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**Assimilation and Transformation  
through Healthcare:  
Case of Houston Foreign-born  
Healthcare Workers and their  
Community Engagement**

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# **Assimilation and Transformation through Healthcare: Case of Houston Foreign-born Healthcare Workers and their Community Engagement**

## **Abstract**

The Texas Medical Center (TMC), located in Houston (TX), is the largest medical complex in the world and the largest single employer in the most racially and ethnically diverse metropolitan city in the U.S. Like other medical centers in the country or the U.S. healthcare system in general, the TMC depends heavily on foreign-born workers to maintain its steady institutional growth and meet the needs of an increasingly aging American population. Mobilizing U.S. Census data, as well as interview data drawn on a sample of the Filipino American, Indian American, Nigerian American, and Vietnamese American Nurses Associations i.e. associations that represent some of the largest foreign-born nursing populations in the U.S., we explore how foreign-born healthcare workers in Houston are assimilating to American life through their employment and are transforming Houston in the process. Findings suggest that a significant part of Houston's growing diversity in areas such as Fort Bend County is a result of foreign-born healthcare workers immigrating or moving to the region. However, more than diversifying their residential neighborhoods, foreign-born healthcare workers are building healthcare networks both inside their places of employment and in the community that are transforming Houston's healthcare system by a) forcing awareness of cultural and medical issues that are specific to their ethnic communities and b) providing free or reduced medical screenings and treatments through clinics and health fairs for those who cannot afford it. As a result, Houston is not only increasingly dependent on, but being transformed, by its foreign-born healthcare workers.

## **Introduction**

The Texas Medical Center (TMC), located in Houston, Texas, is the largest medical complex in the world and the largest single employer in the most racially and ethnically diverse metropolitan city in the United States (Texas Medical Center Facts and Figures; Emerson et al. 2012; Schiflett 2004). Comprised of twenty-one hospitals with seven acute care, six pediatric care, and eight specialty care facilities in addition to three public health organizations, two universities, three medical schools, six nursing programs, two pharmacy schools, a dental school, eight academic and research institutions, and thirteen support organizations, the TMC served over 7.2 million patients in 2012 through the care of 106,000 healthcare workers (Texas Medical Center Facts and Figures). Although the nativity of these employees is not fully known,<sup>1</sup> the TMC, like other medical centers across the country or American healthcare in general, increasingly depends on foreign-born workers to maintain its steady institutional growth and meet the needs of its increasingly diverse city (McCabe 2012; interview with TMC officials 2013).

Historically, as far back as World War II, the United States has experienced a series of critical healthcare workforce shortages that have resulted in the nation drawing on foreign-born healthcare workers to fill its needs (Choy 2003; George 2005). Today, the ongoing retirement and aging of the Baby Boomer generation, coupled with the continued failure of the nation to raise and educate a native-born healthcare workforce, has stressed the American healthcare system and once again given way to an increase in healthcare professionals immigrating to the country. Immigrants now make up a sizeable proportion of the U.S. healthcare workforce. In 2010, for example, sixteen percent of all healthcare workers in the U.S. were foreign-born, roughly 1.8 million people. Twenty-seven percent of all physicians and surgeons and twenty-two percent of all nurses, psychiatrists, and home health aides were also foreign-born (McCabe

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2012). The majority of these foreign-born workers are women (75%) and roughly forty percent immigrated to the United States from Asia (Ibid). In Houston (Texas), this trend appears to be the same (see U.S. Census), but what this means for the city itself or other major metropolitan areas of the country has yet to be fully explored.

Considerable debate surrounds immigration policy today with many people questioning whether the continued growth of foreign-born populations will cause lower wages and worsen conditions for American-born workers or even reduce incentives for some industries, such as healthcare, to recruit native-born workers (Borjas 1990; Lutten and Tanton 1994; Brimelow 1995; Moore 1997). Echoing these concerns over healthcare specifically, President Obama stated in 2009 that, “the notion that we would have to import nurses makes absolutely no sense...” (Herbst 2009). Although the point of Obama’s message was to explore creating new jobs for native-born Americans in the wake of a recession, many immigrants working in healthcare took the message as an indication that Obama, and perhaps the nation as a whole, did not appreciate them and/or the doors of opportunity for others to immigrate and seek employment in healthcare were now closing (summary across interviews; also see Lapan 2012; Truth About Nursing 2009). These sentiments echo long standing fears of American xenophobic backlash and fit into a wider environment in which many social pundits and policy makers continue to not only question what the so-called importation of healthcare workers means for American healthcare, but also the degree to which these new immigrants will assimilate or acculturate to the United States over time (Abernathy 1993; Nelson 1994; Zhou and Bankston 1994; Zhou 1997). This, of course, has been a long historic concern (Gordon 1964).

Milton Gordon was one of the first sociologists to systematically analyze the ways in which newly arriving immigrants at the turn of the 19<sup>th</sup> century into the early 20<sup>th</sup> century were

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assimilating into large metropolitan areas across the United States. Outlining a seven-stage linear process, Gordon (1964) believed new immigrants would eventually integrate into mainstream American society and become average citizens in the cities in which they resided. Today, the United States is once again becoming a nation of immigrants and many, like in the past, question what the sheer size and composition of these newly arriving immigrant populations means for the future of the nation's largest metropolitan areas (see contributions in Hanley, Ruble, and Garland 2008; Card in Inman 2009; Card and DiNardo 2000; Passel 2005 in Inman). Although many critics of current U.S. immigration policy point to the presumed negative effects of lower-skilled immigrants with poor English proficiencies on both the economy of these cities and their general cultural and economic metropolitan environments (see Card 2009; Huntington 2004a & 2004b; Passel 2005; Rector, Kim, and Watkins 2007), at least a quarter of all new immigrants are highly-skilled and are essential to the growth and vitality of their cities' economies (Card 2009). They are also important to both the racial and cultural diversity that makes these cities attractive to new economic markets. This is especially true of the ongoing growth of the American healthcare industry and its increasing dependence on foreign-born workers; yet few scholars have explored what the specific impact of foreign-born healthcare workers is on these cities.

Mobilizing U.S. Census data as well as interview data drawn on a sample of the first-generation Filipino American, Indian American, Nigerian American, and Vietnamese American Nurses Associations, associations that represent some of the largest foreign-born nursing populations in the U.S., we ask how, if at all, foreign-born healthcare workers in Houston are structurally assimilating to society through their employment in the Texas Medical Center (TMC). Specifically, we ask to what extent they are a) joining or contributing to major cliques, clubs, and institutions in their host society and b) becoming civically engaged in the wider city.

## **Assimilation and Incorporation**

During much of the 19<sup>th</sup> and early 20<sup>th</sup> century, cities across the United States were often thought of as a melting pot where ethnic and racial groups from around the world would become a single people. The metropolis was seen as a mass social experiment where immigrants would integrate into these cities and slowly lose what made them so-called ethnic by adopting mainstream American values, norms, beliefs and practices. Gordon Milton (1964), a classical sociologist and theorist who helped to perpetuate this metaphoric view of the new American city, believed that all immigrants could assimilate into the United States by acculturating into the daily customs of their host society, adopting the English language, and practicing the normative values of American society. Additionally, Gordon outlined six other key linear steps immigrants must take to become virtually indistinguishable from average native-born Americans (Gordon 1964). Central to these linear steps, and of key importance to this study, are structural and civic assimilation. By structural assimilation, Gordon and others, believe that immigrants will join major institutions, clubs, and cliques in mainstream American society thereby becoming structurally integrated into the fabric of the cities in which they lived. By civic assimilation, scholars suggest that immigrants, over time, will no longer struggle for power or the need to assert their own non-American values but will defer to a common good and actively participate in civil society to promote that aim (also see Park and Burgess 1994).

Although the case of the late 19<sup>th</sup> century Irish or Italians immigrants, somewhat serves as evidence for Gordon's perspective, today the classical assimilation paradigm has increasingly been challenged, particularly in how we understand the processes of immigrant acculturation, structural adaptation, and incorporation (Arias 2001; Wildsmith 2004). Contemporary theorists who support the more general assimilation framework still hold to the idea that new immigrants

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will become less ethnic the further generationally and by time they are removed from their ancestral homeland but they also suggest that immigrants do not necessarily lose their culture but rather mainstream society can absorb it over time (Alba and Nee 1997). We might look at the popularity of certain ethnic foods, or Americanized versions of them, as evidence of this trend. However, those who support a more segmented assimilation perspective, suggest that there are multiple trajectories that shape and inform the assimilation process—a case in which immigrants may become more ethnic in regards to some cultural practices, such as religion, and more mainstream in other cultural practices at the same time regardless of the acceptance and/or popularity of their food or culture (Brubaker 2001; Portes and Zhou 1993; Warner 2005; Warner and Wittner 1998). Important to these processes is the context of assimilation and the opportunities present for incorporation into mainstream society through the defining and engagement of community (Portes and Manning 1986; Arthur 2000; Cutler, Glaeser, and Vigdor 2008a; 2008b; Grenier and Perez 2003; Portes and Rumbaut 2006; Gordon 1964). Few scholars have explored these relationships and even fewer have done so looking at the city or local neighborhood context (Tong 2010).

Definitions of community can vary as much by immigrant population as the types of communities in which they live (Cherry 2014). Some immigrants, for example, may enter the United States and move directly into an ethnic or immigrant enclave in their new cities because they have no choice where they live due to socio-economic necessity or a sense of survival (Portes and Rumbaut 2006; Zhou and Bankston 1994; Ebaugh and Chafetz 2000). Although several scholars have explored the role ethnic enclaves and institutions play in immigrant civic life, their findings have not been conclusive (Cutler, Glaeser, and Vigdor 2008a; 2008b; Portes and Rumbaut 2006). Some find that these enclaves limit civic incorporation by further isolating



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immigrants from the wider society, while others suggest that they provide a host of physical and psychological resources that immigrants can mobilize as they find their paths to incorporation (Portes and Manning 1986; Massey and Denton 1985; Arthur 2000; Grenier and Perez 2003; Portes and Rumbaut 2006).

At the other end of the spectrum, some immigrants may choose to live in an ethnic community to preserve their cultural and ethnic identity. This is not out of necessity but choice—a matter of pull versus push (Logan et al. 2002). This context matters. An immigrant who chooses or has the socio-economic mobility to make the choice to live in an ethnic community or a racially and ethnically diverse community, may have more opportunities to work in the mainstream economic sectors of their cities and thus have greater opportunity to structurally and civically incorporate or assimilate (Tong 2010). This is especially true in the context of increasingly diverse suburbs in major metropolitan areas across the nation (Goodkind and Foster-Fishman 2002; Logan et al. 2002; Gibson 1988). Those who are forced into ethnic enclaves, on the other hand, may face certain barriers, such as language or contact with native-born Americans that inhibit their ability and/or opportunities to do the same (Portes and Bach 1985; Wuthnow 1998; Tong 2010).

Where immigrants live can serve as a buffer or barrier to their structural and civic incorporation or assimilation (Zhou 1997). Likewise, where immigrants enter the nation socio-economically, their starting status or position, and under what context and circumstance, can not only effect where they live but the relationship between time, how long you have lived in the United States, and both the extent and frequency in which they ultimately engage the wider society. The process is not uniform across immigrants and is by no means as linear as Gordon suggested (Greenman and Xie 2007). The classical assimilation perspective largely conflates

upward mobility with assimilation and suggests that the process is not only linear but dependent on time—the duration or length of stay in the United States and the birth of subsequent American-born generations (Warner and Stole 1945; Gordon 1994; Greenman and Xie 2007). Some immigrants, however, enter the United States already at the top of the socio-economic ladder thus challenging how we view the impact of time on these processes. This has clear implications on the structural and civic incorporation of high-skill and upwardly mobile immigrants such as those working in healthcare today, who are increasingly moving into diverse or mixed suburbs comprised of like professionals, both native-born and foreign-born.

### **Immigration, Volunteering, and Civic Engagement**

Although civic life can be measured in a variety of ways, building on previous scholarship on the civic life of immigrants, we focus on what immigrants actually do in civil society (Cherry 2014; Cherry and Ebaugh 2014; Kniss and Numrich 2007; Foley and Hoge 2007; Eckland 2006; Wong et al 2011). Civic engagement constitutes a host of ways people can participate in their community. Whether it is participation in political groups and community or professional associations or even acts of volunteerism in a host of settings and contexts, an active civic life can be an important expression of care and concern for others both at the micro and macro level (Williams 1999; Wuthnow 1995). For immigrants, where these acts of civic engagement occur and under what circumstances, within an ethnic enclave for co-ethnics or outside their own ethnic groups in the larger city, for example, are important ways to measure their structural and civic assimilation and incorporation (Tong 2010). However, considerable debate exists not only in the nature of the terms we use to describe civic engagement, such as volunteering, but the extent to which these terms carry meaning for the immigrant populations we study (Cherry 2013).

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New immigrants may or may not make a distinction between the words volunteering and participation. If they do, it is possible that something may get lost in the translation of what these words mean in English versus their own cultural understandings of what it means to engage the community (Cherry 2013). This is further complicated by survey research conducted among non-English speakers or those who speak English as a second language—they simply may not associate the same meanings with volunteerism as scholars studying them (see Tossutti 2003; Cherry 2013). Likewise, as Musick and Wilson point out (2008), first-generation immigrants may be less familiar with the volunteer role as it is practiced in the United States and thus may not register their volunteerism as such on surveys. This has complicated how we understand immigrant volunteerism.

In general, immigrants have largely been seen as either on the receiving end of volunteering or engaged in some form of informal volunteerism in their own immigrant enclaves (Smith 1999; Tong 2010). It is true that the volunteering rates of new immigrants are relatively low (Burns et al. 2001; Musick and Wilson 2008; Putnam 2000; Ramakrishnan and Baldassare 2004); however, new immigrants may not get asked to volunteer at the same rates as native-born Americans (Howlett 2006; Lopez and Safrit 2001; Musick and Wilson 2008). Since being personally asked to volunteer is among the top reasons people participate in their communities, being secluded in an ethnic or immigrant enclave has clear implications on their opportunities for immigrants to get involved in the wider cities in which they live.

Although cities are often thought to be less conducive to volunteering in general, volunteering has more to do with a larger context than just the city in question. The characteristics of the individual and the community context within these metropolitan areas both matter (House 1981). Acknowledging this, we recognize that not all immigrants live in ethnic

enclaves nor do they live exclusively in ethnic communities. The majority of the studies we cite above largely ignore the so-called other side of immigration—high socio-economic and upwardly mobile foreign-born professionals. The relevance of this social context has been recognized in studies of immigrant assimilation, but few, if any, have studied the volunteerism of foreign-born professionals, especially those working in healthcare (Zhou 1997; Zhou and Bankston 1994; Serow and Dreyden 1990; Wilson and Musick 1997; Tong 2010).

### **Data and Measurement**

Data are drawn from a stratified snowball sample of 32 first-generation foreign-born healthcare workers, primarily Asian nurses, currently living and working in the Houston, Texas metropolitan area. Given that roughly 40% of all foreign-born healthcare workers in the United States in 2010 were born in Asia (see McCabe 2012), largely from India and the Philippines, we initially recruited our sample through the Filipino and Indian American Nurses Associations in metropolitan Houston and expanded it to include members of the Vietnamese, Korean, and Nigerian American Nurses Associations; all foreign-born groups with a growing national presence in American healthcare (McCabe 2012). Although the sample was drawn from these associations, not from the hospitals and clinics themselves, the people in these associations represent healthcare workers from across the city, including every major hospital and clinic and all points in between. The final sample is comprised of workers at eighteen hospitals and clinics and is overwhelming female (88%), as we might expect (McCabe 2012). The respondents range in age from 39 to 63 (mean 47), with the majority of the sample immigrating to the United States after 1980 (83%). Socio-economically, the mean income of the sample is over \$100,000 a year with all respondents having a Bachelor's degree or higher. Demographically, our Houston sample is fairly consistent with that of other foreign-born national healthcare workers (U.S.

Census 2012; McCabe 2012).<sup>ii</sup> All face-to-face interviews were conducted in English and typically lasted anywhere from one to four hours. Respondents were all given a brief survey prior to the interview and in many cases interviews were followed-up with email or phone conversations. Additional data was also gathered through participant observation at various community events and associational meetings.

Across both sets of data, qualitative observation and quantitative survey analysis, we measured civic engagement by what our respondents said they did in the community and what we saw them doing in the community. This includes measuring whether they volunteered in the last 12 months and the arenas in which the volunteering was carried out e.g. healthcare, youth, sports, etc. It also includes assessing whether our respondents had worked on a community project, self-defined, in the last 12 months.

### **Changing the Face of Houston**

From 1990 to 2010, the Houston metropolitan area (Texas) grew dramatically both in the size of its population and its ethnic and racial diversity. Today it is the most racially and ethnically diverse city in the United States (Emerson et al 2012). However, for the first time in the history of the area, the City of Houston is not the most diverse city in the region (Ibid). Missouri City and Pearland, as of 2012, are the region's most racially and ethnically diverse cities and the City of Sugarland has emerged as the largest center of Asian Americans in the region (35% of the city's residents are Asian). Both Missouri City and Sugarland are in Fort Bend County, which is now the most racially and ethnically diverse county in the Houston metropolitan area. One of the reasons the region has grown to be so diverse is its proximity to the Texas Medical Center as well as the growth of medical business and hospitals in the region itself; hence the influx of medical professions, largely foreign-born (Forbes 2010).<sup>iii</sup>

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When you ask foreign-born healthcare workers in Houston why they have moved to Fort Bend County, most highlight the fact that it is a convenient drive from the area to the Texas Medical Center (TMC) and downtown. As one first-generation Filipina American nurse in her early fifties told us,

*Sugarland and Missouri City has everything we need. Obviously it is a straight shot from here to the Medical Center (Texas Medical Center) where I work and that's important to me and my husband who also works in there. All you have to do is hop on Fort Bend toll to 90 which becomes Main and you are there in like 20 minutes with very little traffic, most of the time. Our kids are grown so living in an area with good schools was not too important to us but Fort Bend has some of the best schools and that does matter for property values and the type of people who are your neighbors.*

For others, such as a first-generation Vietnamese American doctor we interviewed with young children, the quality of the schools in the area were an important draw for his family, in addition to its proximity to the TMC, but what was most important, across all respondents we interviewed was the area's diversity. As one first-generation Indian American nurse described it,

*Sugarland is so diverse, there are many Indians, many from Kerala like me...it's just such a joy to live where people understand you, where you can find places to eat and shop [groceries]. We are not the foreigners; everyone is a foreigner or looks like they could be if you know what I mean. There are plenty of Americans, don't get me wrong, but I think we are the majorities.*

Echoing these sentiments, a first-generation Filipina American oncologist explained,

*We wanted to be in a diverse place, with people like ourselves, and the diversity that we work with in the hospital. This was so important. Whatever you want to eat, it is out here; every ethnic food and grocery store you can imagine. There is even a Filipino restaurant that just opened out by 288. It's just a pleasure to live with other professionals, immigrants like me, who are proud to call America home and are looking to build a better life. They care about our community. I mean, some groups out here (Sugarland and Missouri City), still stick together, that happens, but they are all at the minimum tolerant of diversity because it is all around them. It's not like other place where you get the feeling that when you move in they are like 'there goes the neighborhood' and you can tell they really wish you were not their neighbor.*

Contrary to these fears, Fort Bend County, and the City of Sugarland and Missouri City more specifically, have the highest residential occupancy rates in the Houston metropolitan area (Community Impact Newspaper Vol. 1, Issue 7, March 6- April 2, 2014: p1). The diversity of the

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region has not inhibited its growth, but rather fueled it for the very reason that our respondents outline above. However, unlike what classical theorists such as Gordon (1994) might anticipate, the foreign-born healthcare professionals in the region are not being pushed into ethnic specific enclaves and gradually becoming more so-called American over time, but instead, they are moving into these diverse cities by choice; drawn by the diversity and the areas' proximity to the TMC as well as the region's own growing medical industry.

Given that the average median income in Fort Bend County has steadily climbed over the last six years and average property values are comparatively high to other regions in the Houston metropolitan area, the medical professionals we interviewed are not assimilating into these cities over time as a process of migrant upward mobility. Instead, they are able to move into these areas because of their relatively high socio-economic entrance status when they arrive in the United States (Forbes 2010; Fort Bend County Web). They do not need time, in the classical sense, to linearly assimilate (see Gordon 1994). Their high income is a relative manifestation of their professional educational attainment from their country of origin which they bring with them. They may go on to gain additional education in the United States, but they are entering as professionals as a base status. This yields like professional neighbors across a host of fields where high English proficiency is required; thus allowing a common language and socio-economic status to build a diverse community. Fort Bend, at least from the perspectives of the foreign-born healthcare professionals we interviewed, is thus built around a desire to be amongst diverse people, accepted or at least tolerated, with good schools for their kids and relatively short drives to work. None of this would be possible without their professional socio-economic entrance status.

### **Answering a Need or Transforming Houston Healthcare?**

Without a doubt, foreign-born healthcare workers are making an impact on the racial and ethnic landscape of the Houston metropolitan area, especially in areas such as Fort Bend County. However, the continued diversification of Houston is, at least on one level, a product of the area's increasing dependence on foreign-born healthcare workers. Like the rest of the nation, Houston is unable to fill its growing healthcare needs as the population ages and native-born workers fail to answer the area's healthcare employment needs (McCabe 2012). By answering this need, foreign-born healthcare workers are not just diversifying Houston racially and ethnically but transforming Houston healthcare by a) increasing the industry's ability to serve the area's racial and ethnic diversity with linguistic and cultural sensitivity, and b) by raising awareness of health risks and concerns in specific communities.

Diverse patients have diverse needs (Newman and Willaims 2003). As Houston continues to diversify, the ability of the areas' healthcare industry to serve these populations hinges on its ability to communicate with patients effectively. Roughly 46% of Houston residents speak a language other than English at home. Of those 46%, 82% speak Spanish while 9% spoke an Asian language. 52% of those who speak a language other than English at home reported not speaking English very well (American Community Survey 2009-2011). Regardless of proficiency, illness and emergency may complicate point-of-care interactions thus necessitating a need for bilingual healthcare professionals and/or those with the cultural proficiencies to better understand their patients (Newman and Willaims 2003; Femea et al. 1994). As one first-generation Filipina administrator we interviewed at M. D. Anderson Hospital pointed out:

*We [M. D. Anderson] are the number one cancer institute in the world. Do you think we just serve Houston? Think about it. Yes, Houston is diverse, and that presents its own problems for delivering good care, but we have patients arriving every day from every country you can imagine. We even have a V.I.P. entrance for princesses, celebrities, and sheiks to enter the*



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*hospital without fuss and media attention. We need to make everyone feel comfortable and to better serve them. We must be able to communicate effectively regardless of how much money they make or how well they speak English. We have an entire cultural diversity department; not to keep us out of trouble with disputes but to better serve patients. If you have a patient who refuses to take their medicine and you find that the color of the pill in question is inauspicious, then you better have someone on-board who knows this before they die just because they won't take the red pill. It sounds funny but it happens!*

Echoing this need, a first-generation Chinese American gynecologist we interviewed talked about the sensitive nature of cultural and family needs of women during labor:

*My patients are very diverse. I feel it is my responsibility to meet each of their cultural and family needs as best I can within the scope of what the hospital allows during the delivery process. Every family and ethnic group has their traditions. The more we can accommodate these needs, the better mom feels and the better mom feels, the better everything else goes. It is not just a matter of doing what they want but making it a better experience if possible. Sometimes they make request we just can't do. I know from my own background that women are expected to eat certain foods and stay confined at home after the birth for like 30 days. Some people may not understand this, so it is really important that the person who is delivering your baby understands or is open to diverse cultures to make the process more pleasurable for all involved.*

These sentiments resonated across the majority of those we interviewed; however many emphasized the need to understand specific medical needs in these ethnic communities versus cultural preferences and taboos.

Many Filipino American nurses, for example, highlighted the need to better screen for high-blood pressure and diabetes in the Filipino community. “Our food is so rich, so sweet and fatty with so few vegetables. We really need to educate our community on better healthy eating, particularly for the men. We nurses know better and need to make this change in our community and get doctors to check for the problems that can follow earlier to prevent death or long-term health issues.” Likewise, various groups, including the Chinese and Filipino Associations were all active throughout the duration of this study in promoting cancer awareness in their communities. This is particularly true with the continued emergence of the Filipino Cancer Network of America of Metropolitan Houston, spearheaded by a first-generation Filipina

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working at M. D. Anderson Cancer Institute. “As a cancer survivor myself, I understood the need for early detection and wanted to make sure we got people diagnosed as early as possible. So many people think people of color don’t get skin cancer, but they do... So many people think it can’t happen to them, but it does and then it’s too late because no one educated them on the risk or told them that they were high-risk themselves. This is why I started the Network!”

While attending an accredited continuing education seminar at a meeting of the Vietnamese American Nurses and Doctors Association at a local Italian restaurant, the case of *Helicobacter pylori* and its effect on the Vietnamese community was the central focus of discussion. Although most people in attendance were there solely for their continuing education credit, the focus on an illness that disproportionately affects the Vietnamese community and other immigrants migrating from poor nations or from lower socio-economic classes, generated considerable debate and led to further community organization. As one attendee suggested, “We need to make sure doctors know how this effects some groups more than others to make sure the proper tests are run and they catch the problem sooner rather than later.”

Likewise, we attended both a meeting for the Nigerian American Nurses Association and a separate conference put on by Daya, a South Asian non-profit serving families in crisis which was also attended by members of the Indian Nurses Association, where the subject of domestic violence was the center of community advocacies. One first-generation Indian American doctor, whom we later interviewed, stated:

*We need to make sure that family practitioners and hospital staff understand the signs of domestic violence and the mask that educated professionals can wear to hide it. So many people think that domestic violence is a lower class affair; something that happens to the poorly educated and those without resource, but it is something that strikes our Indian community at the very top and all the way down. Nurses, highly educated with comfortable incomes, are being abused by their husbands and the doctors and nurses who treat them in the emergency room never think that it is domestic violence because they think it does not happen to people like this.*

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*They essentially buy into the lies the patient tell about falling or running into a cabinet. This must stop!*

Members of the Nigerian American Nurses Association echoed similar sentiments and worried what would happen if nothing is done about the problem. “It all starts with education and it is up to us Nigerians to make sure non-Nigerians understand what issues face our community so they can help us in our cause to end domestic violence.”

Whether it is diabetes, cancer, domestic violence, or a broadening of the cultural understandings about their communities, foreign-born healthcare professionals are doing more than filling a need in one of Houston’s strongest economic sectors. They are also transforming healthcare by drawing attention and education to specific needs and trends within their own ethnic communities. And, of course, these workers also bring tremendous medical expertise to the field. At the same time, by engaging their community and the metropolitan area at large, they are further assimilating or incorporating into American society but perhaps not as others have theorized to this point.

### **Engaging the Health of the Community**

Roughly 97% of our sample indicated that they had volunteered or participated in some civic association in the last twelve months. 95% stated that they worked on community projects during that same time, in addition to giving money to some charitable group or organization. Although, given our sample size, the generalizability of these findings is suspect, it is not outside the realm of other studies among the same or similar professional foreign-born groups in Houston (Cherry 2014 on the case of Filipinos). The foreign-born nurses and doctors we surveyed are volunteering or informally participating at higher rates than the average native-born American

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(national average is currently 26%). Not surprisingly, the majority of their community engagement occurs through healthcare related causes and fields.

From running health screening clinics at Star of Hope Mission for the homeless to cooking and advising proper nutrition at Fishes and Loaves Food Kitchen to screening for skin cancer at local libraries and finally, to participating in medical missions to India and the Philippines, the sample of foreign-born nurses and doctors we observed and surveyed are engaged in a host of health related community projects. Most striking among this long list of engagements are the number of health fairs and free or sliding-scale permanent clinics in lower income neighborhoods they have founded or currently operate. In 2002, for example, the Asian American Health Coalition of Greater Houston (AAHC) founded HOPE Clinic with the mission of providing culturally and linguistically competent healthcare to various underserved populations in the greater Houston area, foreign-born or not (Vu 2013). Although AAHC was founded by second-generation Asian women, largely of Chinese and Vietnamese descent, the emergence of the clinic itself was built on the labor of first-generation Asian healthcare professionals and their role in expanding the scope of its care following Hurricane Katrina.<sup>iv</sup>

Hurricane Katrina forced one of the largest internal migrations of people in American history (Brunsma 2007). Among the evacuees were thousands of Filipino and Vietnamese Americans, many of whom fled to Houston and ended up in either the George R. Brown Convention Center or the Astrodome (Cherry and Alred 2012; Vu 2013). HOPE Clinic, in partnership with S.O.S. Boat People and a host of other organizations, including Filipino Disaster Relief of Texas (FDRT), mobilized a quick response to evacuees' needs (Cherry and Alred 2012). Within hours of their initial meetings, HOPE established a triage clinic at Hong Kong City Mall in southwest Houston and found foster families for many of the evacuees. The

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clinic saw over 3,000 patients during this time—more than any other community health center (Vu 2013). None of this would have been possible without the volunteering and financial support of Houston’s foreign-born healthcare workers, not to mention the critical linguistic and culturally sensitive care they provided. As one Chinese nurse we interviewed explained:

*HOPE is as its name suggest... we [foreign-born nurses] make it run, we support it financially and with our time, and in doing so are able to give back to those in our community that need it most. Many of us understand the poverty they face; it's like back home but obviously not something all of us experienced. I was fortunate to come from a middle class family and get an education. Not everyone came here with such resources, so I do what I can, understanding their culture and speaking their languages. I speak Spanish not just Mandarin and Cantonese... Hope is why I learned!*

Today HOPE clinic continues to serve Houston, seeing nearly 16,000 patients a year as of 2012 and giving care in fourteen different languages—including Mandarin, Cantonese, Vietnamese, Korean, Burmese, Arabic, and Spanish. (Vu 2013; also see <http://hopechc.org/>).

Beyond HOPE’s permanent free clinic, the sample of foreign-born nurses and doctors we observed and surveyed engage in annual or bi-annual health fairs across the city throughout the time of our study; one of the most notable being the Alief Health and Civic Resource Fair. Like HOPE, the Alief Health and Civic Resource Fair started out rather small and with the aid and mobilization of the city’s foreign-born healthcare workers and local parishioners of a Catholic church (see Cherry 2014). In 1997 a local outreach forum for community and parish problems entitled S.A.V.E. (Stand Against Violence Everyone), grew into a broad coalition of groups and individuals (Cherry 2014). The first fair was held in 2002 with a modest attendance of 1,000 attendees with nearly sixty providers and sponsors. By 2005 the Fair had nearly tripled in attendance with 500 people receiving some form of health screening, 135 children receiving close to 450 immunizations, and nineteen pints of blood donated. At least 200 underprivileged families received nearly 14,000 fresh produce items, and over 600 children received backpacks

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and school supplies (Cherry 2014). Today, the Fair has grown so large that it is no longer held in the parking of local parish churches but now at the larger school facilities in the Alief ISD school district. Like HOPE, the fair serves largely lower income families in Houston and in a host of languages. All Fair literature, for example, is printed in Spanish, Mandarin, Cantonese, and Vietnamese.

Although the Alief Health and Civic Resource Fair is one of the largest and most broadly serving fairs our respondents support and volunteer at, it is by far not the only one. In fact, a casual perusal of the Indian, Filipino, Vietnamese, Nigerian, and Korean American Association webpages for the local Houston chapters demonstrates a rather tight schedule of fair support across the city on a monthly basis. Some of these events are larger fairs, while others are small and directed to serve specific groups or neighborhoods. For example, during the time of our observation, the Indian Nurses association in Houston ran a free clinic, with support from a host of sponsors, to support the medical and psychological needs of Bhutanese and Nepali refugees/asylees. Describing the event, one nurse admitted:

*I am not sure how it all happened. They called us or we called them... or maybe it was through their Baptist church, Fishes and Loaves? All I know is that our home is practically the same, we share culture and food and they are like our northern brothers and sisters. If you know what is happening in Bhutan and Nepal, you can't but feel sorry for their situation. It is so dire, and so many of them are in critical psychological states. Our Indian community here in Houston is doing well, most of us make really good livings, so it was nice to give back to people who need it and share some of our own history. It was personal, spiritual...*

It is difficult to fully capture the number of events, like the one described above, that our respondents are involved in on a monthly basis, but all of them make time and/or give financial support to a host of causes in between the demands of their busy work and family lives.

When you ask first-generation healthcare workers why they volunteer and participate in these fairs, the responses are fairly uniform across respondents with most highlighting a sense of

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duty. As one first-generation Vietnamese American nurse explained, “So many in our community are poor. I was fortunate to make it out of poverty and get an education. My parents worked so hard to help me get through school and now I really don’t have a choice whether I want to give back to the community or not. It is my duty. They need me and I need to do for them what was done for me.” When we asked how he makes time for all he does for the community, he stated:

*I work my shifts [at the hospital], meet with my nursing association—I am the president, volunteer at least once a week at the free clinic, and run a TV show on the local access Vietnamese channel. I guess it is a lot but to be honest, I don’t understand what my American colleagues [native-born] do with their time? I guess it is the privilege of growing up here but I just seem to have more that I think needs to be done in the community and just manage my time better, and still make time for my wife and son. It has to be done, so I make it work!*

Likewise, a first-generation Filipina American nurse explained:

*We have to a certain amount of volunteering as part of our so-called required job, but most of us go beyond what’s required of us. Our faith compels us to get involved to meet the needs of our broader human family. It is our duty to give back to the community, to this country, because it has done so much for us. If you truly understood the poverty of the Philippines, you could appreciate what it means to care for those who are in need but here in the States [U.S.], people needs us too... they need the care that only a Filipino nurse can give.*

All of our respondents offered sentiments such as this, suggesting that their migration and unique character play a major role in their desire to help others in the community. From a Korean nurse who joked that volunteering was, “from the soul, get it? [Seoul]” to a Nigerian nurse who said she was, “honor-bound to serve those of her community,” the foreign-born nurses and doctors we interviewed not only volunteer and work on community projects at high rates but feel obligated to do so; whether it is for members of their own ethnic communities or those in the wider Houston metropolitan area.

## **Discussion/Conclusion**

The central questions over assimilation today are not so much whether immigrants will become more or less ethnic or even whether they will be incorporated into American society, but the degree to which their environment and the region of the city in which they live will impact their incorporation and the terms and conditions under which it occurs (Cherry 2014; Foley and Hoge 2007; Portes and Borocz 1989). For the foreign-born healthcare professionals in this study, their entrance status and the professions in which they work challenge how we view these classical theoretical assumptions about immigrant incorporation and assimilation as well the time over which these processes occur. Although our study is limited in its generalizability, given the relative size of the sample, several noteworthy findings emerged from our unique data collections.

First, findings suggest that a significant part of Houston's growing diversity in areas such as Fort Bend County (Sugarland and Missouri City) is a result of foreign-born healthcare workers immigrating or moving to the area. Unlike previous studies which have largely focused on the presumed negative effects of lower-skilled immigrants with poor English proficiencies on the metropolitan environments to which they migrate (see Card 2009; Huntington 2004a & 2004b; Passel 2005; Rector, Kim, and Watkins 2007), we find that high-skill immigrants with high English proficiencies are having a positive effect on the areas of Houston in which they live by a) raising the median average income thereby mobilizing more resources to the area, and b) raising the average property values to the area which has a tremendous impact on school funding and hence the quality of education in the area (see Forbes 2010).

Second, and perhaps more urgent to the longevity and health of the Houston metropolitan area, foreign-born healthcare workers in Houston are filling the city's growing healthcare needs



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as native-born workers, like much of the nation, fail to answer healthcare employment needs (McCabe 2012). By answering this need, foreign-born healthcare workers are not just diversifying Houston racially and ethnically, as we have noted, but transforming Houston healthcare by increasing the industry's ability to serve the area's racial and ethnic diversity with linguistic and cultural sensitivity. Foreign-born healthcare workers volunteering at HOPE or the Alief Health and Civic Resource Fair, for example, are able to provide free or sliding-scale care for low-income Houstonians in fourteen different languages. Beyond being culturally sensitive as a courtesy, this ethnically and linguistically tailored point-of-care not only increases patient satisfaction but also their ability to understand and follow through with their prescribed wellness regiment. Likewise, by raising awareness of health risks and concerns in specific communities, such as *Helicobacter pylori* among Vietnamese or skin cancer among Filipinos, foreign-born healthcare workers in Houston are rallying needed attention and education to specific trends and issues of which the general health community may be less aware.

Third, rather than becoming more so-called American over time and generations, foreign-born healthcare workers in Houston, through their entrance statuses, are able to make an immediate impact on both their communities and their professions contrary to what Gordon (1964) and others have theorized. This not only challenges how we understand classical models of assimilation and incorporation, but the way we view immigrant volunteerism. Foreign-born healthcare workers in Houston enter the United States with above average education and enter jobs that pay above average incomes (U.S. Census; McCabe 2012). Given that working in healthcare requires wide public service and interaction, the majority of these immigrants also have high English proficiencies (McCabe 2012). This all has a tremendous impact on the communities in which they live as well as their ability to lead active civic lives.

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Education is the most consistent predictor of volunteering (McPherson & Rotolo 1996:181, Sundeen & Raskoff 1994:392; Wilson 2000: 219-20). It can facilitate volunteering by heightening awareness of social or community problems, increasing empathy for those experiencing these issues, and building the self-confidence generally needed to get involved (Brady et al 1995:285, Rosenthal et al 1998:480). More importantly, however, education can impact leisure time and the extensive social networks and resources that not only increase the likelihood that people volunteer but encourages them to do so (Jackson et al. 1995:75; Marwell and Oliver 1993; McPherson et al. 1992:157; Smith 1994:255; Wolf et al. 1993; Wilson & Musick 1997; Midlarsky & Kahana; Wilson 2000). Likewise, education impacts where people live and the types of communities they engage—moderating both their likelihood to interact with natives and the time it takes to structurally and civically assimilate or incorporate (Tong 2010).

Where previous studies, viewed immigrants largely on the receiving end of volunteering, we complicate this picture by highlighting how much of Houston's voluntary health sector would not be able to serve the city in the same capacity if it were not for immigrants. Likewise, and perhaps more important theoretically, where previous studies have suggested that immigrant volunteering rates are lower than native-born citizens because they may not understand the volunteer role or may not be asked to volunteer (see Tossutti 2003; Musick and Wilson 2008), we find that our sample fully understand what it means to volunteer, although rallying different cultural meaning to the English term, and are both asked and do not need to be asked to volunteer at the same time. Much of what we have described in the previous pages is self-initiated; however, as we have seen, this is largely a result of their entrance status, the neighborhoods this status affords them, and the resources and networking their professional work makes available for mobilization. As the nation continues to age and Americans healthcare needs

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continue to increase in the face of drastic healthcare worker shortages, future studies must continue on the path we have outlined in this study if we are to fully understand the reality of the new American city.

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<sup>i</sup> While some hospitals in the TMC obviously have personnel departments to aid foreign-born employees with their statuses and any related employment or tax paperwork, see M. D. Anderson for example, others, such as Michael E. DeBakey Veterans hospital, a federal institution, does not have such a department and does not keep records of nativity, given that all employees must be U.S. citizens. However, analysis of nine TMC academic institutions suggest that in 2012 there were roughly 4,936 foreign-born students enrolled in the TMC with an additional 133 exchange students and 1,692 exchange visitors as professors, researchers, and short-term scholars and specialists from twelve different countries (TMC International Students, Exchange Visitors, and Employees March 2012).

<sup>ii</sup> Census data reveals that of non-citizen health care workers are 37% Latino, 14.3% white, 13.9% Black, and 33.8% Asian. However, if you look at health care practitioner professionals for the Houston metro area, and look at non-citizens, 11.5% are Latino, 23.8% are White, 13.3% are Black, and 49.2% are Asian.

<sup>iii</sup> There are roughly 227,860 total healthcare workers in the Houston metropolitan area and 18,690 are foreign-born non-citizens. The 18,690 healthcare workers do not include foreign-born healthcare workers who are citizens. In Fort Bend County, 6.4% of all health care professionals are Latino, 31.6% are White, 26.5% are African-American, 0.1% are Native American, and 34.1% are Asian. For the Houston metro area, the numbers are as follows: 10.3% are Latino, 51.2% are White, 16.7% are African-American, 0.2% are Native American, and 20.2% are Asian (US Census Bureau).

<sup>iv</sup> Although fundraising and support from federal and local agencies also played a tremendous role in the HOPE clinic emergence, much of the labor came from foreign-born volunteers from the Chinese Baptist Church in addition to other foreign-born nurses, such as Filipinos, after Hurricane Katrina (Vu 2013).