

BRINGING IT HOME: CANADIAN UNDERGRADUATE NURSING STUDENT  
EXPERIENCES IN UNDER-RESOURCED COUNTRIES

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By

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## **Abstract**

International practica offer a unique and in-depth immersion experience for nursing students to learn about diverse healthcare settings, cultures, and ways of living. When students complete practica in under-resourced countries, some of their receptiveness to learn may be impeded when they are faced with circumstances that are vastly different from those in their home country. The purpose of this study is to understand the experiences of registered nurses who, as undergraduate students, participated in international practica in under-resourced countries and to inform an understanding of particular conditions and situations students experience while practicing in such countries. Secondary purposes are to explore moral distress related to these experiences and the perceived effects on participants' current nursing practice. Using narrative inquiry and thematic analysis, this research aimed to validate nursing students' unique experiences while abroad. Participants were sampled based on their completion of an international practicum in an under-resourced country as an undergraduate nursing student from 2009-2017. Consenting participants took part in two open-ended interviews via Skype where they had the opportunity to tell a story of their experience. The data collected revealed themes of moral distress, personal and professional development, why it was worth it, and threats to preserving international practica for future generations. This study supports the idea that international practica are overall positive experiences for undergraduate nursing students and highlights growth in cultural awareness. The research concludes with recommendations for the provision of future international practica, as well as evidence-based strategies for students and nurses to effectively recognize and manage moral distress.

*Keywords:* nursing students, international practicum, under-resourced, moral distress

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## DEDICATION

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## **CHAPTER 1: INTRODUCTION**

### **1.1 Introduction**

Emerging and global trends in health and healthcare impact the way that healthcare professionals provide care (Geale et al., 2015). Nurses must be competent in applying knowledge, skills, and attitudes to maximize respectful relationships with diverse populations (Canadian Nurses Association [CNA], 2017). Although nurses are responsible and accountable for incorporating cultural competencies in relationships with clients, nursing students often are not adequately prepared to provide culturally competent care (Button, Green, Tengnah, Johansson, & Baker, 2005). Nursing students must also be prepared to provide care that is culturally safe. Cultural safety ensures individuals feel respected and safe when they interact with the healthcare system, which includes freedom from any form of discrimination or racism and encouragement to draw from cultural strengths (Northern Health, 2017). Both cultural competency and cultural safety are necessary for effective communication and have the potential to improve the overall quality of a patient's care (Vaughn, 2015). One such strategy for enhancing these culturally appropriate behaviors in undergraduate nursing students is participation in an international clinical placement.

International clinical placements offer nursing students a means of learning about new cultures and diverse healthcare systems. These placements do, however, come with a certain level of risk, especially when it comes to exposure to potentially distressing conditions (Vaughn, 2015). Nursing students must learn to navigate a foreign environment, manage new language(s), cultural norms, and distinct healthcare approaches. Their decision-making processes may be strained working in an under-resourced environment due to challenges to personal and professional beliefs. In Canada, nursing students' beliefs about health may be influenced by

Medicare, our publicly funded healthcare system. Under this system, all Canadian residents have reasonable access to medically necessary hospital and physician services without paying out-of-pocket (Government of Canada, 2016). Canadian Medicare receives funding from general taxation and is a platform that leads to a more equitable use of resources for each citizen and is based on need, not on the ability to pay. In contrast, people living in under-resourced countries must pay for healthcare services, and when they cannot pay, they often do not receive treatment.

## **1.2 Background**

Global health is of interest across several academic disciplines including nursing. International mobility contributes to an increasingly diverse Canadian population and requires that nursing programs re-evaluate how culture is taught within nursing education (Murray, 2015). There is a need to enrich nursing programs with methods that expose students to the cultural diversity that exists in the population and the nursing profession. The structure and delivery of global health content and the inclusion of international clinical placements differs among institutions in Canada, however, literature suggests that nursing students are generally dissatisfied with global health curricula and international opportunities. According to a survey conducted by the Canadian Nursing Students Association (CNSA) in 2016, more than 80 percent of respondents reported being dissatisfied with global health opportunities available to them, including courses containing global health content and international practica (Jones, 2017).

Learning about global health is essential to assist future nurses in providing culturally competent care, addressing health inequities, and effectively meeting the needs of our changing society. For students with a particular interest in these aims, international placements may be a part of this learning. Teaching undergraduate nursing students about global health can be achieved through a number of different educational strategies, but there are particular benefits to

participating in a clinical placement abroad (Geale et al., 2015). This learning strategy will, however, only be efficacious if placements are effectively designed, implemented and evaluated by their institutions.

“Study abroad refers to a broad range of credit-granting programs, courses and learning experiences that take place internationally” (Kent-Wilkinson, Dietrich-Leurer, Luimes, Ferguson, & Murray, 2015, p. 941). The motivation for studying abroad varies among students. A study by Behrnd and Porzelt (2012) revealed several reasons students choose to partake in international placements: to learn about different cultures, broaden mental horizons, extend knowledge, improve language skills, and to prepare the student for their future in a globalized working environment. Not all students are suited for an international placement; they must demonstrate behaviours and dispositions consistent with cultural competence, including a willingness to learn, empathy, self-awareness, optimism, tolerance of ambiguity, and goal orientation (Behrnd & Porzelt, 2012).

Nursing students who choose to take part in an international practicum have made a conscious decision to experience nursing care delivery in a foreign country, and for the purposes of this study, an under-resourced country. If students are to have positive international experiences, they must be introduced and acclimatized to the culture and healthcare system of the country they will be traveling. It is essential that students are encouraged to gain an understanding of the healthcare system in which they will be traveling to recognize how gaps in the system impact patient outcomes.

### **1.2.1 Support for International Clinical Placements**

With an expanded emphasis on globalization, international health concerns, and the need to deliver culturally competent care, an international student experience has numerous benefits

(Egenes, 2012). These benefits include aiding in the development of cultural awareness, personal and professional growth, development of global citizenship, a broader understanding of the social determinants of health and their impact on healthcare delivery, and implications for future practice (Brown, Boateng, & Evans, 2016; Kent-Wilkinson et al., 2015). Nursing in a foreign and under-resourced environment likewise may challenge one's patience, resilience, and willingness to learn new ways of doing things. Nursing students are challenged to communicate across language and cultural gaps to assess needs, develop therapeutic relationships, and deliver competent care (Geale et al., 2015).

Nursing in a different country allows one to be sensitive to the cultural factors that impact healthcare delivery, experience the influence of culture on a country's healthcare system, and recognize cultural influences that affect clients' views on health and illness (Egenes, 2012). Being immersed in a new culture not only increases one's awareness of that culture, but it may also lead to greater tolerance and empathy for minority groups (Standage & Randall, 2014). Additionally, international experiences expose nursing students to cultural variations within a context of social, political, and economic forces (Murray, 2015).

Findings from an integrative review by Kelleher (2013) suggest that participation in an international experience benefits nursing students personally and professionally, with particular development in cultural sensitivity, cultural competence, and cognitive development. Additionally, Button and colleagues (2005) found that nursing students who participated in an international program displayed a better understanding of cultural differences and had improved intercultural communication skills. The literature also implies that nursing students must experience diversity if they are to embrace it and learn from it (Bohman & Borglin, 2014). International clinical placements in nursing may help students to develop cultural competence

but are not in themselves enough to advance their development to a higher level. Complementary strategies, such as discussions with colleagues whose cultural competence is more advanced, have been suggested to support student learning (Garneau & Pepin, 2015).

### **1.2.2 Challenges and Barriers**

Despite the many benefits associated with international clinical placements, it is vital that students and faculty also consider the potential down side of this learning strategy. Culturally diverse settings entail distinct challenges that impact students' emotional reactions to clinical work (Arieli, 2013). Inherent challenges for students include language and cultural barriers, culture shock, health and safety risks, financial costs, family considerations, time-consuming preparation, and moral distress (Brown et al., 2016; Kent-Wilkinson et al., 2015).

In under-resourced contexts, factors associated with poverty have significant detrimental effects on the health of a population (Briggs, 2011). Poorly organized and under-resourced healthcare systems may be unable to meet the needs of the population, leaving individuals and families unable to access the services they need to get well. Poor infrastructure, obsolete equipment, and the lack of resources may be shocking to students who have no prior exposure to such conditions. Nurses, and especially nursing students, who witness this lower standard of care may feel uncomfortable, anxious, and upset. Even though nursing students may know what healthcare is required, it is often impossible to provide that care due to a lack of resources.

Being unable to provide a high standard of care due to financial constraints in an under-resourced country may give way to moral distress. A critical review by Button et al. (2005) reports that it is almost inevitable that nursing students participating in international practica will experience some form of moral dilemma or distress. Not only are they delivering care in countries with insufficient resources, but as students are still new to healthcare, they are more

vulnerable to moral distress. Nursing students have often not yet developed substantive moral decision-making skills, which are vital when placed in an international setting (Button et al., 2005). The development of these skills may be fostered by educating nursing students about ethical issues that can arise during international placements so they are more readily able to identify and manage them.

### **1.3 Purpose of the Study**

The purpose of this narrative inquiry is to explore the experiences of registered nurses who completed clinical placements in an under-resourced country during their undergraduate nursing program. The secondary purpose is to explore the ways that the international placement is perceived to have affected the individuals' current professional practice and personal life.

### **1.4 Relevance and Significance of the Study**

Stories are the gateway to understanding how individuals exist in the world (Clandinin, 2007). Narrative inquirers come to understand lived experiences through the way stories are told (Clandinin & Connelly, 2000). The findings of this study will help to inform an understanding of conditions and situations nursing students face while in under-resourced countries and provide insights for schools of nursing to better support students who take part in these placements. Currently, qualitative studies of moral distress continue to be important as exploration of the phenomenon extends to various disciplines and geographical and clinical locations (Hamric, 2012). There is a gap in the literature that signals the need for research to improve our understanding of international practice and how nursing students are impacted by nursing in an under-resourced environment.

### **1.5 Definitions of Key Terms**

There are a multitude of ethical issues and dilemmas that frequently occur in nursing practice, making the moral component of nursing education particularly important (Koharchik, Vogelstein, Crider, Devido, & Evatt, 2017). “When nurses can name the type of ethical concern they are experiencing, they are better able to discuss it with colleagues and supervisors, take steps to address it at an early stage, and receive support and guidance in dealing with it” (CNA, 2017, p. 7). Recognizing an ethical concern can often be a turning point that allows positive outcomes to emerge from challenging experiences.

### **1.5.1 Moral or Ethical Distress**

Moral distress is a term coined by Andrew Jameton in 1984 (as cited in Cohen & Erickson, 2006). Jameton observed the phenomenon among the nursing students he was teaching and developed a framework to aid nurses and other healthcare providers to distinguish among three categories of ethical issues (Cohen & Erikson, 2006; Krautscheid, DeMeester, Valorie, Smith, & Livingston, 2017; Rafaela & Margarida, 2015; Sasso, Bagnasco, Bianchi, Bressan, & Carnevale, 2016; Silen, Tang, Wadensten, & Ahlstrom, 2016). Moral distress is described as knowing the ethically right action one ought to take but feeling forced from acting on one’s beliefs because of internal and external constraints. It is associated with the psychological, emotional, and physiological suffering that may be experienced when we act in ways that are inconsistent with deeply held moral values, principles, or moral commitments (Krautscheid et al., 2017).

Moral distress frequently occurs in the healthcare setting, particularly among nurses who are providing direct patient care. It is linked to care-related issues, including ethical dilemmas that can put professionals in challenging positions and give rise to feelings of discomfort and unease (Sasso et al., 2016). A nurse’s values are compromised as a result of not taking what he



or she feels is the right course of action, which may include fear or circumstances beyond their control. Sources of moral distress will always manifest in different ways as different people have different opinions on what is the right thing to do in any given situation (Cohen & Erickson, 2006). Additionally, organizational constraints will play a role to some degree. When nurses are faced with organizational constraints or when they perceive professional values and healthcare standards are being compromised, they often experience moral distress (Cohen & Erickson, 2006; Sasso et al., 2016).

Circumstances in which moral distress may arise more frequently include end-of-life care, policy constraints, medical prolongation of dying without informed choice, the definition of brain death, inadequate staffing, and effects of cost containment (Mendes, 2014). Moral distress is “not only detrimental for nurses during and in the immediate aftermath of the decision they have made but, if left unresolved, is also associated with moral residue and longer-term burnout, which has been linked to a lack of compassionate patient care” (Mendes, 2014, p. 1219).

Because nursing students are primarily guided by professional rules, norms, and duties, they may be more vulnerable to moral distress. Although schools of nursing have screening procedures in place as to what students are chosen for international placements, even the most robust, confident students will likely experience some morally distressing events (Sinclair, Papps, & Marshall, 2016).

### **1.5.2 Moral or Ethical Dilemma**

According to Garity (2009), the cause for moral distress may be associated with the type of education and training that nurses receive related to analyzing and evaluating ethical or moral dilemmas in a clinical setting. An ethical or moral dilemma is different from ethical or moral distress and refers to situations in which “you have a problem that can be resolved by two or

more ethically justifiable but mutually opposing actions, but often there are significant downsides to each potential solution” (Sasso et al., 2016, p. 524). Ethical dilemmas often arise from end-of-life issues, conflict with other nurses, physicians or families, patient privacy concerns and organizational constraints.

Similar to an ethical dilemma, a micro-ethical dilemma can be classified as everyday ethical decisions that are so common they may go unnoticed. Examples of micro-ethical dilemmas may include breaking infection control practices, violating confidentiality, failing to implement sterile technique, ignoring medication administration precautions, and mocking patients (Krautscheid et al., 2017). When students are faced with micro-ethical dilemmas, “the risk for moral distress is present because they are confronted with making a decision between two choices: speak up and advocate for quality patient care or remain quiet and permit the substandard practice to occur” (Krautscheid et al., 2017, p. 314). Although present in any healthcare environment, these dilemmas are of particular concern for nursing students in under-resourced countries due to a lack of resources and being unable to speak up due to language and cultural barriers.

### **1.5.3 Moral Residue**

When moral distress leads to compromised integrity, moral residue can surface. Jameton (1984) first described moral residue as “reactive distress” occurring after the “initial distress” in the acute phase of a situation (as cited in Epstein & Hamric, 2009). Moral residue is also described by Webster and Baylis (2000) as “that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised” (p. 208). Moral residue can be intensely felt, enduring, and often very painful (Hardingham, 2004).

#### **1.5.4 Concepts of Ethical Theory**

In addition to the terms moral distress, moral dilemma and moral residue, it is likewise important that all components of ethical theory and its concepts are understood, including autonomy, beneficence, fidelity, nonmaleficence, and justice. These concepts are outlined in the *CNA Code of Ethics* regarding the ethical responsibilities which are central to ethical nursing practice. The Code of Ethics also “provides guidance for ethical relationships, behaviors and decision-making and is used in conjunction with professional standards, best practice, research, laws and regulations that guide practice” (CNA, 2017, p. 2).

#### **1.5.5 Ethical Knowing**

As Canada continues to grow in cultural diversity, it becomes increasingly important to promote and demonstrate concepts of cultural competence. It is the nurse’s job to advocate for the standard of care clients deserve: “Nurses do not discriminate on the basis of a person’s race, ethnicity, culture . . . mental or physical ability, socio-economic status, or any other attribute” (CNA, 2017, p. 15). Ethical knowing goes beyond the nursing code of ethics and involves a sensitive and knowledgeable nurse (Carper, 1978) who is able to recognize when they are experiencing a morally distressing event. Acknowledging ethical and moral dilemmas or distress is the first step in managing its negative effects and preventing long-term self-harm.

#### **1.5.6 Sociopolitical Knowing**

The lack of resources which contribute to poor health outcomes can be examined through a sociopolitical lens. The high number of maternal deaths in certain areas of the world reflects inequities in access to health services and highlights the gap between rich and poor. There are significant disparities between countries, within countries, between income levels, and between women living in rural versus urban areas (WHO, 2015). It is important to consider inequalities in

socioeconomic status and geography which are linked to sources of disadvantage and poor outcomes (Bermejo, Firth, Hodge, Jimenez-Soto, & Zeck, 2015).

Many communities in developing nations are located in isolated regions that are far from healthcare services. Geographical location has a large impact on access to care, especially when resources are less abundant. Additionally, while healthcare services may be offered to individuals of all income levels, many people are unable to access care due to inability to find or pay for means of transportation. Wide disparities across income levels also contribute to social injustice in healthcare (Huntington, Banzon, & Recidoro, 2012).

## **1.6 Motivation for this Research**

My primary motivation for this research stems from the experiences I had during the final practicum of my undergraduate nursing degree. My interest in completing a practicum overseas, and specifically in an under-resourced country, began before I even entered nursing school. In fact, the potential to work abroad in the future was a consideration I had when choosing nursing as a career. Having traveled previously to developing countries such as Kenya, Tanzania, Guatemala, El Salvador, and Cuba sparked my interest in not only wanting to travel more, but to provide nursing care in developing countries. I knew that before beginning my research on this topic, before I could ask nurses to ‘unpack’ their experiences, I needed to unpack my own.

### **1.6.1 Unpacking My Own ‘Suitcase’**

*Before my international practicum, I knew what moral distress was, but I don’t know if you can ever fully understand it until you feel it. My first feelings of moral discomfort occurred during my very first day in this foreign hospital. Before any nursing duties began, we were given a tour of the facility. What stuck out most in my mind was the distinction between the ‘pay wards’ and the ‘charity wards.’ While the ‘pay wards’ had air conditioning, private rooms, and*

*adequate staffing levels, the 'charity wards' consisted of large rooms full of patients, no curtains to separate them, and very few nurses. The air was hot and thick, the kind that sticks to your skin and sits heavy in your lungs. The windows were open with attempts to provide relief. I remember watching a bird fly across the room, struggling to get out. I wondered at the time if the nurses might also feel like that.*

*A number of days later, I watched a medical resident change the dressings on my patient's grade IV pressure ulcers. I stood in awe. Unable to move, the patient lay in a decorticate position, completely emaciated except for severe edema in his upper extremities. The patient did not have this pressure ulcer before coming to hospital. Repositioning patients isn't an arduous task, but it does become challenging when you're caring for upwards of 20 patients. Perhaps, though, the part that struck me the most was that the patient's family was paying out-of-pocket for all these hospital bills, while the patient was unlikely to ever improve. Seeing my patient in that state left me feeling distressed. I did not want to accept that this is the reality of so many people in this country.*

*Even in the pay-for-service units, resources were very limited as patients pay out of pocket. One day I received an order for my patient to receive a new blood pressure medication. Working alongside my nursing instructor, I showed her the chart, eager to prepare the medication and educate my patient on the drug. Even though it was only an oral medication, nursing students tend to get excited about this kind of thing. As it turned out, I never had the opportunity to give this patient their new medication. I didn't make an error preparing it nor did I run out of time. The patient couldn't afford to pay for it. This realization made me sick to my stomach.*

*The moral distress I experienced was a result of what I witnessed directly, but also from what I was told. In one instance, a tuberculosis patient could not provide a sputum sample for analysis because the closest health center was too far away for him to walk and he was unable to pay the fare for a tricycle. Living conditions in this country (cramped quarters, extreme heat and humidity, insect infestations) have an immense impact on health outcomes, especially on illnesses such as tuberculosis, malaria, dengue fever and pneumonia. In fact, every patient I cared for in this hospital had community-acquired pneumonia. Not all of them lived.*

*Like many other health outcomes, the largest contributing factor impacting maternal mortality is income. Most working-class women in this country are only able to come to health clinics in the morning as they have childcare, cleaning, and cooking duties in the afternoon. If they cannot get to the clinic in the morning, they often forgo any prenatal care. I recall being told about 'maternity homes,' where women who can't afford to give birth in-hospital go. Most care in these 'homes' is provided by nursing students, who are not fully qualified nor licensed professionals. These women do not receive necessary medications and interventions, leading to increased maternal and infant mortality. As I've always had an interest in obstetrics, I asked if we could spend a couple of clinical days there. The response was no; the nursing instructors thought it would be too traumatizing for us. I didn't ask again.*

*What surprised me most about my international experience was how much income impacts life and death. Looking back, all of the moral challenges I faced were a result of health disparities and inequities within the country. Many social determinants of health in this population are not being met, including food security, education, housing, unemployment and income. Realizing how much money determines patient outcomes brought me to tears. Those with money survive and those without it don't. Working directly with patients who could not*

*afford to pay for care and seeing them deteriorate to the point of death was life-altering. It made me feel ashamed of how much we take for granted in Canada. Often, I still feel this way.*

As a researcher, I believe that my own experiences nursing in an under-resourced country allowed me to take a subjective position in connecting relationally with my participants. As a methodology, narrative inquiry allows for the researcher and participants to come to the interview with considerations of their own experiences. When a relationship based on equality is established, narrative inquiry offers participants the reassurance needed to be open and honest in sharing their narratives (Clandinin, 2013). Stories have the unique ability to heal, restore, and provide hope. As a researcher, I was given the opportunity to learn not only from my participants, but also from my own stories as they came to light. Did my experiences overseas change me? Of course they did. My stories have made me the nurse I am today and my stories are what inspired this study.

## **CHAPTER 2: LITERATURE REVIEW**

Current literature reveals that international placements are beneficial to the professional progress of nursing students, including growth in cultural competence (Button et al., 2005; Callister & Cox, 2006; Coatsworth, Hurley, & Kolleen 2017; Egenes, 2012; Geale et al., 2015; Ruddock & Turner, 2007; Small & Pretorius, 2010; Vaughn, 2015). Research also acknowledges that both practicing nurses and nursing students have experiences of moral distress in various settings, including specific research on mental health, oncology, and neurology units (Cohen & Erickson, 2006; Silen et al., 2008; Wojtowicz, Hagen, & Van Daalen-Smith, 2014). Moral distress in these settings is frequently due to inappropriate or inadequate care, a lack of confidence in colleague competence, treatment decisions that fail to factor in the patient's wishes, and problematic attitudes towards patients and their families (Palese et al., 2018; Wojtowicz et al., 2014). The purpose of this chapter is to present an overview of the literature focused on the experiences of nursing students participating in international placements as well as ethical issues and moral distress that occur in other nursing environments.

### **2.1 Search Strategy**

Literature for this review was retrieved through electronic searches of the PubMed, CINAHL, Google Scholar, and MEDLINE databases using the keywords moral distress, ethical distress, international, practicum, placement, under-resourced country, developing country, and nursing students. The search was limited to peer-reviewed articles published in the English language between 2000 and 2018. Articles were retained if: (a) their primary focus was international clinical placements for undergraduate nursing students; (b) they examined moral distress among nurses or nursing students or; (c) the challenges and benefits of international placements were examined; or (d) they are considered seminal works in discussing moral and ethical distress within healthcare.



## 2.2 Literature Review

Eighteen articles, published in Australia, New Zealand, Brazil, Italy, Denmark, Sweden, the United Kingdom, Canada, and the United States, were included in the full review. The majority of studies (n=16) reviewed are of qualitative design focusing primarily on the impact of international practica on participants' personal and professional development, as well as the development of cultural competence (Button et al., 2005; Callister & Cox, 2006; Coatsworth et al., 2017; Egenes, 2012). Challenges of international practica discussed include culture shock, communicating across language and cultural gaps, and inadequate preparation and debriefing (Egenes, 2012; Geale et al., 2015; Murray, 2015; Wojtowicz et al., 2013). Moral distress is discussed in the context of acute nursing care but is restricted to developed nations, and more research has been done on practicing nurses than on student nurses. The literature also reflects that all nurses experience ethical dilemmas and distress in their job at some point and to some extent (Rafaela & Margarida, 2015; Silen et al., 2008).

A few studies (n=3) employed a survey or questionnaire in an attempt to quantify experiences of moral distress by asking participants to rate their most distressing issues, identifying the frequency at which ethical issues are experienced by nursing students in different years, and documenting the most commonly reported reasons that nursing students do not act upon their ethical convictions (Button et al., 2005; Palese et al., 2018; Sinclair et al., 2016; Small & Pretorius, 2010). The literature reviewed suggests that additional education on ethical considerations may enhance students' understanding, resilience, and ability to respond to distressing situations. Students should also have the opportunity to discuss any ethical issues with their instructor during clinical experiences (Palese et al., 2018).

Healthcare systems are influenced by the culture and ethics of those they serve (Button et al., 2005; Vaughn, 2015). Evident in the literature are disparities in resources, education, and ethical standards between countries (Murray, 2015). These disparities are important considerations when discussing international nursing practica as educational institutions have a responsibility to prepare nursing students to recognize these differences and respond to diverse patient populations while abroad (Button et al., 2005). Schools of nursing must develop and support leaders in cultural care to enrich the nursing profession. Approaches to prepare nursing students for culturally competent patient care include global health courses, video conferencing and international placements (Vaughn, 2015).

### **2.2.1 International Placements**

International placements for nursing students should include mandatory preparation strategies. A study by Murray (2015) found that students consistently had more positive experiences in overseas study programs when they were prepared for the experience with some knowledge about what they may encounter, as well as some practical information about the country and traditions of the people with whom they will be living and working. Preparation strategies support students in understanding what will be expected of them during clinical, as well as the country's demographics, history, and healthcare system. Nursing instructors in charge of facilitating international clinical practica should ensure students take part in mandatory preparation, including language courses, lectures, assignments, and readings before departure.

Evidence shows that there are numerous benefits of international clinical practica, but they are not without challenges. For example, studies have found that, as a result of their international experiences in an undergraduate program, some students have chosen to pursue graduate level education (Button et al., 2005). Conversely, challenges with international clinical

placements include issues surrounding cultural shock in a new environment. What has not been addressed in the literature is individual students' experiences of potentially morally distressing events, occurring due to a lack of resources in this new environment.

Button et al. (2005) published an analysis of the literature evaluating the influence of international placements on the lives and practices of nurses. Their literature review consisted of both qualitative and quantitative studies found through electronic databases. They established that nurses reported significant changes in their personal development and transcultural adaptation after providing nursing care in another country. The authors evaluated differences between short and long-term placements, as well as developed and developing countries, but none of the studies explored the impact of moral distress as a result of nursing in an under-resourced country.

Callister and Cox (2006) also examined the personal and professional meaning of participating in international electives during undergraduate nursing programs. Through a series of interviews with 20 former nursing students, they established several themes: "increasing understanding of cultures and peoples, increasing understanding of global sociopolitical and health issues, . . . experiencing personal and professional growth, contributing to professional development in the host country. . . and developing cultural competency" (Callister & Cox, 2006, p.95). Experiences of moral distress were not discussed in this study.

Coatsworth and colleagues (2017) reported that delivering healthcare in the context of a developing country forces nursing students to be creative and think outside the box. Themes related to a lack of resources were examined as their research was specific to student nurses volunteering in Nepal. Students recounted that witnessing Nepal's healthcare conditions firsthand created an improved understanding of equality and an enhanced appreciation for the

people. Similarly, Egenes (2012) discussed international experiences for undergraduate nursing students as providing a meaningful opportunity for students to recognize and accept positive and negative characteristics of a different culture while evaluating the characteristics of their own. The benefits and challenges of nursing in a foreign country are described, mostly regarding cultural factors. Murray (2015) likewise explores the personal and professional growth reported by undergraduate nursing students following an overseas placement in Africa. No specific data on moral distress was collected in these studies.

Using a hermeneutic phenomenological approach, Ruddock and Turner (2007) explored the usefulness of international practica for promoting cultural sensitivity in nursing students. Their findings are consistent with much of the other literature and suggests that study abroad is a useful strategy for developing cultural sensitivity and growing both personally and professionally. In his master's thesis, Vaughn (2015) also found that international immersion experiences for baccalaureate nursing students serve to benefit professional practice and particularly one's cultural competency. These studies focused predominantly on the positive aspects of international placements and only briefly touched on the challenges of adjusting to cultural differences.

Geale and colleagues (2015) investigated overseas placements of Australian nursing students in Tanzania, India, Thailand, and the Philippines during their final year of study. Similar to Egenes (2012), benefits and challenges of international practica are explored, including cultural and language gaps. The authors also discuss the importance of reflective practice which was unique to this article. As a part of the students' international experience, debriefing sessions were held with the purpose of communicating concerns regarding differences in care compared

to the students' home setting. While students in this study struggled with differences in care, the article does not label these difficulties as causing ethical or moral distress.

### **2.2.2 Ethical Issues and Moral Distress**

Moral distress is a serious problem that affects nurses and nursing students in different contexts within healthcare (Rafaela & Margarida, 2015). Moral distress can generate feelings of dissatisfaction, physical and emotional symptoms, fatigue, and even abandonment of the profession. Due to its negative consequences, moral distress has a profound impact on the quality of healthcare delivery:

When nurses are unable to deal with an ethical demand, they may experience moral distress which can lead to dissatisfaction, rage, isolation, anxiety, depression, changing department or job, or leaving the profession, causing consequences for aspects of quality and satisfaction with the care. (Rafaela & Margarida, 2015, pp. 571)

Nurses have identified that a general lack of autonomy prevents them from confronting moral issues (Wojtowicz et al., 2014). This holds true for nursing students who have significantly less autonomy than professional nurses. Additionally, "nursing students may become disillusioned when caring is not the primary focus of nursing as they previously believed" (Palese et al., 2018, p. 2). In a demanding, acute care environment, high nurse-patient ratios and administrative expectations take time away from patient-centered care, resulting in poor communication, lack of assessment of patient preferences and values, and caring practices which threaten moral principles. When these moral principles are threatened, a nurse or nursing student's moral integrity is also threatened, giving way to moral distress.

Using a quantitative descriptive survey design, Sinclair and colleagues (2016) investigated the common causes of moral distress among nursing students. The findings were

similar to those of Wojtowicz et al. (2014); however, unique to Sinclair et al. (2016) were themes related to lack of support and supervision, as well as bullying. Even though situations causing moral distress may be similar for both nurses and nursing students, it is imperative that nursing students be studied independently as they may experience ethical problems that are unique and different from those of registered nurses (Palese et al., 2018; Sinclair et al., 2016). Wojtowicz et al. (2014) found that overall, nursing students reported significant moral distress related to situations previously identified in the literature; however, some of their additional findings were unique to a Canadian mental health setting.

Palese and colleagues (2018) discuss ethical issues during student clinical learning experiences (CLE) and specifically address the idealistic vision students have regarding what it means to be a caring nurse: “Nursing students are fresh from ethical notions taught in the classroom... Therefore, students are in the best position for detecting ethical issues when entering the CLE” (Palese et al., 2018, p. 2). In their naturalistic inquiry, Wojtowicz and colleagues (2014) found that although nursing students can detect ethical issues, they often felt there was ‘no one to turn to’ to receive support for their moral distress. Ethical issues encountered in clinical learning environments may cause severe moral distress for nursing students that can negatively affect caring competencies as well as their outlook on the profession as a whole (Palese et al., 2018).

According to the literature, undergraduate nursing students perceive a lack of opportunity to discuss ethical issues during their clinical placements (Palese et al., 2018). Although a necessary component of undergraduate nursing education should include ethical content in theory courses, this alone is not sufficient to prepare students for the complex situations they will encounter in practice. Students should be given the opportunity to voice their ethical concerns to

instructors to develop professional decision-making skills and to prevent moral distress (Palese et al., 2018). In clinical environments where safety and care quality are threatened, there is an increased need for students to be able to examine ethical principles and discuss any feelings of moral distress.

Howland (2018) and Sinclair et al. (2016) emphasize how vital it is that nurses know how to express their feelings and handle them in a professional way to deliver safe, quality care. As a component of undergraduate education, nursing students should explore various ethical issues that they will inevitably face as nurses. Because ethical behaviour is often confrontational, this becomes a challenging endeavour. Koharchik et al. (2017) describe how to integrate ethics into education in a classroom environment to provide a safe setting for discussion on moral behaviour.

While Krautscheid and colleagues (2017) considered moral distress among undergraduate nursing students, they did not look at the nature of this distress in international contexts. Through a descriptive cross-sectional survey design, the authors measured moral distress and reasons for not taking action. The study discussed external resource restraints within a North American context, which may be indirectly compared to a lack of resources encountered by students while participating in an international practicum.

Silen et al. (2008) examined ethical dilemmas and distress experienced by nurses working in a neurological setting. They found that all 21 of the nurses interviewed experienced ethical dilemmas in their job to some extent and that these dilemmas frequently caused distress. Silen and colleagues' (2008) study points out that nurses working in different areas of practice reported similar stress levels, but rank the various stressors differently. The study also found that when trying to manage the distress, the nurses mainly used coping strategies and sought support

from colleagues but had no regular opportunities to discuss morally difficult situations. This type of intervention must be advocated for in the future, not only for practicing nurses but also nursing students.

Sasso et al. (2016) describe how ethical dilemmas combined with environmental, relational, and organizational factors contribute to moral distress in undergraduate nursing students. Their systematic review revealed that inequalities and healthcare disparities, student-mentor relationships, and students' individual characteristics all have the potential to generate moral distress. Unique to Rafaela and Margarida's (2015) study, in addition to examining the ethical situations experienced by nurses, these authors also identify the coping resources which nurses utilize. It is important to determine what coping resources are being used in order to propose future strategies for managing moral distress.

### **2.3 Gaps in Literature**

There are a number of gaps in the literature related to moral distress among nursing students. Nursing students are at particularly high risk for developing distress when they encounter moral dilemmas throughout patient care experiences. There is currently a lack of research investigating the long-term effects of international practica and the narratives of individual students' experiences. Additionally, a number of the articles evaluated were published more than ten years ago, reflecting a lack of current literature regarding moral distress among nursing students. It is also imperative that resources available to students on return to their home country be considered. It is crucial that nursing students have access to adequate resources to assist them in working through their unique experiences of distress.

Quantitative studies about the most commonly reported reasons that nursing students do not act upon their ethical convictions have yet to be done (Krautscheid et al., 2017). This



knowledge gap suggests that further research needs to be carried out to improve our understanding of the phenomenon of moral distress and to identify preventive interventions. This aim should include achieving a deeper understanding of the way in which moral distress is manifested, signs and symptoms that characterize it, and educational factors and experiences that have the most substantial influence on students.

Few studies have been conducted on the experience of nursing students completing clinical practica abroad, and even fewer have examined practica in under-resourced countries. To begin to redress these identified gaps in knowledge, this study sought to explore narratives of registered nurses who have had experiences in under-resourced countries as nursing students which may or may not be articulated as moral distress. As such, the research question that guided this work is: *What is the experience of registered nurses who participated in an international clinical placement in an under-resourced country?* These findings may contribute to current nursing knowledge and highlight the need for additional research in this area. It is necessary that we gain an understanding of student experiences to more effectively deliver international nursing practica in the future.

## **CHAPTER 3: METHODOLOGY & METHODS**

The use of narrative inquiry in nursing research is an evolving trend, often selected by academics to explore nurses' experiences across various contexts and situations (Haydon, Browne, & van der Riet, 2018). Narrative inquiry is unique from other qualitative methods in that it offers an "insider view" and involves a certain way of caring about how knowledge is constructed (Haydon et al., 2018). In this study, a thematic analysis of the narrative data was utilized to understand registered nurses' clinical experiences as students in under-resourced countries and to describe the phenomenon of moral distress. This approach was also intended to advocate for this population and to uncover nuance and detail of previous experiences.

Thematic analysis, which is the process of identifying patterns or themes within qualitative data, allowed for a robust and refined analysis of the narratives (Braun & Clarke, 2014; Maguire & Delahunt, 2017). Although Riessman (2008) states that such thematic approaches "eliminate the sequential and structural features that are hallmarks of narrative" (p.12), she also attests that category-centered models of research such as thematic coding may be combined with close analysis of individual cases. A thematic analysis in which semantic themes are described is consistent with a study that is exploratory and descriptive in nature and thus was appropriate for the purposes of this Master-level study. This study was likewise interpretive to a degree as it captured certain underlying ideas, patterns, and assumptions.

### **3.1 Philosophical Underpinnings of Narrative Inquiry**

Ontology, which may be defined as the nature of being, truth and knowledge of the world, is key because all inquiry makes important assumptions about truth and knowledge that inform epistemology. Ontology pertains to the nature of reality and, therefore, what can be known about reality (Guba & Lincoln, 1994). There are fundamentally two ways to look at

reality, from a received view or perceived view, with constructivism falling under the perceived view. Constructivism is a philosophical viewpoint, which holds that knowledge and truth are co-created and that there are multiple ways to view reality (Yilmaz, 2013). Human subjective experience is a source of valid knowledge and knowledge is contextual, situated, located, and value-laden (DeGroot, 2012). Narrative inquirers see the importance of understanding the world through stories, as an approach to create knowledge with individual truths. This study can help us more deeply understand its purpose, but we can never have the whole truth of these experiences.

Epistemology, on the other hand, is concerned with the development of knowledge. In narrative research this process involves understanding the world through storytelling (Wang, 2017). The nature of narrative inquiry is both constructive and inductive, meaning that the researcher and participants co-create an understanding of the topic being researched. To achieve this, it is important that the researcher builds a trusting relationship with participants to add depth and richness to the data (Wang, 2017).

Fundamentally, people live and tell stories, and this is our way of thinking about experience (Clandinin, 2016). We live out and tell stories about our lives. In this research, I came alongside participants to hear their stories and, in that way, live it with them. Storytelling provides a context for understanding human experience by articulating one's innermost thoughts to the rest of the world (Khanom et al., 2015). There is a commitment to engaging in and validating people's experience through honouring their stories and the experiences they have had. In narrative inquiry, the researcher has an intention to understand participants' experiences (Clandinin, 2012).

Narrative inquiry was first used by Clandinin and Connelly (1990) as a methodology to describe teachers' personal stories: "Stories are fundamental ways our brain organizes our experiences of the world and then processes and presents the complex information in manageable narrative forms so that we can understand events that have occurred" (Wang, 2017, p. 45). Through stories, narrative researchers look for ways to understand and represent the lived experiences of participants. Because narrative inquiry is a very relational form of research, the researcher must also explore their own stories (see Chapter 1). This is because we are more aware of another's complex experiences once we are aware of our own. I am personally invested in the study because of my own experiences abroad and my desire to make a difference in the future generations of nursing students (Wang, 2017).

### **3.1.1 Three-Dimensional Narrative Inquiry Space**

Temporality (past, present, future), sociality (personal, social, cultural), and place (environment and institution) make up the building blocks of narrative inquiry. This three-dimensional space provided a context which allowed me to think across participants' stories and to notice how nursing students and their unique environments were the same and different (McAllister, 2001). Awareness of these dimensions enabled me to organize the stories and provided a conceptual framework that helped me to understand how each participant experienced their international nursing practicum in the context of time, social milieu, and physical environment. Using this framework allowed me to gain a deeper understanding of the participants' experiences (Haydon et al., 2018). Each story was told because it holds significance; thoughts, ideas and feelings are chosen to be told by the participant because they are important and have meaning.

## 3.2 Research Design

The process of thinking narratively includes outlining the *research puzzle* (Clandinin, 2013). Narrative inquiry is structured around a particular curiosity and rather than thinking about framing a research question with a precise definition or expectation of an answer, there is a belief that there is no absolute truth to be discovered. Instead of a research question, “the research is seen as a research puzzle, where each narrative contributes to a clearer image to be seen; as environment and social norms change over time so does the image” (Haydon et al., 2018, p.128). The *research puzzle* that led to the research question that guided the study is, ‘What are the experiences of registered nurses who participated in an international clinical placement in an under-resourced country?’

A narrative inquiry methodology is the most appropriate approach to address the research puzzle because it incorporates all dimensions that impact the person’s experience, such as social, cultural and environmental influences (Haydon et al., 2018). Additionally, narrative inquiry is appropriate when not much is known about a topic and when the researcher wants to explore ethical matters and shape new theoretical understandings. Narratives may be verbal, written, or visual stories (Clandinin & Huber, 2010). For this study, narratives were verbal accounts with supplementary references made to reflective journals participants kept during the practicum if they chose to do so.

### 3.2.1 Purpose

The existing literature attests that some nursing students working in an under-resourced setting experience some form of moral distress, however little is known about the defining experiences that trigger this distress. I also anticipated that participants may describe experiences of morally distressing events, but may not label them as such. Because of this, I encouraged

participants to consider events which were particularly challenging for them but did not begin our conversation by requesting stories of moral distress. I made active intentions to openly explore any impactful experiences the participant wished to discuss. Because no existing research had examined the narratives of nursing student experiences while practicing in under-resourced countries, this investigation was warranted to provide awareness and develop an understanding of their unique experiences. Using narrative inquiry, this study was carried out to understand registered nurses' experiences as undergraduate students participating in international clinical placements in under-resourced countries.

### **3.2.2 Setting**

The study was conducted in Canada as part of my Master of Nursing at the University of Saskatchewan. Data collection and analysis occurred in Victoria, British Columbia, where I live. The study was carried out during the spring, summer and fall of 2019.

### **3.2.3 Recruitment**

Participants were recruited through social media. The social media post (see Appendix D) included detailed information about the study, evidence of ethical approval, and my contact information. Individuals were invited to email me to request more information about the study or to volunteer to participate. When an individual volunteered to participate, I emailed them back with the demographic and consent forms (see Appendices E and G) for them to fill out and instruction to send them back to me. If individuals met inclusion criteria and consent was given, they were formally enrolled in the study and an email was sent to schedule the first interview.

Social media is emerging as a promising way to identify and recruit potential participants for research (Lunnay, Borlagdan, McNaughton, & Ward, 2015). Recruiting participants through the social media outlet of Facebook was attractive in this context because it enabled me to reach

many more members of the population of interest than may have been otherwise accessible. Although using social media for research is relatively new, its use was ethically appropriate for this study as the participants had to contact me if they saw the post and decided they were interested (Lunnay et al., 2015). There are potential risks to privacy and confidentiality intrinsic to communicating through the Internet; however, it was believed that the benefits of engaging in recruitment via Facebook for the purposes of this study was ethically acceptable. No data was taken from individuals' profiles or posts. Any risks were made known to the participant prior to becoming involved.

### **3.2.4 Sampling Procedure and Strategy**

Narrative inquiries are often conducted with small sample sizes, most commonly with four to six participants (Haydon et al., 2018). Working with a small sample size is beneficial because the intention is to gain depth, not breadth, in the experiences (Clandinin, 2007). As in all qualitative studies, the aim was not to generalize the findings to a population, but to deeply explore experience in order to understand it in innovative ways (Lindholm, Lindstrom, & Wiklund, 2002). Accordingly, six participants provided informed consent and were enrolled into the study. Limiting the number of participants was likewise appropriate based on the scope of the study.

Purposive sampling was used to recruit potential participants who were capable of revealing and willing to share their stories. Because there is knowledge of the population under study, the participants had to be handpicked to be included in the sample (Richards & Morse, 2013). Purposive sampling was likewise appropriate for use in this narrative inquiry as a random sample would not have guaranteed recruitment of participants who could add their perspectives to the study.

The participants were recruited via Facebook. According to Whitaker, Stevelink, and Fear (2017), “there is growing evidence to suggest that Facebook is a useful recruitment tool and its use, therefore, should be considered when implementing future health research” (p. e290). When compared with traditional recruitment methods (print, radio, television, and email), benefits include reduced costs, shorter recruitment periods, better representation, and improved participant selection in young and hard to reach demographics. A poster which outlined the study was posted via the U of S College of Nursing Facebook page (see Appendix D) and then reposted numerous times by me and other individuals who saw the post. It was anticipated that posting this recruitment poster on Facebook would attract enough participants, and although it was viewed by many, responses were few. The recruitment poster was then additionally posted to the PAWS webpage to be viewed specifically by USask alumni. At that point, several more participants were recruited.

### **3.2.5 Sample Selection Criteria**

Participants were selected if they met the following criteria: (a) practicing nurses registered with a regulatory body in Canada, (b) took part in an international practicum in an under-resourced country 0-10 years ago as part of an undergraduate nursing program, and (c) were willing and able to sign an informed consent and share an experience or experiences they had during this practicum. The sample was not restricted by participants’ cultural or ethnic background, nor was it restricted by age or gender. Country of clinical placement was not an inclusion criterion but had to fit into the low- or middle-income category, as established by The World Bank (2018) (see Appendix H).

### **3.2.6 Data Collection and Analysis**



Data collection for the proposed study was generated through Skype conversations, which were efficient, secure, convenient, and more personable than a telephone interview. Because it was anticipated that participants would reside across Canada, Skype was chosen rather than in-person conversations. Although it turned out that two participants did live in the same city as me and it was possible to interview the participants in-person, to keep the data collection as consistent as possible, a Skype interview was used for every participant. Skype allowed for convenience of the participant to participate from the comfort of their own home, which also supported privacy. Because interviews had to be scheduled to fit both the researcher's and participants' schedules, with shift work, children, and other commitments, it was often difficult to schedule interviews in a timely manner. Follow-up interviews did not always occur one to two weeks following the initial interview as intended. Although most data collected was detailed, data from one participant lacked the depth that the others provided.

The conversations were guided by a conversation guide consisting of open-ended questions and prompts intended to elicit stories about participants' experiences (see Appendix F for conversation guide). The main prompt used was: "Think back to a memorable experience or experiences you had while completing your practicum in <blank>. Tell me a story about this experience." It was anticipated that this format would invite participants to talk openly about their individual experiences without feeling constrained by a set of questions. I reiterated that this could be any experience that holds meaning for them and impacted them in some way. I then moved into more prompting questions that would allow for participants to possibly describe an experience that may have been distressing. The purpose of not addressing moral distress too soon in the conversation was to avoid potentially biasing the participants' responses.

Participants were encouraged to refer to journals, photographs, or memorabilia related to their international experience (Clandinin, 2016). This was outlined in the consent form as well as an email sent prior to the interview. The initial interviews lasted approximately 60 minutes but there were no strict time constraints, which fostered an ease of discussion. Interviews were audio-recorded and transcribed by the researcher to then create an interim text of the interview.

Field notes were taken immediately following the interviews including any technological issues that may have occurred, any nonverbal cues portrayed by the participant, and any initial themes that arose. Reflections and these notes gave me purpose and focus. With each consecutive interview I was then able to easily identify new themes and connect similar themes within participants' stories. I kept a personal journal separate from the data as a way to reflect on my own feelings and experiences during the interview process. I believe this contributed to my own wellness throughout the data collection period as it was, at times, an emotional process.

Data collection and analysis proceeded simultaneously as preliminary analysis can inform subsequent interviews. Data in narrative inquiry are referred to as field texts, which are storied accounts from participants that are captured as interview transcripts (Clandinin & Connelly, 2000, Clandinin, 2013; Riessman 2008). The process of analyzing data in narrative inquiry involves the generation of "interim texts" (Clandinin, 2013; Clandinin & Connelly, 2000). Interim texts are the iterations of emerging participants' stories gathered through the first interviews which allowed me to share my interpretation of the participant's story with them. I sent the interim text to each participant via email one to two weeks following their initial conversation, and allowed them time to review for accuracy of their account. When the interim text was sent to the participant, I asked the participant for potential dates and times they would

be available for a brief follow-up conversation. Participants were not offered to review their transcripts, only their interim texts.

After conducting initial interviews and developing interim texts, the follow-up conversation was conducted to clarify interpretations and maintain authenticity of the participants' stories. This occurred approximately three weeks following the initial interview. The follow-up interview gave participants the opportunity to provide additional information, check for accuracy, and allow for revisions as desired to fully capture their experiences. The follow-up interview was also intended to last approximately 60 minutes, but in all cases lasted less than ten minutes. Although none of the participants had anything new to add, several requested specific alterations to their narrative, which I made. These alterations were not related to the richness of the story but were regarding added details for clarity of their setting or situation. Two participants did not schedule a follow-up interview because they had other family and work commitments; these individuals provided corrections to their narrative via email.

The interviews were audio-recorded and the recordings were transcribed verbatim before beginning data analysis. While both the first and second interviews were recorded and are considered data, the second interview was not transcribed. Transcription was completed manually by me. I went through each transcript twice to ensure accuracy and used the program VLC Media Player to slow down the recording for ease of transcription. The interview transcript was then read over multiple times so that I became familiar with and immersed in the information while making notes of significant findings for the purpose of creating the interim texts.

Thematic analysis of the data focused on what the participants said and on the content of the language used in the text. The thematic analysis was performed following Braun and

Clarke's (2006) six-step approach to identify major and recurrent themes in participants' stories. Phase one: familiarization with the data, comprised of listening, transcribing, and familiarization with the raw data. Phase two: generating initial codes, concerned with exploring the field texts and coding for themes. Phase three: searching for themes, involved identifying potential themes and subthemes which looked to fulfill my research purpose. In phase four: reviewing themes, themes were examined, refined, and links between themes were made. In phase five: defining and naming themes, themes were further refined and restructured to capture deeper relationships and patterns. The final phase: producing the report, included the presentation of findings in a formal report (Braun & Clarke, 2006).

The coding process began after a process of data familiarization during which I made notes of my initial analytic observations about the data. I then coded across all of the data items. Next, I organized the data relevant to each code as I continued to code, and then again at the end of the coding process (Braun & Clarke, 2006). I generated codes and then clustered codes to form categories and preliminary themes. Following the coding process and assigning codes to various categories, a thematic map was created for the overall conceptualization of data patterns and the relationships between them. At this point, codes were manually sorted into potential themes by writing the name of each code and assigning a colour associated with its category. Potential themes were verified with each transcript to ensure authenticity of the participants' words. The initial list of themes was refined several times. The significance of the theme was not dependent on quantifiable measures per se, but rather if it captured something important in relation to the overall research (Braun & Clarke, 2006).

The analysis went beyond the content of the data in an attempt to say something about what the data really *means* and the implications of the patterns that were identified. Both

narrative representations and thematic analyzing approaches were employed. Narrative inquiry as a theoretical framework informed the use of thematic analysis so that I was able to produce a descriptive overview of the semantic content of the data. According to Braun and Clarke (2006), two to six themes are usually suitable for a single project. For this Master's level project, I employed both narrative representations and thematic analyzing approaches.

As knowledge is co-constructed in narrative inquiry, all substantial themes have been supported by narrative accounts and I worked to ensure there is a clear distinction between what the participant said and my interpretation of their account. I have supported my findings with direct quotations. Field notes that were taken during the interview also served to support my interpretation of the data during analysis and allowed me to comment upon impressions, environmental contexts, behaviors, and nonverbal cues that were not always adequately captured through the recording.

In the re-storying of the participants' narratives and the sharing of the resulting themes, I included rich detail about the setting and context of the participants' experiences (Ollerenshaw & Creswell, 2002). Participants' narratives supported the thematic analysis, and each individual account is presented in Chapter 4. My own experiences have been woven into the analysis and findings as an overall narrative. The result of this process is the creation of individual narrative accounts which offer a glimpse into participants' experiences (Clandinin & Connelly, 2000). These narratives offer a perspective for readers to begin to consider the experiences registered nurses have had while completing placements as students in under-resourced countries.

### **3.2.7 Incentives to Participate**

All individuals who contacted me to participate were very eager to have the opportunity to share their experiences. The benefits of participating in this study potentially included

empowerment in opening up about difficult experiences, a feeling of not being alone when participants realize others have had similar experiences, and the opportunity to share experiences which could lead towards positive change. Participants received a \$10 Starbucks gift card after completing the first interview to thank them for their time.

### **3.3 Ethical Considerations**

Ethical approval was obtained from the University of Saskatchewan, Human Behavioural Ethics Review Board (Certificate #1016). I gave each participant an overview of the study purpose, aims, and what was expected of them. I also reiterated that participation is voluntary, and that individuals were free to withdraw from the study at any point in time, without consequence. Informed consent to participate in the study and to audio-record the interview was obtained prior to beginning any data collection.

I assigned each participant a pseudonym for use in the study and reinforced that the participant's real name would not appear in any reports or presentations associated with the study. The only place their real name appears is on the consent form, which is stored in a locked cabinet in my supervisor's office at the University of Saskatchewan, College of Nursing, Regina Campus, and is separate from all other study materials. This data will be stored for a minimum of five years in accordance with University of Saskatchewan requirements. Electronic data will be stored on a password-protected computer and files encrypted. Additionally, the University of Saskatchewan secure cabinet on PAWS will be used for backup purposes. Audio recordings were erased once transcription and analyses were complete and any hard copies of data will be destroyed after the five-year storage period.

Narrative accounts were shared with participants prior to the start of the second interview to identify if what I have written resonates with each individual. I also described to participants

how they may receive a copy of the study when it is finished. Although participating in qualitative research comes with a level of vulnerability, there has also been evidence to show that qualitative interviews offer many therapeutic benefits (Murray, 2003). Due to the nature of the research question, a contingency plan was established in the event that a participant became overtly distressed while describing their experiences. This contingency plan was not used for any of the participants as no one became visibly distressed.

### **3.4 Rigour**

Narrative inquirers insert themselves into the storyteller's unique perspective (Clandinin & Connelly, 2000; Riessman, 2008). Narrative inquiry requires stories to be not only believable but also meaningful and authentic. The inquiry process must work to uncover the multidimensional nature of the stories while adhering to ethical research requirements (Whitley & Crawford, 2005). Rigour in this study was demonstrated through the use of Braun and Clarke's (2006) six-phase framework for doing a thematic analysis as well as the twelve touchstones of narrative inquiry. These touchstones are used to judge the validity and rigour of a quality narrative inquiry and are outlined by Clandinin (2013): "Recognizing and fulfilling relational responsibilities; being in the midst; having a commitment to understanding lives in motion; negotiating relationships; narrative beginnings; negotiating entry to the field; moving from field to field texts; moving from field texts to interim and final research texts; attending to temporality, sociality, and place; interacting with relational response communities; explaining justifications (personal, practical, and social); and attending to multiple audiences" (p. 212).

The credibility, transferability, and dependability of the study determines its trustworthiness (Richards & Morse, 2013). I ensured credibility and honoured the truths of the participants by verifying emerging themes with each participant (Haydon et al., 2018). Initial

narrative developments were first presented to the participants in a process of member checking to determine if my interpretations communicated their experiences accurately. Using quotes and precise language as well as including multiple field texts also served to support the trustworthiness of my study (Murray, 2015). Transferability was ensured through a detailed description of the data collection procedure, study design, sample size, study site and selection of participants. I also ensured transferability by having a committee member audit the data. They reviewed and critiqued the research process and the interpretation of my findings to ensure it aligned with and responded to the research purpose.

Dependability and consistency in the research process was ensured through an audit trail. Keeping records of the raw data, field notes, transcripts, and a reflexive journal helped to organize, recount, and cross reference data, as well as keep the reporting of the research process straightforward (Halpren, 1983). Creating a clear audit trail was likewise established through returning to the field notes and transcripts and comparing them to the developing themes to ensure that all conclusions were firmly grounded in the original data (Guba & Lincoln, 1994). As a novice researcher, I also consulted my advisory committee to determine whether the themes were clear, comprehensive and did not warrant further modification. As stated by Guba and Lincoln (1994), written records of each advisory meeting can help to develop the audit trail and act as a reference to justify methodological decisions.



## CHAPTER 4: NARRATIVE ACCOUNTS

This chapter presents the stories told to me by the six participants in the study. Using the transcriptions from our interviews, I developed interim texts for each participant which were reviewed for clarity and accuracy. All six stories are set up to have a beginning, middle, and end, which follows the narrative inquiry methodology. They all begin with a description of the participant's physical environment, they all recount a significant experience the participant had during their practicum, and they all end with how the experience has impacted the participant and their nursing practice. Each participant was able to be vulnerable in a way that allowed me to truly see the impact these experiences had and still have in their lives today. These stories are stories of learning, of bravery, and of self-discovery.

### 4.1 Holly's Story

#### Setting the Stage

*As I looked out the bus window, I watched the trees pass by. There was so much beauty around me, but it was hard not to focus on the poverty. Staying in one of the nicer areas in Windhoek, our instructor decided to drive us by one of the slums. I wanted to get off the bus and say hello to the kids or buy some fruit from the market, but we never stopped. We just kept driving by, our instructor pointing things out and watching the scene disappear behind us. I felt like a tourist, like we were on a tour and were looking at these people through a lens of privilege. I wished we could have spent more time in that setting—in the little markets or just being immersed in the community. Where we stayed, we were very separated from that.*

#### Nursing in a Foreign Land

*Windhoek, the capital city of Namibia, was quite modern, but we worked in a public hospital. I soon found out that there was a stark difference between the public and private*

*sectors. When I became sick I was taken to one of the private hospitals where I spent several nights. Comparing it to the hospital we were working in was like night and day. The public hospital had seven floors and there were usually forty patients on each unit. I remember stepping into the hospital for the first time—a sense of shock washing over me as I witnessed the conditions that patients stay in. Row after row of stretcher-style bunk beds and mattresses on the floor. I saw, firsthand, how a lack of resources impact healthcare delivery—like getting only two pieces of gauze to do a dressing change.*

*I never once thought it was because they didn't want to give everyone the best care possible. It's just...that's the way it is. Or that's what I told myself. I think this is what helped me overcome feelings of helplessness. I watched some of my peers, especially those lacking previous travel experience, battle feelings of distress. This stemmed from not being able to do what they thought was a proper dressing change, watching patients writhe in pain with no access to medication, and seeing children be neglected.*

*I spent most of my practicum on the adult surgical ward where there were two nurses to forty adult patients. We were essentially left to our own devices, so we really had to make the most of our days and seek out learning experiences. One of my favourite days happened outside of the hospital setting. There was a really beautiful public park in the city and we took some kids from a soup kitchen out to have a picnic. We had food and played and painted faces; it was just a day about fun. And I think meant a lot to these kids, some of them who lived more than 10 kilometers away in the slums and had never been to a park before. To see the excitement in their eyes was an unforgettable feeling.*

*In the hospital, I had the opportunity to follow a patient's journey from the adult surgical ward to the operating room (OR) and back. This patient was a diabetic whose foot was*

*completely necrotic and he needed a trans-metatarsal foot amputation. Once we got to the OR, we met two other nursing students from Norway. We all just stood there, in this small, lifeless room, anxiously awaiting what would happen next.*

*The first thing we saw happen was the doctor nerve block my patient's leg. He then put a drape over his head, separating his eyes from what was about to ensue. Then, he picked up a hand-saw and used it to perform the amputation. A hand-saw! I was looking at the other students from across the room, all of us wide-eyed in disbelief. I thought to myself oh my gosh, this is just a nerve block! And his foot is being amputated! With a hand-saw! This sense of shock was due to knowing how the procedure would be carried out in Canada and seeing something so different occur. But my patient was totally fine after; it went great. I witnessed how these healthcare professionals have to work with what little they have in order to save someone's life. It was something I will never forget.*

### **Bringing it Home**

*Being back in Canada, I still find it challenging. My next placement was very difficult for me, particularly to see how much waste there is within our hospitals. You don't just hit a button and automatically adjust to things like that. But I've learned that maybe it's something we can work on. That being said, I don't think you ever fully disconnect from an experience like this. Partly because you can't forget a foot being cut off with a hand-saw, but mostly because it made me the nurse I am today.*

## **4.2 Rebecca's Story**

### **Setting the Stage**

*Sri Lanka was beautiful—the landscapes, the people, the culture. It was typically sunny and warm, and the city of Kandy was surrounded by mountains and lush tropical foliage. If it*

*rained it was almost always a downpour, but even the rain here was beautiful. My favorite place was this spot on top of a hill nearby that overlooked the whole valley. We'd go there at sunset and it would be like looking at watercolors on a canvas sky. It was a really special place.*

*The country itself may have been beautiful, but it came with some unpleasant realizations. One being that in Sri Lanka women are not seen as having a voice. As a fairly well-versed traveler, I maybe should have anticipated it, but this was different. Not to say I wasn't expecting it, but the nursing staff, the women, they don't speak up to any men. It's not their place and it's not their role. Even though they know what they want to say, what they need to say, they don't. They are incredibly vulnerable. So, for myself, being in Sri Lanka as a woman was challenging. For this reason I tried to always stay in a group. But sometimes there were crowds so thick this became an impossible endeavor. One time, on the train, I was separated from my friends. I was groped, called names.*

### **Nursing in a Foreign Land**

*In Sri Lanka you don't have to pay for healthcare, but you also don't have access to a lot of things. The public hospital...it was huge. It stretched over acres and acres of land and the buildings were monstrous. It only took ten minutes to walk to the hospital, but once I got there, it took another fifteen minutes walking uphill to get to the infectious disease ward where I was working. The unit could hold 110 patients. Fifteen of them were acute and needed continuous monitoring. Adjacent, there were 55 beds lined up next to each other. You could reach out and touch your neighbor, that's how close people were. The remaining 40 beds weren't actually beds at all—they were lawn chairs. And this is what those 40 people sat in, ate in, and slept in. One bathroom was positioned at the very end of the hall for all 110 patients to use. This is also where*

*the one sink was located, with no paper and no towels. People don't wash their hands like they do in Canada because you're just not able to. There isn't the space or the resources.*

*In the hospital, all female nurses are called sisters. And so that's what I became, a sister. Our head nurse was someone I held in high regard. She was an advocate. She ran the unit and she ran it top notch. If there was equipment that needed to be brought in, she got it. She found it, she staffed it, and she was there Monday to Friday. We didn't ever have everything we needed, but she was always adamant that you do the best you can with what you have. She was truly an inspiring woman.*

### **Dying With(out) Dignity**

*There was this man who was dying of liver failure. He was dirty and had no clothes. From his waist down he was covered in dark red blood. No one made any effort to clean or clothe him. I wanted to, felt I needed to, provide this man with some sense of dignity in his final days. So I went and got him some clothes. Another nurse and I cleaned him up, washing away the blood from his dark, weathered skin. I knew this man was dying but I never would have guessed that he would die, literally, in my arms.*

*And he did. He stopped breathing. His heart stopped. The nurse and I finished washing him and positioned him in a way that appeared comfortable. I was sad, but I was also at peace because I felt I had done my job as a student nurse. It was at that moment that the doctor came to the bedside. He had been notified of the death. And then, to my disbelief, he started doing compressions on my patient. I stood there, next to a family member who was also watching in disbelief. I was flabbergasted, enraged, distressed. My patient now laid, uncovered, a mess on the small bed.*

*I later found out that every patient in Sri Lanka is a full code. No matter their age, diagnosis or prognosis. It's just something that's done. The crash cart is prepped every morning and sometimes by 11 o'clock it's empty. This man was obviously palliative, but to them, there's no such thing as palliative care. At that point I couldn't fight the tears, they were pouring out of me. I left the unit and sat by myself awhile. When I came back, the family expressed their gratitude. They were grateful that he was able to be like that in his last moments—clean and clothed—and I cried with them.*

*It took me weeks to process things. I was upset. I was angry. About every two weeks I would get really depressed. It felt like any energy I had left was sucked right out of me. I was still processing what had happened. It took me a week or two just to get over the fact that a person had died in my presence, and what happened after was another challenge in and of itself. It wasn't until several weeks later, back in Canada, that I felt okay. I had coped and done the processing I needed to do. I felt relief and such an immense appreciation for all the things I have in my life. I think this man and those compressions will forever be etched in my mind, but so will the family's gratitude. And the hope that maybe this man did die with a little more dignity.*

### **Bringing it Home**

*It's hard to describe this experience to others. And how can you, really? It's the things you see with your own two eyes that no picture can capture. It's the smells, the conversations, the feeling. There are no words for that. The nurses I worked alongside, my sisters, they gave me so many opportunities to develop as a person and a nurse. They taught me to be creative and innovative, to find ways to do things with next to nothing, and I will forever be a better nurse because of it.*

### 4.3 Chloe's Story

#### Setting the Stage

*The banging, the bells, the smells—I grew very attached very quickly to the people and the culture in Nepal. Sometimes I can still hear these sounds in my mind and I'm caught in a reverie. It is a truly incredible country—the vastness of the landscapes, the mountain ranges that seem to span forever. One of the things I treasured most was the community of teatime. Any time we would arrive at a site, it would be teatime. It was always served by an elderly Nepali person who didn't speak any English. They would hand us our little teacup and we would bow to each other. It was the hottest tea you could possibly drink, even though it was thirty-two degrees outside and you were dripping with sweat. But sitting on the floor with the Nepali people, and the community that it built, I absolutely loved that.*

#### Nursing in a Foreign Land

*Nursing in Nepal—it was eye-opening to say the least. There are various grades of healthcare in Nepal because health insurance is not something that people often buy. If you think about it metaphorically, you may purchase a cup of tea for your health or you may purchase healthcare insurance. In Canada, you can go to a hospital or a clinic and will most often have your needs met. In developing countries like Nepal, people choose the cup of tea. The rationale behind this is the cup of tea is something that grounds them and is guaranteed in the moment. Alternatively, if you get sick and go to the emergency department, nothing is guaranteed and it's very difficult for you to get reimbursed for the services. It's going to be expensive and it's going to set your family back.*

*We spent two weeks in Katmandu, the capital city of Nepal, before traveling to Pokhara for two weeks, and finally ending the practicum back in Katmandu. We toured two different*

*hospitals in Katmandu. You don't often describe hospitals as beautiful, grand, sparkling, but that's exactly what they were. These hospitals were brand-spanking-new and they were empty. And while they were clean and state-of-the-art and I've never seen marble floors shine the way these did, there were no patients in them—not a single one. People can't afford to go there.*

*In Pokhara we would climb in a tuk-tuk and drive two to three hours on a gravel road to clinics and rural birthing centers. This was a more realistic area of nursing that I witnessed and participated in. These clinics consisted of blue-tarped huts where women would go for their prenatal and postpartum visits. There were three little areas with three nurses and a small table where the women could lay down and be examined.*

*They weren't clean, these huts, but how could they be when the floor isn't even a floor? It's just dirt. Women were having cervical checks with gloves, but the nurses weren't necessarily washing their hands between patients. There wasn't any clean water to do that. It was either you wash your hands in contaminated water and then perform an invasive exam, or you do a clean glove exam with maybe a bit of hand sanitizer in between each patient. The standards—they were just completely different. And that's not to say that these people weren't resourceful. The resourcefulness of these nurses was incredible, but it was very difficult to come from Canada, knowing what we have, and to see the standard of care that was available to these women. Difficult doesn't even come close to describing it.*

### **Fourteen Years Old**

*There was one experience that occurred inside that blue-tarped hut that has never left me. It has become a part of who I am. It was a sunny morning the day I showed up to the clinic. At some point in the day there was a girl who arrived at the clinic, and she really was just a girl. She was small—her body was tiny but she had this big pregnant belly. As it turned out, she was*



*in labor. Her face told me how absolutely terrified she was. I had never seen a child so scared. She was damp with sweat and her eyes were huge. You could tell she didn't know what was happening. The nurse explained to her, in Nepali, that she was in labor and was going to give birth to a child. I later learnt that she was fourteen; she was still a child herself. I also learnt that her family had disowned her. The baby she was carrying was a result of sexual assault by a family member. Her family had pressured her into having an unsafe abortion but this girl, this fourteen year old girl, said no.*

*While she was on the table being examined by the nurse, her water broke. The nurse said something in Nepali and the two other nurses that were working in the other little rooms rushed over and helped her into a tuk-tuk so she could get to a birthing center. I wondered what was going to happen to this girl. I would likely never see her again. After she left, we continued on like nothing happened. The nurses cleaned up the breaking of the waters and proceeded to see other women. I felt distressed; I had never seen anything like this before. The nurse told me, "It happens all the time," and went about her day.*

*This girl never really left my head. For the days following, she was always there. Then, on our final day in the clinic, she came in with her baby—her teeny, tiny new baby. Only six days old, naked and wrapped in an old towel. She had come for her postpartum visit. Midway through the visit, the girl asked about birth control. The nurse's reply which she translated to me was, "You're too young. We can't give you birth control. You're only fourteen. We will have to wait until you're sixteen." And I thought to myself, this child has been sexually assaulted and now has a child of her own, why wouldn't we prevent subsequent pregnancies by giving her oral birth control? Or a Depo shot? I couldn't even begin to understand the rationale behind not providing her with something to prevent this from happening again.*

*This fourteen year old girl left with some condoms and a brand new baby. She left, back into the world, to take care of herself and a six-day old infant all on her own. She didn't have anywhere to go and no family to help her. The potential for subsequent abuse was still there, perhaps heightened due to not having a safe place to stay. I thought back to how I felt unsafe at sunset, walking with my four friends, and I couldn't begin to imagine how it might feel to be fourteen with a brand new baby, after dark, with nowhere to go.*

### **Bringing it Home**

*Of course it's always exciting to travel and see new places, but I think that removing myself from the comfort zone of my own home, my own country, and my own reality really enabled me to grow into the person I am today. This experience has also transpired into my professional life. Not only has it made me more cognizant of the way I communicate with my patients who don't speak English or have English as a second language, it's also made me much more aware of the resources available to me in the clinical setting. Working in the specialty of forensic nursing, I care for patients following intimate partner violence or sexual violence. Having the opportunity to practice internationally within the context of sexual health definitely peaked my interest in finding this specialty. I often think back to my experience with the fourteen year old girl inside that blue-tarped hut. She was the first person I cared for who was subject to sexual violence, and my practice will forever be transformed by that one day in Nepal.*

## **4.4 Rachel's Story**

### **Setting the Stage**

*Arriving in Uganda was mesmerizing. I had never been to Africa before, never even set foot outside of Canada, so stepping off the plane into this foreign land was very foreign to say the least. It was far different than I ever imagined. When I thought of Africa I pictured it akin to*

*something I had seen in the Lion King. But Uganda took me for surprise. It was lush, the rolling hills green and bright, the red clay a striking contrast. The town of Rugazi where we were staying had a seemingly endless number of crater lakes where we would often go to relieve ourselves from the heat. The country was beautiful and I was in awe of it.*

*'Mzungu, mzungu!' is what people would yell when we went anywhere outside of our living quarters. This translates literally to 'white traveler' but it was yelled even if you weren't white. The Ugandan people weren't used to seeing any lighter-skinned person, let alone a group of nine women. For the most part it was quite comical.*

*Where we stayed resembled a five bedroom home with one bathroom. There was no running water and we flushed the toilet using a bucket. This I shared amongst eight other girls. We had little cot beds where we slept. It was simple and it was vastly different from what I was used to, but that's what made this experience what it was.*

### **Nursing in a Foreign Land**

*I loved going into local communities alongside the Ugandan nursing students to do health teachings and learn about their collective health needs. The Ugandan people were so kind, loving and accepting. Even when you couldn't understand a single word they were saying and they couldn't understand you either, they'd still say good morning. They'd still hug you and welcome you into their community and their homes. It was the kind of feeling where your heart just feels warm. It may sound cliché but as poor as these communities are, they are rich in so many ways.*

*We began our practicum working in a rural setting in Rugazi which was comparable to an emergency department—it was that chaotic. It served a large enough population that we were delivering five to six babies per day. In the hospital we bounced around from unit to unit, but*

*much of our time was also spent delivering babies. The hospital was made of concrete and the windows were open to air with bars lining them. It was dirty, there were bugs, the beds were ripped. On the maternity ward, 20-30 flat, foam mattresses laid atop old metal frames. This narrow room housed not only the mothers and their newborns, but also their mothers who slept on small straw mats beneath the beds. They need help to be looked after because the nurses don't provide any personal care. This room of about 30 women and 30 babies was run by two nurses.*

*The hospital we were placed in was a university hospital located in Mbarara and it operated on a pay-what-you-can system. If you could afford to pay, then you got a little bit extra, more care and more supplies. If you couldn't pay, you got whatever they had. One of my patients had a C-section and post-op her wound was dehiscing. The doctor re-sutured it, but because the woman had no money, she didn't receive any pain medication. When the doctor would return to clean it, fully aware that she had no pain medication whatsoever, he'd pour water on it, put a piece of gauze through the space and rub it in and out, in and out. In Uganda, women don't often express pain. So she laid there, with a stoic face and tears streaming down her cheeks.*

### **The Last Breath**

*During my time spent in Rugazi working in labour and delivery, there was this beautiful baby girl. She was delivered by emergency C-section due to complications during vaginal delivery. When she finally made her grand entrance into the world she had extensive respiratory issues. Access to emergency services were very poor because this birthing center was three hours away from a tertiary hospital. So this baby arrived, her respiratory rate low, secretions blocking her airway as she struggled for each breath. The medical staff tried suctioning the baby manually with bulb suction. They had no oxygen to provide. It was decided that she was going to die, so the nurses wrapped her up, placed her on the counter, and left her there.*

*Another student and I continued to try and suction, do whatever we could with what was around us to help her. We tried to talk to the doctor, begged him to do something, but his response was, “She is a girl. If she has any chance of survival she would have a hard life because it’s Africa and she’d have some type of disability.” For them it was easier for her to die. They didn’t give her back to mom. They didn’t give her to anybody. She was left there alone. So I wrapped her up tight, took her in my arms, and held her until she took her last breath.*

*It was crushing. It was breaking. It was frustrating. These feelings were intense. In that moment I wanted to be a savior. I wanted to save a life. But there was nothing I could do. I couldn’t save this baby’s life, I couldn’t hurt for it, I couldn’t bathe it. I felt helpless and angry because nobody was listening to me. The other student and I were mocked for even trying and for being so involved.*

*It probably wasn’t until a week or so after when we were paired with the Ugandan students and had some open conversations about why this happened and the complexity of it did I begin to process these events. And although I still disagree with how it happened and I wished there was more we could have done, I began to come to terms with it. My feelings of distress, brokenness and frustration diminished over time. It wasn’t easy but I knew I had to move on.*

### **Bringing it Home**

*Even though I had my share of struggles throughout the three months I spent in Uganda, I would never change them. Uganda shaped me into the person and the nurse I am today. Whether it was the postpartum mother who was getting her C-section cleansed or the baby that died in my arms, these were defining moments for me. No matter how difficult and emotionally exhausting it may have been, I’ve come to understand that this is their normal. This is what happens. And no matter how much I may disagree with it, I have come to terms with it. I have*

*had feelings of anger and distress throughout the process, but I can now see things with a new perspective. Looking at the greater scheme of things and seeing what other factors are in play, I have begun to understand why things are the way they are; why there's less funding or why a child with mental or physical disabilities isn't as likely to survive in countries such as Uganda. I'm also much more cognizant of how and why I'm doing what I'm doing—using things appropriately and effectively. How much gauze I grab, if I'm going to open an extra package of something, or just appreciating that many of the supplies and medications I use daily aren't available or are limited in other countries.*

#### **4.5 Alexa's Story**

##### **Setting the Stage**

*When I'm in India I love India. But it isn't an unconditional love. It definitely has conditions. For me, India is like a kettle. You fill the kettle with water, careful not to pass the max capacity line. If and when this line is crossed, the water begins to boil and some of it will surely spill out. In India, the streets are always crowded with people and the heat can be unbearable. It's a sticky, humid heat that makes you feel like you could physically melt. People are constantly staring at you and you become conscious of your every move. You crave space. When the kettle reaches max capacity, I can't wait to leave India. And that's not to say I don't want to go back, I absolutely do, it's just that I need a little time to empty my kettle.*

*There were only two of us nursing students who traveled to India for our practicum. We stayed in a guest house that belonged to the NGO we were working with in Bhubaneswar. Outside our window you could see cows grazing in a field the size of a small city block. People continually passed by with carts, selling foods and colourful trinkets. We were given bikes to use*

*and sometimes we'd take them out to explore the city. There were lots of beautiful parts. It was lush and green and I loved going up into the mountains. But there was also poverty.*

*I had been to India before so I knew what to expect. I knew of the slums where people are forced to defecate in the streets because they can't afford to construct private toilets. I knew to expect people with leprosy and the disfigurements that come with it. I knew to expect disabled children on the street begging, and I also knew that sometimes these children are intentionally disabled for the purpose of begging.*

### **Nursing in a Foreign Land**

*The NGO we were partnered with had discussed with us pre-arrival that we were to work in the hospital in addition to doing some community work. When we arrived in India we quickly learnt that the hospital we were supposed to be working in was still under construction. This disorganization was a challenge in and of itself, but aside from this, it was challenging for me to work within a system that has such a distinct hierarchy. You're expected, as a young woman, to be submissive. When we worked alongside doctors, they were both older and male, and I never felt respected as an individual or as a student nurse.*

*Most days we would travel between communities and show up at clinics or workplaces to assess patients and their medical needs. Most often the only treatment we had to offer was Advil, Tylenol, multivitamins, and worm medication—but sometimes we didn't even have that. One day, we had an Indian preceptor demonstrate to us how to give an injection. After administering the medication she took the needle between her fingers and bent it in half. I think my jaw nearly hit the ground. She told us they do it to prevent needlestick injuries—then she asked us to do it.*

### **A Band-Aid Solution**

*In India, many men, women and children work inside brick kilns. These kilns are hot and dusty and people are often treated as slaves. We would go to these brick kilns and see people in what consisted of five to ten minute interactions. People were seemingly pretty pleased to talk to us and receive a few days of medication, but this was all we could really offer. Our resources were very limited and I never left feeling settled.*

*We completed a number of these one-day clinics where we would see people on an informal basis. Time was also something we didn't have a lot of. We would ask individuals to describe their symptoms, hand them a couple pills if we could, and move on to the next person. My colleague and I continued to discuss how uncomfortable we felt with this situation, how we didn't feel like it was ethical. We were uncomfortable feeling like we weren't actually helping anyone—because really, we weren't. This caused a lot of internal conflict.*

*We were frustrated that this was the situation we were in. People looked at us in our lab coats and white skin and assumed that we were going to do something, that we could help them. But really, we couldn't do anything. We didn't have the resources to. So even if we gave someone a few days of Tylenol to numb their pain, it wasn't really helping. Even though we knew it didn't feel right, we continued on for several weeks because we didn't know what else we could do. I felt paralyzed by that.*

*We thought about this long and hard, about what being a nurse truly embodies. The nursing care we were providing was reactive—it was a Band-Aid solution. We wanted to make a difference, even if it was a small one. We came up with the idea to do a “train the trainer” project with some of the women in the rural areas that we had started to meet. Our aim was to take the knowledge we had gained from doing assessments with people in the community and from there develop a two-day health promotion workshop.*



*One of the groups we got together was a group of Indian women working for an NGO. Our topic areas included nutrition, hygiene and sanitation, common complaints and solutions, physical activity and stretching, and women's health. We wanted to focus on what was going to be the most useful information for the population. So many women and their families don't have access to a healthcare provider on a regular basis or they don't have the money to manage their health needs. Our goal was to teach the women working for the NGO so they could later disseminate their knowledge to rural villages outside of Bhubaneswar. We focused on building new knowledge, but also on validating the women's current knowledge and solutions that work for them, their families and their communities. We sat and talked, taught and were taught. And in the end, even though it may have been small, we felt like our difference was more than just a Band-Aid.*

### **Bringing it Home**

*India was an incredible experience. Although it may have been a struggle to get there, it really solidified my understanding of standards of practice and ethical nursing care. It also solidified who I felt I was as a nurse. In fact, I never really identified as a nurse prior to this experience—I never even wanted to be one. My experience in India fueled my passion for working within communities. It forced me to return to the basics of what nursing is, so that I could understand what I was experiencing through a nursing lens.*

*Coming home, this experience really gave me something to hang my nursing practice on. Whether its frameworks, best practice standards, or ethical principles, it has changed my outlook on nursing and the kind of nurse I am today. I witnessed and muddled through numerous ethical challenges while in India, and I think that's something I consider a lot in my practice now. Working in Indigenous health there are countless ethical issues that arise, and I know how to*

*interact with communities in a respectful and supportive way. I know that the knowledge I bring is only a very small piece of the puzzle. The communities themselves make up the rest.*

#### **4.6 Chantel's Story**

##### **Setting the Stage**

*What I remember most vividly about the Philippines is the poverty. It was inescapable, always right in your face like a mosquito that won't leave you alone. It was hot, 45 degrees Celsius hot, and it was unbearable at times. We stayed in the city of Cebu where we were housed in an old nunnery. Each day we walked 1.3 kilometers to the hospital, there and back. Because there were no sidewalks, we had to step over people that were sleeping in the street while simultaneously dodging oncoming traffic. There were sixteen of us, dressed head to toe in white. To say we stood out would be an understatement. Sometimes we would be hissed at, spit at. I grew to hate these uniforms.*

##### **Nursing in a Foreign Land**

*Differences in the medical system became very obvious very quickly. Our nursing placement was in a county hospital and it was publicly funded. The medical system in the Philippines is based on pay-per-use and the cost is on the patient. This means that if you don't have the money, you won't receive the medication or the CT scan or the surgery. We saw countless patients come in with dehydration, diarrhea, community-acquired pneumonia, malaria, and dengue fever. On top of this, in the emergency department, we saw many traumas—some patients who were saved and others who weren't. And when I say they couldn't be saved, this wasn't a result of incompetent medical staff or the injuries being too extensive. It was most often due to a lack of resources or the inability to pay.*

*Outside of the hospital setting, we traveled to what was called a scavenger community. The government donated a piece of rural land as a means of creating a self-sustained community. The people living here forage items from garbage dumps to then make things they can sell—jewelry, purses, crafts and household items. We spent a day in this community, talking, sharing food and playing with the children. Everyone was very welcoming to us. Even though they had next to nothing, they were so incredibly kind.*

*One of my favourite aspects of my overall practicum experience was the teaching I was able to provide. This involved education on dehydration in children, as well educating women on birth control and healthy pregnancies. I felt like I was able to leave women feeling empowered, and this was a good feeling. Just the look in their eyes, knowing that they held knowledge that was beneficial to others and that they could share, was really special. It was something I could go to sleep feeling good about.*

### **John Doe**

*On a particularly hot day working in the emergency department, a man was rushed in with a head trauma from a motor vehicle accident. He was not in good shape and it didn't take me very long to realize that he wasn't going to survive. The man was unidentifiable for quite some time and was known to us as John Doe. The medical team advised that he have a CT done, which came with a price of seven Canadian dollars. Unable to determine if the man could, in fact, pay for the CT scan, we waited until a small Filipino woman came in and identified the man as her son. After finding out how much the service would cost, the woman left. I later found out that she went and prostituted herself in order to get the money.*

*From a Canadian nursing standpoint, myself and my instructor knew that we were not going to gain any information from the CT that was going to save this man's life, especially if it*

*was not done imminently. The mother did something that was, in our eyes, unnecessary, but so sacrificial. I later discovered that this occurrence was not in isolation. I learnt that people frequently make many different sacrifices to pay for their family's medical needs, including selling property, drugs and themselves for sex. This was difficult for me to wrap my head around, but even more difficult to witness first hand.*

## **The Twins**

*Working on different units throughout the hospital, I grew most comfortable in the NICU. I found that there, I wasn't exposed to as many ethical dilemmas, or at least they weren't so in my face. The babies were kept separate from their moms and dads, so you were really just there with these tiny little babes, working to keep them alive. In other clinical settings, there would be 10 plus family members at the bedside, which created a whole other set of stressors.*

*I found myself in the NICU for about eight shifts out of my five weeks there. On my first day, I began looking after a set of twins. They were teeny tiny, just a few pounds apiece. They were very premature and very dehydrated, to the point where their fecal matter was hard and their fontanelles were sunken. I made it my mission to care for these babies the best that I could, to get them a little stronger each day.*

*I was feeding them, changing them and holding them all day long. I wanted to, but I also felt like I had to. It seemed the NICU nurses barely even looked their way. Maybe this was because they felt there was nothing they could do, or maybe because there were other babies they believed needed their attention more, but whatever the reason, it made me sad. Their mother was not around much either. These were her fourth and fifth children, and it was not a planned pregnancy.*

*In my mind, I felt these babies were being left there to die. I didn't have any reason to believe otherwise. But what I was holding on to was the fact that some of my interventions seemed to be helping. Their fontanels were starting to become less sunken and they were beginning to have proper poops. They were getting stronger.*

*On my fourth day, I walked into the NICU and the twins were gone. A bolt of panic shot through me. I asked, out loud and to no one in particular: "Where did the twins go?" The response I got, from across the room, was, "Oh, they went home." I didn't believe it. Why would they be sent home? They weren't ready. They were nowhere near ready. I held back tears. I held back anger. I learnt that the mother had come and picked them up, taken them out of the NICU. I learnt that she took one of the twins home with her and left the other at the front doors of the hospital. I didn't know what to do with this information, where to go from there. I couldn't even believe it had actually happened. I still don't know if I do.*

### **Bringing it Home**

*My main motivation for wanting to participate in an international nursing experience was so I could be exposed to an under-resourced environment. I wanted to learn to think on my toes and find alternative ways of doing things. I wanted to be forced to think critically. Although I had all of these desires, and I think I did, in fact, achieve a lot of these goals, this experience presented me with more challenges than I could have ever imagined.*

*I did encounter a lot of negative experiences throughout my practicum, I won't deny that. But I also believe that I've been able to take most of these negatives and find a way to turn them into something positive. I can apply situations I encountered in the Philippines to my practice so that I can benefit from them instead of having them weigh me down. This experience has impacted my nursing practice on so many levels. I have gained relational skills, clinical*

*competencies, and cultural safety and awareness. It may have taken a lot of time and a lot of professional help, but years later, I am happy with where this journey has taken me. Today I continue to process some of these events and experiences. Really, I'm still unpacking.*

## CHAPTER 5: READING ACROSS THE STORIES

Reading across the stories is a practice outlined by Clandinin (2013) as a means to begin to think narratively about the research findings. It moves from “thinking about” to “thinking with” stories. While thinking “about” stories seeks to locate similarities or themes as a method of validating these stories, thinking “with” stories helps us to think differently about moral issues in practice by raising questions about how the stories are in conversation with each other (Clandinin, 2013). When you think with a story, you become embodied in that story with the participant. This becomes an important part of narrative inquiry, as the researcher creates a narrative account through negotiation with the participant (Clandinin, 2007; Clandinin & Connelly, 2000).

Seven individuals expressed interest to participate in the study but only six individuals met inclusion criteria and were formally enrolled in the study. One individual did not meet inclusion criteria as they had participated in their international practicum 16 years ago. Each participant traveled to a different under-resourced country in either their second, third or fourth year of study and for five weeks to three months in duration. The longest amount of time since any participant had left on their international practicum was ten years ago while the shortest amount of time was one year ago. All participants are currently employed as registered nurses working in different clinical areas including the emergency department, long-term care, medicine, community health, forensics, and rural/remote nursing.

In this chapter, connections were made across participants’ stories to find repeated patterns of meaning (Braun & Clarke, 2006). These connections began to occur while interviewing my second participant. I began to take notice of how the participants’ experiences abroad were interwoven. There were obvious reoccurrences and similarities between stories as

well as ideas that were less transparent and required greater analysis to surface. The negotiated narrative accounts in Chapter 4 contain information on what participants' international experience meant to them and how they were impacted by it, but after transcribing and analyzing each individual interview, four significant themes were identified. These themes are presented with support from other literature to substantiate my findings.

*Navigating moral distress in a foreign land* is the first theme which is discussed in terms of its development and course. It was found that the moral distress experienced by students overseas was largely a result of either a lack of resources or cultural differences and this is elaborated on in this chapter. The second theme, *developing the personal and professional self*, details the growth experienced by these nurses, with a focus on building the traits of a culturally competent, empathetic nurse, as well as learning to provide nursing care with fewer resources. *Looking to the future and why it was worth it* is the third theme. Although it is discussed at the least length, it captures perhaps the most meaningful discovery—it was worth it. *Threats to preserving international practicum experiences for future generations* is examined as the fourth and final theme. It focuses on the poorly executed components of participants' practica which ultimately has resulted in the cessation of such international opportunities. Future suggestions and implications are given.



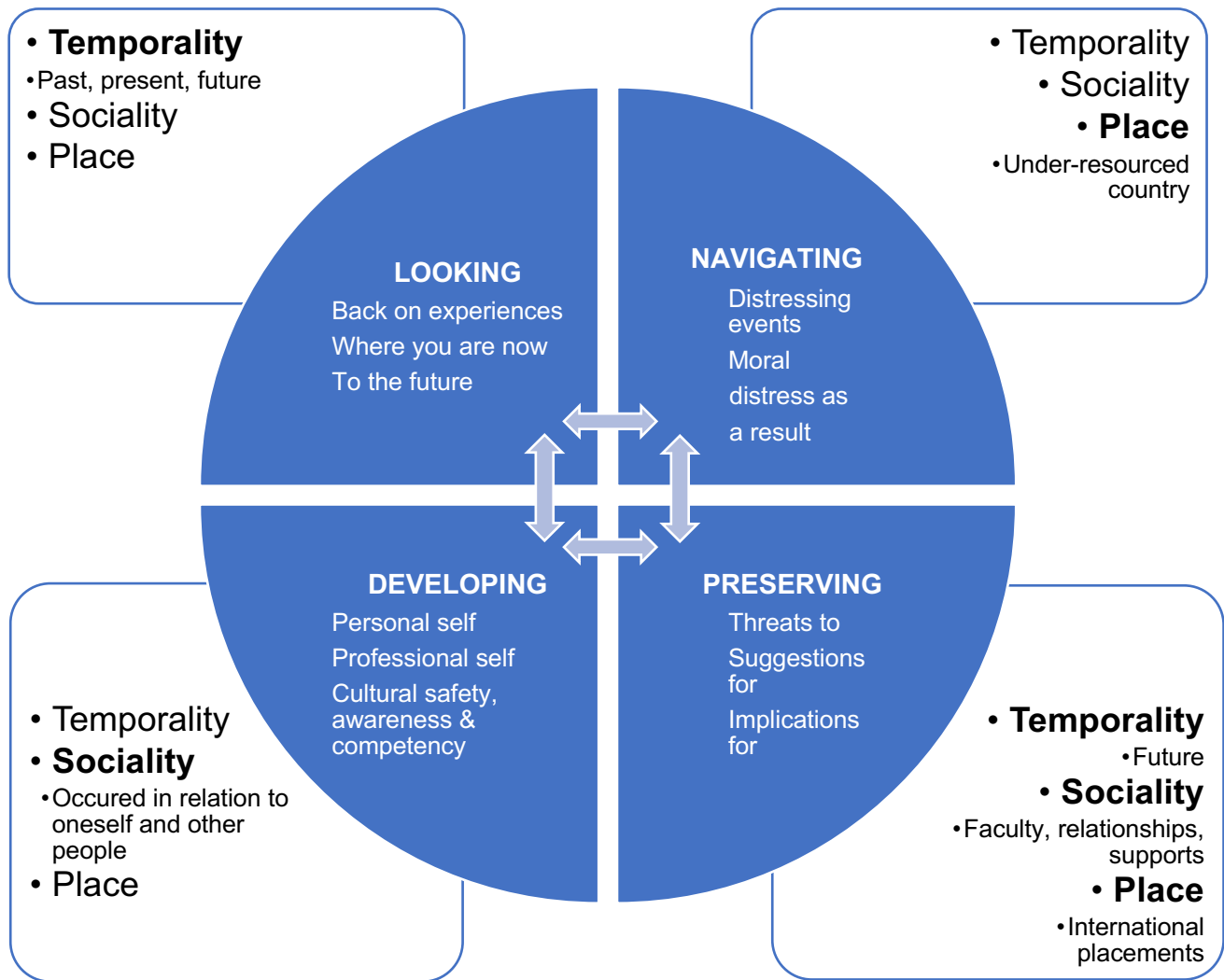


Figure 1. Themes from nursing students' practicum experiences in under-resourced countries.

This figure is a visual representation of themes established from participants' narratives as they fit within the three-dimensional narrative inquiry space.

### 5.1 Navigating Moral Distress in a Foreign Land

Moral distress is evident across diverse healthcare settings. In a North American context, high levels of moral distress have been recorded in situations of heavy workloads and understaffing (Sasso et al., 2016; Wojtowicz et al., 2014). In these circumstances, the fear of making mistakes is greater, heightening the risk of medical errors and poor patient care.

Additionally, working in an environment where the atmosphere is marred by conflict, competition, and poor communication among professionals, moral distress is more likely to occur (Sasso et al., 2016). For these participants, the probability of experiencing moral distress increased exponentially the moment they immersed themselves in a culturally different, under-resourced setting.

The increasingly complex nature of healthcare has caused a rise in ethical conflict for nurses and nursing students, whether they take part in an international practicum or not (Ulrich et al., 2010). Nurses and nursing students are vulnerable to moral distress when faced with any ethical dilemmas or difficult decision-making in clinical practice. Moral distress can be described as a feeling of discomfort or psychological imbalance and “may be manifested by feelings of guilt and frustration, a desire to give up the profession, loss of self-esteem, depression, and anxiety, and may even culminate in burnout and emotional breakdown” (Sasso et al., 2016, p. 525).

The first theme pertains to the negative events experienced by nursing students while completing their practicum overseas. Participants described their international practicum as having both positive and negative aspects, however, oftentimes the negative aspects were all-consuming. Negative experiences were consistently discussed in terms of morally distressing events that occurred due to a lack of resources as well as cultural differences that existed. The nurses’ stories reveal how they made sense of their moral distress and how they were able to navigate this distress in a foreign land. They also reveal how this distress impacted their mental health and wellbeing during their practicum, once they returned home, and in their practice today.

Handwritten memos following each interview allowed me to make preliminary connections between interviews. Notes were taken in relation to the three-dimensional narrative inquiry space of temporality, sociality, and place (Clandinin, 2013). This provided me with a framework from which to think across the narratives and notice how each participant existed in and interacted with their new environment. As I reflected across stories, I noticed patterns in the narratives which led to the establishment of several themes. While each participant had a unique story to tell, there were definite points of similarity. I first identified a connection across the stories following the interview of my second participant. Chloe's experience of moral distress was evident not only in her words, but also in her facial expressions and tone of voice.

And I'm thinking to myself...this, this child has been sexually assaulted and now has a child of her own...why wouldn't we prevent the risk of subsequent pregnancies by giving her oral birth control?... Like what is your rationale between, behind not providing this child...who is now an adult, like, grow up you have a child now...[Pause, makes a sound]...so sorry...[Longer pause]. I don't talk about this experience often.

The moral distress Chloe described was not in isolation. Even though each participant traveled to a different country for their international practicum, they were all considered to be under-resourced countries, as this was a criterion of inclusion for the study. Although it was not known previously, it was anticipated that this notion of place would bring forth similarities in experiences.

All of the participants' experiences of moral distress stemmed from cultural differences and a lack of resources, both of which are a direct result of the environment or *place*. According to Ruddock and Turner (2007), "support from nursing staff, and becoming involved in nursing patients, enabled students feel part of the new environment" (p. 365). Participants must be

provided with a supportive environment in order for them to compare and critically reflect on differences in both the culture and healthcare setting. Ruddock and Turner (2007) found that a supportive environment allowed students to reflect critically on differences that challenged their personal and professional values and beliefs. The participants in this study all described how they did not feel supported throughout their practicum, which likely contributed to their feelings of distress. Although not in an international setting, Palese and colleagues (2018) similarly found that nursing students frequently felt there was ‘no one to turn to’ to receive support for their moral distress, thus decreasing the quality of their clinical experience.

The only participant who did not experience any feelings of moral distress during their international practicum was Holly, who believed her previous experience traveling to under-resourced countries safeguarded her from these feelings.

I don't think it's because they didn't want to give everyone pain medications or antibiotics, it's just that's the way it is. Um or I guess that's kind of what I told myself. But I think it's just kind of like helped me sort of like overcome those feelings of like helplessness. Because I was like okay well what else can I do that might make like, better their care?

Although Holly described her experiences as “crazy, challenging and unforgettable,” she denied any feelings of moral distress. She did, however, describe distress experienced amongst her peers:

Yeah um... a few of the girls definitely had some very emotional evenings. Dealing with kids. Just not being able to like do what they thought was a proper dressing change and having kids in pain and uh, neglect with kids as well. So there was definitely a lot of distress amongst some of the girls.

Holly believed she was more mentally prepared than a lot of her colleagues and because of this, she was able to offer them support and when challenging things happened, talking about it afterwards seemed to help. Holly was fortunate to have peers to discuss her challenges with. Oftentimes, when there is a lack of opportunity for discussion, students can lose ethical competencies and increase the risk of moral distress (Palese et al., 2018). Holly also attributed her absence of moral distress to being situational. She stated, “I think I just happened to not experience that whereas I know like if I were to see a helpless child it would be completely different and I just didn’t see that.”

### **5.1.1 Lack of Resources**

In many healthcare contexts, professionals perceive a lack of human and material resources as a chief cause of ethical and moral challenges. Environments which are impaired by a lack of resources lead professionals to feel distressed due to the inability to provide care to a standard and quality that they would like and the feeling that patients are not receiving the care they have a right to (Rafaela & Margarida, 2015). Although participants in this study experienced moral distress as a result of insufficient resources, they also recognized the ingenuity of the people in “making do” and managing with what they had.

All participants identified poverty as a barrier to healthcare and a lack of resources as a barrier to healthcare delivery. Access was often based on the ability to pay for services and distinct differences between public and private sectors were identified. Participants also noted differences in asepsis, infection control, surgical procedures, end of life care, medical diagnostics, and the provision of oxygen and pain management practices. Similarly, Geale et al. (2015) found that students witnessed clinical issues and complications related to a lack of resources; however, while they attribute these challenges to an increase in cultural awareness and

cultural understanding, they fail to explore student perspectives, which may have led to findings of moral distress.

Like Holly, Rebecca also had previous experience traveling to an under-resourced country. In that way, Holly and Rebecca's stories were similar, but Rebecca's prior experience did not safeguard her from experiencing moral distress in her practicum. Rebecca's story revealed the greatest contrast between the beauty of the country and its people and the dirtiness and corruption that exists within it. She spoke of the challenges that came with being a woman, the rape culture, the pollution, and the lack of access to resources within the healthcare system. She spoke of doing the best you could with what you had, of investigating and figuring out how to do even the simplest nursing task with next to nothing.

...They had one sink...for the whole unit...and when you think about that...and it's not like in the most opportune place. And there's no paper towel. Or really any hand towels. So it's like you're kind of just waving your hands around drying them... And people don't, people don't wash their hands like they do here. Because it's just not, you're not able to.

She told me that despite all the challenges that arose due to a lack of resources, "There was a system and it worked. And it was broken but it worked." Akin to Rebecca's admiration of the resourcefulness of her Sri Lankan nurse colleagues, Chloe asserted: "...That's not to say that these people aren't resourceful. The resourcefulness of these [Nepali] nurses was incredible."

Rebecca expressed her feelings of moral distress related to a lack of resources openly: "Every two weeks, I would get really low, like depressed type. Because I just, my energy was just so sucked out." She described feeling burnt out and exhausted while trying to process everything that was happening. Not being able to give patients the medication they needed

because it wasn't available, seeing patients tied up in restraints for days, patients in pain with no relief, heavy workloads, and patients dying in front of her all contributed. This finding is mirrored in Silen and colleagues' (2016) study where they found that demanding and stressful working situations contributed to workplace distress. The consequences of these workplace conditions led to fatigue during leisure time, exhaustion and frustration. Although international placements are typically only a few weeks in duration, feelings of moral distress have the potential to affect nurses' ability to care for patients, causing feelings of negativity, discomfort, and burnout (Cohen & Erickson, 2006).

Chloe's story echoed the other participants' narratives regarding a lack of resources leading to feelings of distress. For her, a dirt-floored, blue-tarped hut will forever be etched in her mind—her experience with a young girl in labour and her new baby that was a product of sexual assault: “It was actually kind of...not traumatic but a big experience for me cause I had never seen anything like that before, but this nurse was like, ‘oh yeah, it happens all the time’ and went along with her day.” Chloe also spoke of her distress as a result of not being able to offer the kind of care she believed this young girl deserved, and the kind of care that would be given in Canada. She talked of the different standards that existed in Nepal compared to Canada.

Rachel's story also echoed the challenges that come with providing nursing care without sufficient resources:

We were doing our maternity rotation and there was a lady, they did a C-section and she ended up, her C-section, ended up coming apart so it got infected and the doctor came in to do her dressing change and while she had no money, so there was no, she got no pain meds and so the doctor had to clean it...and she just laid there and, in Africa, showing pain is such a...like you don't, as a woman you don't do it.

This experience was difficult for Rachel to handle. It was hard for her to watch because she knew that this wouldn't happen in Canada; if someone is in pain, they receive pain medication. But this wasn't the most challenging experience Rachel went through. Next, Rachel told me the story of one of her days spent helping with labours and deliveries. This story was a defining moment for Rachel as she watched a newborn baby take her last breath, all the while knowing that had this baby been born in Canada, she would have lived.

Over time, Rachel was able to navigate her distress by looking at the larger context of things. She went through cycles of anger, frustration, and helplessness throughout the process, but she has come to an understanding of why things are the way they are. Having open conversations with the Ugandan students gave her a better understanding of the complexity of it and helped her to process it. Being given the opportunity to talk to peers and colleagues about ethically difficult situations can be beneficial in managing distress (Silen et al., 2016). Although she still disagrees with how it happened, she managed to cope with it in a healthy way. She recognizes while this may not be acceptable in Canada, "there's nothing you can really do about it cause that's their normal."

Alexa had a similar experience in that she wanted to do something, she wanted to help but couldn't. She was frustrated with trying to provide care with limited resources and knowing that she wasn't making a difference for people.

Knowing that it didn't feel right...because we knew, I know that as a white woman in a lab coat going into those situations people look at you and they think "you're going to help me" or "you can do something". And we couldn't do *anything*. And like didn't have the resources to. So even if we gave someone a few days of paracetamol to numb the pain in their back, it wasn't helping. Really.



Eventually, Alexa took initiative to change the course of her international practicum. She was able to work through her distress and take on a more proactive approach. Alexa and her partner came up with the idea to design and carry out a community health promotion workshop. This way, the only resource they really needed was knowledge, and they knew this was something they had and something they could give to others.

Chantel experienced a great deal of distress during her international placement. While this distress was a result of an amalgamation of different things, it was largely a result of a lack of resources.

[It] was extremely challenging because if someone didn't have money, they couldn't get a service such as a CT scan or what not...So, there was a lot of experiences like that.

People going and selling property. Going and selling drugs. And we would learn that they were doing these things...because [they] don't have enough money to buy the medications or the, you know, the services that [they] need.

Chantel expressed that "the challenges were almost insurmountable at times." She described the medical overflow unit she worked on while at a public hospital in the Philippines, of the ethical problems, poor standard of care and having "nothing to work with." At times she felt she was having an out of body experience.

We knew this man was going to die...he wasn't wearing a helmet of course in the accident...and so in all of the mayhem, the family gets to sit there and use the bag valve, the family is asked to do that...it's the expectation...we had no mechanical ventilation for this man because this hospital, their ICU doesn't have the proper support for someone in this situation.

Chantel told me another story of two twins she took care of in the NICU. This experience was likewise a cause of her moral distress. These twins weren't medically stable enough to leave the NICU and definitely not stable enough to go home, however, while Chantel was off-shift, the mother had come and picked them up. She kept the son and gave the daughter away at the front door of the hospital. Maybe the mother took this action because she felt there was nothing that could be done—that the hospital did not have the resources to save her daughter—or maybe her actions were influenced by cultural factors.

### **5.1.2 Cultural Differences**

“International experiences are a means of exposing nursing students to cultural differences within environments where the dominant beliefs, values, attitudes, and behaviors are likely to be different than their own” (Murray, 2015, p. S65). Although it may seem obvious that these cultural variances could give way to moral distress, this has not yet been explored in the literature. Current literature has scrutinized the benefits of immersion in a new culture for nursing students, but has yet to add any evidence on cultural differences as a potential cause of distress. Participants in this study indicated that the distress they experienced was, in fact, due not only to a lack of resources in their new environment, but also as a result of culture.

Chloe's experiences of moral distress may be attributed to differences in cultural values. Her understanding of the events that occurred with the fourteen year old girl that gave birth were very different from how her Nepali nurse colleagues perceived the situation. While the Nepali nurses appeared to go about their day as if nothing had happened, Chloe was consumed by it. She found the cultural values and beliefs and that guides the care they provide very eye-opening.

Although I think I'm at peace with it now, my head still kind of goes to that question of like, why? My own values...my own values versus their values...It all came down to

cultural values and we weren't there to change that. That wasn't the purpose of our practicum. So, I had to come to peace with that.

The moral distress Alexa faced during her time in India was also related to differences in cultural beliefs and values. The treatment of women in India is very different from how women are regarded in Canada. What was obvious to Alexa was the clear power imbalance between genders. Women were malnourished because men and children were always fed first, they lacked access to knowledge, particularly surrounding women's health, and they were expected to be submissive. Inequality and oppression of women were similarly discussed as challenges experienced by several other participants.

Rachel's narrative demonstrates that the distress she endured was due to a lack of resources within Uganda's healthcare system, but cultural differences related to 'being a woman' also played a part. When the Ugandan medical team refused to provide any further lifesaving measures, Rachel and her classmate "tried whatever [they] could" and when they realized they couldn't do any more, they wrapped the baby up and held her until she took her last breath. The doctor told Rachel that he refused to intervene any further because he did not have the resources to do so, but also because "if she [had] any chance of survival she would have a hard life because it's Africa and she'd have some type of disability."

Rachel likewise discussed the concept of pain within Ugandan culture. The concept of pain and its expression are shaped by experience, learning and culture, and thus vary across cultures (Peacock & Patel, 2008). Rachel learnt that in Uganda, women are discouraged from verbally or visually expressing pain. Rebecca, too, witnessed a similar cultural value in Sri Lanka. Although they had some forms of pain control, it was rarely used: "And that's not to say that people weren't in pain...but it's not something that's heavily prescribed, it's expected that

you just man up. That concept that you just don't have pain." This can be a very foreign concept for a nursing student coming from Canada and is often difficult for students to see patients in extreme pain that could be prevented.

Chantel recalled maneuvering cultural differences relating to sex outside of marriage. Because Catholicism is such a large component of Filipino culture, someone who's unmarried and pregnant is often shunned and left with no support. She witnessed women who were completely alone during the birthing process and who were spoken about negatively in the delivery room. Although such behaviours may occur in a Canadian healthcare setting, they must not be tolerated as nurses should always provide care that is safe, compassionate, competent and ethical (CNA, 2017). These beliefs are not dominant in Canada as they are in the Philippines. This cultural difference was an uncomfortable experience for Chantel as she worked to provide the care she knew this woman deserved and is in line with the CNA Code of Ethics (2017) while also maintaining cultural respect.

Another cultural difference that resulted in moral distress for Chantel occurred as a result of attending a Tuli clinic. In the Philippines, it is a cultural practice for young boys to be circumcised, but sometimes not until they are age six or older. The clinic was held in a gymnasium-like setting with 50 or so stretchers. Donors provided funds for the medical supplies to perform the circumcisions free of charge. Chantel and her clinical group were given permission to attend. Many students, including Chantel, described this experience as traumatizing.

[We] get out of the van and all you hear is blood-curdling screaming going on because the team of doctors decided they were in a rush because things had fallen behind and were not letting the anesthetic set in. So it was *horrendous*. To the point where some of

the girls on the trip with me were crying, they were visually very distressed...I was having moral issues with it because I was witnessing mothers smacking the kids...one mother...got so mad and started punching the child...

For Chantel, a nursing student coming from Canada, this felt unethical. It is a practice heavily set in cultural beliefs and values predominant in the Philippines. These cultural differences, as well as differences in standards of care, made it unbearable for Chantel to watch. It challenged her ethical views, both as a nurse and an individual.

## **5.2 Developing the Personal and Professional Self**

The second theme is developing the personal and professional self, with subthemes of building the traits of a culturally competent, empathetic nurse and learning to provide nursing care with fewer resources. The literature tells us that international practica challenge students' established beliefs and perspectives, thus stimulating their cognitive and personal development (Button et al., 2005; Callister & Cox, 2006; Murray, 2015; Ruddock & Turner, 2007; Vaughn, 2015). Button and colleagues (2005) and Murray (2015) both identify personal development and transcultural adaptation as primary effects of international practica, while Coatsworth and colleagues (2017) also include growth in participant nursing capabilities as an outcome of international practica. The current study confirms existing findings related to personal and professional development, with an extended focus on how working with limited resources has transformed participants' current nursing practice.

It was clear from the nurses' stories that they benefited from their practicum experiences in both domains. This is evident in Rebecca's words:

There were so many opportunities that I was given and I will never forget that. I had to learn how to be independent in a different way in Sri Lanka and it taught me to be my

own nurse...My confidence and independence stems from being given the opportunity to flourish there.

Although participants may have been presented with substantial challenges throughout their time abroad, this was one of the many reasons it was worth it (Egenes, 2012; Geale et al., 2015; Murray, 2015). In the midst of adversity, momentous growth emerged. These participants developed the traits of culturally competent, empathetic nurses, learned to provide nursing care with few resources, and were able to process and work through their distress.

### **5.2.1 The Personal Self**

Murray (2015) found that students' experiences abroad increased their awareness of how other people live and helped them to grow as individuals. The most frequent comments had to do with having developed a greater appreciation for life in the United States and more compassion for others. Ruddock and Turner's (2007) findings also suggest personal growth in terms of "learning to relate to patients with empathy, respect and understanding as part of the process of adjusting to the host culture" (p. 365). Several participants in the current study described their own personal growth in a similar way.

For Chloe, personal growth was her favourite part of the whole experience. "Coming back and seeing the person I had become was my favourite part...It was really an experience that enabled me to grow and really changed the person that I am." Removing herself from the comfort zone of her own home, country, and way of being and immersing herself in somebody else's reality was an experience that enabled her to develop into the person that she is today. Several other participants also highlighted personal growth as a positive outcome of their experience. For Holly, her experience confirmed that she chose the right career path. Nursing

was never something she felt passionate about, but being able to practice nursing as a student in Namibia was the affirmation that she needed and what has made her who she is today.

Rachel describes her personal growth in terms of shaping her to be kinder to people. Although she believed she was a kind person prior to her international experience, the people of Uganda taught her a kindness and a friendliness that she didn't fully appreciate before. Chloe likewise learned lessons in kindness and community (Murray, 2015). An example of this was a story she told me about the cultural practice of teatime in Nepal:

Just sitting on the floor with the Nepali people, and just the community that it built. I absolutely loved that. And I actually tried to bring that back home. So, whenever I want to kind of ground myself or encourage the sense of community with the person I'm talking with, I make us tea.

Chloe came back and re-evaluated how she was living, the waste in her life, and how she could be living more presently. She started to make active intentions to restructure the way she does things and the way she cares for herself.

Rebecca talks about her personal growth as occurring once she had fully processed and worked through her moral distress. She remembers feeling like a new person. Being able to identify all the things that made her upset helped her to process and appreciate the things she has in her life. She ended up leaving an unhealthy relationship and diving into a career as a community health nurse. As a community health nurse you must be able to work independently and Rebecca credits much of this to her time spent in Sri Lanka.

Chantel learned valuable leadership skills as she stepped forward as a leader for her peers while in the Philippines. With many issues arising throughout their placement and a lack of institutional support, Chantel became that advocate and support for the rest of the group. Her age

and maturity may have designated her as a natural leader, but being in this new role advanced her leadership potential substantially (Button et al., 2005). This potential has become evident in both her personal and professional life.

### **5.2.2 The Professional Self**

All participants experienced professional growth on some level, which is consistent with existing literature (Callister & Cox, 2006; Murray, 2015; Sasso et al., 2016; Vaughn, 2015). Professional growth was discussed in terms of cultural awareness, cultural competence, resourcefulness, flexibility, relational practice and evidence-based practice. Participants have been able to not only develop these skills for themselves, but also reported being able to teach these skills to colleagues. Students in Murray's (2015) study also identified resourcefulness and flexibility as ways their experience helped them to develop as professional nurses. Participants also reported improved critical thinking and communication skills, specifically when asking patients about cultural practices and preferences (Murray, 2015; Vaughn, 2015).

Chantel described her international experience as having a significant impact on her professional career. Rebecca stated that this experience was when she really "found [her] own practice." Similarly, Alexa attributes her understanding of standards of practice and ethical nursing practice to her time spent in India, even if it was a bit of a struggle to get there.

This experience it really sort of...solidified who I felt I was as a nurse. I never really identified as a nurse prior to this experience. Umm...I never really wanted to be a nurse. But in [this] situation I really had to sort of go back to my nursing practice standards and review them and try and...incorporate what I was experiencing or understand what I was experiencing and what I was doing through the lens of the nursing standards. And so that, for me, was a really solidifying experience as a nurse...that personal-professional thing.



While Wojtowicz et al. (2013) found that students in that study did not want to pursue a career in mental health following their clinical rotation on inpatient psychiatric units due to experiences of moral distress, Alexa's experience confirmed her desire to be a nurse, even amid her distress.

**Building the traits of a culturally competent, empathetic nurse.** International practicum experiences were consistently described as having positive impacts on participants' abilities to provide culturally competent and empathetic care in their future nursing careers (Callister & Cox, 2006; Geale et al., 2015; Murray, 2015; Ruddock & Turner, 2007). All participants believe they learned lessons in cultural care during their time abroad that have allowed them to deliver nursing care that is culturally sensitive and appropriate. Cultural awareness and cultural competence is an essential skill for nurses in all clinical areas (CNA, 2017).

Cultural competency is best understood, not as an end goal, but as an ongoing process within nursing. Nursing theorist Campinha-Bacote (2002) defines cultural competence as being comprised of five constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Cultural desire is described as a nurse's motivation to want to engage in the process of becoming culturally skillful and aware and seeking cultural encounters (Campinha-Bacote, 2002). Each participant expressed some degree of cultural desire as their interest in learning about a new culture was an important motivational factor when deciding to participate in an international practicum.

The *Cultural Care Diversity and Universality Theory* formulated by Madeleine Leininger in the mid-1950s states that human caring is universal, though it varies amongst cultures (Leininger & McFarland, 2002). This philosophy is one of the oldest and most holistic theories of nursing and describes the need for development of cultural competence amongst healthcare

professionals. Developing cultural competence means preparing nurses to be compassionate, competent, responsible and effective in their service to people regardless of their cultural origins or circumstances (Leininger & McFarland, 2002).

Even though each participant now practices in a different care setting, they all recognize their international experience as a major contributor in developing this ever important nursing trait. Several participants commented that their experience is what pushed them to realize that no matter a person's country of origin, language, or culture, a universal language still exists among us. Holly mentioned this when she stated: "I think that maybe what I enjoyed most about it or learnt from it I think relates or translates into my practice. It's that you don't always need words or the same language to recognize when someone's in need." She goes on to say:

I think that just kind of goes like wherever you are, even it's like palliative and someone's passing or they've had a stroke and they can't get their words out, you know that they're looking for something, they need something. Whether it's for you to just talk to them or hold their hand. So that's probably one of the biggest sort of practice pieces for me.

Rebecca identified that aspects of nursing care in Sri Lanka varied from those in Canada, and she attributed this to being influenced by culture. She remarked on the different foci of her nursing education compared to those in Sri Lanka. She commented on her own school of nursing being very heavily focused on relational practice whereas in Sri Lanka, she noticed nurses were a lot more focused on physical skills with a physiological basis: "They're taught the nursing skills, like a physical skill whereas I was taught the skill and the whole encompassing person. So it just it...showed." I likewise noted this difference participating in my own international practicum. This discrepancy ultimately helped me to appreciate the significance of relational practice and

establishing rapport. Relational practice involves respect, trust and compassion delivered in a culturally safe manner. This kind of nursing goes beyond technical skills and practical expertise to value interpersonal connection, empathy, and caring (Fyers & Greenwood, 2016; Ruddock & Turner, 2007). Relational skills are likewise valuable in helping nurses to recognize and cope with moral distress, as well as other complexities and challenges of everyday nursing practice (Sasso et al., 2016).

Rebecca believes that in addition to relational skills and cultural competence, she was also able to cultivate empathy. She told me a story of an interaction she had with a particular patient in which she was able to exhibit compassion and caring: “This man was unconscious but when he woke up he remembered me. And he was telling everyone what I did and...all’s I did was hold his hand.” She went on to comment on how being immersed in a setting where cultural and language barriers were present encouraged her to develop these skills to a new degree.

Similar to Rebecca, Chloe attributed her practicum in Nepal to her ability to be cognizant of the way she communicates and builds rapport with her patients who have English as a second language. Being aware of cultural differences played a seminal role in Chloe’s experience as her practicum was focused on healthy sexuality. Because sex is considered a taboo subject in Nepal, part of her clinical group’s initial planning was assessing and establishing a strategy to gain community members’ trust. Chloe told me of the time they spent going into little areas of the town and doing free blood pressure clinics, offering tea, and conversing with the people. In a very short period of time, they were able to build a strong rapport with members of the community. From there, they were able to go out and disseminate knowledge on healthy practices in a way that maintained respect for the Nepali culture.

Alexa was another participant who discusses her professional development in terms of becoming more culturally competent. As a nursing student in India, Alexa gained an understanding of nursing frameworks, best practice standards and ethical standards in which to base her practice. She came to the realization that these may vary across cultures, and respecting others views and practices is key to providing safe and competent nursing care. This theme is consistent with the literature exploring the impact of international placements on nurses' professional lives. It has been argued that international placements stimulate students to incorporate a multicultural perspective into their practice upon return to their home country, further improving their nursing knowledge, practice and research capabilities (Button et al., 2005). Alexa frequently adopts a multicultural perspective in her practice today working in Indigenous health. In this practice setting there are a large number of ethical issues and she must ensure she interacts with communities in a respectful and supportive way. Alexa recognizes that she can't come to the table with all the answers: "I have a very small piece of knowledge and then communities also have a piece of knowledge and so it needs to be a collaboration."

**Learning to provide nursing care with fewer resources.** For some, the desire to gain clinical experience in an environment with less available resources was a motivation for participating in an international clinical placement. Chantel expressed her desire to take part in this type of experience as craving exposure to more critical and less-resourced environments.

...Being able to have to think on your feet and find resources that are alternative to traditional medical environments. So maybe less technology available to you, in my situation it was no running water, so sanitation, no electricity, trying to think on your feet quickly with emergencies. So just really wanting to get that critical thinking piece elevated early in my nursing schooling.

All participants credit their ability to be creative and innovative in their current practice to the experiences they had abroad. Participants likewise developed an increased sense of confidence when trying new ways of doing things and getting creative when access to clinical resources are not readily available. Not only did exposure to an under-resourced healthcare environment aid in the development of critical thinking skills required in nursing practice, but participants also stated it increased their awareness of available resources that were previously underappreciated. Rachel expressed that, “Returning to Canada made me realize just how fortunate we are to receive acetaminophen or ibuprofen or just not taking those things for granted and realizing that yeah, there are people in other parts of the world that don’t have access to that.” She also discussed being mindful of waste. Whether it means stopping and thinking twice about opening an extra package of something or just remembering that these supplies are limited in other countries, she works to use them appropriately and effectively.

While Rachel has identified these discrepancies between Canada and Uganda, she has also become attentive to their similarities. Rachel currently practices as a nurse in Northern Manitoba where she has compared clinical settings and circumstances to those in Uganda. She expressed to me the stark realization that she didn’t need to travel thousands of miles to see such poverty and lack of resources—there were definite resemblances between the two. Making this connection has allowed Rachel to remain cognizant of these circumstances not only so she can adapt her practice to provide the best possible care for her patients, but also to strive and work towards hope for the future.

### **5.3 Looking to the Future: Why it was Worth It**

The third theme is reflected in each participant’s words and motivation to tell their story. After telling me of hardships, challenges and distress, they all told me reasons it was worth it.

The participants' international experiences did not end the day they came home. They are experiences that will live with them forever, as nurses and as individuals. They live in the stories they tell. One participant revealed that it was a long road to process all of her distress and emotions, but ultimately she overcame it and is a better person because of it.

I've been able to take all those negative experiences, the ones that are fresh in my mind as individual experiences and sort of find a way to look at what, well what did I learn from that and how do I make this positive in my life? Or how do I apply it to my practice so that I'm actually benefiting from the experience versus it just weighing me down and sitting on my shelf there, you know? So...that's how I've kind of tried to work through it. She went on to reiterate that everything she now speaks of in a positive light took her a year or more to process and become okay with, but now that she has, she has been able to identify why the experience was really worth it in the end.

Several participants expressed that they do not necessarily wish to work in acute care forever and that their futures may include international work in some capacity, either as nurses or as nursing instructors. Literature suggests that faculty and clinical instructors must be culturally competent and increase the emphasis of cultural competence in their programs (Allen, 2010; Callister & Cox, 2006; Gallagher & Polanin, 2015; Gibbs & Culleiton, 2016; Mitchell, Del Fabbro & Shaw, 2017; Sloand, Bower & Groves, 2008). In this way, each of these participants would be highly capable of facilitating an international practicum. Not only do they have firsthand experience dealing with the challenges that are frequently faced, but they also have achieved a level of cultural competence that can't always be taught in a person's home country. Despite differences in location and culture, each participant gained knowledge that will prepare

them for diverse roles within nursing, whether that be locally or internationally. As Chloe stated, “I don’t think any doors are closed in nursing. There’s so many options that you can do.”

Reflecting on her experience, Rebecca believes that her confidence and independence stem from being given the opportunity to flourish in Sri Lanka: “There were so many opportunities that I was given and I will never forget that. The things I learned were so unique there too. And you learn to do things creatively as well. Like that you would never, that you don’t think about here because you have access to so much stuff.” Long-term benefits such as this may be magnified for all participants due to the length of their placements.

Literature on international clinical placements includes the discussion of long-term versus short-term placements. In this study, participants’ placements ranged from five weeks to three months. As the literature outlines short-term placements as one to four weeks in duration and long-term placements as four or more weeks in duration, all participants in this study can be said to have participated in a long-term placement. It has been reasoned that long-term (four or more weeks) placements are more influential because participants experience another culture for a longer period of time (Button et al., 2005). This may be attributed to the fact that it often takes up to two weeks for students to adjust to cultural differences in the host country before being receptive to the benefits of cultural immersion (Button et al., 2005).

International nursing practica were described by participants as experiences they will never forget. They will carry their unique experiences with them wherever they go, and whether they recognize it or not, many of their clinical judgements will be influenced by these experiences. Participants did endure many challenging experiences, but international practicum experiences were ultimately discussed as having positive outcomes beneficial to personal development and future nursing practice. Even so, literature shows that unpleasant experiences

are actually valuable to the professional progress of nursing students as they learn to accept differences in healthcare practices (Button et al., 2005). Looking to the future, benefits associated with international practica may be enhanced if schools of nursing can make revisions to how these placements are designed and executed.

#### **5.4 Threats to Preserving International Practicum Experiences for Future Generations**

Participant stories included the discussion of threats to the continuation of international practicum experiences for future generations of nursing students. These threats were largely related to a lack of university support throughout the practicum, which participants described as “floundering”. This finding is consistent with the literature that suggests that many institutions provide little or no meaningful preparation for students and do little to ensure their health and safety while they are abroad (Behrnd & Porzelt, 2012; Button et al., 2005; Imperato et al., 2016; Ruddock & Turner, 2007). These deficiencies can affect students, their foreign hosts, and sponsoring institutions. Students participating in clinical practica in under-resourced countries require the investment of considerable professional time and effort if they are to be successful and benefit from the experience (Imperato et al., 2016). Participants in this study discussed their university’s involvement and support before, during and after their practicum experience.

##### **5.4.1 Lack of Preparation**

All participants mentioned that they did not feel fully prepared to embark on their practicum. While Holly, Rebecca, and Alexa had previous travel experience to developing countries, Chantel had some previous travel experience, and Chloe and Rachel had never left the country. Participants discussed either having an interview or writing a paper describing their desire to participate in such a placement. This is both a necessary component and something the



participants' universities executed well. However, just because they seemed to be a good fit doesn't mean that they shouldn't have received adequate preparation beforehand.

Holly recalls reflecting on how unprepared her and her peers were for their practicum. Although Holly was able to jump in and go with the flow, she recognized that many others struggled with this. Holly went on to discuss the need for more group meetings prior to leaving in order to get a good idea of their group dynamic, setting and nursing responsibilities. This could be achieved through a series of meetings to review objectives, expectations, and give students an idea of what to expect (e.g. opportunities to talk with others who have participated in international practica).

In a study of ensuring the health, safety and preparedness of United States medical students participating in overseas electives in a resource-poor country, Imperato and colleagues (2016) outline five areas that must be addressed in preparing students for their overseas elective in a resource-poor country. They include: health preparations and precautions for participants, issues concerning travel and lodging, the general nature of the host country's healthcare and public health systems, specifics about the assignment site, and characteristics of the host country culture. The program provides extensive preparatory measures to assure the health and safety of its students while overseas (Imperato et al., 2016). Although this study sampled medical students, the findings could be translated to fit the needs of nursing students. Holly believes this preparation would "help you prepare so that you can support yourself and support others that are having a harder time."

Rachel reflected on similar experiences related to a lack of preparation, but unlike Holly, Rachel never had the chance to meet the rest of her group members before arriving in Uganda. This lack of team building eventually led to conflict between members while abroad. Although

the conflict was resolved, this contributed to Rachel's overall feeling of lack of support from her college. She expressed that she wished the program could have been set up in a more supportive way. Although there is some evidence to show that the degree of preparation impacts a student's international experience, more research must be done to expand on this subject (Button et al., 2005; Imperato, 2016). It is important that evidence-based strategies be developed in order for students to be successful.

#### **5.4.2 Lack of Support While Abroad**

Not all participants had faculty from their home university accompanying them on their placement abroad. It may be of importance to note that those participants who did have faculty travel and stay with them often reported more positive experiences. Alexa commented that her experience would have been enhanced had a preceptor accompanied her and her classmate. Because they were both mature students who had been to India before and "knew what [they] were getting into," they ended up being okay. Alexa went on to mention that if someone didn't have that same previous experience, she doesn't think it would have gone very well.

Chantel, who did have nursing instructors accompany her group abroad, had an issue with the relations between her instructors and the host country's faculty.

The big hurdle we had was that those relationships weren't very strong so trust and rapport was not there. So we found things very challenging because there was a lot of disorganization, poor communication, and you felt a little bit unsafe or kind of just dragged around in a sense?

Words such as 'floundering,' 'dragged around,' 'figure it out on our own,' and 'left to the dust' were commonly used across participants' stories to describe how they felt over the course of their practicum. Similar to Chantel, Holly had a couple nursing instructors who came on the trip,

but also felt a lack of support from them: “So I spent three and a half weeks on that floor. And I was, I saw a teacher once. So, it was very self-directed.” Nursing schools make a huge commitment when they administer an international practicum: “Schools are required to establish relationships with institutions in the receiving country, send academic staff with the students, and accept the additional financial burden this imposes” (Geale et al., 2015, p. 97). In order for the benefits to outweigh the risks, nursing schools and their faculty must be prepared so that their students can too.

Several participants expressed that they either didn’t have opportunities to debrief during their time abroad or did not have them frequently. These participants likewise commented on the idea that having support, debriefing and reflecting on their experiences throughout their practicum would have also benefited them long after their practicum ended. Instead of letting reactions and emotions build, students would be able to deal with things they saw or had to do. Suggestions were to achieve this through formal or informal end-of-day discussions or journaling. Participants’ ideas were similar to ideas proposed in the literature. Sasso et al. (2016) suggest discussion and debriefing groups as a potentially useful strategy to promote individual reflection within an academic setting, while Callister and Cox (2006) recommend meditative writing as a valuable strategy to aid in the development of critical thinking skills.

An advantage of Alexa’s program was that although not present, her instructors back home were responsive to her needs and concerns through email. When the course of her placement took a turn during her time abroad, she sought assistance from her faculty. Alexa’s narrative described her distress that stemmed from the community project that made up her practicum, and how she took a proactive approach to steer away from further exposure to

distressing incidents. Alexa was able to take initiative and change the outline of her placement with consultation from her instructors.

Once we had finished that workshop and did a few other things, we agreed with our professors back in Ottawa that we had sort of met all of the objectives that we were supposed to meet during our preceptorship? And so we actually ended up leaving a little bit early...because there was nothing that we could have continued to do that would have felt...that we would have felt right doing.

If Alexa had faculty accompany her on her practicum, she may have experienced less distress related to these events because she wouldn't have had to continue doing what she was uncomfortable doing for such a long period of time. She wouldn't have had to wait for responses from her instructor via phone or email because they would have been there to provide direction and support immediately.

Rachel, Chantel and Rebecca all experienced considerable miscommunication among their colleges. This created an additional stressor for them while trying to adjust to a foreign environment. Rebecca communicated with her college strictly through email except on one occasion to resolve an incident. Looking back on it, she believes that communicating via some sort of audio, whether that is in-person, by phone, or by video chat would help to avoid misinterpretations that can be made when you don't have facial expressions or tone of voice to aid in clear communication.

### **5.4.3 Lack of Support Returning Home**

None of the participants received a formal debrief at the end of their practicum. Chloe spoke for all participants when she said, "The period of reintegration after this huge, life-changing experience, I didn't feel so supported." Similarly, Holly felt her college of nursing "just

didn't really seem to care." All participants agreed that there should be a debriefing that occurs immediately upon return home in order to fully process what they went through. Because her university did not offer such a resource, Chantel turned to other outlets to work through her distress. This included seeking professional counselling, consulting with her nurse mentor, and talking with classmates who were also on the trip. Rachel, by contrast, wished she had been able to attend counselling, but did not know where to seek this support when she returned home.

Chloe recalled her lack of support upon returning home very clearly. Because her practicum ended just as summer was beginning, she had two and a half months to herself, surrounded by people who hadn't been in Nepal with her and who hadn't experienced all the things she had. Chloe felt she could talk about her experience to some friends and family, but only to a certain extent. She didn't feel she could be as detailed and reflective on her experience as she wanted to be. The need for formal debriefing within the nursing college is again highlighted here.

#### **5.4.4 Future Suggestions and Implications**

Five out of six of the participants went to different universities across Canada. All participants stated that the university they attended no longer offers international practicum options to students. Alexa, Holly, and Chantel all shared that their clinical group was the last to have this type of experience and their program has not had international clinical placements since. In reflecting on this reality, all participants expressed the value of participating in an international practicum and their disappointment that future generations may not have the same opportunity they did.

Rachel explained that "I know we're working on getting ourselves to be independent and independent nurses but... I don't know...there's a certain amount of support and guidance I

think that needs to happen, especially within international borders.” Why should nursing students receive more support completing practica in their home country than in a foreign country? To many participants, this doesn’t seem fair. They are seeking this opportunity to grow not only their clinical skills, but also to be exposed to a new environment which offers them lessons in cultural awareness, cultural competence, language skills, interpersonal skills, as well as exposure to a new healthcare system. Exposing Canadian nurses to a different healthcare system not only allows them to share knowledge with their host country, but through this they are able to teach their peers, re-evaluate current practice, and create positive change within Canadian healthcare. If we are to continue seeing evidence of these positive outcomes, we must make changes to the way international practica are executed.

Future suggestions for international practica were discussed in terms of selection, preparation and debriefing. Selection for an international practicum could include consideration of the students’ year in the program, motivation, and intellectual and emotional abilities to meet the demands of the practicum (Imperato et al., 2016). While most participants went on their practicum in third or fourth year, one participant went in her second year, and was also accompanied by first year nursing students from her university. In general, it might be more beneficial to offer this type of placement in a student’s final year of study as they not only have significantly more nursing knowledge, but may also have a higher level of maturity, coping skills, and conflict resolution skills. In their quantitative study, Sinclair et al. (2016) found that stress levels were greatest for nursing students in their second year of study, possibly due to engaging in more clinical practice but not having yet learnt skills to address stressors inherent in nursing.

Another factor which was discussed to improve future practica experiences was accompaniment by nursing faculty. This was noted in my earlier discussion of students' lack of support while abroad. All participants, whether they were accompanied or not, believe it is beneficial to have faculty from their university travel to the host country with them. In implementing future international practica, all participants alluded to this being valuable for the outcome of positive learning experiences. No existing research has investigated the impact of this influence on international student experiences.

Participants discussed improving international practica through a more extensive preparation period. Several participants stated they wish they felt more prepared going into the experience. They suggested that groups meet more than three times prior to departure to establish and build relationships, learn about the host country language and culture, and create strategies for conflict resolution and dealing with culture shock and other stressors. Icebreaker activities, looking at photos, giving presentations, practicing simple words and phrases, trying different foods, and even organizing a group Skype call with faculty from the host country's university were all ideas presented to alleviate nervousness and have a successful practicum experience.

### **5.5 Summary of Findings**

Shared themes were identified throughout participants' transcripts and narratives. These themes were established with the goal of understanding participants' experiences and their effects on individuals' current nursing practice, exploring potential occurrences of moral distress, and validating their stories. While each participant traveled to a different country, they shared many similar experiences. These experiences were connected and categorized into four different themes which aided in making sense of participants' stories. They were also scrutinized

alongside existing literature in order to substantiate current evidence as well as challenge and add to it.

The participants collectively reported that although incidents occurred which challenged their morals and were distressing to them, they all perceived their practicum to be positive experiences in which they grew personally and professionally. A number of studies reviewed similarly reported an overall positive experience in the realms of personal and professional development as well as enhanced cultural competency (Egenes, 2012; Geale et al., 2015; Vaughn, 2015). Throughout the participants' stories, examples of moral distress were evident, even if participants did not label them as such. Each participant reflected on how they are able to use their experiences abroad in their role as a nurse today, and how it has taught them to be resourceful and innovative. Throughout the interviews it became obvious that participants were dissatisfied and frustrated with the lack of preparation, involvement, and support from their universities. It is essential not to underestimate this influence on their experience, especially as they process and work through their distress.

It is evident across the participants' stories that their practica were characterized by both positive and negative experiences occurring as a result of cultural immersion, moral distress, and exploring a country that is unlike Canada. Though it may have taken more time for some, each participant was able to work through and overcome their distress in their own way. As each participant revealed that they have come to fully process their distress, they are now able to reflect on their individual experiences through a positive lens.

At the end of the initial interviews, participants were eager to know what others experiences were. Were they similar to their own? Did they also witness things they wished they hadn't? How did they overcome this? Their eagerness to have their experiences validated and



feel connected to others who went through the same process tells me that sharing their story was impactful. They didn't want to be silent; they felt they had a story to tell. It was evident that participants found these experiences valuable and would like future nursing students to have the same opportunity they did—only they want it to be better.

Each nurse developed various new skills and competencies, including moral knowledge. Examining the many different ways of knowing and types of knowledge within nursing, it is evident that moral knowledge is not only based in theoretical knowledge, but it is also instinctual. Moral knowledge can be defined as knowing and implementing a combination of moral values and principles (Sarvimäki, 1995). The past moral distress experienced by these participants has ultimately fostered moral growth as they have found the courage to process their distress and move forward to find meaning in their practice. These experiences will continue to shape each participant's practice throughout their nursing journey.

## CHAPTER 6: DISCUSSION

The results of the study are discussed below in terms of significance, limitations, implications, communication, and recommendations for future research. This study sought to understand the experiences of nursing students who complete practica in under-resourced countries and the impact these experiences have had on their personal and professional lives. The findings offered in this chapter both echo and extend the existing literature.

As I reflected across the six different stories I am reminded of the courage of these nurses, both in their narratives and in coming forth and sharing them with me. I observed similarities and patterns within the narratives related to acts, activities, meanings, participation, relationships, and settings. While each participant's story was distinct, there were points of convergence which allowed me to establish themes. These themes capture important evidence related to the research question and have allowed me to theorize the significance of these patterns and their implications (Braun & Clarke, 2006).

### 6.1 Through a Narrative Inquiry Lens

The narrative accounts in Chapter 4 are told within the three-dimensional narrative inquiry space: temporality, sociality and place. Participants' stories are told with a beginning, middle and end (temporality), they occur in relation to other people and to oneself (sociality), and the experience happened somewhere (spatiality or place) (McAllister, 2001). As a narrative inquirer, I considered the multiple and complex interactions between these three narrative dimensions (Clandinin, 2013). In terms of temporality, this relates to the participants' descriptions relating to preparing for the practicum, actually arriving and being immersed in a new country and culture, and then finally heading home. It likewise relates to the evolution of the participants' moral distress. While for some this was more of a gradual process, for others it happened quite quickly. In terms of sociality, participants described their relationships with their

instructors, other students on the trip, and nurses in the host country. Ultimately these relationships either helped or hindered their experiences in general, as well as helped or hindered their ability to process and cope with their distress. If we look at spatiality, or the place in which the story occurred, there is a connection across each story related to immersion in a new and under-resourced environment.

As I reflected on these ideas, I recognized that these dimensions were largely what impacted and shaped each individual experience. The *restorying* of participants' stories was based on my understanding and interpretation of these elements. In restorying, I likewise added rich detail and made casual links to both identify themes and provide a fuller narrative. By highlighting meaningful experiences and interactions, I was able to deeply explore and begin to interpret the meaning international practicum experiences hold for nurses in the past, present and future.

## **6.2 Research Significance**

Feelings of moral distress are long-lasting (Cohen & Erickson, 2006; Rafaela & Margarida, 2015; Sasso et al., 2016; Wojtowicz et al., 2014). Working to manage moral distress through effective preparation and end-of-experience debriefing is crucial when considering international clinical practica in nursing. Giving participants the opportunity to voice their experiences through story will serve to benefit current nursing students, practicing nurses and nurse educators. Clandinin and Connelly's (2000) framework for narrative inquiry has the potential to shine a light on moral distress in nursing from a different angle, giving new insights into a person's experience. By capturing these narratives and exploring the themes within them, new knowledge can be generated. To be able to share the experience of a challenging subject

such as moral distress will allow nurses to gain a better understanding of their encounters with moral distress.

The stories presented in Chapter 4 are the negotiated narrative accounts of participants in this study. These stories build the foundation to explore how nursing students exist in under-resourced environments, both within a nursing and non-nursing context. The themes developed from the six nurses' accounts reveal how nursing institutions and their educators can implement more effective international practica in the future. If nurse educators are able to understand the root causes of distress, they may be able to make these practica safer and more valuable. We are able to travel back in time alongside them to begin to appreciate what participants experienced and *how* they experienced it. We see how they navigated situations unique to being immersed in a new culture and an under-resourced healthcare system.

### **6.3 Research Strengths and Limitations**

A narrative inquiry with thematic analysis was chosen to collect rich data to support the research purpose. This approach is well-suited to healthcare research and nursing research in particular as it focuses its analysis on the individual experience. Although not considered a limitation, narrative inquiry is exploratory and interpretative, therefore the findings are not generalizable (Lindholm et al., 2002). Likewise, narrative inquiry does not follow a step-by-step account and procedure for data collection, analysis, and interpretation, so the approach taken by every narrative inquirer may differ (Clandinin & Connelly, 2000; Clandinin, 2007). For this reason, the repetition and interpretation of narrative inquiry work is much more difficult and results may not be the same even the research process is replicated in precisely the same fashion. Narrative inquirers recognize that studies are a single glimpse in time and space that will change over time, so results may not be the same over time (Clandinin, 2007).

In adhering to the philosophical belief that reality is dynamic and constantly in flux, narrative inquiry is considered an interpretive methodology (Dewey, 1980). The narrative inquirer uses their *a priori* knowledge and understanding as motivation to extend or gain new insights and cannot bracket their *a priori* knowledge (Clandinin, 2007; Riessman, 2008). Stories were co-constructed through conversational exchanges with the participants, which follows a constructivist philosophy. Consequently, my own perspectives and experiences informed the analysis and helped to shape the co-created narratives (Clandinin & Connelly, 2000).

A limitation of the study was that practicing nurses were asked to report on international nursing student practicum experiences ranging from 0-10 years ago. Depending on the length of time that had passed, individuals may have had a less vivid recollection of specific details of their practica; however, the way they were impacted by their experiences was so powerful that these memories will likely always remain with them in some way. It is also possible that the effects of age, individual student personalities, and learning styles which contribute to learning and coping mechanisms may have influenced the telling of narratives, and therefore influenced the conclusions that were drawn. Additionally, it may have been difficult to make comparisons across contexts in which participants had their experiences as different countries have their own cultural, professional and educational characteristics.

As all participants in the study were female, this may also be a limitation of the study. Each participant alluded to what it felt like to be a woman in their host country and many discussed experiences they had in the context of gender inequality. The experiences of male students in these countries would likely be very different and could provide a distinct perspective on various situations. Due to the fact that females make up the large majority of students in

nursing school programs (approximately 90%), the likelihood of obtaining any male participants was inherently low.

#### **6.4 Implications**

In 2018, the Canadian Nurses Association (CNA) added cultural competence and cultural safety as core competencies (CNA, 2019). This reiterates the duty we have as nurses to exhibit cultural competence and safety in our own practice and instill it in our students. International practica experiences are seen as having numerous benefits for nursing students. Therefore, if schools of nursing are offering such opportunities, they play an influential role in fostering the development of culturally competent nurses who are leaders in their field. These nurses will have a greater knowledge of global health and development and providing care across language, cultural, and resource barriers (Callister & Cox, 2006; Vaughn, 2015). Although the focus of this study was on the experiences nursing students have while completing practica in under-resourced countries, its implications may also be relevant for current and future nurse educators to inform their students about the benefits and challenges of such a learning strategy.

#### **6.5 Research Communication**

Knowledge translation is a crucial step in the research process and, within nursing, serves to improve health at the individual, community, and global level (Titler, 2018). This study will be submitted in partial fulfillment of my Masters of Nursing degree at the University of Saskatchewan. The findings will later be submitted for publication in one of the following online nursing journals: *Journal of Transcultural Nursing*, *Nurse Educator*, *Journal of Nursing Education*, *Nurse Education Today*, *Qualitative Health Research*, *Nursing Education Perspectives*, *Teaching and Learning in Nursing*, or *Nursing Education in Practice*. The findings are appropriate for submission in the above journals as the current research findings have direct

implications for the delivery of culturally appropriate healthcare and for the education of nursing students who will provide that care. A summary of the findings will also be shared via email with all individuals who participated in the study as well as with nurse colleagues through presentations at professional conferences or upon request.

The findings of this project may aid in developing, sharing, and using the research findings to improve the well-being of nurses and nursing students. This research has the potential to not only increase awareness of moral distress within nursing but also to influence how international nursing practica are delivered in the future. It is crucial that nurses have access to findings so they can gain knowledge on what moral distress is and be conscious of the detrimental effects it can have. With increased awareness, it is hoped that moral distress can be more readily identified and strategies to help students work through this distress be employed.

### **6.6 Recommendations for Future Research**

The substantial amount of literature on moral distress means that it is well-defined; however, moral distress in the context of nursing student practicums in under-resourced countries must be further developed. Understanding student experiences of moral distress through narratives will allow nursing programs to acknowledge the effects this distress has had on students, and encourage them to work towards improvement. Expanding the nursing body of knowledge on moral distress is essential for educating future nurses to manage distress in the workplace as well as providing culturally competent care.

The current study provided insight into how appropriate preparation and debriefing may aid in effective coping strategies. Its findings may be beneficial in that they may open up the potential for new possibilities in nursing research and to begin thinking differently about international nursing practica and experiences of moral distress within nursing (Clandinin, 2007).

Although the findings of the study are consistent with the existing literature, there are still gaps that remain, mostly related to confirming and extending current findings. While this study offered some insight into experiences nursing students have when participating in international practica in under-resourced countries, there is still progress that needs to be made on this subject. This research has provided awareness into how a follow-up study may better investigate these questions in the future.

Future research should focus on expanding the current nursing body of knowledge surrounding international practica while evaluating in greater depth the effects of moral distress on students practicing in under-resourced countries. This may be done by conducting research on a larger sample size or conducting an online survey for nurses and nursing students.

Alternatively, it would be of interest to explore how nurses who experienced moral distress in an under-resourced country now experience moral distress in their current workplace. Has their previous experience made them more resilient to moral distress? What do they do to manage existing or new moral distress in their practice? This research would help to inform how this distress may be prevented and managed. Additional research on the same topic using a different methodology may also be of value to strengthen current findings.

### **6.7 Future Considerations**

Students who take part in international nursing placements to under-resourced countries require adequate preparation, support, and debriefing. Imperato and colleagues (2016) report that schools of medicine wishing to send students on international placements must be prepared to create an administrative structure to assure the preparedness, health, and safety of its participants. They go on to report that failure to recruit qualified professionals who are able to oversee such placements could result in serious consequences for both their students and themselves (Imperato



et al., 2016). This is congruent to the administrative structure also required by schools of nursing. Schools of nursing must ensure a well-designed program and recruit educators who are knowledgeable, accountable, and well-suited to support students participating in clinical placements in under-resourced countries.

Part of the preparation and support required for nursing students includes education on managing culture shock and moral distress. Although there is an abundance of learning that occurs as a result of being immersed in a foreign healthcare system, students can only fully benefit from all there is to learn if they are able to effectively manage these feelings. In this section, recommendations for the delivery of international nursing practica are given, including considerations for preparation, support and debriefing. Educational strategies for teaching nursing students about moral distress, moral strength, and making moral decisions are also outlined with suggested use of potential models and frameworks.

### **6.7.1 Adequate Preparation**

If we are to see international nursing practica into the future, appropriate changes must be made so that nursing students are adequately prepared to embark on such a placement.

“Preparing selected students for a global health experience overseas is an extensive and arduous process” (Imperato et al., 2016, p. 444). All six participants in the present study stated they did not feel their institution adequately prepared them for their international experience, and five of the six participants attended different schools of nursing. Extending these findings, several participants commented that their schools no longer offer such placements. They expressed their disappointment that future students will not have the same opportunity they had.

In terms of recommendations for future educational strategies for the implementation of international nursing practica, after a strategic selection process, selected students should take

part in a rigorous pre-departure preparation. Due to their already intense workload, this pre-departure preparation should be integrated into their programs and graded for credit toward their degree. This would reduce their workload and enable them to focus on their upcoming immersion experience.

### **6.7.2 Support During the Placement**

During the practicum itself, it is advised that faculty or personnel from the university travel with students; however, if this is not possible, frequent video calls for discussion and support should occur. Faculty who facilitate the experience should be aware of the potential for and continually screen for moral distress in students, encourage discussion around it, and provide strategies for coping with distressing events. After returning home, students should participate in several in-person group meetings and have opportunities to meet with faculty on an individual basis if they desire. Resources for professional support and counselling services should be available and students should be given the opportunity to provide feedback about their experience, perhaps through an online questionnaire. Additionally, presentations to classmates who didn't attend the practicum may be helpful for others to understand the objectives of the experience, as well as gain cultural awareness.

### **6.7.3 Further Suggestions- Schools and Workplaces**

In the present study, almost all participants mentioned strategies necessary for a successful experience in an under-resourced country. This included clear objectives, adequate group preparation, traveling with a nurse mentor or faculty member, role clarity, end-of-day discussions, written reflections, and formal debriefings upon return home. Thinking back to my own experience, I would make similar suggestions. I would argue that there are many aspects that must change if international practica are to exist into the future. Schools of nursing must

become accountable and recognize existing flaws if they are to offer and execute successful international practica in years to come.

There is also a need to refine evidence-based debriefing strategies for students and nurses. Within schools and workplaces, moral distress should be continually addressed and discussion on the topic should be encouraged. Modules and self-quizzes on moral distress could be helpful tools for nursing students and employees upon starting a clinical placement or during the hiring process, as well as workshops and activities that teach how to build moral strength. If nurses can identify their moral values and build moral strength, resilience and courage, this will assist them in navigating moral distress in practice (Hubbauer, 2015). Additionally, resources must be readily available for students and employees.

The climate of the workplace is a critical factor in making moral decisions. Nurses may feel they are powerless to resolve moral dilemmas, which may lead to moral distress. Having the ability to recognize when you or a colleague is experiencing a moral dilemma is essential in constructively managing the dilemma and preventing moral distress. Additionally, nurses may fear punishment, alienation or other consequences if they question authority in a hierarchical setting (Cohen & Erickson, 2006). Workplaces must create environments that enhance clinical collaboration, reward nurses who are supportive team players, and offer opportunities for ethics education and dialogue. In practice, nurse leaders should create time for employees to share their experiences and how these experiences made them feel. In bedside nursing practice we rarely have time to discuss the relational side of nursing practice. Creating space for this discussion could help to foster feelings of belonging, empowerment and courage.

#### **6.7.4 Moral Distress Models and Frameworks**

When addressing moral distress, contextual factors such as cultural beliefs, organizational policies, and available resources must be taken into consideration. It is important that students and nurses are provided with guidance to acquire the information necessary to help them process their distress. I suggest nursing-specific models for debriefing be used because key aspects of nursing practice such as concepts of caring and relational knowledge must be included. A universal tool that can be taught in nursing school would give students a framework to base their moral decisions on and direct their course of action when experiencing distress.

A potential model was developed by Purlillo (2005) for nurses to analyze and resolve ethical problems in clinical situations. It includes a six-step process: (1) assess, (2) identify the ethical problem, (3) analyze the problem, (4) explore the options, (5) implement the action, and (6) evaluate the process outcome. This model can be utilized once nurses or nursing students recognize an ethical dilemma or moral distress and are motivated to take action; however, students must have background knowledge on ethical principles and major ethical theories from which to base their ethical decisions and understand the root cause of their distress (Cohen & Erickson, 2006). In addition to teaching nursing-specific ethical principles and theories, nurse educators should teach students about ethical decision-making using clinical case studies to learn this process.

Another model which can be used to address moral distress in nursing practice is the *American Association of Critical Care Nurses (AACN) 4 A's* (McCue, 2010). Although originally designed for use in the critical care setting, it is adaptable and applicable for use across diverse nursing settings. The 4 A's are: ASK, AFFIRM, ASSESS, and ACT. The first step involves asking yourself whether what you're feeling is, in fact, moral distress; what are your symptoms? The second step relates to affirming your feelings about the situation; try to figure

out what aspect of your moral integrity is being threatened. Third is to assess for the source of distress; think about what you believe is “right,” what is currently being done, who is involved, and if you’re ready to act. The fourth and final step involves making a plan of action and getting prepared to implement it. Attention to moral distress is vital to ensure quality patient outcomes as well as mental health and wellbeing amongst nurses and nursing students. The *AACN’s 4A’s* framework provides educators and professionals with a useful tool to help reduce moral distress. If educators are aware of and familiar with such a tool, they can provide nursing students with a means for addressing potential distress (McCue, 2010).

In this Chapter, a discussion of the significance, limitations, implications, and communication of the study was given along with recommendations for future research. Moral distress models and frameworks were suggested for use in schools of nursing, as well as strategies for nurses working in the clinical setting. These frameworks are critical in assisting nursing students to make ethical decisions and work through their distress, but they are not proactive approaches. Perhaps the most fundamental difference we can make in nursing students’ experiences with moral distress is the environment it happens in. We must create and foster environments for students to feel comfortable sharing experiences that are aren’t so comfortable. Making moral decisions is difficult, but coming forward and asking for help shouldn’t be.

## CHAPTER 7: CONCLUSION

This study sought to understand the experiences of nursing students who take part in international practica in under-resourced countries and how this has impacted their personal and professional lives. The results of this study support existing research that has been published on international nursing student practica as being a useful strategy for nursing education. It extends the current literature to add a focus on students' experiences of moral distress. Nurses must be aware of moral distress in order to articulate it and cope with it effectively. These nurses were able to appreciate the positive aspects of their experiences, which ultimately helped them to overcome the many challenges they faced.

The present study indicated that nursing students are often underprepared to embark on international practica and as a result may experience consequences that may be preventable. Five out of six participants stated they were morally distressed either by something they witnessed or participated in. For four of these five participants, this distress followed them home where it took time to process and overcome. Nonetheless, all six of these individuals have gone on to lead successful careers in nursing despite this distress. They all benefited from their experience in some way and are grateful to have been given the opportunity.

Exposing nursing students to differences in culture, language, and healthcare systems is not guaranteed to produce more knowledgeable, culturally competent, empathetic nurses, but it is guaranteed to challenge them—and when they're challenged, they usually grow. It's often difficult to put into words an experience such as this—an experience that has undoubtedly changed us in some way or another. As Rebecca so eloquently said: "I feel like there's a lot of stuff that people don't know that I did or what it was like because you come back and it's like, 'how was your trip?' And it's like well, it wasn't really a trip, it was an experience. And they're like, 'well what did you do, how was it?' And how do you say all of it in a small piece?"

## **EPILOGUE: BRINGING IT HOME**

The stories in this thesis are not static and unchanging—each participant continues to live within them (Hubbauer, 2015). These stories weren't easy stories to tell. It took a lot of courage for these individuals to open up and share them with me and I will forever be grateful for that. I set out to explore nurses who may have had similar experiences as I did. I wanted to validate their stories and let them know that their story is important. While some of the participants had an easier time talking about what they went through, they all contributed valuable information. Listening, reading, analyzing, and reflecting has been an emotional endeavour. Since the end of this study I have thought often about the stories they told, of their bravery and perseverance. Looking to the future, I hope that these individuals can continue to tell their story. I hope for the advancement of international nursing student practica. I hope for nursing research that makes a difference, and that this difference starts where nursing begins—with our students.

There are a lot of things I brought home with me, and not all of them fit into a suitcase. This experience was bigger than that. Like tiny grains of sand that made their way into my bag, I left with countless memories, lessons and understandings—some of which I anticipated and others which I did not. When you go to the grocery store you don't always bring home what you expect to. I think this holds true for an international placement. You don't know what you're going to bring back, but I can tell you it'll be worth it.

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**Department of Graduate and Postdoctoral Studies,  
College of Nursing  
University of Saskatchewan**



**NURSES NEEDED FOR  
RESEARCH IN INTERNATIONAL PRACTICUM  
EXPERIENCES**

I am looking for volunteers to take part in a study of  
*Canadian Baccalaureate Nursing Student Experiences in Under-Resourced  
Countries*

As a participant in this study, you will be asked to tell a story about your  
experience(s) as a nursing student in an under-resourced country and how  
it has influenced your current nursing practice.

Your participation will involve two approximately 60 minute Skype  
interviews in April-June 2019. All information provided will be kept  
confidential.

In appreciation for your time, you will receive  
a \$10 Starbucks Gift Card.

For more information about this study, or to volunteer for this study,  
please contact:

Misha Sojonky  
College of Nursing  
Email: [misha.sojonky@usask.ca](mailto:misha.sojonky@usask.ca)

**This study has been approved by the Human Behavioural Research Ethics  
Board, University of Saskatchewan.**



Appendix B  
Demographic Form



**Study Title: Bringing it Home: Canadian Baccalaureate Nursing Student Experiences in Under-Resourced Countries**

Date: \_\_\_\_\_

**Participant**

Age: \_\_\_\_\_ (years)

Name of University Attended: \_\_\_\_\_

Country/City of International Placement: \_\_\_\_\_

Year of International Placement: \_\_\_\_\_

Duration of International Placement: \_\_\_\_\_

Current Employment Status: \_\_\_\_\_

Appendix C  
Conversation Guide

Your real name will not appear in any of the reports or presentations associated with the study, instead, a pseudonym (fake name) will be used. The only place your real name appears is on the consent form and that will be stored in a locked cabinet, separate from all other study materials.

Pseudonym: \_\_\_\_\_

Hi there,

My name is Misha and I am a graduate student at the University of Saskatchewan. Thank you for agreeing to talk with me today. I would like to remind your participation is voluntary and you may choose not to answer certain questions or to withdraw from the study at any time without explanation. Our conversation will last for about an hour. Is that okay for you? If you would like a break at any time, please let me know.

There are no 'right' or 'wrong' answers to the questions that I am going to ask. I am interested in learning about the experiences nursing students have while completing practica in under-resourced countries. I hope that by learning about these experiences, I can help inform nurse educators to understand students' international practicum experiences.

I am recording our interview so that I can transcribe what we talk about. The recording will be destroyed at the end of the study.

**Questions:**

- What drove you to want to take part in an international placement as part of your nursing education?
  
- What was it like living in \_\_\_\_? (Prompts: What do you remember most vividly? What did you like about living there? What were the challenges living in \_\_\_\_?)
  
- What was it like nursing in a new healthcare system? (Prompts: How was it different from Canada? What stood out for you? What were some of the challenges?)

- Think back to a memorable experience or experiences you had while completing your practicum in \_\_\_? Tell me a story about this experience. (Prompts: What were you thinking? How did you feel?)
- Did you feel supported by your university (professor, faculty, mentor) during your time abroad?
- What supports do you think should be in place for undergraduate students who participate in international practica? (Prompts: Prior to leaving Canada? During the practicum? After the practicum?)
- Did your international practicum affect you personally? If yes, how?
- Did your international practicum affect your nursing practice? If yes, how?
- Have you ever heard of the term moral distress?
- Did you think you experienced moral distress as a student nurse in \_\_\_\_\_?
- Is there anything you would like to ask me?
- Do you have anything to add?
- What has it been like for you to participate in this research interview?

## Appendix D

### Consent Form



### *Participant Consent Form*

**You are invited to participate in a research study entitled:** Bringing it Home: Canadian Baccalaureate Nursing Student Experiences in Under-Resourced Countries

**Researcher(s):** Misha Sojonky, Graduate Student, College of Nursing, University of Saskatchewan, Email: misha.sojonky@usask.ca

**Supervisor:** Dr. Diane Campbell, College of Nursing, diane.campbell@usask.ca

#### **Purpose(s) and Objective(s) of the Research:**

The purpose of this study is to understand the experiences of registered nurses' as undergraduate students participating in international practica in under-resourced countries. Secondary purposes are to explore moral distress related to these experiences and the perceived effects on participants' current nursing practice. Their stories will provide insights for nurse educators that may help to improve students' experiences.

#### **Procedures:**

- Participants will be asked to tell a story about their international practicum in an online (Skype) interview. Participants will be encouraged to refer to journals, photographs, or other souvenirs from their international experiences prior to or during the interview.
- The initial interview will be about 60 minutes long. It will be audio-recorded and transcribed for analysis. The researcher will transcribe the recordings with the use of Apple Dictation software.
- After the interview, I will summarize our conversation and send the summary to you to read.
- During a follow-up interview, which will be about 60 minutes, participants can add to or clarify their story.
- Participants may request to have the recording device turned off at any time without giving a reason.

#### **Potential Risks:**

- There are no known or anticipated risks to you by participating in this research.
- There may be some discomfort in answering questions related to challenging past experiences you may have had.

- I am here to support you in a sensitive and caring manner. If you feel uncomfortable answering any questions, you have the option to pass on the question.
- Contact information for confidential counseling services from providers within your city will be offered to you should you feel distressed following the interview(s). This includes the Nurses' Employee Assistance Program offered by the Government of Canada which is free, confidential, and offered 24/7/365. The contact information for this service varies by province and will be provided to you during your first interview.

### **Potential Benefits:**

- There are no direct benefits participating in this research.
- Some participants may feel positive about being in a study that aims to improve students' international placement experiences.
- This study will add to existing research on experiences nursing students have while completing international placements and may lead the way for new standards of international practica in nursing programs.
- Participants will receive a \$10 Starbucks gift card after completing the first interview to thank them for their time. Participants will still receive the gift certificate even if they withdraw during the first interview.

### **Confidentiality:**

- Participation is voluntary and you are free to withdraw from the research project at any time without penalty.
- Data will not contain any personal identifiers and will only be linked to you by a pseudonym.
- Any identifying information (i.e., consent forms and master list) will be stored separately from the data. The master list will be destroyed when data collection is complete and is no longer required.
- Findings from this research project has the potential to be published in professional journals or presented at conferences. The data will be reported in aggregate form, so that it will not be possible to identify individuals. Moreover, the consent forms will be stored separately from the materials used, so that it will not be possible to associate a name with any given set of responses. All identifying information will be redacted from demographic forms.
- **Storage of Data:**
  - Electronic data will be stored on a work computer in the Principal Investigator's office at the University of Saskatchewan, Regina campus. This computer is password-protected and files will be encrypted.
  - Data will be retained for five years as per University of Saskatchewan Guidelines.
  - When the data is no longer required, it will be destroyed. All data obtained electronically will be permanently deleted.

### **Right to Withdraw:**



- Your participation is voluntary and you may opt not to answer any question or withdraw from the study at any time, without explanation or penalty of any sort. If you withdraw, your data will remain anonymous in the study or may be deleted at your request.
- Your right to withdraw data from the study will apply until data has been pooled (three months from entry into the study). After this date, it is possible that some form of research dissemination will have already occurred and it may not be possible to withdraw your data.

**Follow up:**

- To obtain results from the study, please email myself at the email address listed above.

This research project has been approved by the University of Saskatchewan Human Behavioural Research Ethics Board. Any questions regarding your rights as a participant may be addressed to the Research Ethics Office by email: [ethics.office@usask.ca](mailto:ethics.office@usask.ca) or phone: (306) 966-2975. Out of town participants may call toll free at (888) 966-2975.

Your signature below indicates that you have read and understood the description provided; I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the research project. A copy of this Consent Form has been given to me for my records.

Verbal consent will be obtained at the initiation of each interview.

<i>Name of Participant</i>	<i>Signature</i>	<i>Date</i>
<i>Researcher's Signature</i>	<i>Date</i>	

***A copy of this consent will be provided to you and a copy will be retained by the researcher.***

## Appendix E

### List of Acceptable Countries

#### World Bank Country Classifications, 2018

Source: <https://datahelpdesk.worldbank.org/knowledgebase/articles/906519>

Low Income Countries (\$1,000 tuition)			
Afghanistan	Ethiopia	Mali	Syrian Arab Republic
Benin	Gambia, The	Mozambique	Tajikistan
Burkina Faso	Guinea	Nepal	Tanzania
Burundi	Guinea-Bissau	Niger	Togo
Central African Republic	Haiti	Rwanda	Uganda
Chad	Korea, Dem. People's Rep.	Senegal	Yemen, Rep.
Comoros	Liberia	Sierra Leone	Zimbabwe
Congo, Dem. Rep	Madagascar	Somalia	
Eritrea	Malawi	South Sudan	

Middle Income Countries (\$1,500 tuition)					
Albania	China	Guatemala	Macedonia, FYR	Papua New Guinea	Timor-Leste
Algeria	Colombia	Guyana	Malaysia	Paraguay	Tonga
American Samoa	Congo, Rep.	Honduras	Maldives	Peru	Tunisia
Angola	Costa Rica	India	Marshall Islands	Philippines	Turkey
Armenia	Côte d'Ivoire	Indonesia	Mauritania	Romania	Turkmenistan
Azerbaijan	Cuba	Iran, Islamic Rep.	Mauritius	Russian Federation	Tuvalu
Bangladesh	Djibouti	Iraq	Mexico	Samoa	Ukraine
Belarus	Dominica	Jamaica	Micronesia, Fed. Sts.	São Tomé and Príncipe	Uzbekistan
Belize	Dominican Republic	Jordan	Moldova	Serbia	Vanuatu
Bhutan	Ecuador	Kazakhstan	Mongolia	Solomon Islands	Venezuela, RB
Bolivia	Egypt, Arab Rep.	Kenya	Montenegro	South Africa	Vietnam
Bosnia and Herzegovina	El Salvador	Kiribati	Morocco	Sri Lanka	West Bank and Gaza
Botswana	Equatorial Guinea	Kosovo	Myanmar	St. Lucia	Zambia
Brazil	Fiji	Kyrgyz Republic	Namibia	St. Vincent and the Grenadines	
Bulgaria	Gabon	Lao PDR	Nauru	Sudan	
Cabo Verde	Georgia	Lebanon	Nicaragua	Suriname	
Cambodia	Ghana	Lesotho	Nigeria	Swaziland	
Cameroon	Grenada	Libya	Pakistan	Thailand	

High Income Countries (\$2,000 tuition)					
Andorra	Cayman Islands	Gibraltar	Latvia	Panama	St. Martin (French part)
Antigua and Barbuda	Channel Islands	Greece	Liechtenstein	Poland	Sweden
Argentina	Chile	Greenland	Lithuania	Portugal	Switzerland
Aruba	Curaçao	Guam	Luxembourg	Puerto Rico	Taiwan, China
Australia	Croatia	Hong Kong SAR, China	Macao SAR, China	Qatar	Trinidad and Tobago
Austria	Cyprus	Hungary	Malta	San Marino	Turks and Caicos Islands
Bahamas, The	Czech Republic	Iceland	Monaco	Saudi Arabia	United Arab Emirates
Bahrain	Denmark	Ireland	Netherlands	Seychelles	United Kingdom
Barbados	Estonia	Isle of Man	New Caledonia	Singapore	United States
Belgium	Faroe Islands	Israel	New Zealand	Sint Maarten (Dutch part)	Uruguay
Bermuda	Finland	Italy	Northern Mariana Islands	Slovak Republic	Virgin Islands (U.S.)
British Virgin Islands	France	Japan	Norway	Slovenia	
Brunei Darussalam	French Polynesia	Korea, Rep.	Oman	Spain	
Canada	Germany	Kuwait	Palau	St. Kitts and Nevis	