in was 203,433 persons (Retrieved from <http://www.census.gov/popest/data/maps/11maps.html>).

Participants

Purposeful sampling was utilized to select the participants for this qualitative study. Maxwell (2005) defines “purposeful selection as a selection strategy in which particular settings, persons, or activities are selected deliberately in order to provide information that can’t be gotten as well from other choices” (p. 88). Participants in this study focused on

ELLs who successfully completed a healthcare education program at a particular small, private, health sciences college in the Midwest.

Following approval from the Institutional Review Board (IRB) at Iowa State University and the small, private, health sciences college in the Midwest, this researcher contacted the administrator and staff involved in the programming for the ELLs at the small, private, health sciences college in the Midwest. Following the participation requirements of being an ELL who successfully completed a healthcare education program at this institution, a review of student records revealed twelve potential participants. All twelve potential participants were contacted by telephone. Communication was achieved with each of the twelve potential participants. In conducting each telephone conversation, the researcher followed a script that included:

- Identification of who the researcher was, how they obtained the person's name and contact information, and why they were being contacted;
- The purpose of the research study;
- How the person was qualified to participate in the study;
- An overview of what each participant would be asked to do and an approximation of the time commitment involved;
- Assurance of anonymity of all participants;
- Contact information of the researcher.

During this telephone conversation with each of the potential participants, confirmation or declination to participate in the research study was obtained. From the initial twelve contacts, five ELLs agreed to participate in the research study and seven declined. Each participant

received a follow-up written letter from this researcher which provided an overview of the research study detailing each item discussed during the telephone conversation.

Of the five participants, three were male and two were female. Each participant was from a different country of origin. Countries represented included (a) Bhutan, (b) Burma, (c) Mexico, (d) Nepal, and (e) Vietnam.

The individuals who declined to participate in the study each expressed appreciation of being asked. After discussing the anticipated time commitment involved, each of the seven individuals who declined to participate indicated they were very busy and did not feel they had the time available to dedicate to participating in the study.

Patton (2002) identifies participants as “key informants”. These are the individuals who possess the knowledge pertaining to the subject matter to be studied. In the case of this particular research study, the ELLs knew first-hand what support services were most beneficial to their success as an ELL in a healthcare education program. This study had five “key informants”.

The researcher scheduled a time to meet individually with each participant following the initial contact by this researcher with each of the five ELLs who willingly agreed to participate in this research study. Each of these meetings was held in a private study room located within the library of the small, private, health sciences college in the Midwest. The purpose of this initial meeting was for the researcher to begin to establish rapport with each participant and review the purpose of the research study, answer any questions, confirm their willingness to participate, review and sign the Informed Consent document and schedule interview times.

Data Collection Methods

In qualitative research, the establishment of trust and rapport with participants is important. “The development of trust between researcher and participant is an essential part of the research process” (Darlington & Scott, 2002, p. 54). With the intent to further establish rapport and begin to build a sense of trust with each participant, the researcher began the first interview session by sharing information about themselves and why they were interested in this research. The purpose of the research study was reviewed and each participant was assured strict confidentiality would be maintained.

Each participant completed two 60-90 minute interviews totaling 10 interviews for the study. The interviews were scheduled based on participant and researcher availability and were conducted in a private study room located within the library of the small, private, health sciences college in the Midwest. Each interview was recorded with the permission of the participant on two digital recorders to ensure recording in case there was a malfunction with one recorder. Darlington and Scott (2002) identifies the critical importance for interviews to be recorded to ensure accuracy of the data and focus of the researcher. The researcher took descriptive field notes during each interview. The researcher conducted all individual interviews utilizing a semi-structured, in-depth set of 10-15 questions per interview. The first round of interviews had the same set of guiding questions and the second round of interviews had the same set of guiding questions; questions used in the first round of interviews were different to those utilized in the second round of interviews.

Patton (1980) designates “the purpose of interviewing is to find out what is in and on someone else’s mind. We interview people to find out from them those things we can’t observe” (p. 196). Esterberg (2002) distinguishes semi-structured interviews as less

conforming than structured interviews, which allows for a conversational tone and exchange of ideas. In-depth interviewing recognizes the participants are the “experts” of the content they provide based on their own experience (Darlington & Scott, 2002).

During each interview, the participant was not rushed to answer questions and was allowed time to process and respond to each question. The researcher did not ask the next question until the participant responded to each question. The participants were encouraged to ask for clarification of any question or comment they did not understand during the interview. The researcher clarified any comment made by a participant they did not understand or felt they had not heard clearly. Having the immediate opportunity to clarify meaning is beneficial (Darlington & Scott, 2002). Probing and the use of re-directive questions were used as indicated to facilitate a more detailed or clarified response (Denzin & Lincoln, 2000).

A minimum of 30 days was allowed between each participant’s interview to provide time for reflection by both the participant and researcher. This time also enabled the researcher opportunity to transcribe the interviews verbatim, carefully review both the transcriptions and field notes, and prepare the next set of interview questions. Accuracy of each transcript was validated by the researcher listening to the digital recordings while reading the transcripts. In addition, “member checking” was utilized by having participants review the transcripts of each interview to validate accuracy and provide an opportunity to correct any errors within the transcripts. Glesne and Pashkin (1992) and Lincoln and Guba (1985) indicate “creative use of ‘member checking’, submitting drafts for review by data sources, is one of the most needed forms of validation of qualitative research” (as cited by Denzin & Lincoln, 2000, p. 450).

Data Analysis

The interview transcripts and field notes collected in this study were analyzed according to Creswell (2009) six steps for data analysis in qualitative research:

- Step 1: Organize and prepare data for analysis (p. 185). During this step the researcher transcribed all interviews verbatim, reviewed all field notes, and took reflective notes on this activity and the research study.
- Step 2: Read through all data (p. 185). During this step the researcher read and reflected on all data and took reflective notes.
- Step 3: Begin detailed analysis and code the data (p. 186). During this step the researcher organized and separated the data into broad related categories that were labeled with terminology identified by the participants as initial categories of support services and emerging overarching themes.
- Step 4: Use the coding process to generate a description of the setting or people as well as categories or themes for analysis (p. 189). During this step the researcher carefully examined the broad categories that had emerged in Step 3, refined these categories and themes, and began to develop interwoven threads from the data.
- Step 5: Advance how the description and themes will be represented in the qualitative narrative (p. 189). During this step the researcher made further adjustments to the categories and themes, and began connecting the interwoven threads and developing narrative for the categories of support services and overarching themes the participants had identified.

- Step 6: Make an interpretation or meaning of the data (p. 189). During this step the researcher completed a comprehensive review of the results and compared the results of this study with the findings from the literature review.

During Step 6, the researcher also conducted peer debriefing by confidentially sharing the data and results of the analysis to validate this researcher's interpretation (Lincoln & Guba, 1985). The peer debriefer was qualified to participate in this process based on understanding of the research study and subject matter.

Trustworthiness

Schwandt (2001) defined trustworthiness as the quality of the inquiry that makes it significant to others. As a researcher, it is the intent of this study to ensure quality throughout the entire research process. Lincoln and Guba (1985) and Schwandt (2001) identified four criteria for trustworthiness in qualitative research: (a) credibility, (b) transferability, (c) dependability, and (d) confirmability.

Credibility is ensuring the researcher clearly and accurately articulates the findings in a manner congruent with the intended meaning (Schwandt, 2001). In this research study, credibility was maintained by having participants review the transcripts of their interviews to verify accuracy, and clarify and correct any misrepresentations. This validation process is known as member checking (Merriam, 2002 & Schwandt, 2001). The researcher also insured prolonged engagement in data collection by conducting two, 60-90 minute interviews over a two-month time period. Lincoln and Guba (1985) identified saturation of the data occurs when the researcher repeatedly hears the same information and without any new comments provided by the participants. Saturation of the data from the interviews in this research study

occurred when the participants repeated their comments or indicated they had nothing else to say; at which point, the interview was concluded.

Triangulation involves the use of multiple sources of data to determine the findings of the study (Lincoln & Guba, 1985; Merriam, 2002). As described by Schwandt (2001) triangulation is used to establish “validity” of a research study. Triangulation in this research study was achieved by drawing upon the data sources from conducting two rounds of in-depth interviews with five different participants, the researcher’s field notes and reflections, and the researcher’s clarification of data interpretation throughout the study process through the use of member checking. Drawing and validating the data from these different sources helped to ensure triangulation of the data.

Transferability is concerned with the researcher being accountable to “provide the database that makes transferability judgments possible on the part of the potential appliers” (Lincoln & Guba, 1985, p. 316). Schwandt (2001) distinguishes transferability as “dealing with the issue of *generalization* in terms of case-to-case transfer” (p. 258). In this research study, transferability was addressed by providing rich detail of each participant’s voice through verbatim transcription of the interviews and synthesis by the researcher.

Dependability “focuses on the logical flow of the process and ensures the materials are traceable and well documented” (Schwandt, 2001, p. 258). In conjunction with the data collection timeline, an audit trail was established which consisted of all materials pertaining to the research study. Materials included digital recordings, transcripts, field notes, reflection notes, and all notes pertaining to the research process and procedures. All materials were filed securely and confidentiality was maintained.

Confirmability “is concerned with establishing the fact that the data and interpretations of an inquiry were not merely figments of the inquirer’s imagination” (Schwandt, 2001, p. 258-259). Confirmability in this research study was achieved by processes closely following those instilled to ensure dependability. In addition to the audit trail, peer debriefing was conducted to validate interpretation of the data.

Summary

In this chapter the researcher outlined the methodology, philosophical paradigm, and methods that provide the framework and anchor points for this study. The chapter also entailed a description of the data analysis and measures taken to ensure trustworthiness of the study. Chapter 4 presents the results of the study.

CHAPTER 4. RESULTS

Introduction

The purpose of this study was to determine if ELLs, who had successfully completed a healthcare education program, identified support services as having an impact on their academic success, and to identify what support services were critical to their successful completion of the healthcare education program. The following research questions guided this study:

1. Do ELLs identify support services as having an impact on their academic success in a healthcare education program?
2. What support services do ELLs identify as critical to their successful completion of a healthcare education program?

During in-depth, semi-structured interviews, each of the five ELL participants were interviewed individually twice over a two-month period. The participants were very willing to share their perspective and provided meaningful insight into the impact support services had on their academic success as an ELL. The participants identified what support services they viewed as critical to their success as an ELL in a healthcare education program. This chapter presents the findings.

Results

Do support services impact academic success

In response to research question one; all five participants indicated support services did have an impact on their success as an ELL in a healthcare education program. Participant One, Two, and Three each answered this question with the response “Yes”.

Participant Four indicated, “Oh yes, very important”; and Participant Five responded, “Yes; yes, very important”.

The following section describes the six support services identified as critical to their successful completion of a healthcare education program as an ELL. The first five services: (a) additional time for learning, (b) tutoring, (c) build confidence, (d) assign mentor, and (e) additional time for practice were each unanimously identified by all five participants as critical to their success as an ELL in a healthcare education program. The sixth service, integrate ELLs and EFLs in the same classroom, was viewed as a positive experience and would support the learning experience of ELLs by three of the five total participants in this study. Two of the participants did not feel this would be supportive of learning by ELLs. It is noted; the structure of the healthcare education programs each of the ELLs successfully completed at the small, private health sciences college in the Midwest, did not integrate ELLs and EFLs in the same classroom. The researcher asked this question of these participants to gain insight and perspective for potential future consideration.

Additional time for learning

All of the participants identified the need for more time to learn and be successful. As ELLs, more time is needed to process the information and understand the material. In regards to reading the textbook, participants indicated they frequently needed to read each chapter assignment multiple times to assimilate the content. They reported needing to frequently look up words they did not know in order to understand the material. Participant Four stated:

It take me lot of time to read the book. As ELL, I read book two or three times every chapter so I learn. I read with dictionary to help with words. I already spent a lot of time for reading and translating. To read for the first time it didn't help me to

remember. To read for second time it helped a lot for me to read and remember and ask this and that, I had to read for the third time. That is very hard because I had to use dictionary to translate and that's the most I can do because I have to do the next chapter. And we do not just study one chapter for one day; we might study a few chapters. It takes a lot of time.

Participant One shared:

Well, everything take a lot of time. That I couldn't understand some of the words and it was kind-of hard to, you know, try to figure out what it was. When we had to write down a, 'how you call it?', a report from our clinical, it was very hard because I didn't know what words to use, so it took extra hours to help with words. Yeah, time was pretty tough.

Consideration for the amount of time spent in the classroom and the pace of the instruction was identified as a concern for ELLs. The participants spoke of frequently needing to translate words from English to their Native Language, and then back to English so they could understand and learn the material. This translation learning process takes time, and if the pace of the instruction is too fast, the ELL may feel the opportunity to ask a question has passed. Participant Three expressed, "I think about time. ELLs need time to think about what they just heard. May have question before move to next thing. Need time to think and ask question." Participant Five reported:

If you are given a specific time and a long paragraph and some questions; say you were given like five minutes, I would not be able to finish because it takes me a long time to go through the paragraph. I first have to understand that in my language. I

have to think in my language first, and then I can go back to English. So reading takes a long time.

I used to see my friend sitting next to me talking so fluently but they, English as the first language people, didn't like to talk to me because I was a little slow and sometimes they do not understand me, and sometimes I do not understand them when they speak fast, and the teacher sometimes it is hard to grasp them so fast. The teacher needs to go slower in the classroom so we can keep up.

Participant Two also expressed concerns about the amount of time it takes to learn not only English, but also the language of healthcare. "We have to learn English grammar and the new language. We have to learn new words and new, um, different way of making sentences, and way of speaking too. Then we have to learn language of healthcare. There is a lot of language to learn and this takes much time."

Tutoring

Tutoring was viewed as a significant resource in helping ELLs be successful in a healthcare education program. The participants spoke about how the tutors believed in the ELLs, and how this helped the ELLs believe in themselves too. Building confidence in the ELL was designated as a separate support service, and is discussed later in this chapter. Participant Four expressed, "the tutors helped us learn how to be healthcare giver. They helped me so much. They always encouraged me. They believed I could do good; that helped me believe in me too." "When I didn't understand the book, they helped me. The tutors always encouraged me and thought I could do good," indicated Participant One. "The tutor helped me so much. The tutor wanted me to do good; I wanted to do good too," said Participant Three.

The benefit of working with another person who understood the material and who may explain the content differently or provides a different example was identified as helpful. The ELL may not understand how the instructor says something, however, may understand if it is worded differently. Participant Two described the benefit of the tutors as another person who could help the ELL understand the course material:

In tutoring, mostly they talk about the topic a student didn't understand. Different people teach the same thing in a different way. The way they define the same word may be different for different people. If the student didn't understand what the instructor said, maybe they can understand the tutor better. They (the tutor) can share their own experience because they have already completed the course. They can share their ideas how to best learn.

The findings supported the need for there to be a connection between content covered in the classroom and the content covered in the tutoring session. The need for time for the ELL to reflect upon the content covered in the classroom prior to attending the tutoring session was also indicated. The time between the class session and the ELL's time with the tutor allowed the ELL to further process the material, and identify content they did not understand and had questions about. The awareness, on the part of the tutor, of the content covered in class assisted the tutor to ask questions and provide guidance for the ELLs.

Participant Three described:

In the class I didn't understand a lot of things; but when the tutor asked me what I didn't understand, it was easier. I had time to think. Sometimes in class I could not think; but when I went to the tutor I had time to think and could ask the tutor.

Participant Five indicated:

The tutors helped me a lot to learn. I got a lot of help to improve my language. My language was not like this, it was just OK; but now it is a little better than it was. The tutors helped me understand things from the book and from the teacher. Class went fast and it is a lot to learn. I could ask the tutor questions to help me.

The research findings identified the need for small group tutoring, with two or three ELLs attending the tutoring session together. By attending the tutoring with one or two other people, there was a sense of support among the ELLs and they felt more at ease to ask questions. It was identified; there should be no more than two or three ELLs per tutoring session to prevent an ELL from being overlooked or feeling they were unable to ask their question(s). Participant Three indicated:

Lot of time as ELL, you no feel comfortable asking question in big group; too embarrassed. Afraid someone laugh at you. Feel more comfortable in small group to ask question. Two or three people together is better. No more than three, because other than that, it's too big. Get too many people and not be able to ask your question.

Two people would be best.

Participant Four reported, "As ELL you too embarrassed to ask questions, even if you no understand. When you with another ELL, you feel safer asking question. They probably don't know answer either." Participant One described the need for small group tutoring because:

I would say sometimes I feel, and I see other people that want to ask questions. We don't say it, and they don't know because we don't understand something, and we just let it go; and the person, the teacher, doesn't know and sometimes we just let it

go because we don't want to ask in-front of the class. If there was only one or two other people, we would ask more questions. Having another student with you at the tutor helps you feel more comfortable to ask questions you don't know. They (the other student) probably needs the answer too.

Build confidence

The need to help build the confidence of the ELL was evident in the research findings. The participants indicated feeling uncomfortable speaking in public for concern they would say something incorrectly or not be understood. The ELLs suggested small group work and role play with scenarios would help facilitate practice of the language (English and healthcare), learning the course content, and building a sense of confidence. Participant One reported, "As ELL, I am shy and get nervous to talk to people. Like you see with myself, it's pretty hard, I can't find the words. I get nervous." Participant Four agreed assisting ELLs to build their confidence is important and helpful for their success, "It is good to be encouraged and supported so you learn you can do something. We are very thankful for all the help we get. It is very important to us."

Participant Two indicated:

ELLs get nervous talking to people, especially groups of people. It is important to get their respect to build your confidence. When you treat people friendly they start to like you and this makes you feel good. You feel more confident. When I was new here (United States), I was not afraid to talk to people because I was a teacher at home. I stood in front of like 20-30 students everyday and teach them, but if I had to stand in front of like five native speakers I would freak out because I would be scared I was doing something wrong or telling something wrong; like my accent makes me

pronounce something different. Even I speak English I get scared when I have to talk to native speakers. Even when I hear a native speaker talk, I sometimes don't know what they are talking about because those will be new words for me. I build my confidence by speaking English and listening to native speakers.

A good activity to build confidence would be if they give assignments like giving a speech on some topic or organizing something like a presentation where you have to stand up in front of students and tell them in your own words. People get insecure standing in front of people and speaking because they think they are poor in English, because they are English learners. The first time, maybe a couple of times, they will be scared of standing in front of people, but when they keep doing that, they will be confident. They will be able to speak better later on.

In my own opinion, when I came here for the first time, I knew how to speak English, but I was not confident at all to speak to people because I always think maybe they do not understand my language or maybe I speak something wrong, and they may laugh at me or something like that. I was kind of nervous the first time; but when I got used to talking to people, I kept talking to people. Now I can talk to people, even sometimes I feel like I can speak good English, it's really hard to pick up new phrases that people use, like slang words they speak. I can't understand most of them, the same thing happens when I talk to people, I can talk to people to some extent, I will be thinking am I talking something wrong, it's just experience, the more you talk the more you will know. That's all it involves.

Participant One indicated:

Working in small groups would help you. You could do small scenarios and really get into the material. Then it makes sense and makes you feel better that you learned something. The scenarios could get harder as you were more confident and you could do small projects. Maybe even present to class; that would be good.

Participant Five indicated:

We need to have a person from here (United States) who can show us how to improve our confidence in our English language and help build skills. We need to have some type of program, some type of interaction and activities. We had activities in my home country to build our confidence, I don't see those here. We had a lot of competitions; extra activities they organize essay competition, debates, speech, and other types of competitions which helped to build our confidence level. Sometimes, maybe once a month, should have the students to give a speech. Interactions among the students where they have a specific topic from the subject matter and so that we can research more about the topic and present work, so we can be more involved in the other activities too. Not only the book studying, but giving a speech in front of the class. Group projects and interactions among the students is good.

Participant Three identified:

Many people (ELLs) need to improve their confidence. I need to improve my confidence because I'm not talking a lot. A lot of people talk in the Mother Language and not in English. They don't know how to speak English and they don't know the pronunciation, or they don't have the courage, because maybe they make a mistake or

people will laugh because they can't speak. That gives them less opportunity. ELLs need to build confidence to know they speak English correct.

Assign mentor

Establishing a relationship with a mentor was viewed as helpful and favorable for the ELL's success among study participants. The findings indicated the mentor could provide guidance for the ELL in multiple areas: (a) course content, (b) language development, (c) cultural adjustment, and (d) obtain employment. "Someone who could help guide you would be good. There is a lot to learn as a new person here. That person (mentor) could help answer questions and help you learn more. They could help you find a job too," reported Participant One. Participant Three felt, "Someone who would help others would be good. If the person (mentor) knows who needs help, then they can help them. I think that it is a good thing".

Participant Four agreed a mentor would be helpful for ELLs:

Yes, that person (mentor) would help. They could provide me with the information I need to know. The way in the U.S., how to be a student here, to live here, and how to share time. How to be nice, how to use my time, and do donations. To share my time; to me that's ethics. How to bond here. They could help us learn English. Learning English is the most important.

Participant Two also felt a mentor would really be helpful for an ELL and serve a variety of purposes:

In my opinion, practicing with someone who knows English is the best way to learn English. This person (mentor) would know if you made a mistake and could correct you, so you learned English correctly. Because English has so many words and grammar, it's really hard to learn. You should practice every chance you get.

The mentor could help the ELL learn the ropes and help them solve the problems and even how it works and how they are supposed to be in the class, how much time they are supposed to spend in the class and at home reading the book, and getting through the class. If I had a mentor for me, I could solve most of the problems that I have from the book. Even if I have to find a job, I can contact that person to guide me. If I had the opportunity, I would serve as a mentor to help others, I would like to do that. I would like to give back and help others.

Participant Five identified:

The first thing is the mentor could help us with the language. The main problem is the language. We should be learning about the culture. Like if they are helping us find a job, they should give us some tips about how to do the interview, resume, and how to dress up, stuff like that. And for our studies, they might help us find the right school for us, like which school is best for me. The person who is the mentor could take me to the college and introduce me to people over there. Get some information about the school and the new culture over there.

Additional practice for learning

A substantial finding in the research was the need for additional practice for learning. ELLs need to practice the language, both the English language and the language of healthcare, and the skills of their chosen career path. The participants stressed the importance of communication with patients; both in understanding what the patient is saying and what they say to the patient. The results indicated practicing language should include both speaking and listening; the participants indicated this was part of the learning process. Improvement in language acquisition and skill mastery builds the confidence level of the

ELL. Participant Four talked about asking questions to learn and practicing skills to provide good care to their patients:

When I can talk to someone and they talk to me, I will ask what I do not know. So what I don't know, I will ask. At first I be embarrassed of my accent, but I know how to manage, I ask questions because I need to know. It is important to practice the skills. I am very interested in doing good skills. Taking care of patients the best is most important.

Participant Three and Four talked about the value of reading out loud when they practice. "When I read out loud, I get less distraction because I focus on the word more and the sound gets in my ear and I hear it too", offered Participant Four. Participant Three indicated, "If I just read in my mind it is one thing, though if you read out loud, then you will know your voice and then it would go back in your brain. Reading out loud is best for practice and learning."

Participant One reported:

Having conversation is difficult because you can't find the words. I get nervous, you're not as confident because you might say it wrong or they won't understand. I would say sometimes I feel, and I see other people that were kind-of shy too, afraid to talk because we don't really talk regular and sometimes we don't say it and just stay quiet. More practice would really help. Practice helps you learn. I think having more practice with another person or in a small group would help. Letting the students talk; having more practice in a group and everyone telling a story or something. Having more conversations; that's what always comes to be difficult because you can't find the words. That an important thing in medical career; talking to the patient and

sometimes you know, if I would be in my own language with a patient, I could do it real easy you know, talk about it and everything; but in different language it is pretty hard. You get nervous, you are not confident because you might say it wrong or they won't understand you. I think that would be really most important in a medical career to have them have conversations.

Participant Two identified the importance to both practice speaking English as well as practice listening to the English language:

It really helps me to listen to English being spoken to hear how they say the words, so I can pick up their accent, how they talk and speak. I really try to pick up the words that they say. I was thinking that I need to pick up this language because I need to be here for my whole life. There is no other way I can learn this without hearing how other people speak this language. Your environment helps you get better with English if you are not isolated. Repetition makes you get used to speaking English.

Participant Five reported:

The most important thing is to provide enough ELS classes and like keep more hands on experience training and field trips where they (ELLs) can get some experience and communicate more, like you are talking to me now. I think I can improve my language more if I keep on communicating, if I keep on talking to you, like then I can improve my language better. At home we do not speak English; we speak our Native Language and when we are with our other friends, those who speak English, we speak English, only we speak English language which is not going to be helpful because most of the time you need to have the hands on experiences and practice, practice,

practice. If we do not understand even a single word, then it throws everything off.

Practice is most important.

Participant Three indicated:

In my home country, you cannot talk too much outside. In my country they can listen in, if you talk too much you can get problems. But practice talking the language here is very important. Practice is part of learning. I think it would be helpful to have people at different levels get together and talk, to practice and work together. I learned a lot of stuff through reading, but need to practice it. If I don't use it, I forget it. For me, practice would be helpful and also for other people. For me, I have a problem because when I stay home, a lot of my friends are living there and they cannot speak English, when we meet and we talk in only our language we never speak in English, so that is a problem. Less practice talking in English, less time, so just even if we just had enough time to speak, my pronunciation would be better because I could improve my English. If you practice and talking; talking every day the more improvement. You won't forget easily.

Even me when my supervisor is talking sometimes I don't understand, I cannot talk to them, I don't know what they want me to do. Less talking, so then the problem is sometimes when I would talk they wouldn't understand, but I would explain by keep talking to them. I need practice more.

We need to practice more talking. We don't talk that much, so we need to practice more but it's hard to talk, maybe you talk wrong. That why even I don't know exactly what we're talking about, sometimes it's complicated and I just get confused. So in that case we just need to practice every day and take more time and we can improve.

Integrate with EFLs

Three of the five participants reported integrating ELLs with EFL students in the same classroom would be a positive experience and would enhance the learning environment for the ELL. The three participants in support of integration reported having ELLs and EFL students in the same classroom would provide opportunity for ELLs and EFLs to learn from and better understand each other. It was felt the class would be more engaging. Participant Three indicated:

It would be best if they, ELLs and EFL learners, were in the same class. If you separate them into different groups, they (ELLs) will not speak English as much anymore. They will understand, but they won't improve. If you mix them together, then the ESL learners can then ask, they can hear them speaking it and then they can improve how they speak.

Participant Two reported:

I think having native speakers and ELLs in the same classroom would be best. ELLs come from different countries; no one can speak perfect English like the native speakers. If you have ELLs and native speakers in the same classroom, they learn from each other. ELLs will learn better English and about the culture and experiences of the native speakers. The native speakers will learn about the ELLs' home countries and customs, and better understand what the ELLs have been through to get to the United States. They will respect each other better.

Participant Five expressed:

I want to be in the classroom with ELLs and EFL students. I would learn the most from that classroom. There would be more interaction and the class would be more

interesting. We would learn from each other. EFL students are more creative, more creative than us (ELLs), because this is an advanced country. They have computers all the time, and they are creative and can come up with different ideas, and they are friendly. Americans are friendly.

Two of the participants did not advise integrating ELLs and EFL students in the same classroom; they did not feel this would be good for ELLs. These participants indicated they would not feel comfortable in this environment. They felt the ELLs would be self-conscious about their language skills and the pace of instruction would be too slow for the EFL students. Both of these participants would not want to be a student in an integrated classroom. Participant One reported they would not feel comfortable in a classroom with English as the First Language students:

Separate is better. Because myself, I learned a little bit of English, but not correct English. You know and what I see at medical schools, you use more defined terms you know, and sometimes we don't know those words and it's hard, so I think separate would be better.

Participant Four also would not feel comfortable in an integrated classroom of ELLs and EFL students:

No, the first I would say. First, the person with English as their first language would be bored because they would be at a different level of learning, and people with it (English) as a second language, they would be embarrassed because they do not know; they feel like they are lost.

Themes

Five overarching themes were identified in this study: (a) desire to give back and help others, (b) sense of appreciation, (c) pride in their accomplishment, (d) education is valued and honorable, and (e) success and career attainment impacted their life and the lives of their families. Each participant voiced attributes of these sentiments during their interviews.

The desire to give back and help ELLs and other people in their community was vocalized by the participants in this study. Participant Three indicated “I want to improve the life of the people in my community”. “I would like to help others and care for other people” acknowledged Participant Five. Each of the participants seemed to have a sense of obligation to offer help and guidance to others as they had provided to them. The participants indicated a sense of responsibility to help other immigrants and refugees who are new to this country. Participant One offered “I would like to help other people like me who are new to the United States”. “I can help people and then go on and teach other people” reported Participant Two. Participant Four indicated “I would like to do something in return for others”.

All participants expressed a genuine sense of appreciation for all the support and encouragement they had been provided. Participant One reported “They were pretty nice people and it was a great experience. I am very thankful for this opportunity”. Participant Two indicated “The people took responsibility to help me, to help me get it done. I really want to thank them”. Participant Three offered “I want to thank the people who helped me. They told me if I had any problems, I could go to them and they would help me. I like how they work together to provide people like me with a better life”. Participant Five simply stated “I am thankful for this opportunity”.

Participant Four shared warm sentiments for both instructors and tutors:

It is hard to explain in words. It was her (instructor) day off, but she walked into class on the weekend anyway. We got low score on that exam and she walked in on weekend and talked to us about the exam and she wanted us to study harder and I am impressed. She supposed to be off, staying home, but she walked in and talked to us about that; that made me think I had to study harder, I have to know that my instructor is doing my best to help me, so I have to do something for myself to let them know that I am thankful. I didn't want her to be disappointed about me, so I study hard.

They (tutors) encourage us for support, they were wonderful. They were very nice and kind and everything else. They encourage us with their words and like say "never give up hope" and she encouraged us all in that way and make me feel like we were in good hands. We looked at them like parents, they had such warmth and encouragement and help we studied well.

Each of the participants reported feeling proud of their accomplishment of successfully completing a healthcare education program. "I did a good job" indicated Participant One. "It was very hard, but I did a good job" offered Participant Five. Participant Two reported feeling "proud of what I learned. I want to do a good job so everybody will be impressed by what I do". Participant Three acknowledged "I feel good because they believe in me. It makes me feel happy". "I tried my best to use this opportunity and this is a wonderful program that I got a job with. I got a career with knowledge. I am proud to be a caregiver" reported Participant Four.

All of the participants spoke of their cultural sentiment regarding education. They indicated education is highly valued and honored. Participant One reported “Education is important”. Participant Three indicated “Very honorable to learn. In my community, a lot of people don’t know how to get a better life. Very important to learn because of my future life and my career; it is very important to learn and study”. “Education is important. I will be some new person in the United States. Getting through the class is not the destination; working in healthcare profession is the destination” indicated Participant Two. Participant Four reported “Education is honorable; helps us learn about our career as a health provider, health caregiver. We understand well and we hope that we obtain a job as a caregiver”. Participant Five offered “Education is a high value for me; it is key to improving your life”.

Each participant indicated this learning experience would have an impact on their lives and the lives of their families. “This is very good for me and my future” reported Participant One. “I have opportunity to get a career and serve” Participant Four indicated. Participant Five acknowledged “I want to continue my education and go further in school”. Participant Two expressed:

People believed in me. They think that I can do something better in my life and change my life. I am just a new immigrant to this country. When I came here (small, private, health sciences college in the Midwest) they knew I would be someone. This education is going to make a change in my life.

Participant Three indicated:

In my country, I work with “Doctors Without Borders”. I was a medic, so I take care of patients. So I want this job, if you have not certification or license, you can’t do

anything here. At home you didn't need a license. Now I am a caregiver, this will change my life here.

Summary

In this chapter, the researcher reviewed the purpose of the study and the two research questions that guided the inquiry. The results from this qualitative case study were presented in three categories: (a) did support services have an impact on academic success, (b) what support services were identified as critical to the success of ELLs in a healthcare education program, and (c) what overarching themes emerged from the study.

Five overarching themes were identified in this study: (a) desire to give back and help others, (b) sense of appreciation, (c) pride in their accomplishment, (d) education is valued and honorable, and (e) their success and career attainment impacted their life and the lives of their families. Each participant voiced attributes of these sentiments during their interviews.

The results of this research study clearly articulate support services are imperative to the success of ELLs in a healthcare education program. ELLs are highly valued students, who can be successful and transition into professional practice, where they would provide significant contributions in meeting the growing demands for cultural competent care in healthcare. The qualitative case study design of this study enabled the participants' voices to be heard; this provided a rich essence that heightens the impact of the results.

CHAPTER 5. DISCUSSION, RECOMMENDATIONS, AND CONCLUSION

Introduction

The purpose of this study was to determine if ELLs, who had successfully completed a healthcare education program, identified support services as having an impact on their academic success, and to identify what support services were critical to their successful completion of the healthcare education program.

The research design used in this study was qualitative case study. This qualitative case study was conducted by means of answering the two research questions that guided the study:

1. Do ELLs identify support services as having an impact on their academic success in a healthcare education program?
2. What support services do ELLs identify as critical to their successful completion of a healthcare education program?

The case study methodology allowed this researcher to deeply explore the two research questions. The researcher was interested in learning how higher education institutions, that offer healthcare education programs, could better support ELLs to be successful in their chosen program. Qualitative studies provide the opportunity for participants to share their perceptions and wisdom from first-hand accounts of their knowledge and engagement in the subject matter.

The advocacy/participatory epistemology served as the basis for this qualitative case study. According to Creswell (2009) advocacy/participatory worldview seeks to “change the lives of the participants, the institutions in which individuals work or live, and the

researcher's life" (p. 9). The intent of this research was to identify support services that assist ELLs to be successful in a healthcare education program. By increasing the knowledge surrounding ELLs to successfully complete their chosen healthcare education program, their lives will change as will the lives of others they have the good fortune to care for.

The theoretical framework chosen to guide this study was resiliency theory. This theory is based on the premise that individuals have the ability to overcome adversity. Turner et al. (1993) defined resiliency as "the ability to bounce back, recover, or successfully adapt in the face of obstacles and adversity" (p. 170). The success of ELLs pivots on their ability to be resilient and persevere. Resiliency theory provides a theoretical explanation of where this strength originates. The participants in this study were immigrants and refugees who fled their homelands in hopes of building a new and better life in America.

Over a two-month period, in-depth, semi-structured interviews of the five ELL participants were conducted with the intent of answering the two questions guiding this qualitative case study. The participants were very willing to share their perspective and provided meaningful insight into the impact support services had on their academic success as an ELL. The participants identified what support services they viewed as critical to their success as an ELL in a healthcare education program.

This chapter provides a discussion of the results relevant to the literature, recommendations for future research, and concluding thoughts.

Discussion of Results

During the interviews, the participants indicated support services did have an impact on their success as an ELL in a healthcare education program. Six support services were identified as critical for ELLs' successful completion of a healthcare education program. The

first five services: (a) additional time for learning, (b) tutoring, (c) build confidence, (d) assign mentor, and (e) additional time for practice were unanimously identified by all five participants as critical to their success as an ELL in a healthcare education program. The sixth service; integrate ELLs and EFLs in the same classroom, was viewed as a positive experience and would support the learning experience of the ELLs by three of the five total participants in this study. Two of the participants did not feel this would be supportive of learning by ELLs. It is noted; the structure of the healthcare education programs each of the participants successfully completed at the small, private, health sciences college in the Midwest, did not integrate ELLs and EFLs in the same classroom. The researcher asked this question of these participants to gain insight and perspective for potential future consideration.

Do support services impact academic success

In response to research question one; all five participants indicated support services did have an impact on their success as an ELL in a healthcare education program. This finding is supported in the literature. In 2004, the Sullivan Commission reported a vision for the entire U.S. healthcare system focusing on excellence, access, and quality for all people. The commission identified the need to augment diversity in the health professions by constructing creative career pathways and transforming the culture of health professions schools.

Yoder (1996) classified the barriers of ELLs in higher education as: (a) personal, (b) academic, (c) language, and (d) cultural (p. 8). As a result of the multiple barriers facing ELLs in a healthcare education program, support services are necessary to “level the playing field” and allow ELLs to demonstrate their true ability to be academically successful without

permitting the barriers to be the determinant factor in their level of success. The provision of support services does not constitute an unfair advantage for ELLs; rather it helps to ensure an opportunity of equity in comparison to the EFL students.

Additional time for learning

All of the participants identified the need for more time to learn and be successful. As ELLs, more time is needed to process the information and understand the material. When completing reading assignments additional time is needed for translation and the utilization of a dictionary resource to understand the meaning of words the ELL does not know.

The pace of instruction and student learning activities need to reflect the ELLs' learning needs. The participants spoke of frequently translating words from English to their Native Language, and then back to English so they could understand and learn the material. This translation learning process takes time, and if the pace of the instruction is too fast, the ELL cannot complete the translation fast enough to keep pace with the instructor. When questions arise to seek clarity and understanding, the ELL may feel the opportunity to ask a question has passed. The results of this study indicated ELLs need enough time to process the material to determine if they have a question or need to clarify understanding. By slowing the pace of content delivery and adjusting the instructional style to accommodate the learning needs of ELLs, the opportunity for comprehension and learning to occur is enhanced, and the possibility of success is more readily achieved.

The study by Memmer and Worth (1991) indicated the need for flexible classes: loads, times, ratio of students to teacher, clinical lab mix of ELLs and EFL students, as well as decreased faculty-to-student ratio, and additional time for skills learning (p. 391-395).

Tutoring

Tutoring was viewed as a significant resource in helping ELLs be successful in a healthcare education program. The participants spoke about how the tutors believed in the ELLs, and how this in turn helped the ELLs believe in themselves. The tutors were optimistic and always encouraged the ELLs to work hard. This served as a sense of motivation for the ELLs to study and strive for success.

The participants identified the need for time to assimilate the classroom material before they formulated questions. The time between the classroom and the tutoring sessions provided opportunity for this to occur. The participants indicated the classroom time passed quickly and the follow up time with the tutor provided opportunity for them to process the material and determine if they had questions.

The findings supported the need for there to be a connection between content covered in the classroom and the tutoring session. The participants identified the benefit of working with another person who understood the material. They indicated the tutor may explain the content differently than the instructor, or provide a different example pertaining to the material that was helpful. This engagement with the tutor reinforced the material from the classroom and provided opportunity for clarity and understanding.

In the 1991 study by Memmer and Worth, peer tutoring was identified as a support service for ELLs. The intentional connection between the classroom content and the tutoring session was supported in the literature. Guhde (2003) identified the need for intentional and fluid connection between the instructor in the classroom and the tutor. Effective communication between these two points of contact for the ELL facilitated learning through reinforcement of the material and opportunity to ask questions. The tutor needed to know the

lesson plan and the assignment expectations of the ELL. The tutor would facilitate the tutoring session in a way that supported the learning expectations of the ELL.

The results of this research study indicate a need for small group tutoring, with two or three ELLs attending the tutoring session together. By attending with one or two other ELLs, there was a sense of support, and the ELLs would feel more at ease to ask questions. It was identified; there should be no more than two or three ELLs per tutoring session to prevent an ELL from being overlooked or feeling they were unable to ask questions. The participants revealed feelings of embarrassment and hesitancy to ask questions if they were by themselves with a tutor; however, in the presence of one or two other ELLs there would be a sense of comfort and support to ask questions. It was also felt the other ELL(s) probably had a similar question and could learn from the exchange.

While the direct concept of small grouping tutoring was not noted in the literature, studies have indicated study groups are necessary for ELLs. Shakya and Horsfall (2000) identified the need to ensure all students are included in a study group. This research study also identified the importance of creating support groups and advocated the use of a buddy system to ensure each ELL felt a sense of connection and belonging.

The connection of small group study environments for ELLs between this study and the literature demonstrate the need for possible future research focused in this area of inquiry. The exploration of the benefit of small group tutoring for ELLs in a healthcare education program will be discussed later in this chapter.

Build confidence

The need to help build the confidence of the ELL was evident in the research findings. The participants indicated feeling uncomfortable speaking English in public for

concern they would say something incorrectly or not be understood. They worried about being made fun of or feeling embarrassed, and indicated feelings of nervousness, shyness, and fear.

The ELLs suggested small group work and role play with scenarios would help facilitate practice of the language (English and healthcare), learning the course content, and building a sense of confidence. A sense of friendliness and acceptance by others offered positive emotion in the ELL.

The study results promoted ELLs working on class projects and student learning activities in small groups with the sharing of content with others in the group. This group work and presentations should build in depth of content and size of the group to facilitate the comfort level and confidence of the ELLs with public speaking.

In the literature, Klisch (2000) identified the value of providing assertiveness training for ELLs. This training can promote the ELL's confidence and comfort level to speak in public, ask questions, and engage in leadership roles during their academic experience and beyond into their chosen career. In related studies on shame in ELLs, Colosimo and Xu (2006) identified four strategies:

- Teach ESL students to shift the locus of control from external to internal to reduce undue influence from others.
- Teach ESL students to put difficulties into perspective and see the big picture.
- Educate ESL students to set realistic personal goals and expectations, taking into account all the challenges associated with studying and living in a new culture.
- Inform ESL students that they have considerable control over their learning experiences (p. 74).

Multiple sources of data pertaining to self-confidence of ELLs were identified. Research conducted by Sanner (2004) identified ELLs were reluctant to speak in class and experienced intimidation and discrimination because of their accents. As a result, ELLs can be labeled as non-participatory.

In a study by Sanner et al. (2002) aspects of social isolation was experienced by all participants. As a result of the students not having confidence in their verbal language ability and concern about their accent, they withdrew verbally which led to a sense of isolation. Jalili-Grenier and Chase (1997) indicate ELLs in higher education are often isolated from their usual support system. This change in normalcy can be stressful for these students and places them at higher risk of having challenges to adjust and cope with their new environment. Kurz (1993) identifies students in these situations commonly experience cultural shock from the sudden change in their cultural environment.

As a standard resource, professional counseling services should be available for ELLs. Brilliant (2000) identified academic issues for ELLs are often based on the personal chaos they are experiencing stemming from their cultural change. Professionals trained in ELL counseling can be a valuable resource to ELLs and faculty. Using a team approach to addressing the varied needs of these students is preferred to better support positive outcomes with ELL success.

Newman and Williams (2003) identified the need for ELL workshops and handouts on “Strategies for Success” (p. 93). Content included in these workshops could focus on a variety of strategies to build confidence and a positive self-esteem among ELLs.

Assign mentor

The results from this research study indicate the need for ELLs to be assigned a mentor. Establishing a relationship with a mentor was viewed as helpful and favorable for ELL success among study participants. The findings showed the mentor could provide guidance for the ELL in multiple areas: (a) course content, (b) language development, (c) cultural adjustment, and (d) obtain employment. In addition to the concrete achievement of a mentoring relationship, a resulting benefit for the ELL would be realized through the multiple, on-going conversations this relationship would provide. The participants stressed the need for opportunities to have conversation; this relationship would help to provide those opportunities.

The value of mentoring relationships for ELLs was identified by several studies in the literature. In the 1991 study by Memmer and Worth, mentoring programs included partnering alumni or professionals, faculty, or other students with ELLs. Gardner (2005a) promoted the need for mentoring relationships to be established between faculty and students. “Educators must be approachable, sensitive, and nonthreatening so that *all* students feel comfortable asking for help” (p. 161). Abriam-Yago (2002) classified mentor relationships into three categories: (a) professional (role models in the field of study and alumni), (b) faculty, and (c) peers. The mentor-mentee relationship can prove to be invaluable to the success of the ELL as they navigate the complex challenges of their education program both inside and outside the classroom. Wilson et al. (2006) provide a summative report of strategies that can be implemented through a mentoring program (p. 19); see Appendix G.

Additional practice for learning

An overwhelming finding in the research was the need for additional practice for learning. ELLs need to practice the language, both the English language and the language of healthcare, as well as the skills of their chosen career path. The participants stressed the importance of communication with patients; both in understanding what the patient is saying and what they say to the patient. The results indicated practicing language should include both speaking and listening; the participants noted this was part of the learning process. Improvement in language acquisition and skill mastery builds the confidence level of the ELL.

The ELL in a healthcare education program is learning English and the language of healthcare; which includes medical terminology and the language, or professional jargon, of their chosen discipline. Starr (2009) begins to recognize the complexity of the language and culture adjustments ELLs are undertaking.

Language acquisition is a significant barrier for ELLs. The Cummins model of language acquisition (as cited by Abriam-Yago et al., 1999, p. 144-145) identifies two continuums upon which language acquisition occurs. The first continuum is context embedded (facial expressions, gestures, feedback) and context reduced (more complex communication dependent on the student's knowledge of the language such as in a textbook or lecture). The second continuum is cognitively undemanding (subconscious occurrences of everyday life) and cognitively demanding (requires conscious focus of language and concepts). The Cummins model also identifies two categories of language proficiency: (a) Basic Interpersonal Communication (BICS) and (b) Cognitive Academic Language Proficiency (CALP); See Appendix H. The goal of language acquisition with the Cummins

model is to move from cognitively demanding, context reduced content to a more cognitively undemanding, context embedded state of understanding.

Caputi et al. (2006) cited Krashen's work on second language acquisition:

Fluency in the second language is the result of acquiring the language, not just learning it. Acquisition refers to the subconscious process of 'picking up' the language through exposure and [learning refers] to the conscious process of studying. Both processes are necessary for successful mastery of a second language (p. 108).

In the 1991 study by Memmer and Worth, conversation lab for students to practice English was identified as a support service for ELLs. Conversation circles are identified as a support for ELLs by Caputi et al. (2006). This is when a faculty person meets with a group of ELLs on a periodic basis to discuss the following:

- Creating an opportunity for EAL students to share their thoughts and concerns,
- Determine learning needs,
- Share identified learning needs with other faculty,
- Identify areas for faculty development (p.110).

Through this activity, ELLs feel a sense of connection to the faculty and they (faculty) care about the student. The faculty may gain insight into the educational needs for these at risk students, as well as an awareness of cultural competency, and other faculty development topics.

Integrate with EFLs

The concept of integration among ELLs and EFL students resulted in mixed responses from the participants in this study. Three of the five participants reported integrating ELLs with EFL students in the same classroom would be a positive experience

and would enhance the learning environment for the ELL. The three participants in support of integration reported having ELLs and EFL students in the same classroom would provide opportunity for ELLs and EFLs to learn from and better understand each other. It was felt the class would be more engaging, students would learn from each other and develop a better understanding of the challenges they may have had, and develop a sense of respect for each other.

Two of the participants did not advise integrating ELLs and EFL students in the same classroom; they did not feel this would be good for ELLs. These participants indicated they would not feel comfortable in this environment. They felt the ELLs would be self-conscious about their language skills and the pace of instruction would be too slow for the EFL students. Both of these participants would not want to be a student in an integrated classroom.

The integration of ELLs and EFL students was not mentioned in the literature. This concept will be further discussed in the recommendations for future research section.

Implications for Practice

The findings of this study yielded seven strategy categories for implementation when working with ELLs. Table 5.1 identifies these categories and the relationship to the findings from the literature review.

Table 5.1. Implications for Practice

Strategy	Case Study	Literature
Offer Support Services for ELLs	Yes	Yes
Provide Additional Time for Learning	Yes	Yes
Provide Tutoring	Yes	Yes
• Small Group Tutoring	Yes	No
Build Confidence Level of ELLs	Yes	Yes
Assign Mentor	Yes	Yes
Provide Additional Practice for Learning	Yes	Yes
Integrate ELLs with EFL Students	Mixed Results	Not Mentioned
Involve Families of ELLs	No	Yes
Offer College Sponsored Social Events	No	Yes

The participants in this study did not feel their families needed to be involved in any part of their learning or time on campus. They unanimously reported feeling very supported by their families in both understanding the need for and accommodating the time to study, as well as coverage of family responsibilities, such as household chores and childcare. The participants identified both their families and they personally felt a sense of pride and honor in their pursuit of education.

The participants did not feel college sponsored social events would be well attended because of time constraints. Each participant expressed needs for significant additional time for learning and when coupled with non-student responsibilities such as work, sleeping, and other necessary life occurrences, they did not feel there was time left for participation in college sponsored social events.

The concept of resiliency was clearly identified in the literature on resiliency theory; however, was not identified as such by the participants in this study. There is no question there are qualities of resiliency evident in the participants in this study. As legal refugees and

immigrants, from five different countries of origin, qualities of resiliency were necessary to survive their transition to a new country and instill a sense of purpose and determination to pursue their education. Each of these participants demonstrated characteristics of resiliency and have strengthened their resilience by pursuing and successfully completing a healthcare education program.

The five overarching themes identified in this study: (a) desire to give back and help others, (b) sense of appreciation, (c) pride in their accomplishment, (d) education is valued and honorable, and (e) success and career attainment impacted their life and the lives of their families were not noted in the literature relevant to ELLs in a healthcare education program and resiliency theory. Each participant in this study clearly and passionately articulated these desires and sentiments.

Recommendations for Future Research

The purpose of this study was to determine if ELLs, who had successfully completed a healthcare education program, identified support services as having an impact on their academic success, and to identify what support services were critical to their successful completion of the healthcare education program.

The body of literature on support services for ELLs in a non-nursing healthcare education program is minimal. This research study was designed to add to this body of knowledge. The researcher intentionally chose to conduct a qualitative case study for the purpose of providing ELLs, a population typically silenced due to the language barrier, a voice to articulate their wisdom regarding support services for ELLs in a healthcare education program. As a population often silenced as a result of the magnitude of barriers

they face, the opportunity to be heard allows meaningful insight into identifying resources to best meet their needs.

Based on the findings of this study, the researcher recommends the following areas for future inquiry:

- The effect of small group tutoring on the success of ELLs in a healthcare education program.
- The effect of intentional integration of ELLs and EFL students in the same healthcare education classroom on the success of ELLs and EFL students in a healthcare education program.
- The effect of assertiveness training provided for ELLs prior to beginning a healthcare education program on their successful completion of the program.
- The effect of formal mentor relationships of ELL alumni mentors and EFL professional mentors for ELLs in a healthcare education program.
- Assess the impact on the quality of life of ELL graduates of a healthcare education program at 6 month, 12 month, 18 month, and 24 month intervals.
- Assess ELL patients' (healthcare consumers) perception of quality and satisfaction of care and compliance with care regimen, when healthcare is provided by an ELL healthcare provider as compared to an EFL healthcare provider.
- Assess ELL healthcare providers risk for and occurrence of post-employment psychological factors related to the stress of the healthcare provider profession and Post Traumatic Stress Disorder (PTSD) from refugee resettlement trauma.

Conclusion

The United States is becoming more ethnically and culturally diverse. The magnitude of the changing demographics of the U.S. population is critically important to the healthcare industry from both a cost containment and a human respect perspective. Healthcare providers need to provide culturally competent care. Healthcare higher education institutions need to identify ways to provide effective support services to enhance ELL's successful completion of healthcare education programs. The outcomes of the efforts to support ELLs in a healthcare education program are significant for all stakeholders involved in the education of healthcare providers, healthcare policy makers, and healthcare consumers.

This study has helped to fill the void in determining what support services are most effective in supporting ELLs to be successful in a healthcare education program.

ELLs are highly respected students, who can successfully complete their chosen healthcare education program and transition into professional practice. As a healthcare provider, they will make significant contributions in meeting the growing demands for cultural competent care in healthcare.

The purpose of this study was to determine if ELLs, who had successfully completed a healthcare education program, identified support services as having an impact on their academic success, and to identify what support services were critical to their successful completion of the healthcare education program. This study was a step in identifying the critical support services for ELLs in a healthcare education program. While the contribution of this study is small in comparison to the need, it is a step along the correct pathway. The future healthcare providers in America need to resemble the growing culturally and ethnically diverse populace. This researcher is confident in the abilities of ELLs who have

overcome tremendous barriers to achieve their dream of becoming a healthcare professional. For it is through these experiences and their resiliency, that perhaps they are the ones best prepared to provide cultural competent care from the locus point of knowledge, reverence, integrity, compassion, and excellence for all.

APPENDIX A.**INFORMED CONSENT FORM**

Title of Study: A Case Study of English Language Learners who have Completed a Health Care Education Program

Investigator: Theresa Smith, R.N., M.S.N.

This is a research study. Please take your time in deciding if you would like to participate. Please feel free to ask questions at any time.

INTRODUCTION

The purpose of this study is to learn about English Language Learners who have successfully completed a healthcare education program. This information will contribute to the body of knowledge of support services for English Language Learners in higher education. You are being invited to participate in this study because you are an English Language Learner who successfully completed a healthcare education program [REDACTED]

[REDACTED]. You should not participate if you are not an English Language Learner (if English is your primary language) or if you did not successfully complete a healthcare education program in [REDACTED]

DESCRIPTION OF PROCEDURES

If you agree to participate in this study, your participation will last for a maximum of 3 months and will involve your participation in two (2) interviews, each lasting 60-90 minutes. The interviews will be scheduled at your convenience, and will take place at an agreed upon private location. During the study you may expect the following study procedures to be followed:

1. Sign the Informed Consent form.
2. Participate in two (2) 60-90 minute interviews with the researcher regarding your experiences as an English Language Learner who successfully completed a healthcare education program. The interviews will be conducted at an agreed upon private location.
3. The interviews will be audio taped. The audio tapes will be destroyed on October 1, 2013.
4. Field notes will be taken during the interviews. Field notes will be destroyed on October 1, 2013.
5. Review the transcripts and researcher-designated themes of the content of your interviews as a method of assuring the authenticity of the interview.

6. All interview data will be kept on a password-protected laptop computer and will be destroyed on October 1, 2013.

RISKS

While participating in this study you may experience the following risks: There are no foreseeable risks at this time from participating in this study.

BENEFITS

If you decide to participate in this study there may be no direct benefit to you. It is hoped that the information gained in this study will benefit society by providing valuable information about support services for English Language Learners in higher education.

ALTERNATIVES TO PARTICIPATION

Not applicable for this study.

COSTS AND COMPENSATION

You will not have any costs from participating in this study. You will not be compensated for participating in this study.

PARTICIPANT RIGHTS

Your participation in this study is completely voluntary and you may refuse to participate or leave the study at any time. If you decide to not participate in the study or leave the study early, it will not result in any penalty of loss of benefits to which you are otherwise entitled. You can skip any questions that you do not wish to answer.

RESEARCH INJURY

Not applicable for this study.

CONFIDENTIALITY

Records identifying participants will be kept confidential to the extent permitted by applicable laws and regulations, and will not be made publicly available. However, federal government regulatory agencies and the Institutional Review Board (a committee that reviews and approves human subject research studies) may inspect and/or copy your records for quality assurance and data analysis. These records may contain private information. To ensure confidentiality to the extent permitted by law, the following measures will be taken. Participants in the study will be assigned a unique code and will be used on all documents instead of your name. Identifiers will be kept separate from the data. The researcher will have access to the data which will be kept confidential in a locked filing cabinet in the researcher's home and on password protected computer files. All data and

audio tapes will be destroyed on October 1, 2013. If the results are published, your identity will remain confidential.

QUESTIONS OR PROBLEMS

You are encouraged to ask questions at any time during this study.

- For further information about the study contact Theresa Smith at [redacted] or by phone at [redacted] or Dr. Dan Robinson at dcr@iastate.edu or by phone at 515-294-8182.
- If you have any questions about the rights of research subjects or research-related injury, please contact the IRB Administrator, (515) 294-4566, IRB@iastate.edu, or Director, (515) 294-3115, Office for Responsible Research, Iowa State University, Ames, Iowa 50011.

PARTICIPANT SIGNATURE

Your signature indicates that you voluntarily agree to participate in this study, that the study has been explained to you, that you have been given the time to read the document, and that your questions have been satisfactorily answered. You will receive a copy of the written informed consent prior to your participation in the study.

Participant's Name (printed) _____

(Participant's Signature)

(Date)

INVESTIGATOR STATEMENT

I certify that the participant has been given adequate time to read and learn about the study and all of their questions have been answered. It is my opinion that the participant understands the purpose, risks, benefits, and procedures that will be followed in this study and has voluntarily agreed to participate.

(Signature of Person Obtaining Informed Consent)

(Date)

APPENDIX B.**LETTER TO PARTICIPANT**

[REDACTED]

Current Date

Name

Address

City/State/Zip

Dear (Name),

My name is Theresa Smith. I am currently a doctoral student in the Educational Leadership program at Iowa State University. My dissertation focuses on a case study of English Language Learners who have successfully completed a healthcare education program was approved by the Iowa State University Institutional Research Board on (date). Your name, phone number, and email address was given to me by [REDACTED].

Since you were an English Language Learner who successfully completed a healthcare education program in [REDACTED], you are eligible to participate in the study. If you are willing to participate in the study, you will be asked to participate in two separate interviews about your experience as an English Language Learner who successfully completed a healthcare education program in [REDACTED]. The interviews will each last 60-90 minutes, will be scheduled at your convenience, and will take place at an agreed upon private location. The information provided in the interviews will remain anonymous and will be reported in aggregate; meaning in combination with information from all participants in the study and will not be reported in any individual identifiable manner.

If you are interested in participating in this important research, please contact me by email at [REDACTED] by (date). My telephone number is [REDACTED] if you have questions regarding the study. I look forward to hearing from you.

Thank you for your consideration of this request.

Sincerely,

Theresa Smith

APPENDIX C.**TELEPHONE SCRIPT WITH PARTICIPANT**

Hello (Name),

My name is Theresa Smith. Your name and telephone number were given to me by [REDACTED]

[REDACTED]. I am currently a doctoral student in the Educational Leadership program at Iowa State University. My dissertation focuses on a case study of English Language Learners who have successfully completed a healthcare education program was approved by the Iowa State University Institutional Research Board on (date).

Since you were an English Language Learner who successfully completed a healthcare education program in [REDACTED]

[REDACTED], you are eligible to participate in the study. If you are willing to participate in the study, you will be asked to participate in two separate interviews about your experience as an English Language Learner who successfully completed a healthcare education program in [REDACTED]

[REDACTED]. The interviews will each last 60-90 minutes, will be scheduled at your convenience, and will take place at an agreed upon private location. The information provided in the interviews will remain anonymous and will be reported in aggregate; meaning in combination with information from all participants in the study and will not be reported in any individual identifiable manner.

Are you interested in participating in this important research? Do you have questions about what I have shared with you?

If person agrees to participate in the study:

Thank you for your willingness to participate in this study. I will be mailing information to you (verify mailing address and email address for future contact if preferred). If you have questions regarding the study, I can be reached by email at [REDACTED] or telephone at [REDACTED].

If person declines to participate in the study:

Thank you for your time, have a nice day.

APPENDIX D.**EMAIL TO PARTICIPANT**

Dear (Name),

My name is Theresa Smith. I am currently a doctoral student in the Educational Leadership program at Iowa State University. My dissertation focuses on a case study of English Language Learners who have successfully completed a healthcare education program was approved by the Iowa State University Institutional Research Board on (date). Your name and email address was given to me by [REDACTED].

Since you were an English Language Learner who successfully completed a healthcare education program in [REDACTED], you are eligible to participate in the study. If you are willing to participate in the study, you will be asked to participate in two separate interviews about your experience as an English Language Learner who successfully completed a healthcare education program in [REDACTED]. The interviews will each last 60-90 minutes, will be scheduled at your convenience, and will take place at an agreed upon private location. The information provided in the interviews will remain anonymous and will be reported in aggregate; meaning in combination with information from all participants in the study and will not be reported in any individual identifiable manner.

If you are interested in participating in this important research, please contact me by email at [REDACTED] by (date). My telephone number is [REDACTED] if you have questions regarding the study. I look forward to hearing from you.

Thank you for your consideration of this request.

Sincerely,

Theresa Smith

APPENDIX E.**INTERVIEW GUIDE ONE**

1. How would you define “support services” for English Language Learners?
2. Describe your understanding of the support services which were available to you as an English Language Learner?
3. What support services for English Language Learners were you offered/did you participate in?
4. What are your thoughts on the usefulness of the support services you were offered as an English Language Learner?
5. What support service(s) offered for English Language Learners did you find most helpful?
 - a. Why/in what ways were these support service(s) helpful?
6. What support service(s) offered for English Language Learners did you find least helpful?
 - a. Why/in what way were these support services less helpful?
7. Did you encounter any barriers in accessing support services?
 - a. If “yes” – what barriers did you encounter?
 - b. What would you recommend to prevent barriers for English Language Learners to access support services?
8. What other support services would you recommend offering for English Language Learners?

- a. Why do you recommend these support services for English Language Learners?
9. Describe the most important information your family and friends needed to know to support you as an English Language Learner.
10. Is there anything else you would like me to know about being an English Language Learner and/or support services for English Language Learners in a healthcare education program?

APPENDIX F.**INTERVIEW GUIDE TWO**

1. In what ways is additional time for learning beneficial for English Language Learners?
2. In what ways can a tutor be helpful for English Language Learners to be successful?
3. What kind of training or assistance would be helpful for English Language Learners to gain confidence in themselves?
4. What ways can be most helpful for English Language Learners to learn English? To learn the Language of Healthcare?
5. As an English Language Learner, what aspect(s) of learning a new language is/are most helpful to practice more of?
 - Listening
 - Speaking
 - Reading
 - Writing
6. In what ways can English Language Learners best be supported in practicing this/these aspect(s) of learning a new language?
7. Describe ways in which English Language Learners benefit from additional time for practice in a healthcare education program.
8. Describe the most important way(s) a mentor could help English Language Learners be successful.

9. Describe ways in which being in the same classes with English as First Language students would have been helpful in your learning.
10. Is there anything else you would like me to know about being an English Language Learner and/or support services for English Language Learners in a healthcare education program?

APPENDIX G.**STRATEGIES OF A MENTORING PROGRAM**

Communication

Provide forums with faculty/student representatives

Facilitate regular social contact

Foster effective study skills (i.e. tape recording lectures, note taking techniques, test taking strategies)

Model effective ways to cope with stress

Encourage non-directive counseling/listening

Provide academic advising/counseling

Professional Leadership

Examine effective strategies for interacting with authority figures

Involve students in professional groups

Teach assertiveness skill development

Support sharing of professional 'lived experiences'

Confidence Building Activities

Make judicious choice of clinical placements

Share lived experiences/stories of 'professional journey'; novice to expert

Include students in activities for fun and relaxation

Foster career development (i.e. resume assistance, interview coaching)

Support Seeking Strategies

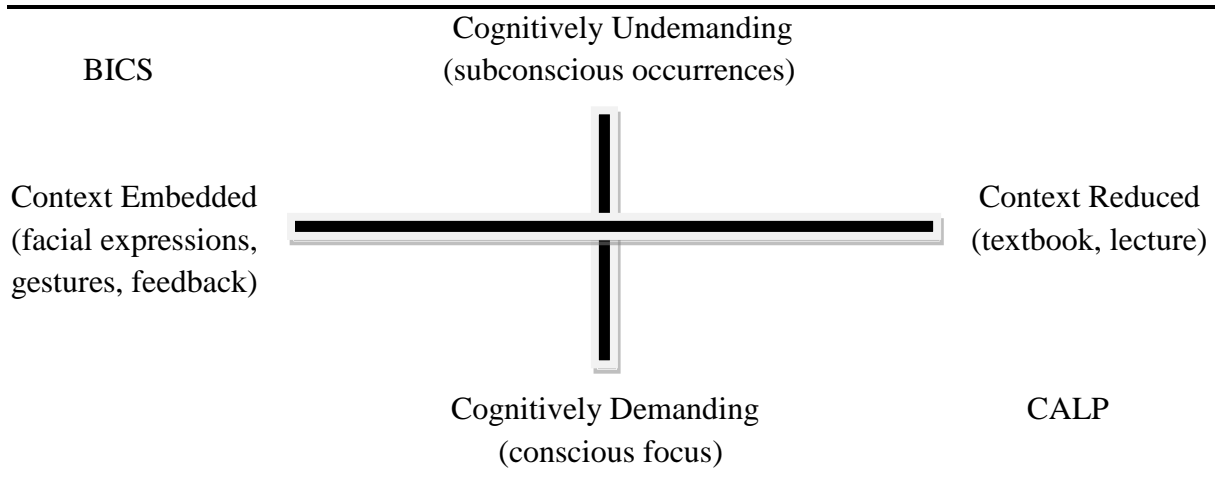
Encourage involvement in support groups

Recognize and support connectivity to extended family relationships

Provide assistance in seeking sources of financial support

Enhance awareness and access to campus/community resources

Strategies of a Mentoring Program (Wilson, Andrews, and Leners, 2006)

APPENDIX H.**CUMMINS MODEL**

Cummins Model (Abriam-Yago et al., 1999)

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