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SAN BEDA UNIVERSITY

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San Beda University, a Catholic educational institution, is committed to the Christian formation of the Bedan Community as its service to the Church, the Philippine society, and the world.

VISION

San Beda University envisions a Community that is:

Fully Human
Wholly Christian
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Knowledge (Scientia)
Virtue (Virtus)

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Study
Community
Pursuit of Peace

EDITORIAL

Where is caring in our nursing curriculum?

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Caring has long been claimed as one of the essences of various professional disciplines, aptly called helping professions, that directly improve the quality of human lives. Prominent among these helping professions are health-related disciplines, including Nursing, Medicine, Psychology, and other allied health disciplines. But caring is also present in other disciplines that are not within the health professions but are part of the helping profession, such as Education and Social Work. Although it is pervasively present and is asserted to be central to these various disciplines, it seems not apparent in the curriculum and not deliberately expressed as part of the disciplines' terminal graduate attributes.

Take the discipline of Nursing and the context of the Philippines as an example. Albeit caring has been asserted as the nursing's unifying domain (Leininger, 1988), primordial construct and consciousness (Ray, 2010), and its essence (Watson, 1985), it is not pronounced in the current version of the Philippine nursing curriculum nor any of the curriculum's past iterations. Deeper scrutiny of the present curriculum shows that caring is not evident nor explicitly expressed in the program outcome. The most prominent mention of caring in the current curriculum is the title of the courses offered for the degree program. How a concept that is considered the core of nursing and one of the elements of its disciplinary focus, the other being human health experience, be inadvertently overlooked in the curriculum is still a mystery. If caring was not deliberately considered or unintentionally left out in crafting the curriculum, its foundation might be resting on weak grounds. Caring as one element of the disciplinary focus of nursing orient future nurses to the unique disciplinary perspective of Nursing and the specific role nursing has in society. A professional discipline whose curriculum is not grounded on its essence is in danger of creating practitioners lacking a full grasp of their unique disciplinary knowledge and at risk of expressing knowledge borrowed from other disciplines as if it were their own. A curriculum like this is susceptible to produce nurses who could practice the skill of a nurse but cannot identify how it is to be a nurse, a nurse whose skills might be exceptional but whose sense of professional self is lacking.

Besides the seeming lack of grounding in caring in the nursing curriculum, caring is not explored in depth in most nursing courses. Despite the assertion that humans are innately caring, the knowledge of caring as expressed in nursing is not genetically transmitted. The expression of nursing knowledge as caring needs to be deliberately taught. Still, there seems to be a lack of focus on effectively educating future nurses on the nature, processes, and expressions of caring in nursing. If the tradition of letting student nurses learn caring only through incidental

experiences in the clinical area will continue, this will add to the persistent dissolution of the uniqueness of nursing as a discipline and the fragmentation of the nurses' professional identity.

Although the current context presents the gap that needs to be filled, it also presents itself as an invitation to reflect on the intended trajectory of the curriculum. There is always the opportunity to revisit and upgrade our curriculum to ground it in caring as one of its foundational philosophies, a move that entails accepting what has been done in the past and moving forward with the learnings of such experience.

When we persistently deny that there are concerns about the curriculum we believe is perfect, we are doing a great disservice to our discipline and its future practitioners.

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RUDOLF CYMORR KIRBY P. MARTINEZ, PhD, MA, RN
Editor-in-Chief

ORIGINAL RESEARCH

Nurses' Awareness, Perceived Knowledge, Attitude Towards and Barriers in Evidence-Based Practice (EBP)

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Abstract

Background: Evidence-based practice (EBP) is one strategy that enables clinicians to succeed in handling emerging literature, and integrating it to achieve high-quality patient outcomes. Although beneficial and innovative it is not considered a priority by many. Most nurses have little, if any, exposure to the clinical research process.

Purpose: This study aimed to conduct a baseline assessment of perceived knowledge, attitude toward EBP, and barriers to adopting EBP in nursing.

Methods: The study used a descriptive cross-sectional quantitative design. A convenient sample of 406 nurses participated and completed the EBP questionnaire. For ethical clearance, granted approval from Hospitals' Research Ethics Committee and to HAU-IRB.

Results: Nurses (n = 156, 38.4%) believes that EBP holistically is composed of patient data and preference, healthcare professionals' skills, and research findings. They (n = 256, 63%) have a positive attitude towards EBP and are willing to accept new healthcare strategies based on research. But expresses less confidence (M = 3.90, SD = 0.64) in identifying clinical issues/problems and translate these into a well-crafted clinical question. They perceived themselves to possess moderate levels of skills to undertake different EBP activities (M = 3.76, SD = 0.61). Knowledge ($x(4) = 12.174$, $p = 0.02$), attitudes toward EBP ($U = 13947.5$, $p = 0.04$) were significantly better among nurses who had previous EBP training. Similarly, respondents with EBP-related training are more confident in integrating EBP into their practice ($U = 13408$, $p = 0.01$).

Conclusion: Nurses' highest level of education and years of clinical experience affects their implementation skills in adopting EBP. The study reflected the benefits of training, continuing education, and length of experience in the acquisition of skills. Findings can serve as a basis for developing programs to improve nurses' knowledge and attitudes towards EBP. Nurse administrators can create policies that address barriers identified in the study.

Keywords: *Knowledge, Attitude, Barriers, Evidence-Based Practice (EBP)*

Introduction

In the past decade, there has been an exponential growth of information, a wealth of knowledge, and experience particularly in the improvement of healthcare (Cabrita et al., 2014). Providing the highest quality treatment is at the core of the healthcare delivery system that is dependent upon nurses (Mitchell et al., 2012). In the clinical setting, nurses need to fortify the profession and one of the strategies for doing so is the utilization of derived findings through the conduct of research (Castro-Palaganas, 2017). Nurses, who mostly spend a lot of time with their clients at the bedside, are the major contributors to the delivery of care. The quality care nurses provide makes a vital difference in the patient's overall health. As a profession, nursing is responsible for the quality and improvement of its practice (Slatyer et al., 2016). To enhance the standards of care, nursing professionals have to work at shifting to a different view to encompass an improved patient's preferences, clinical state, and circumstances.

In the present time, clinicians, both the novice and expert, are expected to utilize the best available research evidence for the most effective interventions to ensure improvement in healthcare. Evidence-based nursing is one strategy that may enable future clinicians to succeed in handling the emerging new literature and advancement of technology, which may ultimately result in high-quality patient outcomes (Melnyk et al., 2017). Evidence-based practice (EBP) is the meticulous, categorical, and prudent use of up-to-date finest research evidence in making a sound clinical judgment for the wellness of the patient, integrating the nurses' clinical expertise with the data obtained from systematic research (Sackett, 1997). EBP to the literature improves patient safety, optimizes care, and minimizes healthcare expenditures (Lavin et al., 2015; Melnyk et al., 2016).

Health care is one of the most vibrant human disciplines. As technology progresses, innovative and improved medicines, medical equipment, devices, and procedures are invented. These advancements in technology and processes are to support doctors, clinicians, and other healthcare practitioners to produce the best healthcare and treatment. EBP is one method that can potentially contribute to improved handling of clinical issues and provide enhanced patient outcomes through research. It advances from the incorporation of the finest research with clinical expertise (Sackett et al., 2000). EBP shifts the practice among providers of healthcare from a traditional prominence of seniority and authoritative opinions to an accent on data extracted from prior research

evidence studies. According to Melnyk et al. (2016), nurses' clinical practices based on research improve the quality of patient care, as equated to old-style clinical practices.

Traditionally, clinicians have been credited with nursing expertise in providing care, this is according to their practice including effective clinical decision making (Hamric et al., 2013). Expertise influences nurses' judgment, when nurses refine both theoretical and practical knowledge in actual situations, it increases the improvement in the delivery of care (Benner, 1984). However, experience is necessary but not a sufficient condition for proficiency, and not all experienced nurses are expert hospital practitioners (Svavarsdóttir et al., 2015). Benner (1984), also noted that several years in practice might create competence; but the passage of time and occurrence of events and interactions does not automatically confer adeptness. It may provide fluidity and flexibility but not the complex reflexive thinking that has been hypothesized to be an important component of good clinical decision-making (Croskerry, 2015). Hassankhani et al. (2018), found that nurses with more experience reported performing more intricate functions than those with less experience.

On the other hand, education also influences expertise, it is when theoretical concepts are combined with practical knowledge and apply it in the actual setting (Chinn, & Kramer, 2013). Although didactic learning alone cannot generate mastery in the nursing practice, evidence from prior smaller-scale studies showed that an individual nurse's level of education and years of experience are directly related to performance (Downar et al., 2017). With their sound educational foundation, it expedites the acquisition of skills through experience (Benner, 1984). Theory and principles enable nurses to hone in the ability to ask the right questions on patient problems to provide safe care and make good clinical decisions. Critical thinking enables nurses to meet the needs of patients within their context, considering their preferences, resulting in a higher quality of care (Groves, 2014). Moreover, critical decision-making can also be affected by age, and the highest level of education (Wood, 2017; Shapiro, & Stefkovich, 2016).

Although EBP is beneficial and innovative it is not considered a priority. Most nurses have little if any, exposure to the nursing research process, despite the expected advantages (Swenson-Britt, & Berndt, 2013). Various factors have made it challenging for nurses to integrate EBP into practice and barriers to utilizing current research evidence are still rampant. Mostly, they do not recognize the concept of the term EBP or how to incorporate it into the clinical setting (Schaefer, & Welton, 2018). It is difficult for professionals to utilize new, decontextualized, explicit knowledge in their daily work practice (Kristensen et al. 2015; Melnyk et al., 2016). Nurses will often rely on established know-how of routines even when decisions to adopt methods are available (Kristensen et al., 2015).

In the history of Philippine nursing evolution, initiatives, and efforts to strengthen the nursing profession were started long ago. It is inextricably linked to the foundation of the Philippine Nurses Association, nonetheless, the journey with EBP has much yet to be done. Authors in the Philippines like Borromeo and Castro-Palaganas believe that nurses "can learn from the exemplary leadership

practices and behaviors that helped her succeed to bring Philippine nursing out of the dark." Fortifying nurses and the profession entails an understanding of our roots, and this historiography provides "the unique perspective and context that spurred Anastacia Giron-Tupas to become an agent of change" (Castro-Palaganas, 2017; Borromeo, 2017). Numerous descriptive, exploratory studies have been conducted on nurses' awareness and attitudes related to EBP (Ammouri et al., 2014; Rojjanasrirat, & Rice, 2017; Schaefer, & Welton, 2018). The majority of these studies were done in North America, Europe, and other Western developed countries. There are only a few studies that could be found for Southeast Asia, which is why there is a need to put focus on a different perspective of the world with its own work culture and environment. Therefore, the purpose of this study is to conduct a baseline assessment of nurses' awareness, knowledge, attitude toward EBP, and factors that are likely to encourage or create barriers to EBP.

Methodology

Research Design, Participants, and Sampling Technique

This study used a descriptive cross-sectional quantitative research design while convenience sampling was used, as all nurses were invited. The inclusion criteria were as follows: registered nurses, assigned in different areas/units, working in a government or private hospitals in Pampanga, a province in the Central Luzon region of the Philippines were qualified to participate.

Sample Size Computation

Using G* Power version 3.1.9.2, the total sample size needed to compare differences between three groups (e.g. in terms of highest educational attainment) that would yield an effect size of 0.25 and power of 0.95 at a 0.05 level of significance is 252.

Research Instrument

The EBP questionnaire developed by Majid et al. (2011) was reviewed for content validity by a team of experts; comprising information studies lecturers, nursing managers, nurse researchers, and registered nurses (Beaton et al., 2000; Afrasiabifar et al., 2006; Acquadro et al., 2008). The questionnaire is divided into three sections. The first section collects demographic information about the participants, the second section seeks information about their attitudes toward and knowledge of EBP, which also includes motivators and barriers to adopting EBP. The third section of the questionnaire solicited responses related to information sources used by nurses for patient care and clinical decision-making. Information was also collected about search features they used for literature searching as well as their knowledge of Boolean and proximity operators. To assess the nurses' database searching skills, a hypothetical topic was given to them along with five possible search statements. They were expected to pick the most appropriate search statement for the given topic.

Data Collection Procedure

The study asked permission to use the EBP survey questionnaire developed by Majid et al. (2011) and from the participating institutions for the data collection. A cover letter about the study and a consent form was attached with the questionnaires. All registered nurses were asked to participate. Copies of the self-administered survey questionnaire were supplied to nursing managers of all units in the participating hospitals as well as in the nurse's station. The nursing managers were personally briefed about the purpose and procedure of the study and were asked to distribute copies of the questionnaire to all nurses working in their respective units who agreed to participate. Nurses were requested to drop their completed questionnaires into a sealed survey collection box, placed at the nurses' stations. To be convenient for nurses and to improve the response rate, 1 survey collection box was placed in each unit. After a week there was a follow-up to the nursing unit to check the response rate of the nurses. Then these boxes were collected at the end of the data collection period after two weeks.

Ethical Consideration

Before the data collection, the manuscript was subjected to ethical clearances; submitted to the Hospitals' Research Ethics Committee for ethical clearance and HAU-IRB.
Attached with the survey questionnaires is an explanation and rationale for the study together with informed consent. Discussing the direction on how to complete the survey form and describing how it will protect their identifications and maintain utmost confidentiality if they decided to participate. To capture the demographic data age and sex were the only personal information needed.

Data Analysis

Quantitative data were analyzed using IBM statistical software version 23. The characteristics of the sample were presented using descriptive statistics and the following (Chi-Square, Kruskal Wallis H Test, Mann Whitney) were tested for the significant differences in the participants' responses.

Results

Four hundred six (*n* = 406) nurses participated in this study. The majority of the respondents (*n* =241, 59.4%) are aged 26-30 years old, most of them are females (n = 273, 67.2%) and one hundred thirty-three of them (32.8%) were males. More than half of the nurses, (*n* = 230, 56.7%) are employed in a government hospital and one hundred seventy-six (43.3%) are working in private hospitals. In addition, two hundred twenty-eight (56.2%) of them are assigned in the ward and the

rest are from different specialty units. Almost all, (*n* = 392, 96.6%), have a bachelor's degree and the rest (3.4%) have master's degrees. Two hundred fifty-four (62.6%) have 5 years of clinical experience, while 122 (30%) have more than 5 to 10 years of clinical experience. The majority (*n* = 299, 73.6%) reported that they had not participated in any specific training on EBP inpatient care.

Table 1. EBP Characteristics of the Participants (n = 406)

Variable	*n* (%)	Mean (*SD*)
Attitude and Knowledge of EBP		
EBP is the combined composition of the following: Patient's subjective and objective data, Previous experiences of health care professionals, Research findings and Patient's value/ Preference	156 (38)	
Attitude towards EBP: I prefer using more traditional methods instead of changing to new approaches.	256 (63)	
Most research articles are not relevant to my daily practice.	222 (55)	
My workload is too high to keep up to date with all new pieces of evidence.	181 (45)	
Self-efficacy of EBP skills		
Identify clinical issues/problems.		3.90 (0.64)
Relate research findings to his/her clinical practice and point out similarities and differences.		3.87 (0.71)
Apply an intervention based on the most applicable evidence		3.86 (0.63)
Barriers to adopting EBP		
Insufficient resources (e.g., equipment, materials) to implement EBP	277 (68)	
Insufficient time at the workplace to implement changes in their current practice.	252 (62)	
Difficulty in finding time at the workplace to search for and read research articles and reports.	244 (60	
Supporting factors in adopting EBP		
Nursing management who embraces EBP		4.11 (0.80)
Given adequate training in EBP		4.20 (0.81)
Given protected time to conduct EBP		4.13 (0.77)
Access to a system for comprehensive literature searching		4.11 (0.78)
Mentoring by respondents who have adequate EBP experience		4.19 (0.81)
Desired areas of EBP training		
Understanding what is EBP		4.25 (0.71)
Identifying clinical issues for implementing EBP		4.18 (0.68)
Implementing recommendations to practice		4.15 (0.76)
Understanding research and statistical terms and methods		4.17 (0.77)

Variable	*n* (%)	Mean (*SD*)
Use of information resources and literature searching skills		
Print information sources		3.32 (0.88)
Electronic information sources		3.33 (1.02)
Human information sources		3.57 (0.91)

EBP holistically is the composition of patients' subjective, objective data and preferences, previous experiences of health care professionals, and research findings, Table 1 shows that 156 (38.4%) of the nurses perceived that. Respondents (disagree, *n* = 188, 46%; strongly disagree, *n* = 68, 17%) when combined, a total of 256 nurses contradict the use of traditional approaches when compared to new patient care practices. In addition, one hundred seventy-six (43%) "disagree" and forty-six (11%) "strongly disagree", a total of two hundred twenty-two nurses (55%) do not believe that research articles they encounter did not apply to their daily clinical practices. Respondents (*n* = 181, 45%), “agree” (*n* = 142, 35%) and “strongly agree” (*n* = 41, 10%), believes that due to heavy workload, they could not maintain updated with all new research evidence.

Regarding their skills in recognizing possible clinical issues, respondents felt they possess a slightly above average capacity to recognize clinical problems, which yielded (*M* = 3.90, *SD* = 0.64). Then decreased when relating research findings to clinical practice (*M* = 3.87, *SD* = 0.71), followed by the application of intervention based on the most applicable evidence.

For the barriers, one hundred ninety-six (48.3%) ‘‘agreed’’ and eighty-one (20%) "strongly agreed", when combined (277, 68.3%) nurses believed that the major barrier to the adoption of EBP was insufficient resources. Followed by 252 (62.1%) nurses who believed that insufficient time at their workplace to apply changes in their existing practice, one hundred ninety-two “agreed” (47.3%) and sixty “strongly agreed” (14.8%). And a total of 244 (60.1%) (“agreed”, *n* = 189, 46.6%; “strongly agreed”, *n* = 55, 13.5%) nurses reported struggling in allotting time at work to search for and read research articles.

The provision of providing adequate training in EBP has the highest mean score of 4.20 (*SD* = 0.81) and is closely followed by mentoring by respondents who have adequate EBP experience (*M* = 4.19, *SD* = 0.81). Another supporting factor is the convenience of a protected time to understand and apply EBP (*M* = 4.13, *SD* = 0.77). This is then followed by the support from their nursing management (*M* = 4.11, *SD* = 0.80) and the availability of a system capable of searching comprehensive literature with the same mean scores of 4.11, (*SD* = 0.78).

The most important training respondents identified is ‘‘understanding what is EBP’’ with a mean score of 4.25, (*SD* = 0.71). This is succeeded by recognizing clinical issues or problems for integrating EBP with a mean score of 4.18, (*SD* = 0.68) and closely followed by “understanding research and statistical terms” (*M* = 4.17, *SD* = 0.77) and “implementing recommendations to

practice" (*M* = 4. 15, *SD* = 0.76).

To determine the overall popularity of different types of information sources, the combined mean scores for printed, electronic, and human sources were calculated. The use of human sources for getting nursing care information was prominent with a mean score of 3.57, (SD = 0.91). Subsequent is the use of electronic information sources (M = 3.33, SD = 1.02), and closely followed by print information sources with a mean score of 3.32, (SD = 0.88).

Table 2. Correlation and Comparison of variables as perceived by the participants (n=406)

Variable	Highest educational attainment	Length of Clinical Experience	Previous Training related to EBP
Perceived knowledge of EBP			
Pearson Chi-Square	5.661	22.012	12.174
df	4	20	4
p value	0.23	0.34	0.02
Beliefs and attitudes toward EBP			
I prefer using more traditional methods instead of changing to new approaches.			
Kruskal Wallis H Test	0.033	3.877	
df	1	5	
p value	0.86	0.57	
Mann-Whitney U Test			13947.5
p value			0.04
Self-efficacy of EBP skills			
Identify clinical issues/problems.			
Kruskal Wallis H Test	0.260	11.016	
df	1	5	
p value	0.61	0.051	
Mann-Whitney U Test			13395
p value			0.003
Conduct online searches (using databases and web search engines).			
Kruskal Wallis H Test	6.289	4.384	
df	1	5	
p value	0.01	0.50	
Mann-Whitney U Test			13627
p value			0.02
Barriers to adopting EBP			
Insufficient time at the workplace to implement changes in their current practice.			
Kruskal Wallis H Test	3.919	3.943	
df	1	5	

Variable	Highest educational attainment	Length of Clinical Experience	Previous Training related to EBP
p value	0.048	0.56	
Mann-Whitney U Test			13542
p value			0.02
Inability to implement recommendations of research studies into clinical practice.			
Kruskal Wallis H Test	6.462	3.543	
df	1	5	
p value	0.01	0.62	
Mann-Whitney U Test			12850
p value			0.002
Supporting factors in adopting EBP			
Nursing management who embraces EBP			
Kruskal Wallis H Test	1.267	14.824	
df	1	5	
p value	0.26	0.01	
Mann-Whitney U Test			14018.5
p value			0.046

Respondents' perceived knowledge of EBP, when associated with their highest educational attainment $x(4) = 5.661$, $p = 0.23$, showed that there was no statistically significant finding. Similar to their length of clinical experience $x(20) = 22.012$, $p = 0.34$, it also yielded a none statistical significant finding when associated with their EBP knowledge. However, when their perceived knowledge of EBP was linked to previous training related to EBP $x(4) = 12.174$, p-value = 0.02, it resulted in a statistically significant finding.

There were also no significant differences were found between overall beliefs and attitudes toward EBP and respondents' highest educational attainment, length of clinical experience, and previous training, except in the respondents' preference to use "more traditional practices instead of adapting to new methods" which showed statistically significant difference when compared according to previous training related to EBP ($U = 13947.5$, $p = 0.04$).

Same with their self-efficacy in EBP skills which also generated a significant finding on the respondents' ability to identify clinical issues ($U = 13395$, $p = 0.003$) when linked to previous EBP training. There was also a significant finding when compared between the respondents' highest educational attainment $\chi^2(1) = 6.289$, $p = 0.01$ and previous training related to EBP ($U = 13627$, $p = 0.02$) when compared with their online searches (using databases and web search engines).

Furtherly, there was also a significant finding when compared between respondents' identified barriers to adopting EBP, particularly in terms of the respondents' insufficient time at the

workplace to implement change in current practice when compared to the respondents' highest educational attainment $\chi^2(1) = 3.919$, $p = 0.048$ and previous training related to EBP ($U = 13542$, $p = 0.02$). Same with the inability to implement recommendations of research studies into clinical practice when compared to their highest educational attainment $\chi^2(1) = 6.462$, $p = 0.01$ and previous training related to EBP ($U = 12850$, $p = 0.002$)

For the supporting factors, specifically nursing management who embraces EBP when compared with the length of clinical experience $\chi^2(5) = 14.824$, $p = 0.01$, generated a significant relationship. Respondents with (5 - <10 Years) of clinical experience had the highest score. The previous training related to EBP also yielded a statistically significant finding ($U = 14018.5$, $p = 0.046$), those with a master's degree had a higher score.

Discussion

The results showed that the majority of the nurses have a positive attitude toward EBP, similar to previous studies by Stokke et al. (2014); Majid et al. (2011). According to Stokke et al. (2014) attitudes towards and implementation of EBP are influenced by education and competence building, accessible resources, providing ample time, and availability of EBP mentors who support nurses in implementing evidence-based practice. Furtherly, the data revealed that respondents were willing to accept new healthcare strategies based on research and not overly dedicated to traditional techniques. Nurses who have knowledge and competence in EBP, access to resources, and experience support have more belief in evidence-based practice.

However, respondents showed less confidence in their skills to adequately express identified clinical issues/problems and translate these into a well-crafted clinical question (Mohsen et al., 2016). Stokke et al. (2014) suggested that every nurse should at least understand the purpose and process of EBP to be able to ask relevant clinical questions.

In addition, participating respondents perceived that they possess moderate levels of ability to perform different EBP activities. Nurses should know and follow the steps in EBP, and each nurse should be able to adjust his/her practice based on valid and relevant current research (Stokke et al., 2014). According to Melnyk et al. (2018), it is a challenge for nurses to utilize decontextualized, categorical knowledge in their actual work practice. Nonetheless, knowledge and attitudes toward EBP were significantly higher among nurses who had previous EBP training. Similarly, respondents with EBP-related training are more confident in integrating EBP into their nursing practice. The data also showed that nurses' highest level of education and years of clinical experience affect their implementation skills in adopting EBP. Interestingly, the nurses with master's degrees scored higher even though they are the minority of the population. Academic programs have a historical background and even at present, master's level students learn or undergo the rigorous process of how to "do" research. Therefore, master's degree holders enhance evidence-based knowledge and

skills that stimulate the utilization of research in the healthcare field. Parallel to pieces of evidence from prior studies by Warren et al. (2016), that showed individual nurses' level of education and years of clinical experience are directly related to performance.

Barriers to adopting EBP were also investigated and the top two barriers in this study are insufficient resources (Mohsen et al., 2016), followed by lack of time (Tacia et al., 2015). Supporting factors in adopting EBP were also explored in this study. Respondents identified the provision of providing adequate training in EBP as an important factor in adopting EBP. Analogous to the research findings of Hohman et al. (2015), that training was one major transference ineffective increase in the utilization of EBP. Respondents recognize the necessity to have a protected time to learn and adopt innovative methodology including EBP. They were also expecting support from the nursing management; the same as a previous study, which noted that support from the management, is known to be a significant factor in the successful application of innovations in an organization (Nawab et al., 2015).

Overall, nurses possess a positive attitude toward EBP and consider it fundamental to their practice, however, several institutional and personal barriers obstruct its smooth implementation. One of which is, a lack of knowledge about EBP (Upton et al., 2015). Others are, inadequate organizational involvement, leadership support, and lack of resources have been identified as barriers that prevent the implementation of EBP (Bianchi et al., 2018; Duncombe, 2018).

The nursing discipline is evolving, and nurses play a crucial role to keep up to date on the latest evidence in the delivery of health care. One methodology to keep abreast of the latest practice is utilizing EBP, which embraces innovative procedures in the delivery of the best possible health care treatment. In this study, nurses are positive toward EBP, which is consistent with prior research (Majid et al., 2011; Stokke et al., 2014). Nurses with a higher degree qualification and who had more experience and previously attended EBP training were likely to appreciate implementing EBP. Theory and principles enable nurses to hone the ability to ask the right questions on clinical issues or problems, and a sound educational foundation expedites the acquisition of skills through experience (Benner, 1984). The result showed higher nursing qualifications and nurses who had attended EBP training tended to face fewer barriers in adopting EBP. Therefore, EBP has an impact on the beliefs, attitudes, and knowledge of nurses in the improvement of patient care. It was significantly higher among nurses with higher educational attainment and previous training related to EBP. It reflected that EBP training increases the knowledge and confidence in integrating EBP into their clinical practice.

Nurses recognize the importance of EBP and realize that commitment to the principles of “best practice” should be embraced and cultivated. This study is one initiative in connecting research and practice, which encourages the integration of research findings into evidence-based practice. It served as an assessment effort, gauging the extent of what is known, and shedding light on challenges in adopting EBP. It could be of use for replication inquiry in a broader and more diverse

setting, perhaps as a basis for developing context-specific interventions.

Conclusion

Nurses play a crucial role to keep up to date on the latest evidence in the delivery of health care. The assessment of nurses' awareness, knowledge, attitude towards EBP, and factors that are likely to encourage or create barriers in EBP, is imperative in the advancement of the healthcare delivery system. It would serve as a beacon in aiming for evidence-based practice, pioneering the multistep process of adopting an EBP. For the ultimate goal of enhancing the health care delivery system. EBP has an impact on the beliefs, attitudes, and knowledge of nurses in the improvement of patient care. The study reflected the benefits of training, continuing education, and length of experience in the acquisition of skills. Findings can serve as the basis for developing programs to improve nurses' knowledge and attitudes towards EBP. This can be done by provision of pieces of training related to EBP. Nurse administrators can create policies that address barriers identified in the study. That could minimize, eventually, eradicate barriers to adopting EBP.

Conflict of Interest

The author declares no conflict of interest and did not receive any funding/grant in the conduct of the study.

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His research work focuses on nursing academics and clinical practice. Looking into the theoretical foundation with consideration of the human aspect of nursing from student to professional nurses and how these academic experiences translate to the clinical practice.

ORIGINAL RESEARCH

Understanding Academic Bullying in an Online Environment as Uncaring Encounter

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Abstract

Background and Objective: The shift to an online from the face-to-face system of pedagogy among Higher educational institutions in the Philippines as a mode of adaptation to the current pandemic has inevitably produced varied set-back among its members, one of which is online bullying. This study. This study, grounded on Halldorsdottir's (1996) theory, explored the structure of bullying, taken as an uncaring encounter, in an online environment within the academic setting.

Methods: Six participants, recruited via a combination of snowball and referral system, were selected based on the following preset criteria: (1) They are nursing students exposed to the online educational system platform for at least one semester and are currently enrolled with at least 18 units (2) They are enrolled in the institution for at least a year at the time of the interview (3) They have witnessed and /or were participants to what they deemed as bullying incident during their online educational experience at least twice, (4) They are willing to express and share their experiences. Narratives from the participants were gathered via two methods: 1) In-depth individual interviews and 2) Storytelling sessions. These narratives were later analyzed using thematic analysis to present the structure of bullying through its expressions, nature, and essence.

Results: From the analysis of the participants' individual experiences, four recurring patterns were gleaned, namely, 1.) Borderless boundaries: the perceived extent of bullying, 2.) Apathetic bystanders as enablers of bullying, 3.) Misplaced empowerment: role assumption in bullying, 4.) Obfuscated reality: The online environment. The essence, "Indifference: The prime ingredient of uncaring," was gathered from these patterns. The patterns gleaned from the narratives posited that bullying, seen as an uncaring encounter, in an online environment on the academic setting is borderless occurring within an obfuscated digital environment, involving apathetic bystanders where the bullied may unconsciously assume the role of the bully in a seemingly apparent role reversal.

Primordial to these encounters is the assumption of being indifferent.

Implications: The need for policies and programs that foster empathy and compassion among all academic community members and continued support for students experiencing and witnessing bullying are implied from the findings of this study.

Keywords: *Bullying, Cyberbullying, Philippines, Uncaring*

Context of the Study

The shift to an online from the face-to-face system of pedagogy among Higher educational institutions in the Philippines as a mode of adaptation to the current pandemic has inevitably produced varied set-back among its members, one of which is online bullying. Bullying is a complex phenomenon present in most schools worldwide (Jenkins & Troop-Gordon, 2020). It comes in many forms and affects its victims differently. The effects of bullying can extend to those who witness them or act as bystanders because they may be targeted too in co-victimization, leading to psychological problems like anxiety and depression (Midgett & Doumas, 2019). Although bullying has been pervasive throughout educational history, its current expression in the "new normal" environment remains unclear and unexplored.

Caring, a value-based concept, has been said to be the essence of nursing and the health care profession (Salehian et al., 2017), so much so that teaching caring to student nurses has been the focus of their undergraduate education. Caring concepts are taught explicitly through classroom pedagogy, while caring expressions are learned implicitly through patterning behaviors. Caring is a value-based concept in nursing.

Although these behaviors, deemed as expressions of caring, are seen both within the University setting and the clinical area, the latter serves as the context where most of these behaviors are observed. Because of the shift to an online platform, caring pedagogy needs to follow suit. In cases of bullying, uncaring encounter develops an environment for nursing students that may be detrimental for them as individuals and the future of the nursing profession (Adams et al., 2015).

Bullying is the antithesis of caring. When understood through the lens of uncaring encounters, bullying can be explicit in a relatively unfamiliar setting in the Philippine educational system. Many studies have focused on how bullying affects a person; however, little attention has been given to exploring its contemporary expressions and structure within the new educational platform.

The student bystander witnessing bullying may pattern this behavior later in their professional career (Bistrong et al., 2019) when these uncaring moments are not explicitly focused

on their learning pedagogy. Educators following students in the clinical area do not have full control over all situations happening in their clinical exposures. Like students, educators in these instances are also mere bystanders, and their presence in the clinical area is just transitory.

Understanding how students make sense of bullying as an uncaring encounter in the online academic setting will let educators be aware of the structure of bullying, composed of its expressions, nature, and essence, from the student's perspective as witness and participants within these moments.

The cycle of bullying as an uncaring encounter can be broken by focusing on its anti-thesis, caring encounter. Educators are in a position to influence this process by making explicit the nature and structure of the bullying incident and offering a restructured alternative to these uncaring moments. A learning climate that is caring and supportive should be emphasized and enacted by nurse educators (Ingraham et al., 2018).

Literature Review

Bullying is an unwanted and aggressive behavior (Waseem & Nickerson, 2017), a complex phenomenon that is present in most schools around the world (Jenkins & Troop-Gordon, 2020). This complex social phenomenon (Simon & Nail, 2013) is still poorly understood. Bullying acts are deliberately done by a perpetrator towards his victim. These acts come in many forms, whether traditional bullying or cyberbullying.

Studies on bullying usually involve participants at the undergraduate level. Corroborating this, (2019) noted that recent studies now focus on online bullying, increasing among university students. The authors stated that it is less likely to be reported than other types of bullying, which opens the possibility of more online bullying than what is reported. Watts et al. (2017) stated that fewer studies investigated online bullying at the college level but that the trend among college students is continuing.

Watts et al. (2017) also identified anonymity as a factor contributing to the trend of online bullying. Online bullies can remain anonymous and not be identified. This worsens the problem of online bullying. There is also a reduced inhibition among online bully students since they cannot see the immediate reaction of their victims, contributing to their lack of concern for the victims.

The negative effects of bullying are well established. Victims of online bullying reported feelings of sadness, fear, anger, and depression (Balakrishnan, 2018). Datta et al. (2017) found out that students bullied by the school personnel are more likely to report lower school engagement and self-reported grades and view the school environment more negatively. Those bullied only by peers experienced more distress.

Adams et al. (2015) stated that clinical instructors who themselves negative behaviors or employed poor feedback mechanisms led students to misunderstand caring through role-modeling. But an instructor that is a good role model is beneficial for students; they should exhibit caring behaviors. The caring behaviors exhibited by instructors, like showing genuine interest in others and respect, make student nurses inspired and hopeful (Ali, 2012). Unfortunately, even instructors can be bullies. A study by Cooper et al. (2011) revealed that all their respondents encountered at least one bullying behavior from a faculty member.

But students are not the only possible victims of online bullying. Even teachers can be victims too. According to Piotrowski & King (2016), online bullying has become evident in higher education, and faculty members can also be targets. Cyberbullies can be from their superiors, colleagues, or even students. They further stated that policies enacted in higher education institutions against cyberbullying are somewhat outdated due to the rapid development of interactive communication technology.

A study by Singh (2017) conducted at the University of New Delhi found that faculty members of a College may be bullied, though the specific type of bullying wasn't specified. The study claimed that the source of bullying acts came from seniors and bosses. Also, part-time faculty members or those who aren't tenured are most likely the victims of bullying among the faculty members.

New forms of negative acts and aggressive behaviors are manifested in an online learning environment. Clark et al. (2012) defined bullying as a type of incivility, and they identified different behaviors by both students and faculty members considered uncivil in an online learning environment. The study showed that for students, behaviors such as making racial slurs, criticizing non-traditional cultures, and taking credit for others' work were top on the list of uncivil behaviors identified. For Faculty members, making personal attacks and name-calling were identified as the top uncivil behaviors they exhibited. On the other hand, the shift to online learning due to the COVID-19 pandemic may have a silver lining. Chawla et al. (2020) stated that victims might be spared from bullying acts that previously required physical presence.

But the school environment itself can be of benefit to its people. A study of schools in Stockholm by Låftman et al. (2017) revealed that schools with strong student leadership experienced less victimization and perpetration of online bullying than schools with weaker student leadership. Students are also more likely to open up to their peers regarding online bullying (Tezer, 2017); thus, strong student leadership appears beneficial.

The studies in this literature review also shed some light on the structure and nature of bullying. The literature speaks of its nature as detrimental, physical or remote (i.e., cyber or online), and inhumane. The structure of bullying involves aggressive and negative behaviors towards another

person or simply an uncaring encounter. Uncaring encounters, like bullying, do not respect the humanness of individuals, which happens to be quite central to the ideology of caring (Adams et al., 2015). It jeopardizes a healing environment and creates one that stunts professional development and maintenance of standards of practice. This uncaring environment also alters the student nurses' perception of what caring should be. Further, they stated that clinical instructors, who themselves exhibit negative behaviors or employ poor feedback mechanisms, led students to misunderstand caring through role-modeling. But an instructor that is a good role model because of caring behaviors expressed is beneficial for students. The caring behaviors exhibited by instructors, for instance, showing genuine interest in others and respect, make student nurses inspired and hopeful (Ali, 2012).

In summary, it is unfortunate that available literature does not view online bullying in the academe from the lens of caring science. Past studies mainly focused on online bullying from a psychological or sociological perspective. One of the few exemptions is the work of Adams et al. (2015), in which bullying was seen from the perspective of caring science, but they focused on bullying in the clinical setting and not in the academe. Moreover, there is a scarcity of studies that attempt to understand individuals' stories and their experiences with online bullying as an uncaring encounter in the academe. Unfortunately, available literature falls short of explaining the mechanisms involved in these uncaring encounters. There is also paucity in the literature that provides a deep understanding of what constitutes uncaring.

Nursing institutions should be proactive, and a caring and supportive climate of learning should be championed by the instructors (Ingraham et al., 2018). Such a supportive environment cultivates nursing students' professional growth and makes them value caring even more (Adams et al., 2015).

Theoretical grounding

This study is grounded on Halldorsdottir's (1996) theory, which proposed that within the health care setting, there exist moments that can be either described as caring or uncaring and within this duality exist the context and reality of nursing and other allied health practitioners. Although this theory was first introduced to describe encounters within a healthcare setting, its assumptions can be applied to other encounters such as those within the University setting.

The specific moment that a person exhibits aggressive behavior towards another will be considered an uncaring encounter for this study. Operationally, bullying is the uncaring encounter involving uncivil or aggressive behaviors towards another person that the participants must positively identify.

Methodology

Research Design

This research is framed within the qualitative paradigm. Qualitative research aims to generate and contribute to the increasing knowledge and source of grounded theory inductively developed from the researcher's observation and interviews from the real world.

Specifically, it utilized thematic analysis as its method for analyzing the participants' narratives. After transcribing the taped recorded interviews into narratives, three analyses were done to explicate the structure and nature of bullying as an uncaring encounter. The first-level analysis was to synthesize significant statements into manageable units, the second level analysis clustered these synthesized units into groups that form a common point or idea, and the third level analysis made sense of the clustered units into a meaningful whole and essential structure which provided a general context of the participants' narratives. (Martinez, 2013)

Sampling Technique and Participants

Six participants, recruited via a combination of snowball and referral system, were selected based on the following preset criteria: (1) They are nursing students exposed to the online educational system platform for at least one semester and are currently enrolled with at least 18 units (2) They are enrolled in the institution for at least a year at the time of the interview (3) They have witnessed and /or were participants to what they deemed as bullying incident during their online educational experience at least twice, (4) They are willing to express and share their experiences.

Exclusion criteria were the following: (1) currently under investigation for a major offense or its equivalent under their institution's rules or (2) condition that will make the participant be considered a member of a vulnerable group, as deemed by the researchers. Further, pseudonyms were assigned for each participant to maintain the participants' anonymity, specifically, Iri, Emm, Ber, Ja, Hubs, Kej.

Data Analysis

Narratives from the participants were gathered via two methods: 1) In-depth individual interviews and 2) Storytelling sessions. The in-depth interview as a method involves a small number of participants who are interviewed individually to explore their perspectives on an idea or a situation (Boyce & Neale, 2006). On the other hand, the story-telling technique relies much on the ability of participants to narrate individual experiences from their lens, with a little prodding from the researcher (Rosenthal, 2003). The storytelling technique enables the informants to situate the context of their life experiences and let the researcher be drawn within this context. These two methods ensure

multiple lenses through which their understanding of bullying will be gleaned. All of these methods were be done remotely with the use of online communications technology.

Each interview with the participants lasted at least 45 minutes per session, with at least two separate sessions per participant. The interviews were recorded with the consent of the participants and later transcribed verbatim to serve as the individual narratives. These narratives were later analyzed to understand the structure of bullying through its expressions, nature, and essence.

Maintaining Ethical Standards

This research was approved by the San Beda University – Research Ethics Board with Protocol No. 2020-035 before the conduct of this study. Ethical standards were upheld throughout its process of inquiry. Human dignity was given high regard and was maintained throughout the study. These said standards are reflected in this paper by the following means.

Before the study, the researchers obtained an ethics clearance from San Beda University Ethics Board to ensure that the study was done within the parameters of ethical research.

Written consent from the participants was obtained, indicating that they are fully aware of their involvement and its voluntary nature. The participants were given the right to refuse and withdraw from the study at any time if they deemed necessary without any form of penalty or repercussion.

The participants were likewise provided with the study's goal and objectives, associated risks, and benefits of participation. Coercion, in any form, was not utilized in the process of participant recruitment. Further, participants were informed that the interviews were to be done multiple times, and they had the right to choose where they would be conducted.

Further, the possibility of this paper to be presented and published was made known to the participants. Strict compliance to the process of maintaining their anonymity was adhered to, such that no traceable information leading to their identification will ever be disclosed.

During this study, each participant was given pseudo names to maintain anonymity and confidentiality. The identities of the participants are known only by the researchers. Their institution's name will remain anonymous throughout the research process and result dissemination.

Any mention of names of their institution or any data that might reveal their identities (e.g., nicknames, etc.) during the tape-recorded interviews were not included in the verbatim transcription of the narratives. Moreover, access to the tape-recorded interviews is only available to the researcher.

All the gathered data from the participants are kept secured and accessible only to the researcher and will be destroyed through appropriate means (e.g., shredding) after three years.

Post-interview processing was done for each participant at the end of every interview session. If the participant expressed a felt need for counseling, a registered guidance counselor would have been provided to them free of charge. However, this was ultimately unnecessary.

Findings

The structure of bullying as an uncaring encounter within the online environment in an academic setting is presented thru its expressions, nature, and essence. The expressions refer to the participants' individual experiences of bullying presented through snippets of their verbatim stories. These expressions are woven through the discussion of the nature of their experiences. The nature represents the recurring patterns within their narratives taken as a whole, presenting a unitary appreciat ion of their experience taken as a collective.

From the analysis of the participants' individual experiences, four recurring patterns were gleaned, namely, 1.) Borderless boundaries: the perceived extent of bullying, 2.) Apathetic bystanders as enablers of bullying, 3.) Misplaced empowerment: role assumption in bullying, 4.) Obfuscated reality: The online environment. These patterns will be presented first then situated with what is already existing in the literature. The essence, "Indifference: The prime ingredient of uncaring" was gathered from these patterns and will be discussed separately.

Patterns (Nature and Expression)

Borderless boundaries: the perceived extent of bullying

"Dati sa classroom lang…ngayon pag uwi mo nabubully pa rin" (Before [bullying] only happen in the classroom… now you are bullied even when you off to home) --- Hubs

The participants described the online bullying that exists now and compared them to traditional face-to-face bullying. When compared, the latter has been generally described as a confined encounter and from which a victim can simply avoid or run away. With the use of social media, one cannot merely run away from these encounters because the borderless nature of bullying in the online academic environment extends beyond the space and time of a physical encounter, as victims can still experience the adverse effects at home. This is in contrast to what Chawla et al. (2020) posited that victims might be spared from bullying acts since the focus of their statement was on physical bullying. Regrettably, for online bullying, the home, which used to be a safe place, no longer affords the kind of protection it once brought against physical bullying because acts like bashing in social media can be experienced by the victims at home.

Sadly, the borderless nature of online bullying extends beyond the person being targeted and effectively takes their loved ones as collaterals who also get affected and involved in the encounter.

"Pati ibang tao… pati pamilya nila nadadamay" (Even other people… even their family is not spared) --- Emm

The involvement of people close to either the victim or the perpetrator seemed inevitable due to the reach of social media. The participants told stories of the victims' relatives being able to feel the suffering of their loved ones and, in turn, get affected themselves. The impact of online bullying radiates from the victim to them. On the other hand, relatives and friends of the perpetrator may also join in the online bullying, further enhancing the extent of the encounter.

The borderless nature of online bullying also allows the bully to carry out her acts during learning sessions that one of them should normally be not included in. A story was told about a school administrator who hijacked an online session after learning that her student target was presenting her thesis. The school administrator was not part of the thesis panel nor involved in the thesis making of the student's paper, so the student was surprised to see the administrator during her presentation.

"She's using her authority to dominate… it wasn't even under her jurisdiction."
--- Iri

Being an administrator, the bully was able to acquire access to the online sessions and, as described by the participant, rudely interrupted and asked outrageous questions to the victim. Bullying is an unwanted and aggressive behavior (Waseem & Nickerson, 2017), and this is exactly how the participant saw the administrator's behavior to be. She felt that the bully did not care about her already difficult situation of a thesis presentation. She believes that the bully has a personal vendetta against her since, at one point, the victim complained about the administrator's teaching method. Evidence suggests that student-teacher conflict increases the student's chances of becoming victims of bullying (Marengo et al., 2018). The administrator only joined in the thesis presentation during the victims' turn, further cementing the latter's belief that the encounter was personal and that the administrator does not care about her situation at all. The participant might not have happened if the thesis presentation had been done in a closed-door session as when done during face-to-face classes in her school.

On the bright side, this borderless nature may have a silver lining because many people can see online aggressive behavior such as derogatory Facebook comments or group chat messages. Thus, other people who care and are empathic to the victim may aid in putting a halt to the ongoing encounter. Their number and anonymity affect their decision to do so (You & Lee, 2019).

Apathetic bystanders as enablers of bullying

"She didn't even bother to help me, to help us, considering she has authority."
--- Iri

The second pattern pertains to bystanders or witnesses who exhibit the uncaring trait of apathy but do not necessarily perform a negative action towards the victim or at least do not initiate

them. One of the possible traits of bystanders would be that of indifference and the intensity of bullying increasing either by allowing the bullying to happen or do not understand the victim's situation (Myers & Cowie, 2017). The participants told stories of bullying bystanders who did not show empathy towards the victim and let the bully continue with their ways. The participants view them as indifferent to the victim's situation. Iri shares that her Dean, who was a panel member of her thesis presentation and witnessed the aggressive behavior of the school administrator, did not even bother to stop the latter despite being an executive of the school. For Iri, the Dean enabled the school administrator to become a bully. After the encounter, the dean did not even bother to ask how she felt.

Another type of apathetic bystander is someone who witnesses the encounter but, instead of being just an idle witness, also joins the bully in harassing the victim and is indifferent towards the victim. The borderless nature of cyberspace allows just about anyone to participate in any encounter between two people. The bully also tends to call for help to "gang up" on her victim. Often, the bullies and the apathetic bystanders believe that their cause is just, but they do not take time to consider the side of others. Unlike in physical bullying, the number of these people ganging up on a person can be too much to handle, especially with public posts.

"Daming nakisawsaw sa social media" (A lot of people join [in bullying] in social media) --- Emm

The anonymity of the bystanders also impacts whether they will join these encounters while displaying negative, aggressive behavior. Their target may also vary by unknown or anonymous to them, and this appears to be one of the reasons why they do not spend any effort in getting to know the other person.

"di man lang nila inalam side ko" (They did not even bother to hear my side [of the story]) --- Ber

Because of the extended nature of these negative encounters, some bystanders came in the middle of the encounter and were unfamiliar with the cause or root of the problem. Yet, they would choose a side and attack the other person. This can also happen without the slightest effort to know the situation. This was reflected in the following quotes:

"Di naman nila alam puno't dulo" (The don't know the whole story) --- Hubs
They gang up against someone they don't even know --- Emm

Misplaced empowerment: role assumption in bullying

"Nag-flip, yung binubully, siya na ngayon ang nambubully" (The role flipped, the bullied become now the bully) --- Hubs

When both victim and bully are indifferent to each other and lack concern for each other, the encounter extends long enough until their acts increase in intensity and roles are seemingly reversed.

The prolonged encounter results in more intensified actions that, at times, can be considered vulgar or illegal. This leads to both parties taking the encounter personally.

One important aspect of this pattern is that a victim may also recruit allies who also take things personally, side with the victim, and, likewise, lack empathy for the bully. Their number and ferocity cause this role reversal, and the bullied now assumes the role of a bully. This happens when the victim tries to fight back but is also indifferent to the bully's situation and condition. Just like in the previous pattern where the bully considers their action to be just, the victim also considers their acts justifiable.

There is time instead of just siding with the victim; they also start harassing the bully --- Emm

It was not only the bully who would ask for help from these bystanders. Sometimes the victims do too. If the bystanders believe that the victim was right and the bully was wrong, they will side with the victim. But they would not even consider what the perceived bully's situation is. They do not even attempt to bother looking into the side of that person. These bystanders and the victim also do not care about the bully.

"wala rin kasi siyang pakialam dun sa side nung bully" (They do not bother to take the side of the bully) --- Hubs

They felt empowered by the bystanders who wanted to help him and became the ones asking to "gang up" on the other person. Instead of just putting a stop to the bullying acts, they took on the mantle of the new bully. They also perceive themselves as correct and the other as wrong, but this perception was not backed up by any form of validation, nor do they express any desire for such validation. The victim and the bystanders would not care about the other person's context.

Obfuscated reality: The online environment

"kung minsan ang interpretation iba, kasi you can't see the person" (Sometimes the interpretation is different because you can't see the other person) --- Hubs

This pattern is recurring among the participants who said that the online environment in the academe made it harder to understand what the other person is saying or expressing virtually without actually seeing the person.

Participants said that a chat message does not show the facial reaction or nonverbal gestures made by a person, which otherwise would have helped them gauge what a person is truly feeling or expressing. Worse, a chat message may be misinterpreted or make a person appear to lack empathy or be indifferent to the other's situation, regardless of whether it is true or not. Participant Ber said, "iba kasi pag sa chat" (It is different in chat). She went further to explain that

misunderstandings sometimes arise from these online chats and that she witnessed it herself. She told a story of her groupmates who went into a heated argument because one of the members thought that a certain message was offending. As a retaliation, the offended member often makes snide remarks in their group chat that all the members read, and the other person would do the same. Retaliation and expression of feelings are possible motives for online bullying (Hammudin et al., 2019). This extended encounter would continue until they had the opportunity to meet face to face as a group, and the misunderstanding was cleared up.

Reality is blurred as the persons involved may not perceive the actions of others as they are intended to be. One participant described the online environment as "opaque" because one person could not see the other person's reaction. Sometimes this altered view of reality fortifies the bully's conviction for her actions. In addition, the obfuscation makes good intention hidden, and empathy concealed from another person's viewpoint.

"di mafeel yung pagiging personal, yung concern kung meron" (You don't feel the concern, if there is any) --- Kej

Participant Kej narrated an incident with her teacher during online classes. She admits that she is having difficulty learning because of the pandemic situation and is longing for emotional support from her teachers. There was this teacher she perceived as apathetic or indifferent because she could not feel the concern from that teacher. This teacher at times also tells jokes to her class, but she could not tell if the teacher was being rude or funny. One particular joke was about Kej, and she felt embarrassed and humiliated because she thought that the joke was very offensive and that her classmates noticed it too. Though the online environment made the joke indiscernible, Kej said that if the teacher just asked if she was offended or showed a bit of concern towards her, she would not have felt that bad. It seems that it is still the person that made the encounter uncaring for Kej, not the environment on its own.

The participants acknowledge the possibility that a bit of empathy may have changed some encounters into caring ones. The participants believe that the obfuscated reality of the online environment may have helped amplify this indifference as the meaningful relationship becomes harder to establish, and there is less opportunity to know the other person better.

Essence

Indifference, the prime ingredient of uncaring encounter

The patterns gleaned from the narratives posited that bullying, seen as an uncaring encounter, in an online environment on the academic setting is borderless occurring within an obfuscated digital environment, involving apathetic bystanders where the bullied may unconsciously assume the role of the bully in a seemingly apparent role reversal. Primordial to these encounters is

the assumption of being indifferent.

Indifferent is the essence of bullying taken as an uncaring encounter. It is a prime ingredient necessary for bullying to occur. The indifference shown by the bullies is what qualifies their actions to be uncaring. The participants would not have considered several encounters uncaring if only the perpetrators expressed substantial amounts of concern for the victims' situation or condition. The participants sensed the lack of sensitivity and awareness of the bullies to the victims' situation and the lack of effort on the part of the bully to attempt and understand the other person.

Implications

The online learning environment is very different from what most people are used to, and it can amplify uncaring encounters between two or more persons. It extends beyond the physical confines of a school. Indifference is the prime ingredient of uncaring that allows these encounters to propagate. Expressive empathy between the persons involved may have averted bullying. Implications include the need for school administrators to create policies and programs that foster empathy and compassion among all academic community members. Continued support for students experiencing and witnessing bullying is also implied.

A limitation of this study is that data gathering was done with students under full online classes. The structure of bullying may be different with the upcoming limited face-to-face classes.

Conflict of Interest

The authors do not declare any conflict of interest.

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ORIGINAL RESEARCH

Stress, Anxiety and Mental well-being among Nursing students: A Descriptive-Correlational study

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Abstract

Background: The COVID-19 pandemic has affected everyone's health and well-being and has resulted in the shift of conventional face-to-face classes to online instruction. This has had major negative effects on students who are facing the difficulty of online classes in terms of their physical and mental health.

Objectives: The study determined the relationship between stress and anxiety on emotional social and psychological well-being among nursing students.

Methods: The study utilized descriptive cross-sectional research and a purposive sample of 210 nursing students was included in the study. The data were collected from November 2020 to December 2020. The Perceived Stress Scale (PSS-10), General Anxiety Disorders Scale (GAD-7), and Mental Health Continuum-Short Form (MHC-SF) (which measures emotional, psychological, and social well-being) were used to collect the necessary data. Frequency, percentage, mean, standard deviation, and Pearson's r correlation were utilized to analyze the gathered data.

Results: The participants were shown to have a moderate level of stress (M=19.53; SD=±3.29), moderate level of anxiety (M=14.43; SD=±7.62), and moderate mental health. Further, stress was shown to have a significant negative correlation with emotional well-being (r= -0.218; p=0.000), social well-being (r= -0.175; p=0.000), psychological well-being (r= -0.219; 0.000), and the over-all mental well-being (r= -0.222, p=0.000). Also, it was noted that anxiety has a significant negative relationship with emotional well-being (r= -0.418; p=0.000), social well-being (r= -0.280; p=0.000), psychological well-being (r= -0.331; p=0.000) and over-all mental well-being (r= -0.362; p=0.000).

Conclusion: In light of mental health concerns among nursing students, faculty and administrators have a professional responsibility to address foreseeable psychological stressors and promote the mental well-being of students in their institution. The protection and development of mental well-being will allow students to maintain academic excellence and facilitate future success.

Keywords: *Anxiety, COVID-19, stress, mental well-being*

Introduction

In 2015, the United Nations Member States adopted the Sustainable Development Goals (SDGs), also called Global Goals is established to aid humanity in grasping the optimum state of the forthcoming years. It is designed to secure effective approaches and ensure the betterment of the global challenges before us, as well as the challenges that await us. Ensuring healthy lives and promoting well-being at all ages is one of the Sustainable Development Goals (SDGs) announced by the United Nations (UN) in 2015. This has highlighted the importance of well-being as a global academic and policy priority (United Nations, 2015). However, the current global situation is under a constant siege against the phenomenal crisis brought by the COVID-19 pandemic which caused a disturbance in the regularity of life in the sense of health, economy, and society.

Before the pandemic, tremendous progress was acknowledged in the improvement of health in global settings. Increased life expectancy, as well as reduced child and maternal mortality rates, were accomplished, however, the world must intensify its efforts to address several global issues specifically the emerging health issues ahead of us. Therefore, adequate funding, enhancement of health systems, improved sanitation, and reinforcement of healthcare professionals, are deemed to be the blueprint for pursuing the sustainable development goal of promoting the health and well-being of individuals (United Nations, 2020). The term “well-being" is agreed to be an individual's state of physical, mental, and social health. It concerns one's frame of mind, sanity, and sense of life. Additionally, It can also be specified as the ideal judgment and perception of life (CDC, 2018).

Currently, the COVID-19 pandemic is significantly influencing the health and well-being of all individuals as it adds complexity to the healthcare systems. Healthcare professionals are distressed due to excessive workload and increased susceptibility to the virus whilst the patients are suffering from the physical and mental consequences of COVID-19. Likewise, since there is inadequate access to healthcare facilities, people are experiencing inequality and are receiving inadequate standards of care. Study shows that socio-economic characteristics such as income, social class, occupation, and educational background can affect one's health outcome. In all likelihood, the health and well-being of healthcare professionals and the public will not be fully addressed and may yield medium and long-term consequences (Otu et al., 2020).

Physical classes had been suspended in the Philippines to prevent the emergence of COVID-19 cases. In the wake of this unprecedented global phenomenon, students have shown remarkable resilience in coping with the concept of taking courses online, establishing a "new normal." The students took advantage of this alternative mode of instruction to remain on track and alleviate concerns over falling behind. However, despite the convenience of online education, distance learning has several detrimental effects on students' physical and mental health (Halupa, 2016). Researchers have raised concerns about the impact of COVID-19 on public health globally. Several studies have shown that students are more likely to suffer from stress, anxiety, and depression, most notably under prolonged home confinement. In addition, uncertainties, infection-related anxiety, bereavement, financial hardship, and poor mental well-being, in general, can adversely affect academic performance and are likely to undermine the success of online learning (Banerjee, 2020; Deo et al., 2020; Galea et al., 2020; Kaup et al., 2020).

Higher education's universal and increasingly competitive nature has exacerbated common academic stressors that lead to mental health problems among university students (Beiter et al., 2015; Fawzy & Hamed, 2017). Research has found that stressors such as meeting institutional and socio-cultural demands, coursework management, and financial commitments are sources of depression, anxiety, and stress in university students (Elias et al., 2011). According to recent meta-analyses, Asian university students studying nursing and medicine have a high prevalence of depression 43% (Tung et al., 2018) and 11% (Cuttilan et al., 2016) in each group, respectively.

The onset of an outbreak and its implications for psychological distress can adversely affect student academic success and overall mental well-being. Changing circumstances surrounding the pandemic disrupted the learning process and created a stressful work environment where anxiety and depression became a concern (Fawaz & Samaha, 2021). Lovric et al. (2020) found that nursing students demonstrated poor motivation, inattention, and performance deficits following the pandemic. Meanwhile, Alici et al. (2021) observed that fear of contracting COVID 19 is associated with elevated anxiety, consequently affecting academic performance. According to other research (Son et al., 2020; Majrashi et al., 2021; Thapa et al., 2021; Park & Seo, 2022), technical issues, course quality, online learning complexities, connectivity issues, and inability to actively practice clinical skills are significant factors contributing to stress and anxiety. As stress and anxiety intensify in times of an outbreak detrimental to academic performance, the study aims to determine nursing students' stress and anxiety levels and their relationship with emotional, social, and psychological well-being.

Methodology

Research design and Sampling Technique

Descriptive-cross sectional research was utilized as the design of the study and a purposive sampling technique was used to determine the relationship between stress and anxiety on mental

well-being (which includes emotional mental, and psychological well-being) among nursing students. The data were collected from November 2020 to December 2020.

Measurement and Instrumentation

The study utilized a three-part questionnaire to gather the data needed. These include the Perceived Stress Scale (PSS-10), General Anxiety Disorders Scale (GAD-7), and the Mental Health Continuum-Short Form (MHC-SF).

Perceived Stress Scale (PSS-10). It was developed by Cohen et al. (1983) consisting of 10 items with five responses ranging from 0 = Never to 4 = Very often. A high score signifies a high level of stress (0-13= low stress; 14-26= moderate stress; 27-40= high stress). The scale has a Cronbach's alpha coefficient of 0.88.

General Anxiety Disorders Scale (GAD-7). The instrument was developed by Spitzer et al. (2006) consisting of seven items with a 4-point Likert scale ranging from 0 = Not at all to 4 = Nearly every day. The score can be interpreted as mild (5 to 9), moderate (14 to 15), and severe (>15). It has a Cronbach's alpha coefficient of 0.90.

Mental Health Continuum-Short Form (MHC-SF). This was developed by Keyes et al. (2008) and consists of 14 items which are divided into the three subscales 'emotional well-being' (Happiness, Interest, and Life Satisfaction), 'social well-being' (Social Contribution, Social Integration, Social Actualization, Social Acceptance, and Social Coherence), and 'psychological well-being' (Self-acceptance, Mastery, Positive Relations, Personal Growth, Autonomy, and Purpose in Life). In addition, the scores on all 14 items can be averaged into a total well-being score. Items are answered on a 6-point scale ranging from 0 (never) to 5 (almost always or always).

Procedures and Participants

Before the conduct of the study, permission was secured from the respective Deans of selected Colleges of Nursing in Manila and Pasay City where the study was conducted. After getting the approval, ethical clearance was secured from the San Beda University- Research Ethics Board (SBU-ERB) with Protocol No. 2020-022. Online-based surveys were distributed to the students who volunteered for the study.

A total of 210 nursing students were included in the study. The average age of the participants was 20.58 (SD=3.51). There were 163 (77.62%) females and 47 (22.38%) males. The undergraduate students included 73 (34.76%) Level 1 students, 50 (23.8%) Level 2 students, and 87 (41.44%) students. A total of 122 (58.1%) students were from a private university while 89 (41.9%) were from a public university.

Data Analysis

The quantitative data gathered via Google forms was exported in Microsoft Excel format. The data were analyzed using frequency, percentage, mean, standard deviation, and Pearson's r correlation.

Results

The mean stress level of the participants was 19.53 (SD=3.29) while the mean anxiety level of the participants was 14.43 (SD=7.62). In terms of mental well-being, the mean average rating for emotional well-being was 9.15 (3.67), the mean score for social well-being was 11.13 (6.15) and the average rating for psychological well-being was 17.12 (7.39). The overall mental well-being means the score was 37.40 (15.74).

Table 1. Level of stress, anxiety, and mental well-being among the participants (n=210)

	Mean	SD
Stress	19.53	
Anxiety	14.43	±7.62
Emotional well-being	9.15	±3.67
Social well-being	11.13	±6.15
Psychological well-being	17.12	±7.39
Over-all Mental well-being	37.40	±15.74

To determine the relationship between stress and anxiety on emotional, social, and psychological well-being among nursing students, a Pearson's r was computed. Results revealed that there was a significant negative correlation between stress and emotional well-being having an r coefficient of -0.218 (p=0.000). Same findings can be noted between stress and social well-being and stress and psychological well-being having an r coefficient of -0.175 (p=0.000) and -0.219 (0.000) respectively. Further, a significant negative correlation was noted between stress and mental well-being (r= -0.222, p=0.000).

Also, the relationship of anxiety to emotional well-being, social well-being, psychological well-being, and overall mental well-being was determined. Findings revealed a significant negative correlation between anxiety and all the measures of mental well-being which includes emotional well-being (r= -0.418; p=0.000), social well-being (r= -0.280; p=0.000), psychological well-being (r= -0.331; p=0.000) and over-all mental well-being (r= -0.362; p=0.000).

Table 2. Correlation of measured variables

	Stress	Anxiety
Emotional well-being	-0.218 (0.000)*	-0.418 (0.000)*
Social well-being	-0.175 (0.000)*	-0.280 (0.000)*
Psychological well-being	-0.219 (0.000)*	-0.331(0.000)*
Mental well-being	-0.222 (0.000)*	-0.362 (0.000)*

*p value is significant at 0.01 level

Discussion

Stress is a continuously occurring phenomenon in nursing and is thought to be one of the major causes of burnout. Among the most common causes of stress, academics are often cited as the main contributors to which subject-related concerns, excessive workloads, and other general difficulties associated with studying are often experienced (Pulido-Martos et al., 2012). Nursing students are now subjected to additional stressors amid the pandemic. Every aspect of their daily lives and functioning has dramatically changed concerning their environment, routine, and social life. Oducado and Soriano (2021) found that nursing students held ambivalent and negative attitudes towards online learning. Their study indicated that the new format of education was less likely to have interactive experiences because of e-learning's perceived impersonality and lack of connection to human experiences.

Majrashi et al. (2021) substantiate this claim, in which they report that nursing students have a perception of lacking competence, interpersonal skills, and the capability to cope under pressure. In their view, nursing should include real-world demonstrations and simulations in their educational programs, particularly given the current learning environment may not impart quality skills. While online learning can be considered to be the only viable option to date, its cost could be a substantial financial challenge since the pandemic has left innumerable people financially strained as a result of job losses and business closures (Burns et al., 2020; Rasdi et al., 2021). Aslan and Pekince (2021) noted that these factors do contribute to students having higher stress levels as they cope with new working conditions amidst seemingly unavoidable long-term stressors.

In today's unpredictable events, stress can be intensified, causing anxiety. Under long-term stressful conditions, anxiety often occurs. In the wake of the pandemic, nurses were confronted with multiple strains, leading to anxiety. Among them are social isolation, apprehensions about the future, and infection concerns. This could be because nursing students are more likely than the general population to experience psychological distress because of their familiarity with health issues (Israelowitz et al., 2021). At the same time, having concerns about their future as registered nurses could be closely linked to their moderate levels of anxiety (Dewart et al., 2020). Several factors may be involved, such as being exposed to death over a long time, dread of the unknown, or uneasiness with how they would perform their roles as registered nurses. Khoshaim et al. (2020) shared this view

regarding future concerns but added that academic pressure, such as managing stressful tasks and assignments and pursuing better academic performance, may significantly influence anxiety levels (Khoshaim et al., 2020). The reality is that, despite its perceived ease in the face of the pandemic, this method of learning may be ineffective in the long term, particularly for courses that require skills and firsthand experience, such as nursing.

To a certain extent, the results are consistent with other studies. As reported by Quiao et al. (2011), the psychological well-being of nurses from China was negatively correlated with several nursing stressors (Quiao et al., 2011). A similar finding was made by Gautam et al. (2020), where it was also discovered that the psychological well-being of nursing students from India was linked with their perceived stress, suggesting a negative correlation (Gautam et al., 2020). Research has been limited on the role of stress and anxiety in nursing students' well-being, but this study contributes to this dearth. The results revealed that Filipino nursing students have a moderate level of anxiety (M=14.43; SD=7.62) and a moderate level of stress (M=19.53; SD=3.29). A significant negative correlation was observed between stress and anxiety and well-being, which encompasses their emotional, psychological, and social wellness. To date, the threat of being placed in unusual circumstances has invoked detrimental outcomes (Savistky et al., 2020). Researchers have found that nursing students who experience a higher degree of stress and anxiety tend to have a weaker sense of well-being. Hence, support from faculty members should be provided to reduce the severity of their stress and anxiety, ultimately reduce the risk of mental health issues and promote academic success (Fitzgerald et al., 2021). By creating a nurturing environment, nursing students are more inclined to excel academically and develop into well-rounded professionals with the competence to provide patients with quality care (Ratanasiripong et al., 2021).

Conclusion

The study has contributed to the limited studies on mental well-being in the Philippines and contributed to the understanding of the role of stress and anxiety on the mental well-being of university students. With the increasing number of mental health problems among university students worldwide, administrators and faculty members are in the best position to implement measures that will reduce mental health problems and enhance the mental well-being of students on their campuses. University students can become leaders in the future. Hence, improving and maintaining their psychological well-being will aid in their academic performance in school and do better in their future careers.

Conflict of Interest

The authors have no conflict of interest to disclose.

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RESEARCH NOTE

An Internationally Educated Nurse's Perspective on Nursing in Canada

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Abstract

In Kristeva's (1991) *By What Right Are You a Foreigner?,* she described the historic images of a foreigner, how these individuals are stigmatized, their *otherness* in a society that paradoxically welcomes and, to a certain extent, puts them on 'leash' as a means of controlling these foreigners, these *others*. Reflecting on this article, and being an immigrant and an internationally-educated nurse (IEN) from a developing country, the author reflects on Kristeva's work in relation to the discourse on IENs' experiences, along with his personal reflections, experiences, and journey of becoming and being a nurse in Canada, with the hope of initiating a dialogue to address the issues surrounding IEN transitioning in Canada.

Keywords: *internationally educated nurse, stigma, Canada*

Introduction

During her first few years in Canada, Kimmy Dora worked in a factory. [She said,] [W]orking in a field that is really different from what you were educated and the experience that I had way back in the Philippines you know it was so demoralizing because remember instead of caring for the patients, I end up carrying boxes and instead of cleaning wounds, I end up like cleaning the walls of the factory and then as well as you have to even sometimes carry plywood so, working that very opposite environment is really hard (Cruz, 2011, p. 34)… [Kimmy Dora stated further,] [o]h working in a factory was very degrading and I am uh as a because I am a nurse back in the Philippines. What uh I was doing there, it was so difficult then. It seems that people think that because I am a Filipino RN, my education is not really equivalent to Canada's standards and then I have a BSN from the Philippines but I still have to study for a year to become qualified here in Canada. It was very so very sad, very degrading, demoralizing

whatever we can describe. It was really like you know, why we cannot even able to practice, being able to go to school, getting a bachelor's degree and we also graduated from a university but the same thing they will not accept you know our education and we have to upgrade and we have to undergo all the processes. (Cruz, 2011, p. 37)

For many years now, Canada has been a destination of choice for many economic immigrants because of its strong reputation as an open and tolerant society committed to diversity and social justice, and has been successful in attracting the best and brightest immigrants from different parts of the globe (Andersson & Guo, 2009; George, 2017). Immigrants' high levels of education and extensive work experience are valuable attributes that contribute to their ability to meet Canada's permanent residence requirements (Houle & Yssaad, 2010). The contribution of immigrants to the development of the country has been well-documented, and Canada continues to rely on immigration to enhance and grow its workforce (Canadian Chamber of Commerce, n.d.). Since the founding of Canada, its immigration policy has relied on immigration as an approach to grow the population, and the labour force needed to fuel the country's economy (Dirks & Foot, 2017; Hussen, 2019; Mendecino, 2020). From 2016 to 2018 alone, Canada welcomed 903,905 permanent residents, an average of 301,302 immigrants per year during this period (Mendecino, 2020). In 2021, Canada expects to welcome approximately 401,000 permanent residents, with a 10,000 increase in annual immigration targets until 2023 (Mendecino, 2021), a huge increase from the initial pre-pandemic target of 351,000 permanent residents in 2021 (Mendecino, 2020; 2021) In addition, there are indications that Canada will only continue to rely on temporary workers. According to a recent report from Statistics Canada, in 2019, there were close to 470,000 temporary work permits issued to foreign nationals (Lu, 2020). However, in spite of this acknowledgment of immigrant contributions to Canadian society, in general, there still exists issues relating to immigrant acceptance and integration, more specifically with respect to the recognition of foreign credentials. As I took a taxi cab a few years ago, I met a Ph.D. graduate from India who specialized in biochemistry and biotechnology and drove a taxi cab in Toronto; it opened my eyes to the reality that there are, indeed, Ph.D.-prepared immigrants working as taxi drivers in Canada!

Immigrants come to Canada to establish a new life for themselves and their families. However, in spite of the hard work that many of them do, there is still an ever-increasing income gap between Canadians and immigrants, notably those from developing countries. In reporting on what has been referred to as Canada's colour coded labour market, Block and Galabuzi (2011) noted that in 2005, "racialized Canadians earn only 81.4 cents for every dollar paid to non-racialized Canadians" (p. 3). A follow-up report indicates that 10 years later, racialized male and female immigrants in Ontario between the ages of 25 and 54 years earned 70 cents and 78 cents, respectively, for every dollar earned by their non-racialized counterparts (Block & Galabuzi, 2018). This income disparity and limited availability of opportunities to immigrants casts doubt on Canada's immigration program. Immigrants are chosen on the basis of their ability to contribute to Canadian society; they are among the best and brightest from a pool of many other applicants. But what kind of contribution does Canada want from the best applicants that have been welcomed into the country?

In Kristeva's (1991) *By What Right Are You a Foreigner?*, she described the historic images of a foreigner, how these individuals are perceived, their *otherness* in a society that paradoxically welcomes and, to a certain extent, puts them on 'leash' as a means of controlling these foreigners, these *others*. Reflecting on this article, and being an immigrant and an internationally-educated nurse (IEN) from a developing country, I thought about the plight of many other IENs in Canada, and how many of these nurses go through their own journey to become nurses (again). I thought about the hegemonic practices in place that hinder the IENs' ability to transition to Canada's health workforce. Many IENs come to Canada because of the many wonderful opportunities they hear from those who came before them. However, upon their arrival, they soon realize the complexities and multiple levels of challenges of getting settled in a new country, and regaining their status as nurses. Kimmy Dora's experience, as cited at the beginning of this paper, is not an isolated case. Many IENs experience similar situations in their journey to becoming nurses in Canada. In this paper, I will be reflecting on Kristeva's work in relation to the discourse on IENs' experiences, along with my personal reflections and experiences, with the hope of initiating a dialogue to address the issues surrounding IEN transitioning in Canada.

IEN Migration to Canada: Issues of the *Foreigner*

Jus Soli, Jus Sanguinis - Brain waste

As an IEN settles in Canada, does s/he ever have the opportunity to *become* a Canadian nurse? Will s/he belong to the group and *become one of the nurses?* Or, does s/he have to struggle to become a nurse in Canada? Kristeva (1991) noted how a foreigner is "identified as beneficial or harmful to [a] social group and its power and, on that account, he is to be assimilated or rejected" (p. 96). From an historical perspective, it is interesting to note that Canada welcomed health care professionals in general, during those days when there was a need for their services. My two aunts who were both educated as nurses in the Philippines, and who came to Canada in the mid-70s shared their interesting experience with immigration and finding work as registered nurses in this country. They initially applied for working permits after receiving job offers from a hospital in Montreal, Quebec. When they reported to the Canadian Embassy in Manila to get their visas on the appointed day, they were horrified to see the officer cross out their travel document with a red marker right in front of them! They were in shock and almost in tears when the visa officer said, with a stern look on his face, that he was cancelling their work visas. He cut short his statement and paused before saying that he was going to issue them immigrant visas. The visa officer smiled. My two aunts said they ended up crying with tears of joy at the prospect of getting immigrant visas. Two weeks later, in June, 1974, they both received their immigrant visas.

Damasco (2012) described that, in the 60s, Filipino health care professionals were directly recruited by Ontario hospitals and, subsequently, worked in professions for which they were trained in the Philippines. During those days, Canada badly needed nurses and whatever contribution IENs

at that time were able to extend was deemed beneficial for the country. Accommodations were made to facilitate their entry into Canada. However, times have evidently changed, yet there continues to be a shortage of *workers* in general that led to an evolving role and career path for many immigrants, IENs included. Kristeva (1991) suggested how states have the power to define the *other* within society to the extent that their status is improved, or not. For example, immigrants, including Filipinos, were expected "to occupy certain (subordinate) roles in the labour market and the workplace" (Kelly et al., 2009, p. 32), such as food service workers or live-in caregivers. In Manitoba, Garang (2012) reported that educated African immigrants are regularly short-listed for employment opportunities "but rarely get the job after a face to face interview" (p. 9).

The state sets the terms of inclusion for immigrants which further legitimizes its regulatory role by acting as a gatekeeper of social differences (Dhamoon, 2009). This power is delegated to regulatory bodies that enforce legislations respecting the admission of IENs into the profession within their respective jurisdictions. From an IEN perspective, gaining registration in Canada is an extremely onerous process, especially for those persons from developing countries. In the absence of a pan-Canadian framework to guide IEN credentialing in Canada, each regulatory body sets its own process of evaluating international credentials which constantly changes. With each change in requirement, IENs are expected to comply with it even if the requirement was already met based on the previous regulations.

IENs experience various challenges at each stage of the credentialing process (Blythe et al., 2009). One of the factors that delay, if not prevent, IENs from obtaining registration in Canada is the non-recognition of foreign credentials of immigrant professionals. This may be due to the prevailing belief that "the knowledge of immigrant professionals, particularly those from Third World countries, is deficient, incompatible and inferior" compared to Canadian credentials (Guo, 2009, p. 37). For example, during the 2007 to 2008 IEN recruitment campaign initiated by the Government of Alberta, majority of IENs from the United Kingdom (UK) who settled in Edmonton were awarded Graduate Nurse recognition by the provincial regulatory body that made them eligible to receive temporary registered nurse (RN) licenses whereas all IENs from the Philippines only managed to gain registration as licensed practical nurses (LPNs) (Taylor et al., 2012). This was further confirmed by Higginbottom (2011) who noted that IENs were brought to Canada to work as LPNs or as nursing aides, even if majority of them possessed either a baccalaureate or master's degree from their source country or elsewhere. Another challenge reported by IENs relates to their ability to meet recent nursing practice requirements. To demonstrate evidence of recent nursing practice, or to meet competency gaps and qualify for RN registration, IENs in Ontario, for example, are often required to go back to nursing school to complete specified theory and clinical elements, graduate from an approved baccalaureate nursing program in Canada, or return to the country where the applicant obtained their initial nursing registration and work there as RN. All of these options require monies that may not be easily accessible to IENs.

Without Political Rights – Stigmatization of IENs

Stigmatization, along with its outcomes, is also an issue faced by IENs in society, and even in the workplace, and this issue has been documented in literature. As noted by Das Gupta (2009), there are IENs who hurdled the tedious registration process in Canada, but who continue to face marginalization and discriminatory treatment even after obtaining employment. This is further exemplified by IENs' ongoing experience of being othered from the moment they apply for registration and licensure, where their "third world" credentials are perceived as being inadequate and, therefore, not equivalent to a Canadian baccalaureate nursing degree, and up to the point of employment, where their language fluency and accent are used as bases in judging their fitness to practice safely. Das Gupta (2009) reported how two black nurses were placed on salary grid with no recognition of their nursing experience outside Canada. This situation adds another level to the issue of transitioning IENs to the workplace. Dhamoon (2009) and Folson (as cited in Dhamoon, 2009) suggested that

> immigrants tend to be explicitly referenced in terms of their so-called different cultures, ethnicities, religions, languages, and nationalities [and] within these discourses lies an unspoken and implicit assumption that immigrants are marked as non-white...; [a non-white] who is professionally challenged and speaks with an accent… and who has a particular labour-market location. (p. 71)

A 2011 study on the transitioning experiences of IENs in a Western Canadian province showed IENs' perspectives on issues of fairness and equity (Higginbottom, 2011). Some IENs felt that being assigned tasks that were unrelated to nursing, such as dishwashing and vacuuming was reflective of employer/supervisor discriminatory practices based on country of origin, while others felt that the IEN's country of origin determined whether or not they were able to relocate with their family members (Higginbottom, 2011).

In my previous role as coordinator of an IEN bridging program, I met an applicant who completed a four-year nursing program from an Asian country, and a master's degree in nursing from the UK. She had her transcripts evaluated by a credential evaluation agency in Toronto and was surprised to learn that her nursing education from Asia was only equivalent to secondary school education in Canada, yet her master's degree from the UK has been deemed equivalent to a Canadian master's degree. She eventually enrolled in a personal support worker. In Canada, personal support workers are unregulated care workers who "provide supportive care to individuals across the lifespan including clients experiencing cognitive impairment, physical disability and mental health challenges, by assisting them with their activities of daily living…, [working in a] variety of care settings including community, retirement homes, long-term care homes and hospitals (Ministry of Training, Colleges, and Universities, 2014, p. 4). At one point during our conversation, this applicant remarked, "I need to do something to help me find a job and survive in Canada!" By offering her an opportunity to enroll in a PSW program, is the system helping her or exploiting her? Can this not

potentially lead to deskilling of this IEN? Salami et al. (2018) reported that IENs who faced challenges in becoming RNs discovered that becoming LPN as an easier path to take; however, they reported experiencing deskilling and feeling dissatisfied in their new nursing role. Is this the contribution expected from one of those who qualified for permanent residence in Canada? Is this the particular labour-market location destined for this IEN? Or is this a way to "mask the desire to use and exploit the intellectual, linguistic, and material capacities of Othered subjects in order to maximize the benefits of a market-driven economy?" (Dhamoon, 2009, p 38). The same questions are posed in behalf of IENs who are currently participants of the live-in caregiver program. Is the IEN, then, fully a nurse? And following Kristeva's line of thought, is the IEN fully a human person in Canada if s/he is not accorded the opportunity to participate in citizenship initiatives, and contribute to the new place s/he would like to call home?

A Second-Rate Right – Supporting IENs

Lochak, as cited in Kristeva (1991), noted that "the power given to the administration to assess, to interpret, or even to modify through *regulations* and *decrees* the current legislation, leads to changing the rights of foreigners into "second-rate rights" (p. 102). Registration and/or licensure of nurses in Canada is a provincial prerogative. Through provincial legislations, these activities are delegated to regulatory bodies that enforce policies and regulations with respect to the *recognition or non-recognition* of IEN credentials in Canada. The impact of non-recognition of immigrant credentials can be devastating. Guo (2009) suggests that the non-recognition of international qualifications, including any prior learning and work experience immigrants professionals possess, can lead to "downward social mobility, unemployment and underemployment, vulnerability and commodification, and reduced earnings" (p. 42). Kelly et al. (2009) reported on the deprofessionalization experienced by Filipino immigrants who were downgraded to low-paying positions in Canada. A Filipino immigrant who was a dentist back home may end up becoming a dental office administrator in Canada (Kelly et al., 2009). These experiences can potentially lead to feelings of distress, anger, and resentment, that not only prevents the integration of immigrants to Canada's labour force, but also negatively impacts their ability to commit fully to this place they hope to call their home, and develop a sense of Canadian citizenship (Grant, 2005).

I once heard a Canadian-educated nursing faculty member criticize a part-time IEN colleague for appending her master's degree, which she earned in another country, after her name. This Canadian-educated nursing faculty member unilaterally declared that master's degrees earned from a developing country are never equivalent to a Canadian master's degree. Interestingly, this Canadian-educated nursing faculty member does not have a master's degree. In order to ensure public safety, IENs are subjected to various forms of checks at each stage of the credentialing process. An IEN may be required to do an objective structured clinical exam, provide additional documentation from the home country that, in many instances, are difficult to obtain, undertake a bridging program to address knowledge and skills gaps identified by the regulatory body, or return to nursing school to obtain a new Canadian baccalaureate degree.

Kristeva (1991) suggested how states determine through regulation or legislation the manner by which society perceives the *otherness* of foreigners which makes these individuals powerless and, sadly, remain as *others* in the eyes of Canadians. They may be arbitrarily classified as a "'good immigrant' (cosmopolitan, adventurous contributor to the economy who replicates existing norms)… [or a] 'bad immigrant' (who is dirty, selfish, backward, dangerous, and a financial drain on the nation)" (Dhamoon, 2009, p. 70). Subsequently, to demonstrate evidence of recent practice, IENs in one Canadian province who have not worked as nurses within three years before they met all registration requirements, including passing the registration/licensure exam, may still be required to go back to nursing school to complete specified theory and clinical elements or to return to their home country to work and accumulate hours of clinical practice.

Teelucksingh and Galabuzi (2007) suggested that, as a result of government's neo-liberal deregulation of labour markets in Canada, internationally educated professionals (IEPs) "are impacted by the full weight of subjective decision making on the part of employers" (p. 206). Are we protecting the public in imposing these requirements? Who are we *safeguarding* the public from? Is it from these *other* nurses or from our fear and perception of these *other* nurses? Or, as Kristeva (1991) suggested, is there a fear that if IENs are fully assimilated, then Canadian nursing "would necessarily lose many features and privileges that defined them as such?" (p. 98).

Another situation that I find disturbing is the limited representation of IENs educated in developing countries in Canada's university nursing programs. Owing to my Filipino heritage, allow me to use, as an example, the case of Philippine-educated nurses in Canada. In the United States, Philippine-trained nurses seem to have more opportunities to thrive in academia. Be:

- Divina Grossman, a nursing graduate of the University of Santo Tomas in Manila, the Philippines. She was previously Chancellor of the University of Massachusetts (Dartmouth), and is currently President of the University of Saint Augustine for Health Sciences (2018) in the United States;
- Rose Constantino, an alumna of the Adventist University of the Philippines (formerly Philippine Union College), who is Associate Professor, Health and Community Systems at the University of Pittsburgh School of Nursing (2020);
- Jesus Casida, a graduate of Bicol University in Legazpi City, the Philippines. He is currently an Associate Professor at the Johns Hopkins University School of Nursing (Johns Hopkins University School of Nursing, 2020; University of Michigan School of Nursing, n.d.)

In Canada, however, this does not seem to be the case. An environmental scan of Canadian university-based nursing programs in 2018 showed that there was only one Philippine-educated RN in a tenure-track position, while up to two-thirds of IENs in tenured or tenure-track positions were from Western countries (Cruz & Patrick, 2020). When the second edition of the book *The Colour of Democracy* was published 15 years ago, Henry et al. (1998) noted the very limited number of minority faculty in Canadian universities in Ontario. Fifteen years later, there are still very few minority, let

alone IENs educated in developing countries, who have been tenured or are tenure-track in Canada's university nursing programs. Why is this so? Should this be a concern? Das Gupta (1996) suggested that "workers of colour have been excluded from better paid, secure, and more desirable jobs in nursing through systemic practices in the labour market" (p. 70). I argue that IENs need to be represented in academia to potentially have a voice that can be heard across the nation, a voice that can initiate a discourse to address the issues confronting IENs, and hopefully allow the emergence of a greater understanding of their issues, not as others but as Canadians. Felipe (as cited in McElhinny, Davidson, Catungal, Tungohan, & Coloma, 2012) suggested that "[a]cademia, when it's done well, speaks for the people. It compiles the voices of the people in a manner that's suitable for academics and scholars, but it's still the voice of the people" (p. 27). As Freire (1970/1988) suggested

> Who suffer the effects of oppression more than the oppressed? Who can better understand the necessity of liberation? They will not gain this liberation by chance but through the praxis of their quest for it, through their recognition of the necessity to fight for it. And this fight, because of the purpose given to it by the oppressed, will actually constitute an act of love opposing the lovelessness which lies at the heart of the oppressors' violence, lovelessness, even when clothed in false generosity. (p. 29)

Furthermore, with the increasing requirement for bridging programs amongst IENs, the presence of IEN faculty members who can mentor them may be very helpful in their transitioning experience; they can serve as role models for other IENs.

It is appalling to note that there are potentially suitably-qualified IENs who are being prevented from returning to the profession, or perhaps prevented from assuming roles within the profession, due to various systemic barriers such as credential recognition issues, constantly evolving registration requirements for IENs, and the absence of a readily accessible central repository of information that can guide IENs through the registration process. Jeans (2006) emphasized that Canada needs "to learn now what to do to ensure that qualified nurses who want to work can actually get licensed and registered" (p. 58S). For those IENs who succeeded in passing the registration exam, what supports have been made available to help ensure their successful integration to Canada's health work force? How can they meet the Canadian experience requirement that many employers are looking for if they are not given an opportunity to gain it? In evaluating the experiences of Filipino-trained nurses recruited by a Saskatchewan regional health authority, Bassendowski and Petrucka (2010) suggested the need to provide support not only to newly-hired IENs, but to agency staff and receiving unit as well, "to enhance and ease [IEN] integration into the care team" (p. 4). They provided 12 key recommendations for future recruitment initiatives; one of the recommendations raised by the participants who were interviewed was the importance of a classroom setting orientation as a way to introduce them to Canadian culture and workplace norms, as well as "a refresher in assessments and pharmaceuticals… [and] some nursing practice of standard of care and policies" (Bassendowski & Petrucka, 2010, p. 60).

Thinking the Commonplace – Discussion and Conclusion

There is currently no straightforward approach to gain registration as a nurse in Canada. This situation is made even more complex by an ongoing perception that IENs' knowledge and clinical competencies are not adequate to meet Canadian nursing standards of practice to ensure patient safety (Sochan & Singh, 2007). From an IEN perspective, there seems to be an endless list of road blocks that hinder IENs from effectively navigating the process of becoming registered in Canada and integrating to our country's health work force. Many of these seem to be rooted in the stigmatization of IENs, both individually and as a group. As more road blocks are placed before IENs, the lesser the chances are for these individuals to seek opportunities to gain registration as a nurse in Canada. It deprives IENs of the opportunity to actively contribute to Canadian society and further reinforces their *otherness*. Deprofessionalized, invisible and unheard, this creates in them "an attitude [that] does not seem to be simply a spontaneous response to the legal, cultural, and psychological discrimination undergone by the foreigner: One does not give me a place, therefore I shall keep my place" (Kristeva, 1991, p. 103). These immigrants, *these IENS*, are "directly subjected to the denial of substantive citizenship" (Dhamoon, 2009, p. 70). IENs, and IEPs in general, are deprived of the opportunity to improve their lives and those of their families.

Teelucksingh and Galabuzi (2007) stated that while the Canadian government actively promotes immigration with the selection of highly skilled and talented immigrants, it has not assumed "any accountability for their successful integration or even bothered to track their progress" which leads us to question the logic of the government's immigration policy (p. 206). It is about time that government leaders address this issue. While this paper focuses on the plight of IENs in Canada, the issue is much greater than this, and generally involves other immigrants.

However, there is also the realization that not all IENs may be qualified to practice in Canada owing to differences in educational backgrounds and standards of practices. Hawthorne (2001) suggested that it may be time for regulatory bodies to analyze IENs' outcomes by country of origin to identify at risk groups and thus provide necessary supports to help them succeed. I am not suggesting that policies, rules, regulations and legislations be changed to favour every IEN that knocks on Canada's doors. Instead, my hope is to initiate a discourse that will allow all relevant parties to come together and discuss the various issues surrounding IEN registration in Canada. As Kristeva (1991) suggested

> facing the problem of the foreigner, the discourses, difficulties, or even the deadlocks of our predecessors do not only make up a history; they constitute a cultural distance that is to be preserved and developed, a distance on the basis of which one might temper and modify the simplistic attitudes of rejection or indifference, as well as the arbitrary or utilitarian decisions that today regulate relationships between foreigners. (p. 104)

There is an urgent need to acknowledge and directly confront the plight of IENs in the commonplace of Canadian society.

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RESEARCH NOTE

Role of Research in Ensuring Continuing Quality Improvement in Outcome-Based Education in the Health Professions

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Abstract

The Philippine Commission on Higher Education (CHED), through Memorandum Order 46 Series 2012, unmistakably espouses outcome-based education (OBE) as the main approach to higher education learning. To attain its goal of developing a critical mass of high-quality graduates, research that will drive technological innovation, economic growth and global competitiveness and provide directions to the country's policies and strategies must be supported. Research plays at least two roles in ensuring quality in outcome-based education – in curriculum development and in the implementation of OBE. Greater student involvement in research to hone their skills in research will help them become independent producers of knowledge and capable lifelong learners. Teachers enrich the content of their courses with research experience and findings, both from reviewing the literature and from the conduct of actual experiments and studies. To overcome problems with OBE implementation, research can be utilized as a problem-solving activity. Researches can provide situational analysis on the level of quality of education and monitor its trends, seek causal factors that account for variations in the attainment of quality standards, test for educational interventions and identify good/best practices in teaching and learning. This paper provides suggestions for designs for the application of research for these purposes.

Keywords: *outcome-based education, quality assurance, student research, teacher research, curriculum development, health professions education*

Introduction

The Philippine Commission on Higher Education (CHED), through Memorandum Order 46 Series 2012, unmistakably espouses outcome-based education as the main approach to higher education learning (Commission on Higher Education, 2012). It stipulates that the quality assurance system is enhanced by the use of learning competency-based standards and an outcome-based system of quality assurance. Under this mandate, the goal of Philippine higher education is to develop "a critical mass of high-quality graduates who meet national and international academic and industry standards."

This mandate recognizes that in order to attain this goal, research that will drive technological innovation, economic growth, and global competitiveness and provide directions to the country's policies and strategies must be supported. This focus on research in the memorandum order is aimed at ensuring the quality of the country's graduates. According to Section 26 of CHED Memorandum Order 46, "All Higher Education Institutions (HEIs) are expected to do research." The performance in research of an institution is a critical criterion for its designation as a Center of Excellence and Center of Development (Commission on Higher Education, 2012).

In this paper, research is taken both as a noun, where it refers to a study that addresses one or several research questions, and as a verb, where 'researching' relates to the different activities performed in conducting a study. Given these definitions of research, it has two important roles to play in ensuring quality in outcome-based education in the health professions. It can be integrated into the curriculum to enrich the content of courses that benefit both students and teachers. Another is its use as a problem-solving activity that finds practical solutions to difficulties encountered in the implementation of outcome-based education.

Role of Research in Curriculum Development

1. Student Engagement in Research

The training of health professionals involves the mastery of existing theories and principles in their respective fields and the capability to evaluate and produce new knowledge. Research is one of the ways through which knowledge is gained. In espousing a Discovery Paradigm in undergraduate education where students are treated as both learners and scholars, Hodge, LePore, Pasquesi, and Hirsch (2008) asserts that research-based learning removes the boundaries of a traditional course and provides a platform from which students' quest for understanding takes off. A student with well-developed skills in research becomes independent of teachers for his/her learning. Research enables students to believe they can become producers of new knowledge. This also leads to the faster maturation to a very capable lifelong learner. In addition, the knowledge base of students developed through research contributes to their practice knowledge (Rubin & Babbie, 1997).

For instance, by conducting research, a student becomes a health practitioner who can distinguish what prevalent untested practices in their fields are effective or not.

A survey of the program outcomes among the different health professions in the Philippines includes the development of research skills of their respective students. The following program outcomes are examples of this:

Table 1. Research as one of program outcomes in a sample of health professions[1]

Profession/Field of Study	Program Outcome
Medicine	Engage in research activities
Pharmacy	Conduct of relevant research and dissemination of findings
Physical Therapy	Demonstrate research-related skills in the application of best practice evidence in the performance of various roles in different practice settings
Nursing	Research (key areas of responsibility)

[1] Obtained from Dr. Melflor Atienza, Dr. Erlyn Sana and Prof. Elizabeth Grageda, professors from the National Teacher Training Center for the Health Professions, who participated in the drafting of these program outcomes.

It then follows from these program outcomes that a graduate with well-developed research skills is significantly more desirable than one who is not.

Research capacity of faculty and graduates in a specific discipline is an indicator of the quality of higher education institutions (Commission on Higher Education, 2012).

Research capacities are developed through instruction, engagement, and application of research. HEIs, especially universities, are expected to be actively producing research outputs. They are rated based on inputs to institutional research such as technical expertise of faculty and staff, facilities and funding, and on outputs of research activities in the form of publications, presentations on scientific fora, and commercial products. The right combination of these inputs (expertise, facilities, and funding) will produce more opportunities for student involvement in research. Thus, integrating an effective research development program in a curriculum can lead to an improvement in the quality of graduates. The greater production of articles in peer-reviewed journals by faculty and graduates is indicative of a better curriculum. In a quick analysis done by this author on the data from the Quacquarelli Symonds (QS) World University Rankings in 2017 of top universities in the world, research score, as represented by citations of published research, was strongly correlated with the ranking of the university.

Using Healy and Jenkins' (2009) model of student research and inquiry defined along two axes, namely student participation and emphasis on research learning, there are four approaches for engaging students in research (Figure 1). Students learn about current research in the discipline but do not actively participate in a research-led strategy. Examples of this are attendance in lectures by

professors or other local academic staff and tutor-led discussions of research articles assigned for reading. A research-oriented approach emphasizes learning of research skills and techniques. Students can be given didactic lessons in research methodology and practical and laboratory exercises in different stages of the research process. Periodic assessment of student research skills may be done to diagnose problems of student learning in research methods. Students engage in discussions on research conducted by their institutions in a research-tutored approach. In these discussions which may take place in a research forum, students may contribute ideas to the refinement of the research problem, the conduct of study such as the development of tools, and implications of research findings. Lastly, in a research-based strategy, self-directed learning is developed by actual undertaking a research. Special studies and theses for undergraduate, master and doctoral students are examples of the applications of this strategy. Healy and Jenkins believed that curricula should provide a balance of these four approaches.

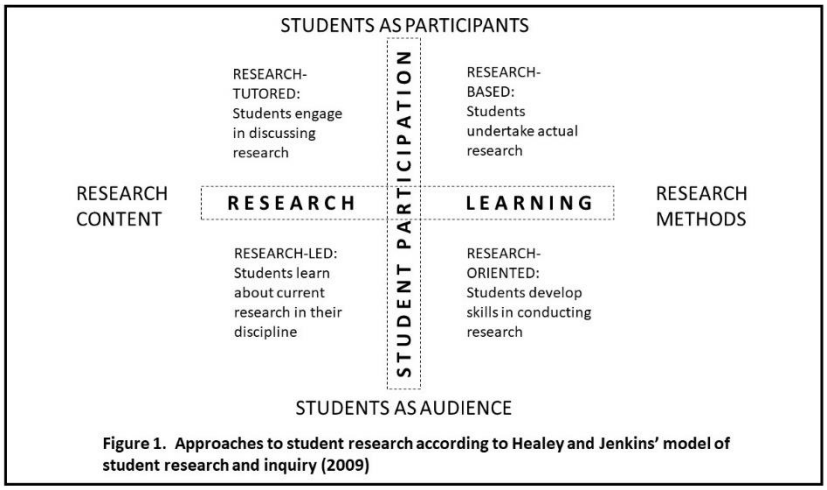

Figure 1. Approaches to student research according to Healey and Jenkins' model of student research and inquiry (2009)

Teacher Engagement in Research

Quality improvement in outcome-based education can also be pursued through teacher engagement in research.

Teachers can use findings of new researches by others in their respective disciplines or conduct their own studies on these fields. Those who are active in research are more likely to have up-to-date information on particular subjects. The content of their course syllabus would usually incorporate more recent advances (theories, methodologies, and findings) in their fields of teaching.

Research by teachers can also focus on their teaching strategies or on the learning environment. In her contributed article to the Learn NC Program of the University of North Carolina School of Education entitled "An Introduction to Teacher Research", Anderson (n.d) described activities of 'teacher research' that distinguishes it from similar daily activities good teachers do such

as preparing and executing plans of action, taking and analyzing observations, and then making adjustments to these plans to make them more effective. Altogether, one can already consider these activities as "researching". Anderson, however, provided a stricter definition: teacher research is "an intentional and systematic inquiry in order to improve classroom practice… Teacher research is simply good teaching that is planned and written down in a formal way."

Teachers can conduct systematic reviews or meta-analysis on the specific teaching strategies or use outputs of their own testing of strategies. By doing so, teachers are said to engage in evidence-based practice (EBP). Goldacre (2013) explains an important benefit of EBP in teaching – it empowers teachers into making informed decisions about what works best for their students, "setting a profession free from governments, ministers and civil servants who are often overly keen on sending out edicts, insisting that their new idea is the best in town." A good example could be the application of the findings of M Murad, Coto-Yglesias, Varkey, Prokop, & A Murad (2010) on the effectiveness of self-directed learning (SDL) on knowledge of students in a variety of health professions. While SDL may be expected to be more effective in imparting knowledge than purely didactic learning approaches, a teacher who finds out from this systematic review that SDL is more effective if students were involved in choosing learning resources, as found in Murad et al's study, will then try to increase available learning resources when they develop SDL curriculum.

The actual experience of conducting researches has immense benefits to the teacher. Aside from the confidence, it brings to the teacher, sharing his/her first-hand experience makes it more interesting to teach lessons to students than simply relating what one has just read from the book or a journal article. Those experiences usually involve unique challenges faced and the solutions adopted by the teacher-researcher to overcome them. For example, a teacher may be able to more effectively convince his/her students of the importance of patient-centered care if he/she learns in his/her research that an important risk factor for drop-outs among multi-drug resistant tuberculosis (TB) patients in directly-observed treatment short-course therapy (DOTS) is an unpleasant experience with the health care providers in a treatment facility. Additionally, teachers' researches are often used as the gateway of students to a live experience in a large-scale study. These collaborations often lead to lasting and deeply meaningful mentoring partnerships in the future career of students.

Role of Research in Addressing Problems with Implementation of OBE

The implementation of OBE is not without difficulty and its critics. Manno (1994) narrated OBE's long history in the USA where its adoption encountered a lot of resistance. Back then in the 1990's, obscure program outcomes were partly to blame by critics for OBE's failure to produce its anticipated results. Another report charged that OBE, as implemented in primary education, of producing 'deliberately dumb' students. Accordingly, because educators had to be accountable to their students in OBE, outcomes had to be set low to guarantee their attainment (Phyllis Schlafly Report, 1993). Kevin Donnelly, Director of Education Strategies in Australia, cited reports that in

Australia, the United Kingdom, and Canada, OBE had also not been at the least consistently successful. In addition to the problem of program outcomes specification, the implementation of OBE required difficult changes in the roles of the teacher and student assessment. The reduction of the emphasis on a strong foundation in subject knowledge in favor of student disposition and attitudes was another criticism (Donnelly, 2007). These problems with the adoption of OBE can lead to a diminishing quality of graduates.

As a problem-solving activity, research can be a tool for ensuring continuous quality improvement. Research, which may also be done in the guise of program evaluation, can be used to assess whether HEIs are meeting quality standards. CHED has provided five key result areas (KRA) for judging the performance of institutions in its recommended quality assurance process. A number of indicators have been defined for each KRA (Commission on Higher Education, 2012).

Table 2. Five Key Result Areas of the Institutional Sustainability Assessment (ISA) in CHED's Quality Assurance Process

1	Governance and Management (including management of resources)
2	Quality of Teaching and Learning (competency, programs, faculty)
3	Quality of Professional Exposure, Research, and Creative Work (including linkages)
4	Support for Students (learning resources and support structures)
5	Relations with the Community (extra-curricular linkages, service learning, outreach)

Source: CHED Handbook on Typology, Outcomes-Based Education, and Institutional Sustainability Assessment

Starting with an assessment of the institution's performance according to these indicators, research can be used to identify efficiency and limiting factors that could account for variations in the attainment of quality standards. These factors can become part of the mechanisms, procedures, and processes that need to be monitored to ensure continuing quality improvement in OBE. Examples of possible researches for quality improvement in OBE are provided along with their suggested designs. Some of these examples can be done by individual teachers while others are suggested for administrators and policymakers.

1. Situational Analyses

Situational analyses can be done nationally to determine the distribution of HEI's according to indicators stipulated for each KRA in the ISA. Baseline levels can be established with this kind of studies. These studies would preferably use representative samples of the population elements (schools, teachers, students, curriculum designs, etc.) under study. For example, to determine baseline levels of quality of teaching in nursing schools in the country, one can first stratify nursing schools according to the region, obtain a sample of schools with probabilities proportional to the number of teachers in a nursing school and then randomly sample a fixed number of teachers in a selected school.

Cross-sectional studies, which include surveys, are conducted to find out associations between the level of these indicators and institution characteristics. Do these indicators differ by geographical location, private-public type of institutional ownership, urban-rural location, organizational structure, etc.? Cross-sectional studies establish these relations in a point-in-time. These can be done by getting selecting samples randomly to meet results need for representative samples as in surveys, or purposely to ensure variability to increase the power of the study to find associations. Useful findings can even come from cross-sectional studies assembled by convenience sampling if bias is not significantly affecting the results. Cross-sectional studies are useful for generating hypotheses about causal factors that could affect educational quality.

2. Trends in Quality Indicators

Monitoring of levels of quality indicators can be done using longitudinal studies. These studies employ repeated measurements of the same units over a period of time. The changes in the level of an indicator is obtained for each unit. A significant trend is established if a large proportion of the units demonstrate a similar pattern over time. Different trends may be observed for specific categories suggesting a relationship between the variable for categorization and the trends of levels of the indicator.

Monitoring can also be done in studies at the aggregate level. These studies consist of repeated cross-sectional studies. Explanations of these trends can come from significant events that occur just prior to these results, for example, the implementation of new policies affecting the curriculum.

3. Search for Factors Affecting Quality

Causal-comparative studies can be used to find causal associations between factors and levels of quality (Frankael & Wallen, 2010). These studies do not introduce any intervention on the part of the investigator. Rather these identify existing groups that represent different levels of a factor. These groups are then compared according to their quality indicators. Differences between groups would be indicative that the factor differentiating them could be causally related to quality.

These studies can also be assembled by identifying two groups of institutions according to levels of quality, for example, a group who meets standards and a group who does not. The characteristics of these groups can be compared to see if there are differences. Those characteristics where differences are found could be considered as possible causes of failure to meet quality standards.

These studies can also be done to test a specific hypothesis. For example, does the quality of instruction in pharmacy schools increase if teachers undergo training in curriculum development from a health professions education school? The design of these studies may consider control of

potential confounders, for instance, size of the school by assembling comparable groups according to the distribution of school size. One way of achieving this is by matching on size in the selection of schools.

4. Testing for Interventions

Factors affecting quality may already be known a priori or from results for recently concluded studies. As in a previous example used, self-directed learning has been found to be more effective in improving the knowledge of students in the health sciences if these students were involved in choosing learning resources. Using this discovery, a teacher may develop a syllabus that would involve more self-directed learning and increase student learning resources and implement this to a new batch of students. Before doing so, he/she can take the assessment of student performance prior to this implementation as a baseline level. Then he/she can implement the intervention and obtain the assessments at the end. This before-and-after study design is often employed for testing effects of interventions.

Randomized experiments are also often used in studies in health sciences education. Results from randomized trials are given high regard because of the greater control of confounders and biases compared to other study designs. As an example, Aggarwal et al (2011) compared online and on-site training in health research methodology among a mixture of Indian scientists in medicine and other professions working on health research. They found similar improvements in knowledge of health research methodology between the two approaches to training.

5. Search for Good/Best Practices in Teaching and Learning

Meta-analysis and systematic reviews involve the critical examination of retrieved studies that address a specific question. These investigations determine 1) if the collective analysis of reviewed studies lead to an overall conclusion that an educational intervention is beneficial or not, and 2) the conditions which could modify its beneficial effects. These studies are frequent sources of interventions in education that turn out to be 'evidence-based practices'. An example of this is the report of the US Department of Education on the evaluation of evidence-based practices in online learning. Blended-learning approaches had significantly higher average learning outcome scores (e.g. standardized test scores, grades, grade point averages) than either face-to-face instruction or purely online approaches (US Department of Education, Office of Planning, Evaluation, and Policy Development, 2010).

A new paradigm in organization development called 'appreciative inquiry' emerged from the Department of Organizational Behavior, Case Western Reserve University. Appreciative inquiry (AI) seeks to introduce change in an organization by seeking best experiences related to an object of inquiry, creating a logical vision of an ideal, planning to achieve this and then trying this out (Bushe, 2011). AI is now being applied in research where it involves asking questions that focus on the

positive aspects, i.e. strengths, of an entity's (organization, group or individual) characteristics, behaviors, processes and experiences, especially the exceptional ones that evoke inspiration (Boyd & Bright, 2007) A common output of studies using appreciative inquiry is the identification of best practices. Giles and Anderson (2007) provide a good example of how appreciative inquiry was able to identify social interactions between teachers and students that had a transformative impact on students' learning where the students were adults entering a tertiary institution for the first time. One theme that emerged in this study was that for adult students, the relationship with the educator as a friend, confidant and companion was critical for learning (Giles & Alderson, 2007).

Summary

Research can be utilized by students, teachers and school administrators to improve quality in outcome-based education. This can be achieved by incorporating research into the curriculum. Research can also serve as a problem-solving activity that seeks causes of the low quality of education, test interventions to improve quality and identify good/best practices in teaching and learning.

Conflict of Interest

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RESEARCH NOTE

Maturing Professional Selfhood through Body Mapping

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Abstract

Nursing education's fundamental goal is to prepare students to effectively transition into practice. Success in this endeavor occurs when the student has a clear sense of themselves as a professional in relationship with their peers and grounded in disciplinary knowledge. Faculty must intentionally create opportunities for students to explore and mature their professional selfhood (PSH) to assist in a smooth transition from academia to practice. Educational strategies which enhance the awareness and continued development of PSH as a birthplace for professional identity may enable the graduate to navigate the healthcare system, mitigate ethical dilemmas, and enhance the quality of life for those they care for and themselves. Aesthetic narratives could be utilized to engage students in the analysis of their PSH as an alternative beyond the dominant text as an expression.

Keywords: *aesthetic; educational strategy; narrative; selfhood; student*

Maturing Professional Selfhood through Body Mapping

How nursing students acquire the necessary knowledge, skills, attitudes, and attributes to create, navigate and sustain professionalism in a variety of settings was the impetus for this article. The purpose of nursing education is to create an environment for experiential learning through a variety of settings - theory, lab, and agency practical work in which to facilitate a successful transition to practice as a professional (Maykut et al., 2019). One would expect the development of professional identity to be stressed during these formative years, to ensure graduates are prepared to enter and navigate a complex healthcare system with competing interests. However, Macginnis and Sturt's (2018) extensive review of the literature, covering 17 years, discovered a paucity of empirical

research regarding the intentional and ongoing commitment to the formation of professional identity in nursing students. Wrigley (2017) has suggested that a curriculum that integrates personal awareness with disciplinary knowledge creates a space where individuals can dissect their worlds in which to revision just ones.

Although there is a vast amount of literature on professional identity for nursing students and practitioners, there is a lack of awareness of the importance of understanding self primordially as a fundamental step to guide how and why we enter into a sacred relationship with another. This examination must address how our social location (power, privilege, and oppression) influences the development of professional selfhood (PSH) (Maykut, 2021). Without this crucial step from self-integration to self-transformation, the ability of the student to create a professional identity reflective of a mature PSH may be limited (Roach, 2002). A mature PSH enables the student to respond to the universal call to be in a relationship as an authentic expression of shared humanity (Roach, 2002) by understanding their situatedness (Heidegger, 2010).

The purpose of this article is three-fold. First, to describe PSH as a foundational concept which needs to be explored in nursing education to lay the groundwork for professional identity. Second, to explain body mapping (BMap) as a potential teaching strategy to create awareness of the multiple influences on a student's PSH. Finally, to share a script to guide the implementation of the strategy and key questions to facilitate a collective discussion. Highlights include the importance of (1) creating an arts-based self-exploration strategy to dissect the world to inform PSH; (2) fostering nursing's voice within the dominant bio-medical paradigm; (3) integrating multiple domains of knowledge to inform PSH; and (4) providing a holistic lens to understand our bodies in the formation of PSH.

Background

Nursing students do not arrive in higher education as a blank slate but bring values, beliefs, and experiences which have informed their identity (Maykut et al., 2019). The purpose of nursing education is to provide the necessary knowledge, skills, attitudes, and attributes to become a safe, competent, ethical and compassionate professional (American Association of Colleges of Nursing [AACN], Canadian Association of Schools of Nursing [CASN], 2019; International Labour Organization [ILO], 2014). Developing a professional self must be contextualized in a humanistic curriculum to inform nursing actions (Curtis, 2014; Curtis et al., 2020). This self must be shaped by disciplinary knowledge of social justice, ethics, relational inquiry, advocacy, and intersectionality. However, critical awareness of PSH must be the initial step to foster self-transformation to begin to dissect who students are as individuals to inform who they are becoming as professionals.

Professional Selfhood

As humans, we come to know ourselves and others when we are in a relationship (Heidegger, 2010; Roach, 2002). Contemplative practices, to examine the self in and with the world, is a critical process for evolving in our humanity to PSH (Roach & Maykut, 2010). Being in a relationship, through the sharing of narratives, creates a liminal space for hearing other's stories which may, in turn, provide insights into our narratives. Fundamentally, as nurses, we must know ourselves first which then informs who we become as professionals. Roach (2002) challenges us as nurses to understand how we come to know ourselves beyond our professional roles to understand how human caring is lived in a relationship.

As nurses, we are in and with the world, suggesting an evolving reciprocal relationship that requires knowledge of, acting on, and engaging with - self, others, and context (Heidegger, 2010). Understanding self is paramount for nursing students to begin to explore how their values and beliefs intersect with their social location and code of ethics to shape their PSH. This initial awareness begins to inform how they are in a relationship with others as multiple perspectives/identities overlap. Being in a relationship with faculty and other role models provides a clear sense of PSH for sustaining and thriving as a professional (Curtis, 2014; Macginnis & Sturt, 2018; Song, 2016; Tan et al., 2017).

Conative Domain of Learning

Nursing education has a long history of foregrounding cognitive and psychomotor domains at the expense of the affective domain. This backgrounding of affective, with conative rarely mentioned in nursing education or practice literature, has limited curricular influence on a holistic approach to PSH development. Conative refers to the commitment to an ideal by embracing attributes, expressed as inherent incentives and willingness, to actualize one's goal (Heiland, 2018; Huitt & Cain, 2011). Integrating the cognitive, psychomotor, affective, and conative domains becomes relevant when understanding the importance of becoming, knowing, doing, and committing to fostering PSH in undergraduate nursing education. Committing to this speaks to the willingness to engage in critical reflection as an individual to enhance a life-long journey as a competent, compassionate, safe, and ethical professional (Maykut et al., 2019).

Developing PSH as a Nursing Student

PSH not only helps the student navigate the healthcare system culture but has also been noted to decrease burnout and improve patient outcomes by providing role clarity (Sun et al., 2016). The responsibility of developing and nurturing a student's PSH resides primarily with the academic institution and faculty. Formative years provide an opportunity for knowledge acquisition, role modeling, and mentoring of said PSH, which then informs ongoing professional identity strengthened by agency partners (Curtis, 2014; Macginnis & Sturt, 2018; Song, 2016; Sun et al., 2016; Tan et al., 2017; Wu, Palmer & Sha, 2020). A difficulty in PSH formation occurs when said curriculum reflects a

biomedical paradigm where nursing's voice is silent and expectations for graduation rely on interpreting and implementing medicine's work.

Body Mapping

BMap initially was an arts-based self-exploration strategy for individuals living with HIV/AIDS to bring the perspective of the sociopolitical influences on their lives (Solomon, 2002). This strategy has been adopted for diverse causes including community building for advocacy and political action (Ebersöhn, 2015; Gastaldo et al., 2013), as therapeutic (Nöstlinger et al., 2015), and as an educational (Botha, 2017; Maina et al., 2013). Gastaldo, Rivas-Quarneti and Magalhães (2018) refined the initial work and introduced BMap as a research methodology.

Nursing education and scholarship have embraced English as the dominant narrative, written or spoken word (Garone et al., 2020; Lahtinen et al., 2014) which privileges individuals who have been educated in this language. Art, as an educational strategy, provides an equitable medium for exploring and challenging this dominant narrative (Darvin, 2019). An aesthetic approach may provide insights into the influences of beliefs, values, relationships, and experiences of the student not fully captured through the dominant narrative of the English text (Darvin, 2019).

BMap as a visual depiction of exploring a phenomenon creates an opportunity to foreground the affective domain, then addressing the cognitive and psychomotor, and eventually culminating in the conative. Thereby, providing a holistic expression and another lens to understand our bodies. Therefore, embodiment (understanding how we express our corporeal reality) is fundamentally important for students as they develop their PSH and also the initial point to understand their client's journey of health (Draper, 2014; Harrison et al., 2019). The body then becomes a place of knowing and experiencing, before interpreting by the mind and expressing outwardly to others. The author developed the script below from a review of the BMap literature and her own Caring Science scholarship informed by 23 years as an educator in undergraduate education.

BMap to Inform the Development of a Selfhood

As human beings, we come to know ourselves when we interact with others and the world around us - a holistic and organic process of sense-making to interpret who we are becoming. Art speaks to parts of our being that are not always stimulated from a purely cognitive and/or psychomotor domain approach (Archibald et al., 2017; Frei et al., 2008). Arts enable us to develop relationality in which to create an identity to interact with the world around us, especially as professionals (Frei et al., 2008). Creativity helps with the unknown by planting seeds of possibility fostering an organic personal learning process. The premise of the script is to guide the nursing student's understanding of sociopolitical influences on nursing practice, enhance congruence between the visual depiction and narration and finally create questions to facilitate collective understanding.

Supplies

Originally BMap used life-size drawings to depict narratives. Certainly, life-size drawings can be utilized or as a cost-saving measure, smaller scales may be utilized on canvas or paper. Craft supplies including but not limited to: acrylics, brushes, crayons, charcoal, colored and pastel pencils, felt, glitter, stickers, sparkle, and watercolors should be provided to the students to stimulate creativity. As faculty, you will need to consider where you will store the BMap between sessions for drying purposes. The script below represents the life-size drawing process, but as earlier suggested scaled drawings may be introduced.

Session One

Body Pose. Each student should be directed to choose a pose that they feel reflects their body stance as a professional. The faculty member or their peer can then use chalk or a pencil to transfer this image onto the paper. Each student will then outline their body using their preferred art tool. Students will then create a powerful symbol and a personal slogan in preparation for session two, as a homework exercise. The script below provides the necessary instructions. Remind students to dress appropriately for the next session as their choice of arts and craft supplies may damage clothing.

Power Symbol. Draw a symbol that represents the integration of your personal beliefs and values with their Code of Ethics. For instance, the pursuit of truth or treating everyone with respect. Think about where this symbol would be located on or outside of your body and why this particular location.

Personal Slogan. Create a personal slogan (a saying, poem, song, or a prayer you say to yourself) which describes your philosophy of life and your life as a nursing student. Think about where you would place the personal slogan on the BMap. You will be asked to share the meaning of the symbol and personal slogan and their location on your body during the collective meaning-making session.

Session Two

The second session begins by providing an overview of what will be accomplished. This session may be broken into three sessions (face, body, and outside of the body) depending on your time commitment. Explanation of the different art and craft supplies (e.g., brushes, paints, and markers) should be provided, you may want to collaborate with other faculty/departments who have expertise in drawing and painting. The scripts below have been developed to facilitate self-awareness while engaging in this aesthetic expression of their professional identity. Bolded words were given more emphasis with tone and body language to reflect their importance in this guided exercise.

The Script – Welcoming. As we begin the process of BMap remember it is an act of self-expression of your physical, emotional, and social health as a nursing student. This is how you see yourself - not how others see you or how you want/wish to be seen. There are no expectations or outcomes, rules, or a particular process of completing this journey. Each one of you will create a unique expression of yourself - What matters to you. Remember, this is your story - your selfhood – all of the experiences to date which live in and on your body! This session has three distinct sections: face, body, and outside of your body. Before beginning each section, there will have a centering exercise to refocus in our body "getting out of our mind and self-talk" to stimulate those creative juices. Please remember to listen to your body and take breaks as needed. I will be circulating throughout the room to offer support and encouragement. Any questions before we get started?

Centering Exercise and Questions: Face. Close your eyes and begin to take deep breaths through your nose and out through your mouth. Our souls are who we are as human beings; this is the essence of our humanity. Soul work for nurses is about finding the sacred. It is about becoming "visible" in our pursuit of finding meaning and purpose in our practice. It's about making a difference - contributing to humanity. You have all decided to enter a nursing program to make such a difference, to leave your mark on the world.

As nursing students creating your **Professional Selfhood** is a life-long journey that has started before today. Who you are has been shaped with many encounters in life; with family, friends, work, and hobbies to mention a few. There are moments of joy and wonder, and also sadness and defeat. Think of how both types made you feel? How does your body respond right now, thinking back and remembering these moments?

REMEMBER: This is who you are, this is your story, and this is what is important for you to tell the world! Keep taking long slow breaths. Our faces capture and reflect our humanity ... joy, wonder, shame, vulnerability, loss of connection - many emotions live on our faces. ***Now open your eyes and let's begin to express ...***

1. We all have the same features (face - eyes, nose, ears, hair, chin, cheeks, eyebrows … lines of tension) yet we all look different.
2. How do you want to represent your face - as you see it or **symbolically**?
3. Do you have a **singular face** you show the world which is congruent with your one? Or do you have two faces - one you show the world and one you keep to yourself; why?
4. What was represented on your face during the moments of joy and wonder, and sadness and defeat?
5. What **colors and shapes** would best depict these moments? Think about the particular aspects of your face - eyes, nose, ears, hair, chin, cheeks, eyebrows … lines of tension.
6. What do you **love about your face**? What do you want people to take notice of? Why is this important to you?

Centering Exercise and Questions: Body

Sit comfortably in your chair. Close your eyes again and take long slow breaths. We ask our

bodies to do much - pull, push, carry, jump, skip … We carry our interactions with others and our environment in our body's posture. Become aware if there are any areas of tension in your body as you relive the experiences you have been remembering. Focus on these areas sending release - giving yourself permission to identify and let go of the negative aspects. ***Now open your eyes and let's begin to express ...***

1. Returning to the moments - how did these experiences live **"visible signs"** in your body - how were they made visible to you and perhaps others? How did you come to process this experience in your body?
2. Were there **specific areas** where these moments continue to live? How do they live in your body (muscles, joints, organs, skin …) what are the signs? What are your body cues when you are at ease and when you are uncomfortable?
3. What **meaning** do you assign to these signs - why are they still around - what purpose do they have?

Centering Exercise and Questions: Outside Your Body

As we move outside our body - we can lose control over what matters to us. Remember there is no right or wrong only what is BEST to represent your journey. You may wish to begin this process by adding your Power Symbol and your slogan to help situate this aspect of your self-expression. ***Now open your eyes and let's begin to express ...***

1. What are the **socio-political influences** on your role as a nursing student? These might include (a) family and friend dynamics, roles and responsibilities, (b) paid or volunteer work, (c) power and privilege within the classroom and/or agency. Think about how these influences are shaping who you are becoming as a future nurse.
2. How do you **manage** these influences? What are the resources (human and material) which support you: relationships, hobbies, and other activities which "feed your soul"? Where do you get your **strength** from?
3. Where do you want to go? How do you want your practice to evolve? What does **your professional life path** look like?
4. Where do you want to place your **slogan**? Where do you want to place your **power symbol**?

Stand back and review your body map ...

1. Have you **captured your journey** as you have begun to understand how the life experiences before nursing education live in your body and influence your PSH?
2. Is there anything **else you want to add** to your story - face, body, and/or outside your body?
3. What do you **want others to see** in this visible representation of self?

Session Three

Sharing of Narratives to Enhance Collective Understanding. As narratives reflect a journey of coming to know shaped by vulnerability, an opportunity not to share their work and/or engage in the process must happen as a democratic act of education (hooks, 1994). Before the commencement of this session, you may want to establish ground rules. A respectful venue for sharing of BMaps and narratives creates an opportunity for students to understand the importance of

multiple influences on PSHs – recognizing everyone has a unique story expressed in their BMap.

Depending on the number of students in your class you may want to separate them into smaller groups initially and then bring them together for a richer discussion. A suggestion of creating groups where students do not know each other very well may provide diversity in personal experiences which will enrich this educational strategy for all students. Realizing there is not ONE preferred expression but PSHs are fluid over a lifetime begins a shift to inclusionary practices necessary for nursing practice (Kagan et al., 2010; Willis et al., 2014).

1. Assign or ask for a student volunteer to transcribe notes of the discussion and one to ask the questions for collective understanding.
2. Each student will share their BMap (body, face, and outside of the body) and their slogan and power symbol.
3. Once everyone has had a turn begins the facilitated discussion.

Facilitated Discussion for Collective Understanding

1. Did you have any difficulties "living in your body" versus wanting to "think about the experiences" while engaged in the exercise? Why do you think other parts of your body (mind) like to take over and interpret the moment?
2. What are the similarities and differences in the BMaps? Do you feel there is value in having diversity in PSHs - why or why not?
3. Now that you know that understanding PSH is the birthplace of developing a professional identity, what knowledge, resources, and support (family, friends, peers, and mentors - faculty and/or healthcare professionals) will you need to continue to develop as a nursing student?

Conclusion

Critical examination of the influences of PSH must begin during nursing education as a formative process in which to inform ongoing development as a professional. Educational strategies which foreground the affective domain while also incorporating the psychomotor, cognitive, and conative domains create space for a holistic interpretation of "What does it means to become a professional?" Faculty could adopt strategies, such as the BMap proposed, which challenge the student to integrate their personal and professional selves and recognize the diversity of PSHs as richness for nursing practice. Collective understanding of the many influences and expressions of PSH provides the student the opportunity to imagine their professional reality while supporting their peer's journey. This journey of becoming professionally caring persons will enable the student to create and sustain a virtuous life for those they are called to care for and for themselves (Roach, 2002).

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About the Author

Dr. Colleen Maykut, over the last 33 years of her career, has upheld the values of professional nursing and acted as an advocate for healthcare system transformation and as a knowledge disrupter for nursing education reformation. She designs relevant learning experiences which are inclusive, engaging, innovative, collaborative, and inspiring; creating opportunities for students to develop as individuals to reach their full potential. She is cognizant of the importance of challenging ideals of privilege, which influences who has power and voice and engages in liberation to address structural inequities. Integrating social justice principles of honouring diversity and creating inclusion are foundational building blocks to be mentored in the classroom to shape and influence all students' future practice.

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General Guidelines

Manuscript submitted for publication must meet the following minimum requirements:

- The research topic is aligned with the research theme (for themed issues) or coverage
- Follow the modified IMRAD structure and APA 7th edition formatting.
- Authors must be willing to subject their paper to peer review.
- The paper must be written in English. Any language other than English must have accompanying translation with it.
- Must have undergone an ethics clearance with proof such as certification or ethics clearance approval sheet.
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The submitted manuscript should have a manuscript title and should not contain information about the author. It should consist of the following parts: Abstract, Keywords, Introduction, Methods, Results, Discussion Conclusion, Acknowledgement, and References.

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Discussion: This section should highlight the current findings and the similarities and differences with previous researches. New and important aspects of the study should be emphasized. Further, end the study with limitations but not confined with the external validity of the results.

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References

The references should be cited in the text and styled in the reference list based on the 7th edition of the American Psychological Association (APA 7th edition). Articles will be returned if the required formatting style is not followed.

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1. Tables should be cited accordingly using Arabic numbers with the appropriate caption above it. Legends, the definition of abbreviation, and explanatory notes must appear below the table.
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About the Cover

In times of a crisis, sickness, and unforeseeable changes, people would always need a hand to help them pave the road through the unknown as it is only then that they would be able to understand, appreciate, and even create meanings out of the situation on hand. The artwork aims to embody Dorothea Orem's Self–Care Deficit Theory in which the main purpose of the theory is to emphasize how nurses provide caring and support for patients when they are not able to do it themselves due to limitations in their physical health.

The nurse's hand carrying the puzzle piece depicts how the act of caring is the missing component which could complete a person's path towards the unknown as it was stated in the theory that two of the five methods of helping include guiding others and supporting another with the hopes of allowing once physically limited patients to meet their needs and demand in the future.

A helping hand towards understanding the unfolding events in a person's life does not always have to be a familiar hand, rather could also be a hand of compassion, empathy, and caring. Nurses are willing to extend not only their hands but also their hearts.