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Nursing Practice During a Mission in Nepal: Ethics and Leadership

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Abstract

The ability of nurses to reflect or critically examine the impact of professional standards of practice, legal guidelines, and ethical frameworks that influence and guide their practice is essential to help patients achieve quality of life and wellness. Regardless of the location and setting where nursing takes place, contextual factors such as the benefits and potential harm resulting from the care provided, availability of resources, the nurse's scope of practice, and evidence-based practice guidelines, all affect a nurse's ability to practice in a safe, ethical, competent, caring, and compassionate manner.

Using an exploratory case study to investigate nurses' (n=9) view of their practice during a 15-day mission in Nepal, semi-structured interviews, perusal of documents, archival records, physical artifacts, and observation contributed to understanding the experience of nursing in the mission. A modified version of constant comparative analysis was employed to examine, code, and triangulate data into themes. Benner's (2001) novice-to-expert levels of proficiency and an ethics of care provided the conceptual frameworks to support and facilitate the research through an Interpretivist lens. A strength-base care approach to nursing practice and the examination of the critical role of effective and ethical mission leadership also assisted to understand nursing practice in the mission. The findings demonstrate the impact of individual, group, and situational factors on the participants' ability to nurse during the mission and practice in a safe, ethical, competent, caring, and compassionate manner. Given the lack of available literature and research, the findings of this study contribute to the current yet limited knowledge about nursing practice during missions.

Keywords: missions, global health, novice to expert, strength-based care, ethics of care, case study research, effective and ethical leadership.

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To all the nurses who care about, for, and with others, thank you for healing our world.

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Positionality

Interpretivist researchers acknowledge that they bring biases into their research. Consequently, their personal background, which includes personal, cultural, educational, and historical experiences influences the interpretation of their findings (Creswell, 2014). Therefore, they make their biases, values, assumptions, and experiences explicit when they describe their research. For the purpose of bracketing, acknowledging, and describing biases and values brought into the study (Gearing, 2008; Ponterotto, 2005), the researcher offers the following reflection about this study.

The researcher is female, middle 40s, and is perceived to be white. This is the first major study conducted by the researcher who grew up, studied, and has worked in Canada. The researcher has been a registered nurse for 23 years, and the last 15 years have been spent teaching as a full-time nursing professor in a College-University system that offers a degree in Nursing. The professional background includes various types of nursing practice in the neurosciences, cardiac care, medicine, surgery, palliative care, oncology, and psychiatry in the hospital, community, and long-term care settings. The researcher has nursed in cities, rural areas, and an indigenous peoples reserve. Before this mission, the researcher volunteered in three missions in developing countries as a nurse, nurse educator, and nursing instructor. The researcher is passionate about nursing practice, social justice and ethical issues, global health, and helping people by using the understandings and skills acquired in life. The opportunity to investigate nursing practice in this study supports the efforts to promote global health and the advancement of nursing practice by contributing to the limited knowledge about the nursing care that takes place during a mission.

Chapter 1

Introduction to the Study

This first chapter provides the background to the investigation and overall format of the dissertation. It begins with a brief discussion of missions and "Western-informed" nursing practice during missions in developing countries, which is followed by the problem of practice, purpose of the study, and the three research questions addressed in the investigation. Next, the definitions of key terms in the study and a brief description of the research design and methodology are provided, followed by an overview of the findings, significance of the research, and the limitations of this study. To end, a general organization of the dissertation is presented, followed by the chapter summary.

1.1 Missions and Nursing Practice During Missions in Developing Countries.

As a 'human caring' science, nursing practice has a moral and social responsibility to address those issues, which impact the health of people on a local, national, and international level (Tyer-Viola, Barry, Hoyt, Fitzpatrick & Davis, 2009). Due to their professional education and expertise, nurses' work promotes global health and contributes to the achievement of the United Nations Sustainable Development Goals (United Nations, 2016). Such goals include

eradicating extreme poverty and hunger; achieving universal primary education;

promoting gender equality and empowering women; reducing child mortality; improving

maternal health; combating human immunodeficiency virus/acquired immune deficiency

virus (HIV/AIDS), malaria and other diseases; ensuring environmental sustainability, and

developing a global partnership for development (Bonilla & Beukeboom, 2017, p. 153).

Volunteering in missions provides nurses and nursing students with an opportunity to promote health, prevent illness, restore health, and alleviate the suffering of vulnerable

populations in developing countries (ICN, 2012). Nurses from anywhere in the world who

volunteer in missions, must follow their homeland's professional code of ethics, legal guidelines,

and standards of practice to ensure accountable, safe, ethical, and competent nursing practice

(ANA, 2010; CNA, 2015; ICN, 2012). To this end, the International Council of Nurses (ICN),

and other organizations such as the International Red Cross, Médecins Sans Frontières (MSF)

also known as Doctors without Borders, the World Health Organization (WHO), the United

Nations Children's Fund (UNICEF), and the United Nations Organization for the Coordination

of Humanitarian Affairs (UNOCHA) have developed general policies and guidelines to ensure

that health care workers provide safe and competent care during medical missions (Abramowitz,

Marten & Panter-Brick, 2014; Hunt, Schwartz, Pringle, Boulanger, Nouvet & O'Mathuna,

2014a; Leader, 1998; Slim, 1997).

The general expectation for health care professionals, from anywhere in the world, during

missions is that they follow the 'latest' evidence-based practice guidelines, as well as their

homeland's professional standards of practice and code of ethics (Hunt, 2011; Hunt, Schwartz,

Sinding & Elit, 2014; Kemp, 2007; Oliphant, 2016). The involvement of nurses in medical

missions is not a new concept; however, a review of the literature suggests that nurses and health

care professionals in general, feel unprepared for handling and resolving many ethical and

practice issues encountered during missions (Arya, 2017; Bajkiewicz, 2009; Collinson, 2014;

DeCamp, 2011; Hunt et al., 2014a, 2014b; Ripp & Scudder, 2011; Tyer-Viola, Barry, Hoyt,

Fitzpatrick & Davis, 2009; Zinsli & Smythe, 2009).

International nursing practice must convey respect and understanding of cultural diversity

with regard to values, beliefs, attitudes, behaviors, and cultural norms. To this end, individual

reflection about ethics, evidence-based practice, and standards of care that guide nursing during

missions is essential. Nurses must critically examine the benefits and harm to patients that result from their practice, availability and lack of resources, contextual factors, and the need to update or develop policy to support nursing practice in missions. Consequently, nursing leaders must develop appropriate frameworks to support and educate nurses and student nurses about safe, ethical, competent, caring, and compassionate nursing practice during missions in developing countries.

1.2 Purpose of the Study, Problem of Practice, and Research Questions

The purpose of this study was to explore nursing practice and the contextual factors that affect a nurse's ability to practice in a safe, competent, ethical, caring, and compassionate manner during a mission in a developing country. Nurses have a professional and moral obligation to assist people in maintaining or regaining health, wellness, and quality of life (ICN, 2012). Advocacy, social justice, human rights, and policy changes are key elements that promote safe, ethical, competent, caring, and compassionate nursing practice regardless of the location where it takes place. Nursing practice during missions must demonstrate respect, understanding of cultural diversity, and avoid paternalistic behaviors and attitudes that continue to marginalize people in developing countries (Benatar, 2002; Davis, 1999; Levi, 2009). Therefore, reflection or critical thinking about their nursing practice during missions helps nurses to evaluate the care provided to patients.

The literature review in this thesis supports the need for further research to assist health care professionals, including nurses, to deliver culturally competent and ethical care during missions in developing countries (Arya, 2017; DeCamp, 2007, 2011; Hunt, 2008, 2011). At present, there is limited literature available regarding 'best practice' guidelines for nursing practice during missions in developing countries. Health care professionals, including nurses, are

generally not satisfied with the application of available resources, which include codes of ethics, evidence-based practice guidelines, and standards of care from developed countries during missions in developing countries (Bajkiewicz, 2009; Collinson, 2014; DeCamp, 2011; Ripp & Scudder, 2011). Consequently, nurses often question their ethical, professional, legal, and cultural competency during missions in developing countries, which in turn often leads to moral distress among those practitioners (Bajkiewicz, 2009; Ripp & Scudder, 2011; Schwartz, Sinding, Hunt, Elit, Redwood-Campbell, Adelson, Luther, Ranford & DeLaat, 2010; Tyer-Viola et al., 2009; Zinsli & Smythe, 2009). Therefore, this research study explored the following three questions:

1) How do nurses make competent and ethical clinical decisions during a mission in a developing country?

2) What factors influence nursing clinical decision-making during a mission in a developing country?

3) How do nurses define and evaluate competent and ethical nursing practice during one mission in a developing country?

Additional research specific to the context of missions is intended to ultimately assist with the development of evidence-based practice guidelines, care protocols, and policies to support the needs of nurses who volunteer in missions and ensure safe, competent, ethical, caring, and compassionate practice during missions in developing countries.

1.3 Definition of Terms

For the purpose of this investigation, the definitions of key terms are provided below.

Case Study. "A study that investigates a contemporary phenomenon in depth and in its real-world context" (Yin, 2014, p.237).

Caring nursing practice. In this study, caring about, for, and with people provided the framework through which the participant nurses interacted with people, including patients, families, and the local and mission teams to find meaning in their experiences, as well as promote health and wellness. Caring nursing practice was reflected through actions and attitudes that nurtured, fostered growth, recovery, health, and the protection of vulnerable people (Roach, 1992, 1997).

Compassionate nursing practice. In this study, this term is operationalized to mean the ability of nurses to recognize and be aware of the suffering of another, while maintaining commitment to providing care with competence, knowledge, and skill (Canadian Nurses Association, 2017).

Competent nursing practice. In this study, this term is operationalized to mean the integrated knowledge, skills, judgements, and attributes required of nurses to practice in a safe, ethical, compassionate, and caring manner (Canadian Nurses Association, 2017).

Confirmability. With regard to a study findings, confirmability is a criterion of trustworthiness that relates to the match between the findings, data, and the researcher's interpretations (Given & Saumure, 2008; Patton, 2015)

Constant comparative analysis. The constant interaction of data, analysis, and theory resulting in the development of theory from the data being examined (Glaser & Strauss, 1967; Corbin & Strauss, 2008).

Construct Validity. "The accuracy with which a case study's measures reflect the concepts being studied" (Yin, 2014, p.238).

Credibility. With regard to the study findings, credibility is a criterion of trustworthiness that refers to the ways in which the researcher's interpretations have accurately and richly

described the phenomenon investigated and the participants' life experiences (Given & Saumure, 2008; Patton, 2015).

Critical thinking. For the purpose of this study, this term is operationalized to mean the habits and skills of the mind, which include cognitive and affective components essential to engage in clinical decision-making that promotes safe, competent, ethical, caring, and compassionate nursing practice regardless of the context and location where nursing practice takes place (Scheffer & Rubenfeld, 2000).

Culture. "The learned values, beliefs, norms and way of life that influence an individual's thinking, decisions and actions in certain ways" (College of Nurses of Ontario, 2009, p. 3).

Dependability. With regard to a study findings, dependability is a criterion of trustworthiness determined through the systematic, logical, and traceable way in which a researcher describes procedures and data collection measures (Given & Saumure, 2008; Patton, 2015).

Ethical nursing practice. In this study, ethical conduct was reflected by fundamental values, responsibilities, attitudes, and behaviors of nurses required to promote patient health and wellbeing. These include but are not limited to providing safe, compassionate, competent, and ethical care; promoting health, wellbeing, respect for informed decision-making and justice; preserving the dignity of patients, maintaining privacy and confidentiality, as well as being accountable (Canadian Nurses Association, 2017; International Council of Nurses, 2012).

Ethics of care or Ethic of care. A normative ethical theory centered on interpersonal relationships, context, empathy, care, benevolence, and women's ways of relating as guides to moral action, which differ from justice and moral obligation masculine approaches to ethics.

Original contributors such as Gilligan, Noddings, and Tronto emphasize care focus feminism, which focuses on the importance of context and social relations. (Gilligan, 1982; Keatings & Smith, 2010; Noddings, 1984).

Ethics. "A branch of philosophy that deals with questions of right and wrong, ought and ought not in [nurses] interactions with others" (Canadian Nurses Association, 2017, p. 22).

Exploratory case study. Intentional, systematic data collection designed to generate insight and understanding about phenomena, which can lead to further investigations (Yin, 2014).

External validity. "The extent to which the findings from a case study can be analytically generalized to other situations that were not part of the original study" (Yin, 2014, p. 238).

Fitness to practice. For the purpose of this study, the term is operationalized to mean the knowledge, experience, skills, as well as qualities and capabilities of an individual required to practice as a registered nurse, including but not limited to freedom from any cognitive, physical, emotional, and psychological condition, and dependence on alcohol or drugs that impairs the ability of an individual to practice nursing in a mission (Canadian Nurses Association, 2017).

Global Health. The optimal wellbeing of all humans from an individual and collective perspective, considered to be a fundamental human right that should be accessible to all people (Canadian Nurses Association, 2017).

Internal Validity. Does not apply to exploratory case studies that are qualitative in nature because they do not seek "to establish a causal relationship, whereby certain conditions are believed to lead to other conditions, as distinguished from spurious relationships" (Yin, 2014, p.46).

Local Team. In this study, the term is operationalized to mean the health care professionals from Nepal.

Mission. In this study, the term is operationalized to mean an experience that requires volunteer health care professionals to provide various forms of medical and nursing care to people of low or no resources in a developing country.

Mission Team. In this study, the term is operationalized to mean the health care professionals that volunteered to go on the mission to Nepal to provide free health care services to people of limited or no resources. They also provided education to the local team from Nepal.

Modified constant comparative analysis. Derived from constant comparative data analysis in grounded theory (Glaser& Strauss, 1967). In this study, the research protocol was implemented, followed by data collection, and most of the data analysis took place after all the data were collected.

Moral distress. "Stress caused by situations in which one is convinced of what is morally right but is unable to act; results when moral issues are unresolved and when supportive processes are not in place" (Keatings & Smith, 2010, p.428).

Moral residue. The reactive distress that arises after a situation of moral distress, which involves lingering feelings of one's failure to deal with moral distress and can lead to a loss of personal moral identity (Epstein & Hamric, 2009).

Nurse. For the purposes of this study, all participants were registered nurses (RNs) with the education, knowledge, and expertise required of RNs to provide care and education during the mission.

Nursing ethics. The concern of nurses about social issues that affect the health and wellness of people requires nurses to maintain an awareness of issues related to social justice.

There are various factors that affect social determinants of health and the wellbeing of people, and therefore, require nurses to advocate for people's needs and act to initiate and implement change in the system (Canadian Nurses Association, 2017).

   Participant. "A person from whom the case study data are collected" (Yin, p. 240). In this investigation, the participants were nine registered nurses who volunteered to provide nursing care in the mission.

   Participant-observation. "The mode of data collection whereby a case study researcher becomes involved in the activities of the case being studied" (Yin, 2014, p.240). In this study, the researcher was also a volunteer nurse in the mission team, and therefore provided nursing care to patients and education to the local team during the mission.

   Reliability. "The consistency and repeatability of the research procedures used in a case study" (Yin, 2014, p.240).

   Safe nursing practice. In this study, the term is operationalized to mean the commitment of nurses to avoid, reduce, and mitigate unsafe and harmful acts within the context of the mission through the use of knowledge, skills, and experience demonstrated to lead to optimal patient outcomes. Safe nursing practice was not an exclusive individual responsibility, and required collaboration with the mission and local teams, as well as familiarity with the context of the mission (Canadian Nurses Association, 2015, College of Nurses of Ontario, 2014).

   Strength-Based Care. An approach to nursing practice that focuses on patients' strengths, capabilities, and resilience, as well as working with people to build and enhance skills to cope and find ways to manage their life challenges (Gottlieb, 2013).

Transferability. With regard to a study findings, transferability is a criterion of trustworthiness that relates to how well others can determine an alternative context to which the study findings can be applied (Given & Saumure, 2008; Patton, 2015).

Triangulation of data. "The convergence of data collected from different sources to determine the consistency of a finding" (Yin, 2014, p.241).

Trustworthiness. Relates to the ways in which qualitative researchers ensure that their findings have worth outside of the context of their studies. It is demonstrated through the criteria of credibility, confirmability, dependability, and transferability, which address the trustworthiness or rigor of the research findings (Given & Saumure, 2008; Patton, 2015).

Vulnerable patients/people/populations in missions. For the purpose of this study, the term is operationalized to refer to people in developing countries who require health care services and various forms of social support, which are not available as a result of social inequities and marginalization.

1.4 The Research Design and Methodology

The purpose of this study was to explore nursing practice and the contextual factors that affect a nurse's ability to practice in a safe, competent, ethical, caring, and compassionate manner during a mission in a developing country. Following Western University's ethics approval of the study, the researcher obtained further approval to conduct the study and volunteer as a nurse with a non-profit, non-governmental American organization that provides cardiac surgical and outreach-community care through medical missions. An exploratory case study research design (Yin, 2014) was used to obtain insight about the phenomenon of nursing practice during a 15-day mission in Nepal. Purposive sampling of the volunteers who applied to volunteer in the mission led to nine participants who provided nursing care during the mission.

An Interpretivist research stance influenced by a constructivist perspective guided this investigation. Various forms of data collection including interviews, direct observation, participant-observation, documentation, archival records, and physical artifacts were utilized. The researcher kept written and audio taped field notes to clarify biases, engage in reflection, and record information, which contributed to creating an audit trail and data base of the knowledge constructed in the investigation. A modified constant comparative method of analysis (Corbin & Strauss, 2008) was used to code data and generate themes, which led to the study's findings. Member checking was used to clarify and validate the accuracy of the data and interpretation of the findings at various stages of data collection and analysis. Triangulation of data increased confidence in the validity of the research findings (Yin, 2014). The validity, reliability, as well as credibility, confirmability, dependability, and transferability to address the trustworthiness or rigor of the research findings were addressed in various ways that are discussed in chapter 3. Ethical considerations and protocols (Appendix G) were followed throughout the study to ensure and promote the safety of participants, patients, and people involved in the investigation.

1.5 Overview of the Findings

According to hospital records and the local team, 75% of their patients were illiterate and worked in agriculture related activities. The local team spoke English but most of the hospital staff and all the patients did not. The local nurses in the intensive care unit were young and had been practicing nursing for six months to three years. They were eager to learn, but were shy to demonstrate what they knew and stated they could not do many things without a doctor's order. In this study, three types of factors affected nursing practice during the mission. The participants' capacity to handle specific challenges triggered by individual, group, and situational factors determined their ability to meet the mission goals while practicing in a safe, ethical, competent,

caring, and compassionate manner. Individual factors included the ability to adapt to the environment while continuing to practice in an autonomous manner. Nurses' knowledge, experience, and confidence in their ability to practice within the context of the mission were vital. Furthermore, the individual participant's capacity to be flexible when problem-solving challenges and meeting needs was an essential skill to possess, as well as the ability to integrate the art and science of nursing while making sense, finding purpose, and 'doing no harm'. Finally, nurses' perception of involvement in meaningful work and vison while serving others, and the moral distress experienced due to the inability to provide the required care influenced the participants' effective, safe, and ethical clinical decision-making. The team dynamics, as well as the application of evidence-based practice and care protocols to guide nursing care and teach the local staff were group factors that assisted to clarify individual roles and expectations. Participants encountered challenges related to critical situational factors associated with cultural norms, hegemony, hierarchy, and power imbalances, as well as the lack of resources due to social inequities.

1.6 Significance of the Study

The findings from this study contribute to the limited knowledge about nursing practice during missions in developing countries. The investigation offers a research format for conducting future research to support nursing practice during missions that promotes 'global health' for vulnerable people in developing countries. The study findings support more discussion, research, and the critical assessment and evaluation of contextual factors that affect safe, competent, ethical, caring, and compassionate nursing practice regardless of the context and location in the world. The phenomenon of nursing practice and leadership within the context of missions is quite complex given the individual capacities, knowledge, skills, experience, and

cultural sensitivity required of nurses. Furthermore, the study generated insight about the need to

further develop policy, evidence-based practice guidelines, and care protocols for nursing

practice during missions in developing countries. It is hoped that the reader will develop an

understanding of the participants' experiences, and will apply that insight as they see fit to their

life experience.

1.7 Limitations of the Study

The study limitations relate to the specificity of the context of the medical mission with

regard to type, length, purpose, and location. While the findings may not be generalizable, they

contribute evidence to what is currently a limited knowledge about nursing practice in a mission,

and the contextual factors that influence nurses' ability to practice in safe, competent, ethical,

caring, and compassionate manner. In this study, a pilot was not undertaken.

1.8 Organization of the Dissertation

The dissertation is presented in six chapters. Chapter 1 provides background information

about nursing practice during missions in developing countries, and the research questions that

facilitated its exploration in this study. The definitions of key terms used in the investigation are

presented, with an overall discussion of the research design and methodology employed in the

study. An overview of the findings and significance of this research is also provided, followed by

a consideration of the study limitations and the overall organization of the dissertation.

Chapter 2 provides a literature review of the phenomenon of nursing practice in missions,

as well as themes and issues pertaining to the research questions and the propositions in this

study. The current knowledge about missions and nursing practice during missions in developing

countries is examined, as well as gaps in the literature that require further investigation and

support the need for the study. This is followed by an examination of Benner's (2001) novice-to-

expert framework and an ethics of care, which are the conceptual frameworks that guide this investigation. A discussion of a strengths-based care approach, and the impact of effective and ethical leadership to guide nursing practice during missions in developing countries is also provided.

Chapter 3 examines the methodology used to conduct this study. After briefly addressing the research questions, the epistemological assumptions and theoretical perspective that guide the study are provided, followed by a discussion of the research design, the role of the researcher, participant-researcher relationship, and the participants. The data collection measures, which included interviews, direct observation, participant-observation, documentation, archival records, and physical artifacts are examined in detail. The data analysis section includes an exploration of the methodology, researcher's analytic and reflective journal, member checking, and peer review. The chapter ends following a discussion about triangulation and trustworthiness of the study.

Chapter 4 examines the findings obtained in this investigation following the transcription of 18 semi-structured interviews conducted with individual participants, as well as the researcher's reflections as a nurse, during and after the mission. Using a modified constant comparative analysis (Corbin & Strauss, 2008), data were coded and categorized into central themes that explain the phenomenon of nursing practice during the mission in a developing country. In this study, three types of factors had an impact on nursing practice during the mission. Individual, group, and situational factors affected the ability of the participants to practice in a safe, ethical, caring, competent, and compassionate manner. The chapter provides a description of each factor and their effect on the participants' nursing practice in the mission.

Chapter 5 provides a discussion of the findings obtained in this investigation in relation to nursing practice and leadership in a mission, which adds to the current understanding of the phenomenon of nursing during a mission in a developing country. Each research question was addressed taking into consideration the application of the findings to promote safe, competent, ethical, caring, and compassionate nursing practice.

Chapter 6 details the conclusions and examines the significance and implications of the study to nursing practice and leadership in a mission. The contribution of the findings to our understanding of the challenges nurses face when providing safe, ethical, competent, caring, and compassionate care to people during missions in developing countries is examined in detail. A discussion of each research question in the study explores their implications for nursing practice and leadership. This is followed with recommendations to support nurses who commit to providing care in missions, and general suggestions for further research and policy development about nursing practice in missions. The chapter ends with a discussion of the study limitations and the researcher's final reflection about conducting the study and nursing in a mission.

1.9 Chapter Summary

The research in this investigation was nested in an exploratory case study that provides valuable insight regarding nursing practice during a mission in a developing country. An ability to study the phenomenon within the context of a mission provided information about the complexity of nursing practice and the influence of contextual factors, which ultimately impact the quality of nursing care provided. This chapter provided the overall framework for the study, which is guided by an Interpretivist research stance, and presented the overall organization of the dissertation. To continue, chapter 2 will explore the literature review and conceptual frameworks that pertain to the investigation.

Chapter 2

Literature Review

The background literature related to the phenomenon of nursing practice in missions, as well as themes and issues pertaining to the research questions and the propositions in this study, and the conceptual frameworks that can guide nursing in missions will be reviewed in this chapter. The knowledge gap about missions and nursing practice during missions is discussed first, followed by an examination of Benner's (2001) novice-to-expert and an ethics of care conceptual frameworks. The consideration of how a strengths-based care approach to nursing practice, as well as effective and ethical leadership can support nursing practice during missions in developing countries is also provided.

2.1 Missions in Developing Countries

The literature review includes peer-reviewed research, nursing practice journals, and grey literature from magazines, books, and social media published in English from the United States, Canada, United Kingdom, Netherlands, Switzerland, Thailand, Tanzania, and New Zealand. The search accessed professional organizational websites including Medècines Sans Frontiéres (MSF, also known as Doctors without Borders), International Council of Nurses (ICN), Canadian Nurses Association (CNA), American Nursing Association (ANA), College of Nurses of Ontario (CNO), Registered Nurses' Association of Ontario (RNAO), and the World Health Organization (WHO). The International Federation of the Red Cross (IFRC), United Nations Children's Fund (UNICEF), United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), Pan American Health Organization (PAHO), Sphere Project, Humanitarian Health Ethics Net (HHE), and the Ethics of Engagement and Service-Learning Project (EIESL) from the University of British Columbia were also included. There were no parameters set for publications given the

lack of relevant literature found at the beginning of the search, which included disaster relief, war, crisis, and humanitarian missions because careful examination of the literature revealed that all the different types of medical missions include a discussion of short-term missions. The online search accessed various databases including Proquest, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), SCOPUS, and Google Scholar. Key article reference searches were conducted, and the two social media sites linkedin and twitter were accessed as well.

The literature review includes material from the disciplines of nursing, medicine, social sciences, women studies, anthropology, politics, education, and ethics. It identified 120 articles from 1995 to 2017 that directly or indirectly examine health care workers' ability to provide safe, ethical, and competent medical care during short-term medical missions in developing countries. The five recurring major themes identified in the literature review regarding short-term missions in developing countries will be discussed next, with an emphasis on how they inform and justify the research that was ultimately undertaken in this study.

2.1.1 Successful missions require careful organization. The literature examines a variety of factors that must be taken into consideration when planning and organizing ethical missions. These include the type of mission, available resources, weather, transportation, food, lodging, taxes and fees, as well as the medical supplies that might be needed (Solheim & Edwards, 2007). Other factors such as the safety of volunteers, recruitment criteria, appropriate cultural training, as well as reflection and debriefing of experiences encountered during and after the mission need careful attention (Arya, 2017; Daniels & Servonsky, 2005). Practical considerations when organizing ethically sustainable international experiences include a 'fit' between the type of mission and an appropriate model to deliver the care. For example, surgical

missions require the means to ensure patient safety and comfort, sterile technique, equipment, and supplies. The development of the mission site, establishment of sustainable relationships with organizations, various stakeholders, and the community, as well as the careful evaluation of the care provided are also critical elements (Memmott, Coverston, Heise, Williams, Maughan, Kohl & Palmer, 2010).

  2.1.2 Nursing guidelines and standards of practice are necessary to guide practice, clinical decision-making, and the implementation of safe, ethical, and competent care. Available intercultural nursing theories, standards of practice, and legal rules in developed countries do not provide satisfactory guidelines within the context of missions in developing countries. There is a lack of research about nursing practice during missions. Also, there is not a lot of information available about what constitutes competent and ethical nursing practice during missions in developing countries. Most of the research identifies that health care professionals experience ethical dilemmas and moral distress due to lack of resources and differences in cultural values and beliefs (Hunt, 2008, 2011), but does not examine how clinical decision-making takes place in general during missions. Further development of appropriate frameworks to guide nursing practice that are based on principles of culturally relevant competent and ethical care, advocacy, and social justice are needed (Douglas, Oierce, Rosenkoetter, Pacquiao, Callister, Hattar-Pollara, Lauderdale, Milstead, Nardi & Purnell, 2011; Douglas, Rosenkoetter, Pacquiao, Callister, Hattar-Pollara, Lauderdale, Milstead, Nardi & Purnell, 2012)**.** Moreover, nurses have an ethical and professional responsibility to involve patients in the assessment of their needs, as well as the implementation and evaluation of the nursing care provided. In developed countries, this typically occurs as nurses establish a therapeutic relationship with patients, discuss concerns, provide care, and obtain feedback about the effectiveness of their

actions. Therefore, during missions, nurses must continue to obtain information about patient needs and the care that is received to be able to maintain or improve the quality of nursing care provided in missions. Nurses also play a critical role in ensuring appropriate and effective communication among organizations, the health care workers involved with the medical mission, and the people and communities that are recipients of the care provided (Solheim, 2005, 2010; Tschudin & Schmitz, 2003).

      2.1.3 Ethical frameworks can assist health care workers to problem-solve ethical issues during missions. The ethical challenges encountered during missions vary greatly because of the different cultural, socio-economic, political, and environmental factors relevant to the specific context of the missions. Comprehensive, relevant, and easy to use ethical frameworks to guide decision-making must be explored (DeCamp, 2007; Hunt, 2008; Hunt, Schwarts, Pringle, Boulanger, Nouvet, & O'Mathuna, 2014; Hunt et al., 2014b). To ensure the correct application of available ethical frameworks, volunteer health care workers must receive the necessary training before the mission (Hunt, 2011; Schwartz et al., 2010; Sheather & Shah, 2010; Zinsli & Smythe, 2009). Current standards of practice, ethical and humanitarian principles applied during missions must reflect the evolution of knowledge, values, and beliefs of humanitarian organizations and support the 'reality' of the situations that health care workers encounter in the field (Fink, Nossiter & Kanter, 2014; Hilhorst & Schmiemann, 2002; Kemp, 2007; Weiss, 1999).

      2.2.4 Appropriate management, use, and sharing of information are crucial factors during missions. Different organizations and individuals collect, analyze, store, and communicate information necessary to make decisions regarding life and death situations (Zhang, Zhou & Nunamaker Jr., 2002). Health care workers must assess the problem, gather

relevant information, make correct judgments, and provide the necessary care in a way that is timely and consistent (Solheim, 2005). Access to information, for example, gives people the capacity to make the best decisions and to act. The ability to collect, manage, and share information among organizations and health care professionals in an efficient, accurate, and reliable manner will ensure collaboration, avoid duplication of services, and the ability to make informed, safe, ethical, legal, and competent decisions during missions (Hunt et al., 2014a). Collaboration between the mission and local teams, local staff, organizations, and communities is essential to assess, implement, and evaluate the care provided in missions.

2.1.5 The evaluation of limitations and effectiveness of missions must include the perspective of the people and communities that receive care. There is paucity of research about the effectiveness of the care provided during missions. Furthermore, there is limited information available about the effectiveness or success thereof regarding care provided during missions. In thematic terms, much of the literature about missions discusses the benefits of volunteering for health care professionals and students, as well as the moral distress experienced by health care volunteers due to the lack of resources and different cultural norms in developing countries. Various authors (Bajkiewicz, 2009; DeCamp, Enumah, O'Neil & Sugarman, 2014; Ott & Olson, 2011; Souers, 2009) advocate for the involvement of the people who receive care during the planning, implementation, and evaluation of missions. The literature proposes that, similar to the rigorous clinical research protocol of developed countries, the care provided during missions must also meet the requirements and standard scrutiny of ethical research boards with regards to protocols that ensure the safety and wellbeing of all patients who receive care in missions (Belski & Richardson, 2004; DeCamp, 2011; Merritt, Taylor & Mullany, 2010; Rid & Emanuel, 2014; Ripp & Scudder, 2011).

Overall, the literature probed for this review indicated that health care workers were not interviewed during the medical missions; research took place six months to five years after the missions. Between three and 10 nurses from different missions were interviewed in each study as members of the participants interviewed in each individual investigation (DeCamp, 2011; Hunt, 2011; Schwartz et al., 2010; Sheater & Shah, 2011; Solheim, 2005; Souers, 2009). The five major themes identified in the literature review support the need for a comprehensive organization of missions that considers and explores factors regarding culture, ethical issues, sustainability, community development, and capacity building following principles of social justice and human rights (Hunt et al., 2014b; Schwartz, Hunt, Sinding, Elit, Redwood-Campbell, Adelson & DeLaat, 2012; Slim, 1997). Furthermore, if health care professionals who volunteer in medical missions cannot support the quality of the care they provide, why and how is this satisfactory against a backdrop of professional, ethical, and legal requirements of safe, ethical, competent, caring, and compassionate practice in developed countries where most health care professionals who volunteer in missions obtained their professional qualifications. In addition, what might health care students who volunteer in missions learn about ethical and professional practice, advocacy, empowerment, and social justice? Learning about cultural diversity and respect for different ways of life begins with humility and self-awareness regarding personal and professional differences that can affect an individual's ability to provide safe, competent, ethical, caring, and compassionate care anywhere in the world (Montenery, Jones, Perry, Ross & Zoucha, 2013; Wada, 2014).

2.2 Nursing Practice during Missions in Developing Countries

At present, there is paucity of nursing literature regarding evidence-based practice guidelines and ethical frameworks to guide clinical decision-making during missions (Arya,

2017; Ripp & Scudder, 2011; Sheater & Shah, 2011). A literature search for available and

successfully implemented ethical decision-making frameworks and standards of practice to assist

in the delivery of ethical and competent nursing care during missions produced limited results.

What emerged was evidence indicating that legal guidelines, professional standards, codes of

ethic, the education, and the role of nurses is different across countries and health care

organizations. Nonetheless, nurses from developed countries such as Canada and the United

States who volunteer in missions must know and understand their scope of practice, as well as

the impact of situational factors that affect the quality of the care they provide in missions

(Oliphant, 2016). This knowledge facilitates the process of clinical decision-making and the

implementation of competent and ethical nursing care during missions.

Reflecting on possible differences in cultural values, beliefs, attitudes, cultural relativism,

and ethnocentrism of individuals and organizations, as well as the effect of politics, social

inequities, paternalistic approaches, and 'deficit thinking' that perpetuate marginalization assists

nurses in the process of clinical decision-making, which is an essential component of nursing

practice during missions (Altmann, 2007; Fraser, Hunt, Schwartz & DeLaat, 2014). Therefore, a

critical examination of the suitable application of nursing standards of practice, legal guidelines,

and ethical frameworks from developed countries during missions in developing countries is

necessary and arguably overdue (Leader, 1998; Levi, 2009; Schwartz et al., 2012; Slim, 1997).

The ability of nurses to empower individuals and assess their needs in a holistic manner

to facilitate the achievement and maintenance of health, wellness, and quality of life depend on

at least the ability to establish therapeutic nurse-client relationships based on mutual respect and

trust. Therefore, it is crucial to research the involvement of communities that receive care in the

assessment, planning, and evaluation of care during missions (Nuffield Council on Bioethics,

2002; DeCamp et al., 2014; Oliphant, 2016). Indeed, the implementation of nursing care

discussed in the literature review often illustrates a biomedical, 'deficit thinking' approach that is

not congruent with fundamental concepts in nursing practice, which include advocacy, social

justice, empowerment, an ethics of care, and the current ICN Code of Ethics for Nurses

(Bowden, 1994; ICN, 2012; McEldowney & Connor, 2011; Polascheck, 1998). The following

sections will examine how Benner's (2001) novice to expert framework, strengths-based care, an

ethics of care, as well as effective and ethical leadership can guide nursing practice in missions

to facilitate safe, competent, ethical, caring, and compassionate nursing practice.

2.3 From Novice to Expert in Nursing Practice

Nurses, in effect, acquire knowledge through time and the integration of practice and

theory whether at work or during training. Nursing knowledge is derived from a variety of

sources or ways of knowing that include empirics, personal, ethical, emancipatory, aesthetic, and

unknowing patterns of knowing (Carper, 1978; Clements & Averill, 2006; Chinn & Kramer,

2011; Mantzorou & Mastrogiannis, 2011). Nurses are required to know about various sciences

and perspectives that impact human life. They need to practice self-awareness to identify

limitations and barriers in the implementation of competent and ethical care. They also need to

know about their patients' unique needs and the context of situations in which people's lives

unfold. Nurses must be ethical and prevent harm, as well as practice according to codes of ethic,

ethical principles, and professional values and beliefs that promote the safety and wellness of the

people who receive care. This also requires awareness of socio-economic and political factors,

which can lead to inequities that perpetuate marginalization and people's inability to achieve,

maintain, and regain health, wellness, and quality of life. Therefore, nurses need to advocate for

vulnerable populations and always ask themselves "whose needs cannot be met?" Additionally,

nurses must reflect about the meaning of values such as privilege, meritocracy, gender, race, ethnicity, health, wellness, and quality of life and thoughtfully challenge deficit thinking approaches to care (Rusch & Horsford, 2008). The way in which a nurse integrates fundamental patterns of knowing in practice reflects the nurse's aesthetic pattern of knowing (Carper, 1978; Chinn & Kramer, 2011). This includes the awareness that one cannot know everything, must always be humble, and explore what we do not know about patients' relevant and unique needs and the context of situations in a holistic manner.

According to Benner (2001), a situation-based interpretive approach is useful to examine nursing practice, which evolves through the stages of novice, advanced beginner, competent, proficient, and expert. In theory, nurses transition through the five levels of proficiency as they accumulate knowledge, practice, and experience. Time does not guarantee the transition; all nurses do not ultimately become experts. Research about the development of nursing expertise and clinical decision-making ranges from descriptions of novice to expert skill development, studies of decision-making in specific situations such as childbirth, and the evolution of specialized nursing roles such as nurse practitioners (Sangster-Gormley, 2013; Sarsfield, 2013; Simmonds, Peter, Hodnett & McGillis-Hall, 2013). According to the ANA (2010), CNA (2015) and CNO (2014), the American, Canadian, and Ontario regulatory professional nursing organizations' standards of practice, it is expected that, regardless of context, American and Canadian nurses must demonstrate competency in five interrelated areas that include professional responsibility and accountability, knowledge-based practice, ethical practice, service to the public, and self-regulation. "A competency is defined as the knowledge, skill, ability and judgment required for safe and ethical nursing practice" (CNO, 2014, p. 4).

The capacity to engage in critical thinking is essential to develop competency, safe, and ethical nursing practice (Axley, 2008; Benner, 2001, 2004). Critical thinking requires contextual perspective, creativity, flexibility, inquisitiveness, intellectual integrity, intuition, open-mindedness, perseverance, reflection about the situation, and the nursing care provided (Chan, 2013; Scheffer & Rubenfeld, 2000). Nurses transition from novice to experts as they move from relying on strict rules and guidelines to developing the ability to use abstract principles, and see patterns and salient cues that allow them to assess and evaluate situations in a holistic manner based on patients' unique needs and the context of situations. Nursing practice is not exact; therefore, nurses develop "techne" and "phronesis" (Benner, Hughes & Sutphen, 2008). In this context, "techne" relates to the scientific knowledge necessary to provide nursing care, and "phronesis" is related to the development of nurses as moral agents in the pursuit of justice, advocacy, and doing no harm to the people who receive their care. Nurses become experts as they integrate knowledge, practice or "know-how", "techne" or know-why", and "phronesis or "know-that" (Benner, 2001; Benner et al., 2008; Benner & Sutphen, 2007).

Depending on the recruitment needs and strategies of the organizations that coordinate missions, nurses who volunteer to participate demonstrate the various levels of proficiency in Benner's novice to expert framework (Anonymous, 2009; Byrne, Collins & Martelly, 2014; Memmott et al., 2010; Murray, 1999). Therefore, they still require support to practice in a safe, competent, ethical, caring, and compassionate manner, as well as continue to improve their nursing practice in general, and during missions. The unfamiliar context of the situations during missions and patients' needs also influence nurses' ability to critically think, make clinical decisions, and apply evidence-based practice during missions.

Nursing practice is relational and occurs through the interaction of content, context, and function (Benner et al., 2008; Sarsfield, 2013). Typically, nurses continue to learn and enhance their practice by interacting with the environment and others. Collaboration with others is essential to clarify and validate the assessment of patient needs, as well as implement and evaluate the effectiveness of care. Collaboration with others also assists to integrate appropriate evidence-based practice and standard protocols of care to the clinical situation based on the context and patient needs. During missions, evidence-practice and standard care protocols from developed countries may not be reasonable or indeed logistically achievable in developing countries (DeCamp, 2011; Hunt 2008, 2011), and therefore must be adapted to the context of the situations encountered during missions.

2.3.1 Strength-Based Care. Unknowing (Munhall, 1993), as a fundamental pattern or way of knowing in nursing practice, requires nurses to be open to possibilities, interpretations, and perceptions by suspending what they know and think, and being fully present in the moment as they listen and try to understand people's experiences as life unfolds for those patients. Nursing practice requires people's needs to be at the center of the care provided, ahead of organizational, systemic, and the individual nurse's personal demands (RNAO, 2015; WHO 2016). A strengths-based care approach respects people's wishes, concerns, values, priorities, perceptions, and strengths. It focuses on people's unique biological, psychological, and social qualities and resources that contribute to their health, wellness, and healing (Gootlieb, 2013).

During missions, nurses must integrate people' strengths and resilience in the care they are able to provide. These include internal and external resources to people such as qualities, capabilities, competencies, capacities, and skills that can be enhanced, discovered, and build upon to find meaning, cope with challenging life situations, and promote health, recovery, and

healing within the context of their life situations and challenges. A strength-based approach to

nursing care does not ignore human weaknesses and deficits, but focuses on supporting and

enhancing patients' resilience and capacity to cope with health challenges.

The application of a strength-based approach to nursing care during missions requires

that nurses integrate core professional values and beliefs about health, person, nursing, and

environment. These include a balance between health and healing that focuses on the uniqueness

of individuals and recognizes the context of their life situations. It also requires that nurses

distinguish patients as whole people who cannot be reduced to body parts, illness, and

treatments. Accurate information must therefore be obtained by the nurse to assist people to

create meaningful care based on the objective and subjective reality of their lives, which respects

their right to self-determination, learning needs, as well as readiness and timing to change and

act. Furthermore, the relationship between individuals and the environment in missions is

integral because the context of people's lives impact their ability to be successful coping with

challenges and developing resilience. Therefore, a collaborative partnership between the nurse

and patient must be established to provide safe, competent, ethical, and compassionate care that

reflects and meets patients' needs. During missions, nurse must find ways to communicate with

patients that allow them to assess their needs and work with them to capitalize and develop

strengths. Furthermore, nurses must explore available resources, as well as advocate for

vulnerable people's ability to access health care services and work towards global policy

changes.

The ability to communicate with patients and local staff during missions requires

awareness of language barriers, as well as an approach informed by cultural sensitivity,

competency, safety, and/or humility. Cultural sensitivity requires awareness about cultural

differences, values, beliefs, and norms in the country where the mission takes place, which leads

to the implementation of care that is respectful of people's needs within the context of the

mission (Briscoe, 2013). Cultural competent care relies on the application of a transcultural

theory or framework, which lays out ethical principles, values, beliefs, and behaviors that guide

nursing practice (Douglas et al., 2011, 2012). These contribute to awareness, knowledge, skills,

and respect for cultural differences and similarities when providing care. Cultural safety aims to

avoid any actions that diminish, demean or disempower the cultural identity and wellbeing of an

individual (McEldowney & Connor, 2011). Cultural humility reminds us that we are limited in

what we know about people's way of life, and tend to use stereotypes to explain behavior

(Ortega & Coulborn Faller, 2011). We cannot possibly know everything about another culture

because people are complex so we must approach them in a caring, respectful, and open manner

to be able to listen and learn from them about their life experiences, struggles, and needs.

2.4 Ethics of Care

As already mentioned, nursing practice is relational; therefore, it requires the

establishment of therapeutic nurse-client relationships that are the vehicle through which nursing

care is given and received (Benner et al., 2008; Watson, 1988). There are many definitions of

caring, and for the purpose of this study, caring is considered to be the essence of nursing

practice as a profession and a human mode of being that requires the nurse to care about, for, and

with others (Caranto, 2015; Nascimento & Erdermann, 2009; Roach, 1992). According to

Watson (1988, 1999), every nurse-patient interaction embodies transpersonal caring and

therefore places a moral imperative for the nurse to care while preserving the patient's dignity

and worth.

Caring for, about, and with others weaves nurses into a network of relationships that leads to a universal meaning and experience of caring (Kittay, 2001; Vanlaere & Gastmans, 2011). As nurses develop "phronetic" expertise, they become moral agents and must therefore examine the ethical implications of the care they provide to people. In developed countries, nurses are professionally, ethically, and legally expected to critically examine the benefits and possible harm resulting from their care, right and wrong of situations in relation to patients' lives, as well as what they ought, ought not, should, or should not do to avoid intentionally or unintentionally causing harm to patients (ANA, 2010; CNA, 2015, 2017). Such considerations reflect competent nursing practice because they avoid causing harm to patients regardless of context and the setting where nursing practice takes place. However, nurses committed to transpersonal caring and therapeutic relationships perceive caring as more than a duty owed to patients. Caring is an inherent moral responsibility manifested through caring about, for, and with people that the nurse establishes a transpersonal connection with (Edwards, 2009).

Consequently, an ethics of care —alternatively care ethics or ethic of care—normative ethical theory approach that guides nursing practice by placing interpersonal relationships and care central to moral action provides guidance for nursing practice regardless of context and setting (Keatings & Smith, 2010; Storch, Rodney & Starzomski, 2013). Gilligan (1982), was one of the first researchers to focus on the context of situations given the interconnection and interdependency of people, as well as the need to consider gender differences in moral reasoning. Gilligan noted that women consider the impact of context and relations when applying ethical principles and rules. Typically, the traditional masculine ethics of justice approach involves analysis and weighing of competing ethical principles, duties, and obligations to arrive at a resolution (Edwards, 2009). Noddings (1984) expanded on Gilligan's focus on context and

relationships by further developing the idea of a feminine ethic of care applied to moral

education. She focused on human existence and consciousness and identified two stages of

caring that include caring about and caring for. Caring about refers to the ideas, values, and

intentions to care about others. Caring for involves the actions one engages in to provide care to

others.

Continuing with Gilligan and Noddings' emphasis on relations and context, Tronto

(1993) later argued that an ethics of care approach involves responsibility-based ethics where

one develops a habit of care. For Tronto, everything we do to maintain and repair our world so

that we can live in it as well as possible constitutes caring. Our world includes people we have a

responsibility to, ourselves, and the environment. Therefore, a habit of care approach requires

nurses to continually ask themselves, "what is the best way to care for people?", which is

dependent on the context of the situation and people's unique needs. Furthermore, social justice

and the awareness of socio-political forces and determinants of health that impact people's

wellbeing demand that nurses also ask 'why and how is this the best way to care for people?'

(CNA, 2017; Watson, 1999). An ethics of care is fundamental to the therapeutic nurse-client

relationship as a moral orientation cultivated through the nurse's habitual consideration of what

is the best way to meet client needs (Lachman, 2012). It demands reflection on the best course of

action, which depends on the specific circumstances.

According to Tronto (1993), caring involves four phases that include caring about, taking

care of, care giving, and the recognition that the receiver of care is affected by the care received.

Additionally, there are also four elements of care that involve attentiveness to people's needs,

responsibility to care for others, competence in providing care, and the response to the care

received. Therefore, volunteering in missions following an ethics of care approach requires the

nurse to care about patient needs by developing awareness through cultural sensitivity and

humility given the context of the mission and unfamiliar cultural norms. Nurses can take care of

patients by asking themselves what is the best way to do so, considering the context of the

mission and people's realities, to be able to provide care that best meet patients' needs given the

lack of resources and ways of life in developing countries. Nurses must also reflect about the

impact of the care received in relation to benefits and possible harm to people. By being

attentive, trying to be culturally sensitive and humble about the lack of familiarity with the

context of missions, a nurse can better assess patient needs. However, one must be aware that

any framework used to guide the nursing care may or may not be culturally appropriate. The

effectiveness of the nursing care provided must always be evaluated by assessing, monitoring,

and evaluating patients' response to care, which determines if the assessed needs were met.

When nursing in missions, nurses give care and exercise responsibility in a competent

manner depending on their knowledge and experience, as well as their ability to adapt to the

context of the mission and the many challenges encountered.

Nursing care is not just an observable entity; it is also an applied morality: it is a

willingness and a commitment to care regardless of all circumstances. An ethic of care is,

in short, an ethic where moral situations are defined not in terms of rights and

responsibilities but in terms of relationships of care often within challenging contextual

circumstances. (Woods, 2011, p. 271)

During missions in developing countries, the context of the situations encountered and

the unfamiliar environment invariably lead to many challenges when providing nursing care. A

lack of resources and social inequities result in ethical dilemmas that lead to moral distress due to

the inability of doing what one thinks is the right thing to do for vulnerable people who need

care, because of system, organizational, and various forms of constraints that nurses experience

(DeCamp, 2011; Hunt, 2008, 2011; Schwartz et al., 2010). Robinson (2011) states that an ethic of care is a form of political ethics. Therefore, nurses must also consider under which circumstances relations of care become relations of domination, oppression, injustice, inequality, and paternalism.

Nursing practice reflects a history of oppression and marginalization that continues to be a struggle in many countries around the world (Dubrosky, 2013; Mooney & Nolan, 2005; WHO, 2013b). Nursing's struggles are thought to be a result of gender oppression given that the majority of nurses are female, as well as general power and hierarchy struggles with the discipline of medicine and the dominance of the biomedical approach to health care inherent in most health care systems (Petruka, 2014). Participating in missions leads to the recognition and witnessing of various forms of oppression of nursing practice that exist in developing countries due to male dominance, physician-nurse power imbalances, and various cultural norms and habits, which marginalize women who are exclusively assigned the 'burden' and responsibility to care for the sick. All societies make decisions about caring that include who will do it and under what circumstances based on relations of power determined by gender, race, class, race, and culture (Robinson, 2011).

Furthermore, when volunteering during missions in developing countries, one bears witness to local nurses' experience of the faces of oppression as described by Young (1990), which include exploitation, marginalization, powerlessness, cultural imperialism, and violence. In developing countries, nursing practice is controlled by medicine, and nurses lack professional autonomy, which are examples of the face of exploitation. Administrators and physicians, who are often males, control which nurses are assigned roles that possess organizational power to further drive their agendas, which continues to marginalize and devalue nursing practice.

Powerlessness is reflected, for example, through nurses' inability to continue learning, developing skills, and achieving their full professional potential, which inhibits the advancement of their scope of practice within the health care system. Cultural imperialism is enacted through medicine's dominance over nursing, which places an emphasis on biomedical and 'deficit thinking' approaches to health care that reduce people to diseases and problems with a focus on curing and tasks (Dubrosky, 2013). Lastly, the face of violence is expressed through negative behaviors and emotions among nurses as they cope with feelings of oppression, as well as uncivilized behavior from physicians and administrators.

Consequently, nurses who volunteer in missions and recognize the oppression and marginalization experienced by local nurses in developing countries assume a leadership role when they educate, collaborate, and model autonomous nursing practice so as to empower local nurses to improve their practice and the quality of care provided to people (Davis, 1999; Shanks, 2002; Stark, Nair & Omi, 1999). However, volunteer nurses must be careful to avoid inappropriately or insensitively pushing personal and professional values and beliefs that do not reflect those held by the local nurses they work with during missions. To be emancipating, education requires more than the transmission of information (Freire, 2002). Therefore, volunteer nurses must critically consider the impact of organizational, professional, systemic, and social cultural norms on their ability to initiate, implement, and sustain change. Furthermore, they also need to consider whether it is reasonable to expect the same responsibilities and full scope of practice from all nurses around the world given the lack of resources available and constraints on nursing practice in developing countries (Davis, 1999; Stark et al., 1999). Of particular importance is the marginalization and oppression of women in patriarchal societies, which extends to nursing practice as it can be a role delegated only to women. When there are

organizational cultural norms related to gender marginalization in place, nurses must be very

sensitive and careful to initiate change in a health care organization because a short-term mission

cannot change long standing cultural norms in society over a two-week period. For example,

local nurses will not be able to practice autonomy and advocacy right away if they have not

learned to 'speak up' for themselves and their needs. Furthermore, depending on the length of

the mission, it may not be possible to make an accurate assessment of gender norms while

focusing on providing nursing care to patients. Therefore, nurses must find ways to assess gender

norms through the use of 'key informants' such as community leaders and key contact persons in

the organizations where the mission takes place.

     Volunteer nurses must also reflect on personal and professional values and beliefs that

influence their ability to provide competent and ethical care that respects people's dignity and

diversity regarding values, beliefs, and ways of life. They also need to be aware of socio-political

factors that influence *their* practice and ability to nurse. These factors include the effect of

hegemony, power imbalances, and other cultural realities that patients face, so nurses need to

advocate for patients' rights and act accordingly. Equity is an important focus of social justice,

which results from the reduction or elimination of inequalities that are avoidable, unnecessary,

and unfair (Bryant, 1997; Stark et al., 1999). However, care must be taken to avoid a position of

ethical imperialism and ethnocentrism that leads nurses to practice based on personal and

professional values and beliefs, which are not congruent and do not reflect the values and beliefs

of the people that receive their care and work with them to provide care during missions

(Benatar, 2002; Davies, 1999; Olsen, 2003). Safe, competent, ethical, caring, and compassionate

nursing practice requires the integration of people's unique needs, which includes their cultural

values and beliefs, in the assessment, implementation, and evaluation of care (CNA, 2017;

Gottlieb, 2013). Given the language barriers encountered in many missions, nurses must find ways to communicate with patients effectively. Furthermore, cultural sensitivity and humility are critical to facilitate the establishment of relationships and assessment of needs, as well as the implementation and evaluation of the nursing care provided in missions.

2.4.1 Effective and Ethical Leadership in Missions. Safe, competent, ethical, caring, and compassionate nursing practice within the context of missions is complex. It also requires effective and ethical leadership that supports culturally sensitive approaches to assess and meet patients' needs, thoughtfully challenges the status quo, as well as advocates and promotes social change while remaining committed to practicing and leading in a way that integrates evidence-based practice guidelines, the reality of the context of situations, and fundamental concepts of professional and ethical nursing conduct. However, nurse leaders must also be able to acknowledge that their practice and leadership behaviors may be based on assumptions that perpetuate oppressive ideologies, which only assign blame to people, ignore their strengths, abilities, and contextual barriers (Weiner, 2006). Effective and ethical leadership is concerned with the wellbeing of others, and meeting organizational and people's needs. Sinek (2009) suggests that leaders must reflect on the why-how-what of their leadership practices. They also need to determine and understand their role, responsibilities, culture, and underlying organizational assumptions (Schein, 2010; Senge, 2006), as well as the ethics related to their work (Shapiro & Gross, 2013) to be successful, meet organizational expectations, and prevent marginalization and exclusion (Anderson, 1990; Griffiths, 2013).

During missions, effective and ethical nursing leaders can apply an ethics of care approach to establish a safe and caring environment for the mission and local teams that promotes collaboration and learning, as well as safe, competent, ethical, caring, and

compassionate practice. Furthermore, they must be consistent with their behavior to support

people's growth and help them develop confidence in themselves, others, and the organizational

system (Kanter, 2006), as well as adopt best practices for successful, effective, and ethical

leadership behaviors. Given the lack of resources, social inequities, and marginalization

encountered during missions, nursing leaders must model the way, inspire a shared vision,

challenge the process, enable others to act, and encourage the heart of their followers (Kouzes &

Posner, 2012). Effective and ethical nursing leaders must carefully assess the context of missions

and cultural differences to be able to assess the needs of local nursing staff and identify

imbalances of power and marginalization. Cultural sensitivity and humility will assist nursing

leaders to avoid further power imbalances and marginalization between the mission and local

nurses. Power is necessary for nurses to act independently, exert influence over others, and

function as professionals. "When power is absent or not utilized, others are more likely to step in

and decide what nursing is and what nurses do" (Ponte, Glazer, Dann, McCollum, Gross, Tyrell,

Branowicki, Noga, Winfrey, Cooley, Saint-Eloi, Hayes, Nicolas & Washington, 2007).

Power, or the ability to influence others, is the energy from which all human action and

interaction arise from; it is inherent in all relationships and is therefore an important concept in

nursing practice (Allan, Gordon & Iverson, 2006; Bradbury-Jones, Sambrook & Irvine, 2008;

Chinn & Falk-Raphael, 2015). Consequently, the careful consideration of the negative and

constructive consequences of using power following an ethics of care approach that promotes

caring about, for, and with people is necessary during missions. According to Allen (1999),

power-over reflects a dominant and hierarchical use of power; power-with displays the ability to

act and work together with people to attain mutual benefit; and power-to "is the ability of an

individual actor to attain an end or series of ends" (p. 126). During missions, nurse leaders must

be sensitive to power-over issues with local nurses and patients given their education, expertise, and socio-economic background. In general, nurses must strive to establish relationships where power-with and "peace-powers make an explicit connection to nursing's core values of caring and high level wellness… which bring these values into action" (Chinn & Falk-Raphael, 2015, p. 68).

Grounded in an emancipatory philosophy that reflects women's ways of being and relating in the world, peace powers require nurses' critical consciousness about the reality of oppressive situations within the context of the mission (Freire, 2002). Peace powers reflect a process that focuses on praxis, empowerment, awareness, cooperation, and evolvement. Nurses must therefore engage in praxis or synchronous reflection and action about their practice and leadership, empower people they interact with following a culturally sensitive and respectful approach that embodies nursing's philosophy, be aware about their practices and other's ways of being in the world, cooperate and commit to achieving solidarity, and evolve as a result of implementing change and the process of caring about, for, and with others (Chinn & Falk-Raphael, 2015).

Moreover, considering the complexity of nursing practice and leadership during a mission, reflecting about ineffective and unethical leadership practices is very useful to help nursing leaders figure out how not to be. Kellerman (2004), provides a description of seven types of leadership to avoid, which are helpful to consider when dealing with challenging experiences in missions. Rigid leaders are unable or unwilling to adapt to new ideas, information, or changing times. Intemperate leaders lack or lose self-control because they focus on individual needs, which become a distraction and interfere with meeting goals. Callous leaders are uncaring, unkind, ignore, and discount the needs, wants, and wishes of people. Corrupt leaders

lie, cheat or steal, and put self-interests ahead of public ones. Insular leaders minimize and disregard the health and welfare of people outside of the group or organization for which they are directly responsible for. Evil leaders commit severe atrocities and disregard the physical and psychological wellbeing of people.

Effective and ethical leadership requires that nurses thoughtfully challenge the status quo they encounter during missions, then implement and evaluate change as they advocate for the needs of vulnerable people they interact with. Nurse leaders must establish a sense of urgency for change, create a coalition of people that support the change, develop a vision and strategy, empower a broad base of people to act, generate short-term wins, consolidate gains to produce more change, and institutionalize new approaches in the culture of the organization (Kotter, 2012). It takes time to introduce and sustain change in organizations; therefore, effective and ethical nursing leaders must work to establish sustainable working relationships that begin before the mission and continue once the mission ends. An ethics of care approach requires leaders to consider the response to the care received; therefore, sustainability and building people's capacity are important considerations when planning, implementing, and evaluating care and leadership practices.

Effective and ethical nursing leadership during missions requires the establishment of relationships based on trust and respect for people's values and beliefs to facilitate their understanding of what change is needed, how and why, to improve their practice, health care services, and the quality of care provided to patients. Improvement of care and advocacy for the right of vulnerable people to access health care services is not the sole responsibility of mission leaders. Everyone who volunteers in a mission and witnesses health care disparities and lack of

resources has a moral responsibility to thoughtfully challenge injustice, inequities, and promote

vulnerable people's access to health care services.

2.5 Chapter Summary

The literature review and guiding conceptual frameworks regarding safe, competent,

ethical, caring, and compassionate nursing practice provide insight and further understanding

about the complex phenomenon of nursing practice and leadership within the specific and

challenging context of missions in developing countries. The application of Benner's (2001)

levels of nursing proficiency provides a framework for the study regarding the impact of

individual factors such as the nurse's professional and mission experience, and the application of

available standards of practice and evidence-based guidelines to assist in the process of clinical

decision-making, which leads to the implementation of safe, competent, ethical, and

compassionate nursing care during missions. An ethics of care approach guides the critical

consideration of contextual factors such as lack of resources, culture, and politics with the

integration of essential concepts in nursing philosophy such as a strengths-based care approach,

holistic practice, social justice, advocacy, social determinants of health, and the critical

consideration of power imbalances and marginalization. Furthermore, effective and ethical

leadership is critical to organize, implement, and evaluate the care provided, as well as

thoughtfully challenge the status quo, implement change, and advocate for the needs of

vulnerable patients who receive care during missions in developing countries. The complexity of

nursing practice and leadership in missions will be examined further in chapters 5 and 6, where

the findings and their significance will be examined in detail. To continue, chapter 3 will explore

the research's design, method, data collection and methodology used to analyze the data.

Chapter 3

Methodology

The purpose of this chapter is to examine the methodology used to conduct the study. After reviewing the research questions, the epistemological assumptions and theoretical perspective are examined before discussing the research design, role of the researcher, participant-researcher relationship, and the participants. The data collection measures, which included semi-structured interviews, direct observation, participant-observation, perusal of documentation, archival records, and physical artifacts are presented. The data analysis section includes an exploration of the methodology, researcher's analytic and reflective journal, and member checking. The chapter ends with a discussion about triangulation and trustworthiness.

3.1 Research Questions

As indicated in chapter 1, the purpose of this study was to explore nursing practice and the contextual factors that affect a nurse's ability to practice in a safe, competent, ethical, caring, and compassionate manner during a mission in a developing country. Due to the context of missions, nurses find themselves making decisions without specific ethical, professional, and legal guidelines; therefore, they often question their ethical, professional, legal, and cultural competency during missions (Bajkiewicz, 2009, Ripp & Scudder, 2011; Schwartz et al., 2010; Tyer-Viola et al., 2009; Zinsli & Smythe, 2009). More specifically, this investigation explored three research questions:

1) How do nurses make competent and ethical clinical decisions during a mission in a developing country?

2) What factors influence nursing clinical decision-making during a mission in a developing country?

3) How do nurses define and evaluate competent and ethical nursing practice during one

mission in a developing country?

3.2 Epistemology

A constructivist philosophy grounded in the view that individuals construct meaning

guided this study. People seek to understand the world they live in, and in that respect, knowing

is not passive but active. We construct knowledge and experience out of events and phenomena

through complex social interaction that involves history, language, and action (Constantino,

2008; Schwandt, 1998). Biological and cognitive processes assist a person to construct meaning,

which emerges through consciousness and reflection (Sommers-Flanagan & Sommers-Flanagan,

2012). Individuals construct subjective meaning and live in society based on their interactions

and communication with the world around them. For this reason, there is not only one true or

valid interpretation of the world; rather, there are multiple realities (Crotty, 1998; Patton, 2015).

The constructivist researcher addresses the process of interaction among people, and focuses on

understanding the complexity of participants' views, rather than just reducing meaning into a few

categories or ideas (Creswell, 2014). Truth is a matter of consensus among the informed

constructors of meaning; although facts exist, they have little or no meaning except within a

value framework; cause and effect exist often by attribution of meaning; data represents the

construction of meaning that results from the investigation of specific phenomena, which can

only be understood within the social and historical context in which it is studied and therefore,

findings cannot be applied to the general population (Guba & Lincoln, 1989).

3.3 Theoretical Perspective

An Interpretivist approach was the research stance that guided the data collection

methods and helped the researcher to understand the participants' experiences in this

investigation. Interpretivists believe that knowledge depends on the social construction of the world, and attempt to understand phenomena through the meanings that people assign to them (Weber, 2004). As well, Interpretivists conclude that to understand meaning, one must interpret how and why things happen; therefore, data collection must involve watching, listening, asking, recording, and examining multiple realities and ways of knowing (Schwandt, 1998). Interpretive methods or forms of research aim to produce an understanding of the context of phenomena, and the process whereby phenomena influences and is influenced by its context (Walsham, 2006). Meaning is embodied in language and action; therefore, to engage in the research inquiry is to construct a 'reading' of the participants' meanings about their life experiences. Reality and the world is interpreted through classification schemas of an individual's mind; therefore, there are multiple realities (Gray, 2014). Furthermore, reality is relative to time, context, culture, and is value bound. It is constructed through meaning and understanding from social interactions and experience.

Our perceptions about the world clearly often depend on our life experiences. The search for meaning and the development of experience are an exploration of culture. Individuals belong to social communities and as they learn to interact, they embrace cultural gestures and symbols. Klein and Myers (1999), identified seven principles of interpretive research, which include the hermeneutic circle, contextualization, interaction between the researcher and the participants, abstraction and generalization, dialogical reasoning, multiple interpretations, and suspicion. The understanding of phenomena must incorporate the interdependent meaning of parts and the whole that they form to lead to holistic understanding. The researcher must critically reflect about the complexity of the social and historical backgrounds of phenomena. Interpretation occurs through the interaction of the researcher and the participant who influence one another,

which leads to the understanding of human action. As occurred in this study, the researcher must

be sensitive to differences between participant interpretations, biases, and the authenticity of

responses in the data collected from participants.

3.4 Research Design

There are many opportunities to volunteer, travel, and see the world while providing care

to people in developing countries, as well as learn to provide care whether the volunteer is a

student or a nurse (Clutter, 2007; DeCamp, 2007; Levi, 2009; Priest, 2007; Oliphant, 2016; Ripp

& Scudder, 2011; Solheim, 2010; Shanks, 2002). The mission organization was chosen on the

basis of information acquired through a general online search of mission experiences available in

the fall of 2015, conversations with various nurse colleagues, and the researcher's professional

experience with missions.

The researcher looked for an experience that appeared well organized, safe, ethical, and

professional based on the general information provided about the location and length of the

mission, free health care services provided to vulnerable people in a developing country, the

involvement of a multidisciplinary health care team, goals and purpose of the mission, and the

required application procedures to volunteer as a nurse in the mission. The researcher focused on

finding an experience by thinking of global health as an ethical enterprise to improve the health

and wellness of vulnerable people, as well as considered social justice implications regarding

how and why might the proposed assistance offered by the mission be best utilized (DeCamp,

2011; Oliphant, 2016). Following Western University's ethics approval of the study, the

researcher approached a non-profit, non-governmental American organization that provides

cardiac surgical and outreach-community care through medical missions and obtained

permission to conduct the study. The researcher also completed the application process required

to volunteer as a nurse in a mission. Please see Appendix G for a summary of the ethical protocols followed in this investigation.

An exploratory case study research design (Yin, 2014) was the method used to obtain insight about the phenomenon of nursing practice during a mission in a developing country. The unit of analysis or case in this study was the nursing practice that occurred during the mission. The type, location, and length of the mission bounded the case. Following the development of the study's questions, an exploratory case study is an appropriate research method that fits the epistemological assumptions and research paradigm guiding the exploration of nursing practice and the contextual factors that affect a nurse's ability to practice in a safe, competent, ethical, caring, and compassionate manner during a mission in a developing country.

Case study research (Yin, 2014) allowed the researcher's understanding and interpretation of nursing practice during a mission from a holistic and 'real-world' perspective while the participants were providing nursing care. The researcher engaged in direct observation of the participants, assumed the role of a participant, and collected a variety of evidence to assist in understanding nursing practice and the contextual factors that affect a nurse's ability to practice during a mission. The researcher conducted in-depth, semi-structured interviews with each participant during and after the mission to engage in deep reflection about the nursing care they provided, and co-constructed knowledge with each of them to understand the phenomenon of nursing practice during the mission. Data were interpreted using a modified constant comparative analysis (Corbin & Strauss, 2008). During and after the mission, the researcher clarified the accuracy of the data obtained and the overall interpretation of the study findings through member checking. The variety of data collected including field notes, a reflective and analytic diary, and memos written during data analysis allowed triangulation of the researcher's

data interpretation and helped to construct knowledge that lead to an understanding of nursing

practice in the mission. Table 1 summarizes the research design used in this investigation.

Table 1

Research Design: Questions, Measures of Data Collection, and Analysis Used in the Study

Research Question	Measure of Data Collection	Analysis	Participants	Person responsible for collecting data
1) How do nurses make competent and ethical clinical decisions during a mission in a developing country?	•Semi-structured, in-depth interviews during & after mission •Direct observation •Participant observation •Documentation •Archival records •Physical artifacts	•Modified constant comparative analysis	•9 Volunteer nurses in mission team • Researcher role as a volunteer nurse	•Researcher
2) What factors influence nursing clinical decision-making during a mission in a developing country?	•Semi-structured, in-depth interviews during & after mission •Direct observation •Participant observation •Documentation •Archival records •Physical artifacts	•Modified constant comparative analysis	•9 Volunteer nurses in mission team • Researcher role as a volunteer nurse	•Researcher
3) How do nurses define and evaluate competent and ethical nursing practice during one mission in a developing country?	•Semi-structured, in-depth interviews during & after mission •Direct observation •Participant observation •Documentation •Archival records •Physical artifacts	•Modified constant comparative analysis	•9 Volunteer nurses in mission team • Researcher role as a volunteer nurse	•Researcher

As noted earlier, this was a qualitative study; therefore, the trustworthiness, credibility, transferability, dependability, and confirmability of the findings are addressed in the data analysis section. However, Yin (2014) suggests that particular forms of validity and reliability can also apply to case study research design. Internal validity does not apply to exploratory case studies because they do not seek "to establish a causal relationship, whereby certain conditions are believed to lead to other conditions, as distinguished from spurious relationships" (Yin, 2014, p.46). Table 2 summarizes the tactics used to establish the quality of the research design and tests of validity and reliability.

Table 2

Tactics for Four Design Tests

Test	Tactic	Phase of Research in which Tactic Occurred
Construct Validity	• Multiple sources of evidence • Member checking • Chain of evidence	• Data collection • Data analysis • Written report
Internal Validity: note that Yin (2014) states it does not apply to exploratory case studies	• Pattern matching through modified constant comparative method • Explanation building	• Data analysis
External Validity	• Use of theory and conceptual framework	• Research design
Reliability	• Research protocol • Research database	• Data collection

(Adapted from Yin, 2014, p.45)

3.4.1 Method. Qualitative case study research is congruent with the epistemology assumptions and research paradigm, which demonstrates internal consistency in the study (Carter & Little, 2007). It allowed the collection of data in ways that cohered with a constructivistic-

interpretivist philosophy of knowledge. Case study research supports the investigation of

phenomena as they occur within the context of the environment when the boundaries between

phenomena and context may not be evident, and in which multiple sources of evidence are used

(Yin, 2014). This method of data collection is particularistic because it allows the study of

specific phenomena, heuristic as it provides insight regarding the phenomena studied, and

descriptive given the wealth of information obtained (Gay, Mills & Airasian, 2012). Case study

research is specific, includes a holistic examination of the context, it is dynamic as it studies the

phenomena in action, and situated on the particular experience while it provides a thick or in-

depth examination (Cohen, Manion & Morrison, 2013).

For the purpose of the study and the bounding of the case, a mission that lasted 15 days in

Nepal, provided cardiac surgical care in a hospital, health promotion in the community, and

education to the hospital staff to help them establish their own cardiac care program and meet the

cardiac care needs of the people it serves was chosen by the researcher with the help of a mission

coordinator. The care provided in the mission required registered nurses who delivered care in

the operating room, cardiac care intensive unit, and were involved in community-outreach health

promotion activities. The multidisciplinary team also included cardiac surgeons, cardiologists,

perfusionists, a biomedical engineer, and lab technician, as well as non-health care volunteers

who collected data about the care provided, took pictures, and helped with miscellaneous

activities. Although the organization that coordinated the mission is American, the mission team

was composed of volunteers from various parts of the United States, Canada, Brazil, United

Kingdom, and Pakistan; most of the volunteers did not know each other before the mission. This

type of experience is also classified as a short-term, medical humanitarian mission with a focus

on sustainability and building the capacity of the local health care team in Nepal (DeCamp,

2007, 2011; DeCamp, Rodriguez, Hecht, Barry & Sugarman, 2013; Hunt, 2011).

3.5 Role of Researcher

Typically, an interpretivist researcher's intent is to understand and interpret the meaning

that people have about phenomena. The focus is on the specific context in which people live and

work to understand the historical and cultural settings that impact people's lives. The actor

constructs reality; therefore, the goal of the interpretivist researcher is to understand the meaning

of phenomena and the lived experiences from the point of view of those who live it every day

(Creswell, 2014). The interpretivist researcher provides one perspective or construction of

meaning grounded on all the participants' individual interpretation and construction of their

realities. Therefore, it was critical for the researcher to engage in reflection and become aware of

biases that would not allow an accurate interpretation of the participants' experiences (Charmaz,

2005). As a volunteer nurse in the mission, the lived experience of the researcher contributed

another reality and individual interpretation about nursing practice during the mission. Please see

the researcher's positionality (p. xiv) for a declaration of competing interests in the investigation.

In this study, the researcher collected and analyzed data to construct knowledge about

nursing practice during the mission, as well as provided care in the role of a volunteer nurse in

the mission team. Therefore, following the impact of social interaction on an individual's ability

to fit into society and construct meaning, it was very important for the researcher to fit in as a

member of the mission team, fulfill the role expectations of the volunteer nurses, and adapt to the

role of researcher. The researcher gained credibility as a nurse from the mission and local teams

through the care provided to patients and by being accountable regarding the expectations and

conduct required of the nurses, and all the volunteers in general, during the mission. In this

study, credibility as a researcher seemed to flow from reciprocity of the mutual respect, trust, and cooperation (Patton, 2015) earned as a responsible and contributing member of the mission team.

During the design of the study and at the beginning of the mission, the researcher decided to first and foremost 'be a nurse' and provide care first in any dangerous and unsafe situation that required the researcher to choose one role over the other. Regardless of the impact on the study, doing so followed ethical and professional conduct required of nurses regardless of context and location (CNA, 2017; ICN, 2012). Although it was challenging to adapt to the researcher role at the beginning of the mission, the researcher quickly learned to observe and assess situations as a researcher while providing nursing care. This allowed the flexibility to engage in direct observation at any time, and as soon as possible, the researcher tape recoded or wrote down the data collected from direct observations. In some ways, the researcher noted many similarities to the evaluation process that nursing faculty need to engage in, directly or indirectly, when teaching and evaluating nursing students.

3.6 Participant-Researcher Relationship

In this investigation, interpretivism supported by constructivist values guides the relationship between the knowers or research participants, and the would-be knower or researcher (Ponterotto, 2005). Meaning is hidden and brought to the surface through deep reflection, which is stimulated by the researcher-participant dialogue as they co-construct meaning (Schwandt, 1998). Interpretivist researchers become the measurement instrument as they interpret the phenomena observed; therefore, the researcher and the research object are interdependent. The research actions of the researcher affect the participants, and the participants also affect the researcher (Weber, 2004). Therefore, interpretivist researchers must ensure they understand and convey the multiple realities of the actors they study as clearly and accurately as

possible. In this study, the use of a reflective journal and member checking during and after the

mission helped to ensure an accurate interpretation of the data.

The researcher's role as a nurse and colleague in the mission team facilitated mutual

respect, trust, and cooperation from the participants. At the beginning of the mission, the

participants observed the researcher's behavior (Patton, 2015), inquired about data collection,

and the researcher's ability to provide nursing care in the mission. The researcher interacted with

the mission group and developed rapport as a member of the team. In this study, this facilitated

the ability to establish credibility and trust, which helped the participants to share their

experiences with the researcher about the mission. The researcher confirmed the authenticity of

data collected during interviews with the direct observations of participants.

Participant trust in the researcher is evident in the data collected, and the thick

descriptions of very frustrating issues, challenging ethical dilemmas, moral distress and residue,

which some participants experienced and shared during their interviews. Some of the participants

expressed feeling comfortable talking to "someone who knows what I'm talking about" in the

interviews during and after the mission. Participants indicated that they engaged in deeper

reflection after the mission and stated that the experience was cathartic for them.

The role of volunteer nurse in the mission facilitated the researcher's understanding and

interpretation of the participant experiences. As discussed already, it was critical to be aware and

reflect about researcher biases that would impact the collection and analysis of data. An

interpretivist researcher acknowledges his or her impact on the participants and vice-versa

(Weber, 2004). For example, listening to the sorrow and anguish of participants, which resulted

from moral distress and residue due to their inability to provide the necessary care to vulnerable

patients was very difficult to hear for the researcher, who also experienced the same feelings in

comparable situations. Awareness of these feelings and reciprocity with participants allowed the researcher to focus on the wellbeing of participants and the study's goals, which facilitated authentic responses that validated participants' feelings and thoughts, and helped them to reflect and learn from painful experiences while co-creating knowledge with the researcher about how and why ethical nursing practice occurs in missions, what it is, what it ought to be, and the need to make a call to action to promote global health, and change in policies that will facilitate health care access for vulnerable populations.

3.7 Participants

In this study, purposeful sampling occurred by inviting all nine nurses who volunteered in the mission to participate in the study (Appendix B & C). The purposeful selection of the participants allowed for rich and illuminative data, which provided in-depth understanding (Patton, 2015) about nursing practice during the mission. The researcher constructed knowledge about the phenomenon of safe, ethical, competent, compassionate, and caring nursing practice based on the participants' multiple realities and interpretations about how and why they did what they did in the mission. Within the complex context of the mission, the knowledge constructed by participants through their interactions with patients, staff, each other, everyone and everything around them, provided insight that helped the researcher understand participant realities in a specific, holistic, dynamic, and situated manner, which allowed the collection of thick descriptions about their everyday experiences.

Most of the multidisciplinary professional health care teams involved in short-term medical missions require one to 15 registered nurses depending on the goals and type of care provided during the mission (DeCamp, 2007; Douglas et al., 2012; Hunt, 2011; Hunt et al., 2014b; Memmott et al., 2010; Ripp & Scudder, 2011; Schwartz et al., 2010). With the help of a

mission coordinator, the researcher looked for a mission experience that required a big team and

therefore, many nurses with various roles to facilitate the understanding of the complexities of

nursing practice, leadership, and the various roles and responsibilities that nurses engage in

during missions. Table 3 summarizes the participant demographics in this study regarding

gender, nationality, nursing and mission experience.

Table 3

Demographic Information of Participants (n=9)

Participant gender	# of missions and nursing roles	Years of Nursing experience	Nationality and age group
A, white male	20+ coordination and patient care	30+ intensive care (adults) and nursing education	American, 60+
B, white male	30+ coordination and patient care	30+ intensive care (adults and children), perfusion and operating room	Canadian, 60+
C, white female	20+ coordination and patient care	20+ intensive care (adults)	American, 40+
D, white female	4, coordination and patient care	30+ operating room (adults), coordination, and nursing education	American, 50+
E, white female	2, coordination, education, and patient care	20+ intensive care (adults), coordination, and nursing education	American, 40+
F, white female	4, patient care	4 intensive care (adults)	American, 20+
G, white female	0, patient care	20+ cardiac care (adults), intensive care, operating room and coordination	American, 40+
H, white female	2, patient care	5 intensive care(adults)	American, 20+
I, white female	1, patient care	6 intensive care(adults)	American, 30+

The mission team required nurses in the role of mission, education, operating room, and community outreach coordinators, as well as perfusionist, operating room, intensive unit, and community outreach-health promotion nurses. There were 10 nurses in the mission team, including the researcher, who volunteered in the mission. All nine volunteers agreed to participate in the study and were interviewed during and after the mission. Following Benner's (2001) levels of proficiency, participants' general nursing experience ranged from competent to expert nurses, and their mission nursing experience included all five levels of proficiency. Depending on the type, purpose, and goals, most missions require volunteer nurses to have a minimum of one to two years of professional nursing experience (Bajkiewwicz, 2009; Daniels & Servonsky, 2005; Memmott et al., 2010).

3.8 Data Collection

An interpretivist researcher uses data collection measures that are flexible, varied, and capture the multiple realities of participants to construct knowledge and an interpretation based on the understanding of all the multiple realities about the phenomenon investigated. Case study research also requires multiple sources of evidence to strengthen the validity, reliability, trustworthiness, credibility, transferability, dependability, and confirmability of the findings and the researcher's interpretation (Yin, 2014). In this study, as previously noted, data collection required 18 semi-structured interviews, direct observation, participant-observation, documentation, archival records, and physical artifacts. The researcher kept written and audio taped field notes to help clarify biases, engage in reflection, and record information about the various measures of data collection, which contributed to creating an audit trail and data base of the knowledge constructed in the study.

3.8.1 Interviews. Semi-structured interviews were used in this study to help the

researcher understand how and why participants acted in certain ways by exploring their

perceptions, experiences, values, and attitudes (Dearnley, 2005; Harvey-Jordan & Long, 2001).

The study participants, in effect, were the experts constructing meaning within the particular

context of the mission, which influenced their practice, and consequently, the quality of nursing

care they provided in the mission. A series of open-ended questions facilitated the participants'

description of their lived experience through in-depth narratives of their stories (Ashton, 2014;

Baumbusch, 2010; Irvine, Drew & Sainsbury, 2012; Peredaryenko & Krauss, 2013). Data were

collected with each participant during and after the mission until no new thoughts, perspectives,

or themes seemed to emerge which indicated data saturation (Corbin & Strauss, 2008, Gay et al.,

2012).

The semi-structured interview questions (Appendix E and F) focused on the participants'

clinical decision-making process and followed an appropriate sequence and wording to

determine and validate the meaning behind the participants' answers. The format was flexible

and allowed the researcher to probe unclear or ambiguous words and phrases to validate the

meaning of participants' answers because words can be interpreted differently (Barriball and

While, 1994). Based on the emergent themes in each interview, the researcher clarified,

compared, contrasted, and collected data to explicate patterns and specific themes among

participants. With the participants' permission, all interviews were audio recorded, and the

researcher also wrote notes about each interview. The interview questions were piloted on a

nursing colleague with mission experience to obtain feedback about the accuracy and

trustworthiness of the data that were collected during and after the mission. Feedback about the

interview questions was also obtained from the researcher's study supervisors and other professors.

Two months before the mission, the coordinator sent emails to the volunteer team to introduce them to each other; an email to the nursing team included an invitation to participate in this study (Appendix B). The coordinator asked the nurses to contact the researcher only if they had questions about the study, or they were interested in participating in the study. The researcher replied to each participant's email and provided information about the study (Appendix C), answered questions, and obtained their consent to participate (Appendix D). Plans were made to conduct semi-structured interviews with each participant during and after the mission at a time and place of the participant's choice.

During the 15 days of the mission, the researcher negotiated a time and a place with each participant that suited their schedule and comfort level. Individual participant interviews during the mission (Appendix E) lasted from 60 to 120 minutes, and took place in various quiet and comfortable settings chosen by the participants. The researcher explained the study, obtained verbal and written informed consent from each participant (Appendix D), and requested permission to record each interview and write notes on paper. After each interview, the researcher asked the participants about doing a second and final interview in person, over the phone, or via skype.

After-mission interviews were conducted between February and June 2016, two to six months after the completion of the mission in December 2015. The researcher contacted each participant via email and arranged a suitable time and medium to conduct the interviews. Based on the location and time availability of each participant, after mission interviews lasted between 90 to 150 minutes and took place in person, via telephone or skype (Appendix F). Before the

after-mission interview, each participant was emailed the original transcript of their mission

interview, and was asked for feedback to clarify and validate the information obtained. At the

beginning of the after-mission interviews, participants were reminded about the study, verbal

consent to participate was obtained, and they were asked about any questions or concerns with

the data obtained in the interview during the mission. The researcher obtained permission to tape

record the interview and write notes. Except for one interview conducted in person at a location

chosen by the participant, eight interviews occurred via skype. After the interview, each

participant was emailed their transcription and invited to check, add, or delete information to

clarify and validate the information obtained in their transcript.

> **3.8.2 Direct Observation.** Case study research allowed the researcher's opportunity to

engage in direct observation of nursing practice as it happened during the mission. The

researcher was also a volunteer nurse, which facilitated being present during many activities,

meetings, and everything that concerned participants' responsibilities and roles in the mission.

This allowed the ability to observe, listen, critically think, experience, and participate in mission

activities with intention, mindfulness, focus, authenticity, and reflexivity (Patton, 2015; Stake,

1995, 2005).

> Patton (2015) provides a dimension of field work that includes sensitizing factors to

observe, which include language, nonverbals, formal activities, informal interactions, physical

setting, the context and history of the environment, and self-reflexivity. At the very beginning of

the mission, for one day, the researched carried a notebook to write field notes but quickly

stopped doing so because the participants' behavior seemed to change when the notebook was

brought out. Researchers impact participants and vice versa, and they also get observed by the

participants (Gay et al., 2012). Fortunately, two decades of experience with in-action and on-

action reflection (Tanner, 2006) when practicing and teaching as a nurse facilitated the

researcher's ability to adopt a researcher stance of critical inquiry regarding what was being

observed, how and why, in every interaction with participants, the mission and local teams,

patients, families, as well as everything and everyone within the context of the mission.

Furthermore, it became 'vital' for the researcher to write or tape-record field notes as quickly as

possible, in an unobtrusive manner and away from participants, to ensure the accurate recall of

the observations. Once again, two decades of nursing practice facilitated the researcher's ability

to obtain and document observations as accurately, quickly, and unobtrusively as possible.

     3.8.3 Participant-Observation. The researcher volunteered as a nurse in the mission,

which allowed the opportunity to engage in active observation while assuming various

responsibilities required of participants (Yin, 2014), which included direct patient care and the

education of the local nursing staff. In this study, participant-observation facilitated the ability of

the researcher to experience the mission from the perspective of the participants, helped to

establish credibility, and the acceptance of the mission team. However, the researcher had to be

very careful to recognize and reflect about personally-held biases. Feedback from the

participants, constant reflection about the interactions within the context of the mission, and

reflective journal entries helped the researcher to develop awareness, be intentional, mindful, and

focused when engaging in critical inquiry, observation, and data collection to construct

knowledge about nursing practice that would lead to an understanding of what happened in the

mission, how, and why.

     3.8.4 Documentation. The researcher collected and looked at different forms of relevant

documentation about the mission. These included emails about the mission, announcements from

the mission organization and hospital, and hospital records and documentation of the care

provided by the local nurses. The final official reports of the mission, and a certificate of

appreciation for the care provided from the hospital are also part of the documentation about the

mission. The researcher wrote and recorded field notes about direct and participant observations,

as well as reflections about the research process, data collection, and analysis, which contributed

further sources of documentation about the mission. All the different sources of documentation

facilitated the analysis of data, triangulation, and the researcher's understanding and

interpretation about nursing practice in the mission from various perspectives that validated,

clarified, or negated conclusions derived from observation and interviews.

3.8.5 Archival Records. Before the mission, the researcher reviewed the public website

of the mission organization and accessed various information including policies, forms, mission

goals, volunteer conduct and expectations, service records, as well as recommendations to

prepare for the mission. During the mission, the researcher viewed educational plans, curriculum,

care protocols, and service records used by the mission team and participants. Additionally, the

researcher viewed the standard hospital forms, records, and policies used by the local nurses to

provide care in the intensive care unit and the operation room. Archival records provided insight

about the availability of evidence-based practice and care protocols during the mission to support

participants and the local nurses.

Participants did not have written care protocols in the unit during the mission. They were

very familiar with standard care protocols of developed countries, and constantly checked,

clarified, and validated treatment orders with the surgeons and physicians who trusted and relied

on their knowledge and expertise. The local nurses did not have many orders to follow, and

waited for physician written orders to provide care and know what was expected of them.

3.8.6 Physical Artifacts. The researcher observed, worked with, or collected objects

relevant to the mission experience. These included the technology and supplies available in the

hospital that allowed or limited the participants and researcher's ability to nurse and provide

care. For example, equipment to take blood pressures, mercury thermometers, chest drains,

dressing supplies, intravenous and oxygen equipment, nasogastric tubes, and the operating room

instruments and various equipment. Additionally, the objects in the general environment of the

mission that facilitated or inhibited working in the hospital were noted. These included the daily

newspaper, advertisement about the hospital, and various resources in the community necessary

for the participants to adapt successfully to the mission.

3.9 Data Analysis

Interviews were transcribed and analyzed in Canada. The researcher used a modified

constant comparative method, which derives from constant comparative data analysis in

grounded theory (Glaser& Strauss, 1967), to analyze the data and understand the phenomenon of

nursing practice in the mission. Constant comparative analysis requires the constant, cyclical,

and reciprocal interaction of data, analysis, and theory, which leads to the development of theory

(Corbin & Strauss, 2008). In this study, data were collected in Nepal, and the majority of the

analysis and interpretation occurred in Canada after the mission. Participants were asked to

verify the accuracy of transcribed interviews, the common themes, and the findings uncovered

from the analysis of data through member checking. Triangulation of the various sources of data

supported the researcher's interpretation and understanding of nursing practice in the mission

(Patton, 2015). Reflective journal entries, field notes, data analysis memos, and the study data

base strengthen the reliability and construct validity of the study findings (Yin, 2014). Each

interview was read many times and coded by hand.

In the first stage of coding or "open coding", the researcher identified block units of data such as single lines, or several sentences that reflected meaning about something, and chose one or a couple of words to assign the interpreted meaning based on ideas, theory, or "in vivo" terms used by the participants (Patton, 2015). In the second stage of coding or "axial coding", the concepts identified during open coding that seemed to relate or connect to each other were organized into categories to further explain the data, which lead to key categories that identified properties, dimensions, connections or associated conditions, and variations of the data. Concepts, categories, and key categories were compared across all 18 interviews following the modified constant comparative analysis method. Memos were written throughout the process of analysis to record the researcher's thoughts and interpretation of the data and coding process. After the researcher examined and reviewed all the key categories, and was not able to identify new concepts or categories with properties, dimensions, and much variation, the researcher achieved theoretical saturation (Corbin & Strauss, 2008) and grouped key categories into core categories or main themes.

The third stage of coding or "selective coding" required the researcher to identify and select overarching themes that provided an explanation for the key categories identified in the data analysis. The researcher 'coded by hand' and used a basic excel program to enter codes, axial codes, selective codes or themes, and short memos about the interpretation of the data. More detailed notes about the analysis process were entered in the reflective journal as analytical or methodological journal entries. Table 4 illustrates 18 'chunks' or blocks of data, the three stages of coding, and the short memos used to interpret and construct meaning about each block of data using excel. Note that the axial codes and themes were arrived at after doing constant

comparison across the participants' interviews and by looking at the actual interviews on paper.

More in-depth memos were written by hand on each interview.

Table 4

Example of Data Analysis and Coding in the Study

open codes	themes	Memos	axial categories
# missions/experience	individual	expert practice nursing & with missions	20 medical missions.
experience	individual	expert practice nursing & with missions	medical missions, disaster response, cardiac surgery in various countries over the past 10 years. Short-term community development. Has nursed for 35 years.
nursing expertise	individual	expert practice nursing & with missions	Roles: ICU recovery (34 years nursing), cardiac ICU, mission director, general care, medical director.
motivation	individual	why was it motivating? Difference with nursing at home?	MOTIVATION: wanted to volunteer for a long time and saw ER doc volunteer to Congo so next day I phoned Medical Teams International and signed up to go to Liberia. Disaster response.
mission expertise	individual	why was it motivating? Difference with nursing at home?	Disaster response: internationally displaced people camps in Liberia. Tsunami in South East Asia and Sri Lanka for a month.
challenge	group	is it easy to use BPGs? How do you figure out how/when/why to use theory? Is it the same in missions? Why yes/no?	RESOURCES at home: best evidence practice and education.
education	situational	continuing education is a luxury in developing countries. Role of education during missions?	CHALLENGE: lack of continuing education, no budget.
autonomy	individual/situational	how/why did we get protocols? What needs to happen for local nurses to have these? Why don't they have them?	AUTONOMY: in US nurses do many things and have privilege and opportunity to work this way but many places don't. 'We' have many well developed protocols.
team	individual/situational	why do doctors trust nurses in developed countries? Why do we have collaboration? When don't we have collaboration? How do teams work in developing countries and why?	COLLABORATION between doctors and nurses is extreme with protocols and very good teaching. This allows us to make pretty advanced decisions without notifying a physician. We can determine what is needed, do it, and then present situation to physician. Many places can't do this.
frustration	individual/situational	why are nurses limited? Power/hegemony? Cultural norms?	AUTONOMY: challenge and frustration to come on a trip where nurses are very well trained and intelligent but very limited in what they are allowed to do on their own. It is very hard to teach a lot of things when they tell you they can't do many things without a physician.

Table 4 continued

Example of Data Analysis and Coding in the Study

		why do doctors have to approve learning? What nurses do? what can nurses do, how and why? Why don't we need orders at home and in missions?	TEACHING: It is very hard to teach when they tell you they can't do many things without a physician's approval.
teach	individua/group/situational	why do doctors have to approve learning? What nurses do? what can nurses do, how and why? Why don't we need orders at home and in missions?	TEACHING: It is very hard to teach when they tell you they can't do many things without a physician's approval.
knowledgeable	individual	need to respect what locals know, establish credibility how?, how do we know we are right? Are we always right? How and why?	KNOWLEDGE & COMPASSION: challenging to share your knowledge while being compassionate because of the context lack of resources, without coming across as a "know it all".
empower & respect	individual	how do we empower local nurses? Can they use the knowledge? How and why? Do they want to learn? How an dwhy do we know?	EMPOWERMENT: you want to share your knowledge without being condescending while empowering the nurses.
satisfaction	individual	is this competent practice? According to what/whom/why/how?	SATISFACTION of being a nurse especially in something like cardiac surgery that's fast paced where big changes in the patient's status can happen in minutes, and the improvements on their well being following your assessment and interventions are overwhelming.
constraints	individual/group/situational	why do doctors have power? What do student nurses learn in school? Do local nurses want autonomy?	AUTONOMY: nurses have to ask the doctor for permission to do things, so there is a physician available 24 hours. They can't even do obvious things such as get an x-ray.
obvious & expertise	individual	expert practice nursing & with missions. Does not realize "obvious" only to the expert :-)	AUTONOMY & EXPERIENCE: you have to do things because you need information to provide care and that comes with experience. They don't have the knowledge yet, but for those of us who have practiced for a long time what you need seems real obvious.
challenges	individual	what is needed to teach local nurses? What are the barriers/how/why?	AUTONOMY & EXPERIENCE: local nurses don't have these, so it's challenging to teach them to help improve their practice.
experience & respect	individual	what is the difference between experience and knowledge? How do we get credibility?	EXPERIENCE: careful to come across as someone with experience vs. "know it all".
time & respect	individual	how do we assess learning needs? Can all nurses teach/train local nurses? What/how/why? What is the reason for training/educating local nurses?	TIME: in the beginning to get to know nurses, show them you appreicate their work, knowledge and experience.

The researcher printed the interview transcripts during and after the mission using two different colors of paper to help distinguish the coding and analysis at each stage easily. The coding data were also entered on excel using a mission file that included all the coding from the 18 interviews; a during mission file that only included the during mission coding; and an after-mission file that only included the after-mission coding. In this study, there were no new key categories or themes that emerged in the after-mission interviews either by looking at the actual color-coded interviews, or by sorting the codes using the excel program. The only significant difference noted by the researcher was the depth of reflection in each interview, which was evident in the thicker descriptions with regard to feelings, expressed emotions, detail of experiences (Patton, 2015; Ponterotto, 2006), and the length of interviews. Three participants had just returned from missions and were dealing with moral residue from past experiences, which included the mission to Nepal.

3.9.1 Researcher's Analytic and Reflective Journal. The researcher kept a reflective written and audio journal about the experiences during the mission, which included methodological and analytic notes related to the overall research, data analysis process, and this written report of the investigation. The field notes and reflective journal helped the researcher to keep a record about questions, concerns, insights, interpretations, theory application, and analysis of the acquired information about the participants, the nursing practice that was observed, and the context of the mission. This information assisted the researcher to become aware and explore biases throughout the investigation, as well as understand and further explore data to gain insight about how nursing practice happened in the mission, what it was, and what factors influenced it, how, and why.

3.9.2 Member Checking. Clarifying and validating the accuracy of the data collected, as well as the researcher's interpretation at various stages of the investigation with the participants promoted openness, collaboration, and balance of power between the researcher and participants (Dearnely, 2005; Morrow, 2005). The researcher spoke to participants during the mission to clarify and validate the accuracy of observations. Once the interviews were transcribed, the researcher emailed each participant his or her original transcript to get feedback and check accuracy. After the data were analyzed, the general research findings were emailed to each participant to obtain feedback and check the accuracy of the researcher's understanding and interpretation of the participants' experiences during the mission. Participants expressed no concerns or disagreement, and some of them replied that they hope to see the study and its findings published in a nursing journal article to contribute to our limited knowledge about nursing practice during missions in developing countries.

3.9.3 Triangulation. The analysis of the different sources of data used in this study identified contextual factors that affected the phenomenon of nursing practice during the mission by either contributing or challenging the process, thus affecting the ability of participants to engage in safe, competent, ethical, caring, and compassionate nursing practice. "When similar results are obtained via multiple methods or techniques, the researchers have increased confidence that their findings are valid" (Hisson, Lape & Bailey, 2015, p. 37). Triangulation of the data collected from interviews, direct observation, participant observation, documentation, archival records, physical artifacts, and the researcher's field journal demonstrated the consistency of the study findings from various sources. Two main purposes of triangulation are to confirm data through various sources, which increases the confidence in the credibility of findings, as well as ensure that all the data provides as complete a picture as possible of

phenomena (Houghton, Casey, Shaw & Murphy, 2013). Furthermore, it is congruent with an interpretivist perspective that incorporates multiple realities and life experiences. From a case study research perspective, "triangulation is the convergence of data from different sources to determine the consistency of a finding" (Yin, 2014, p. 241). Using multiple methods of data collection and sources provided a more complete picture of nursing practice during the mission (Gay et al., 2012).

      3.9.4 Trustworthiness. Qualitative inquiry requires criteria of credibility, confirmability, dependability, and transferability to address the trustworthiness or rigor of the research findings (Given & Saumure, 2008; Lincoln & Guba, 1986). Trustworthiness relates to the ways in which qualitative researchers ensure that their findings have worth outside of the context of their studies. Furthermore, it requires authenticity or reflexive consciousness about the researcher's perspective, appreciation of other people's perspectives, and fairness in conveying the interpretation of other people's values and ways of life (Patton, 2015).

      Credibility is associated with the ways in which the researcher's interpretations have accurately and richly described the phenomenon investigated and the participants' life experiences. In this study, the researcher used member checking and participant feedback to ensure accuracy of the data analysis, and the interpretation of the participants' multiple realities about nursing practice during the mission. Confirmability relates to the match between the findings, data, and interpretations, which was established through triangulation. Dependability is determined through the systematic, logical, and traceable way in which a researcher describes procedures and data collection measures. Therefore, under similar situations, other researchers can collect data and will find similar results. For this study, the researcher has outlined,

discussed, and examined every step of the research process in detail to encourage, support, and promote further investigation about nursing practice during missions.

Transferability relates to how well others can determine an alternative context to which the study findings can be applied. The focus of an interpretivist researcher is on understanding complex human interactions and cultural systems that encompass multiple relativist realities as they happen; therefore, generalization is not a goal of an interpretivist investigation. Case study research is concerned with expanding knowledge about phenomena within its complex and specific environment. Therefore, exploratory case study was suitable because the main goal of this research was to contribute understandings and build on the limited knowledge about nursing practice in missions. However, the study findings support more discussion, research, and the critical assessment and evaluation of nursing practice in missions, the contextual factors that influence it, and the consideration of the implications of practicing in a safe, competent, ethical, compassionate, and caring manner regardless of context and location in the world.

3.10 Chapter Summary

This chapter focused on the methodology used to conduct the investigation to generate insight regarding nursing practice in a mission. It reviewed the research questions, epistemology, theoretical perspective, research design, the role of the researcher, participant-researcher relationship, and the participants. The data collection measures, which included interviews, direct observation, participant-observation, documentation, archival records, and physical artifacts were examined. Data analysis including the methodology, researcher's analytic and reflective journal, member checking, and peer review were explored. As well, data triangulation, trustworthiness, and the study limitations were considered. Chapter 4 follows and will discuss the findings obtained in this study.

Chapter 4

Findings

Following the main themes generated by the data analysis, this chapter provides an outline of the findings obtained in the investigation.

4.1 Study Findings

The data analysis of 18 semi-structured interviews, including the researcher's two reflections in the role of a nurse, conducted with individual participants during and after the mission, employed a modified constant comparative method of analysis (Corbin & Strauss, 2008) to code, categorize the data, and find the central themes that explain the phenomenon of nursing practice during a mission in a developing country. Each theme fits into one of three types of factors that affected nursing practice during the mission. The capacity to handle specific challenges triggered by individual, group, and situational factors determined the participants' ability to meet the mission goals while practicing in a safe, ethical, competent, caring, and compassionate manner. Figure 1 illustrates the three main types of factors that had an impact on participants' nursing practice, which will be discussed in this chapter.
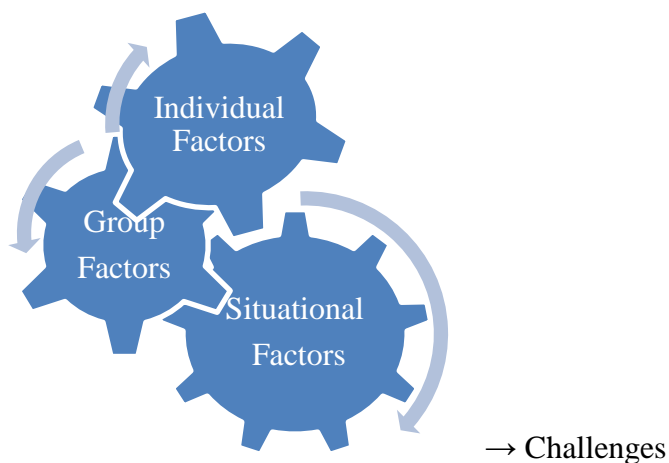
Figure 1. Types of Factors that Influence Nursing Practice During a Mission.

4.2 Individual Factors

Table 5 summarizes the individual factors that had an impact on participants' decision-making during the mission. Based on participants' reflections, the following eight factors affected their interaction with the environment and were conducive to practicing in a safe, competent, ethical, caring, and compassionate manner during the mission. Each of the eight individual factors will be discussed following the table.

Table 5
Factors that Influence a Nurse's Clinical Decision-Making During a Mission

Individual Factors
1 Ability to Adapt to the Environment
2 Autonomous Nursing Practice
3 Knowledge, Experience, and Confidence in One's Ability to Nurse During the Mission
4 Flexibility to Problem-Solve and Meet Needs
5 Art and Science of Nursing Integration
6 Making Sense, Finding Purpose, and Doing No Harm
7 Meaningful Work, Vision, and Serving Others
8 Moral Distress Experienced Due to the Inability to Provide Required Care

4.2.1 Ability to Adapt to the Environment. Participants compared nursing in a mission to the experience of starting a new job because that requires adjustment to working with new colleagues and the routines in a new environment.

> We're not at home. People do things differently and you have to have respect for the way things are done in other places so observing from the beginning is very important, as well as accept that the way we do things at home is not necessarily the best way, and certainly it's not the only way. (# 248, During Mission Interview)

Adaptation required doing a lot of observation to understand cultural norms. "You need to listen with your eyes, look around using all your senses and fundamental knowledge to make decisions and figure out what's going on (# 272, after mission interview)".

Participants travelled from the United States or Canada; therefore, going to Nepal required the adaptation to a new physical, social, work, and health care environment given the overall differences in ways of life and health care practices in a country very different to their own. Regardless of previous experience with travelling and nursing in missions, all the participants required time to become familiar with their new surroundings while they were nursing in the hospital or the community, as well as during their time off duty.

> You may be jet lagged, sleep deprived, and working at a higher altitude. The culture shock is a factor but sometimes so is altitude sickness, and you may be not aware that those things come into play regarding your behavior in a mission. Your personality, behavior, thinking, and problem solving can be impaired and nobody will realize it. (#247, After Mission Interview)

Nursing in a mission can also be associated with discomfort from the lack of familiarity with the environment, including unfamiliar routines, as well as different supplies and equipment that make nursing more challenging when there is a language barrier.

> You have to be willing to be in discomfort. At the beginning of the mission, you may be uncomfortable with the people, even the names of the medication and the dosing can be different; we were very confused about how they dosed certain things. Within our mission team we had people from Canada, US, and the U.K., so the names of the drugs and dosing between us were different as well; that's not something anyone even thought about before the mission. (#221, After Mission Interview)

Therefore, the successful adaptation of volunteers to the context of the mission, which includes the physical environment, cultural norms, as well as the health care system, medicine and nursing cultures impacts the ability to nurse in the mission.

4.2.2 Autonomous Nursing Practice. During and after the mission interviews, participants were very vocal about the crucial impact of exerting control over the patient care they provide because "you can't wait to call the doctor to ask them what to do. You just do what you need to do, otherwise your patient is in danger (#75, During Mission Interview)". The ability to exercise critical thinking and act accordingly allows nurses to make decisions regarding the assessment, monitoring, and evaluation of patient care outcomes based on clinical decisions supported by theory-practice integration.

> By doing the assessment you can decide what is going on. For example, people can be breathing weird but their breath sounds were normal before. Now they have no breath sound on the left lung, so you catch this with your assessment and can do something about it to help the patient. We know we need an x-ray, and we can call the doctor and say that something didn't look right so we reassessed. We cannot make a diagnosis, but we can pick up changes and give as much information as possible so a diagnosis can be made. We are not relying on somebody else to tell us what the problem is, and what we need to do. (#250, During Mission Interview)

However, all the participants voiced their frustration and concern about the inability to teach the local nurses various skills and assessments, which the local nurses could not do on their own without a doctor's orders. Furthermore, participants realized that local nurses were not able to discuss concerns or advocate for client needs following established cultural norms in the Nepalese health care, medicine, and nursing cultures. "I don't feel the local nurses are empowered as much to discuss their concerns with physicians. I think most of them just do what they're told (#387, During Mission Interview)".

Therefore, participants concluded that the lack of autonomy in nursing practice in Nepal negatively impacts the care that patients receive due to the inability of nurses to assess, monitor, implement, and evaluate care without a doctor's order.

4.2.3 Knowledge, Experience, and Confidence in One's Ability to Nurse During the Mission. The local team perceived the participants to be experts given their knowledge, experience, the care provided to patients, and the bedside education given to the local nurses. Participants appreciated the high regard for their knowledge and skills, which contributed to their confidence, credibility, and facilitated the education of the local staff, role modelling, and implementation of suggestions made to the local nurses to help them improve their current practice. Most participants also stressed the necessity to be sensitive, and appreciate the local team's knowledge and skills, as well as respect their understanding and familiarity with the context of situations during the mission.

> One thing I learned on my very first mission was that to make even a small change happen, you have to figure out who and what drives whatever is behind the current practice without insulting people's practice because they are practicing good medicine. It might look different to the way we practice, but they are practicing good medicine. (#158, After Mission Interview)

Therefore, the participants' ability to exercise autonomy over their nursing practice contributed to safe, competent, ethical, caring, and compassionate practice. Furthermore, participants' cultural sensitivity, humility, and respect of the local staff's knowledge and experience facilitated education, and the implementation of various changes in the current nursing practice using a confident, knowledgeable, caring, and professional approach.

4.2.4 Flexibility to Problem-Solve and Meet Needs. Participants acknowledged and stressed on several occasions that the ability to problem-solve effectively required the capacity to be flexible following a holistic assessment of the context of situations and respect for cultural norms while trying to apply evidence-based practice. They stressed that their role of 'expert guests' required them to be respectful of their hosts' education, knowledge, skills, and expertise.

> You need to be able to see the whole picture, identify the different players and stake
>
> holders, understand the context of the situation, use different problem solving strategies,
>
> respect people, and build rapport with them, as well as apply standards of practice,
>
> fundamental theory, and evidence based-practice to the situation while being flexible.
>
> (#106, During Mission Interview)

Furthermore, participants emphasized that an inability to be flexible leads to a rigid, uncaring, disrespectful, and bully-like approach when providing nursing care and interacting with the mission and local teams. Such an approach contributes to unsuccessful adaptation to the environment and the failure to meet mission goals. Rigidity also leads to the inability to educate the local staff, which results from feelings of incompetence, hesitance to learn, and resistance to change. Participants also acknowledged that unrealistic individual expectations about volunteering in the mission significantly affected their overall perception regarding their success to provide nursing care during the mission, and negatively affected their ability to be flexible.

> It's good to have an agenda but know that you have to be extremely flexible once you get
>
> there. Flexibility is really the key, and not letting the ruined agenda discourage you so
>
> that you don't even try to do anything at all. (#158, During Mission Interview)
>
> Therefore, participants concluded that being flexible in the mission was essential.

However, the lack of knowledge regarding what to expect during the mission led to unrealistic

personal expectations and a lack of flexibility, which negatively impacted the ability to nurse and resulted in a feeling of 'uselessness' due to the inability to meet unrealistic personal goals.

      4.2.5 Art and Science of Nursing Integration. All the participants expressed difficulty defining nursing practice in general, based on what nurses do, given the wide scope of nursing practice and the ability to nurse in a variety of settings. They all acknowledged the necessity to be caring and compassionate while integrating fundamental nursing science, evidence-based practice, critical thinking, and experience while caring for, about, and with people. Participants indicated that their ability and confidence to make clinical decisions comes from experience, evidence-based practice, fundamental nursing knowledge, and the capacity to critically think while considering the context of situations to decide the most effective way of providing safe, competent, ethical, and compassionate care and therefore be able to integrate the art and science of nursing.

> Critical thinking is important when providing nursing care. We can provide care in different ways, but must understand the principles supporting our practice to apply the theory in different situations. The application of fundamental principles is different between the beginner, advanced, and experienced nurses. Sometimes you may decide that a way to do things is not necessarily the way you would practice at home, but based on the specific context of the situation, you can see there is another way of doing things. An experienced nurse is able to arrive at that conclusion, and a nurse that doesn't have much experience may tend to follow the textbook and policy manual step by step. (#8, During Mission Interview)

Moreover, nurses do not practice in isolation and must learn to collaborate with everyone and everything that impacts patient care, which includes the health care team, family and

significant others, as well as the environment. Such an approach contributes to holistic nursing

practice and underscores the fact that there are many elements that determine people's ability to

be healthy, as well as their strengths, and resilience when facing health challenges. Nurses are

not responsible for curing disease, instead, they help people to prevent, manage, and recover

from it. In numerous instances, they also provide the comfort needed to help people manage

illness, treatment, and prepare for death.

   The establishment of trust and connections with people while providing care of various

complexities demonstrated the art of nursing practice, which helps nurses to assess, meet needs,

and provide comfort as needed. All participants stated that they would have liked the ability to

speak directly to patients and families, but they felt comfortable communicating through the

local nurses or by using non-verbal behaviors to help them assess and meet patients' needs.

Everyone in the mission had some experience nursing patients who did not speak English.

Participants stated that even at home, they had to communicate with patients who did not speak

English, were unconscious or intubated.

   Following the first surgery and transfer of the patient into the Intensive Care Unit, the

local and mission teams were very excited and anxious to provide care and recover the patient.

While everyone focused intensely on tasks to make sure that the patient was safe and cared for,

the participants provided teaching and support to the local nurses as they worked together with

the teams to provide care. Suddenly, right in the middle of 'the frenzy', the patient woke up after

surgery and found herself surrounded by numerous machines that invaded her body, and she

could not speak and breath on her own. Her eyes showed the panic and fear she must have felt as

she managed to look around, and heard the many strange people working on her body speak in

an unknown language. At that time, instinctively, one of the participants spoke gently to the

patient as she grabbed and held her hand while telling her that her surgery was over and she was going to be fine. Although the patient could not understand English, she focused her eyes on the participant and appeared to squeeze the hand as strongly as she could, which helped her to calm down and patiently wait for all of activity taking place to stop. Every time the patient seemed to experience suffering, she looked for the participant and the hand that was willing to provide comfort to her. The participant's behavior provided comfort to the patient, as well as reassurance to the teams that were learning to work together.

Overall, participants emphasized that the responsibility to ensure safety and comfort by advocating for patients' wellbeing is a key component of autonomous nursing practice, as well as the ability to assess, monitor, and evaluate the outcome of the nursing care provided regardless of the location and setting where nursing takes place. The most important and reliable tool for nursing is the nurse; therefore, safe, competent, ethical, caring, and compassionate practice can take place anywhere with or without the use of sophisticated technology, and participants stated that this was the key teaching they had to share with the local nurses about the art and science of nursing integration.

4.2.6 Making Sense, Finding Purpose, and Doing No Harm. Ensuring patient safety, saving lives, promoting health, and providing competent care while educating staff were the most important team priorities according to the participants and related mission documentation. These priorities facilitated making sense and finding purpose for the care that was provided to patients during the mission, regardless of the challenges encountered.

> You lower your standards and find a balance by realizing that there is more than one way
> of doing things, and that necessity requires you to do things that you wouldn't necessarily
> feel comfortable doing otherwise....We're giving people re-sterilized valves that I

personally have packaged after taking them to our central supply to get them sterilized. I would never do that at home, but a re-sterilized valve is certainly much better to not getting surgery at all. So I feel like my justification is that we can save lives even though we're lowering our standards by not following the same standards of care from home, but we're saving lives. (#314, During Mission Interview)

Participants acknowledged that the need to carefully observe and assess their environment was critical to develop awareness, attempt to understand, and respect people's way of life and reality. The lack of experience and knowledge about the context of situations resulted in difficulties with the application of experience and evidence-based practice. For this reason, the willingness to approach situations in a culturally sensitive, flexible, and holistic manner when making clinical decisions facilitated making sense, finding purpose for the care given, while being safe, avoiding doing harm, and resolving situations in a way that honored patients' needs, strengths, and was culturally sensitive. The pivotal element of clinical decision-making was to maintain and ensure patient safety always and do no harm, while achieving the mission's purpose and goals to deliver safe, ethical, competent, and compassionate cardiac care to patients during the mission, and help the local team to establish their cardiac care program.

Sterilization parameters don't exist because there's no way they can do that. They don't have indicators, so that's where I lower my standards by putting things in their context….We definitely use reprocessing; I use equipment that I re-sterilized myself. That's where I lower my standards, which is very uncomfortable…but they have no other way of doing it, so you have to accept it and go forward believing that you're doing more good than harm. (#150, After Mission Interview)

Based on the overall results of the care provided, surgeries, successful recovery of patients, as well as the education delivered to the local team, all the participants concluded that they were successful in achieving the mission's goal and purpose, which was to help the local team establish a sustainable cardiac program in a safe, competent, and ethical manner. Various records from the hospital and the mission organization regarding the local and mission teams' accomplishments also confirmed the success of the mission through a formal and general evaluation of the care provided.

4.2.7 Meaningful Work, Vision, and Serving Others. Participants' reflections and behaviors consistently validated the fundamental notion that regardless of location and context, nursing practice embodies the belief to care for, about, and with people. This belief is grounded in the individual participants' vision that serving others and advocating for vulnerable and marginalized populations are fundamental responsibilities that bring to life the essence and philosophy of nursing practice.

> People ask me why I go on so many missions and sometimes I don't really have the best answer. If all I've helped is five people, that's still five people who got something that they didn't have. We are nurses and we are in the business of helping people. If you are that one person that gets help, for sure it's going to mean something to you. That's what keeps me going. It's the little baby we found that had a blockage of the salivary glands and couldn't nurse. The baby who was going to die without question. They couldn't feed the baby, we discovered the blockage in the salivary glands and sent him to a clinic that for $50 was able to unblock them through a minor procedure. Mom didn't have $50 but we did, and felt good we were able to help them. It's what we're supposed to do when we nurse. We felt like you gave this baby a second chance, mom, and the whole family. It's

about having faith in humanity, and that's probably why I keep going back because you

hope you can make a difference for even just a few people each time. It comes down to

perhaps what nursing is all about. (#195, After Mission Interview)

Participants determined the value and importance of their work to serve others based on

their contributions to improving patients' lives and wellbeing. Validation was achieved through

patient care outcomes such as stable surgical recoveries, and the elimination of physical pain and

suffering. The ability of the local staff to learn, integrate, and continue to demonstrate changes in

their practice validated the participants' perception about making an impact on the local nursing

practice, and the quality of care provided to patients. The development of standard care protocols

for the local nurses to follow, support their critical thinking, and promote autonomous practice

was perceived to be a very positive result in relation to promoting change in team dynamics and

cultural norms, which the participants hoped will last and continue to evolve similar to the

changes in nursing practice in developed countries.

Knowledge and empowerment are necessary for nurses to discuss their concerns with

physicians. We have a lot of autonomy at home. I think that by having many available

standing orders we can essentially do whatever we need to do to ensure our patients'

wellbeing. This is a significant cultural difference in nursing practice. (#75, During

Mission Interview)

Participants expressed frustration at not being able to make more significant changes to

empower the local nurses during the mission. However, they realized that cultural changes

require time and patience, and are very difficult to achieve. It is not realistic to expect big

changes in traditional cultural beliefs over a two-week period. Moreover, they recognized the

necessity to observe, be aware, understand, and respect people's way of life.

Going on mission trips requires you to step back and take some time to observe and

appreciate the practice that's occurring, while recognizing that it's not going to be the

same as yours. You can't make it the same as yours. Therefore, taking baby steps or

making small improvements in practice and care is often the goal. Then that will feed on

itself, and the more empowered nursing becomes, the more changes that will take place,

which is what happened in the U.S. thirty to forty years ago. (#361, During Mission

Interview)

In addition to the changes in nursing practice required to improve patient care,

participants discussed the lack of support available to families in the hospital. They were only

given a very limited one hour opportunity to visit their loved ones in the Intensive Care Unit. The

local nurses were not allowed to speak to families about the patients' status, so they very often

had minimal or no information about their loved ones following heart surgery as they waited

patiently outside the unit. Participants expressed frustration about the lack of information and

support provided to families, and asked the local physicians to update families about their loved

one's status after surgery. The official report prepared for the hospital at the end of the mission

advocated for families to have the opportunity of spending more time with their loved ones in the

Intensive Care Unit, as well as receive information regarding their health status after surgery.

Using best-practice guidelines and the mission team's experience, participants suggested that

family involvement and support contribute to the healing and the successful recovery of patients.

Additionally, participants also reflected about their inability to really understand the

impact of living with social inequalities experienced by patients in Nepal until they volunteered

in the mission and established a nurse-patient relationship. They spoke of witnessing a different

way of life and cultural norms that help people to cope with the constant challenges they face,

develop the strength to move forward, and cope with their realities. "People here have an acceptance about their lives and the way things are. We feel bad about not being able to do more. We want everything, and we think we should be able to get whatever we want (#433, During Mission Interview)".

Overall, all participants stated that they enjoyed nursing in the mission because they had an opportunity to serve others using their knowledge and expertise. They nursed patients who got surgery that will improve their lives, and helped the hospital and local staff to establish a cardiac program that will give more people the opportunity to have cardiac surgery in the future.

4.2.8 Moral Distress Experienced Due to the Inability to Provide Required Care. A critical factor that impacted nursing practice in an unfamiliar context with a different way of life and health care practices was the application of ethics, which required participants to evaluate the possibility of causing harm to patients resulting from their ability or inability to provide care. Participants acknowledged and reflected about feeling "unsettled", "uncomfortable", "useless", and "heartbroken" following their powerlessness to deal with situational constraints that prevented and limited their capacity to provide care that patients needed, and in many situations asked for. "The unsettling feeling comes from understanding but still wanting to change things. The understanding that you may not be an agent of change (#64, After Mission Interview)". The feelings were unresolved during and after the mission, and participants struggled with a way to cope and reconcile with the reality of the situations encountered.

> We still have to do the best that we can do with what's available. You're still going to walk away feeling frustrated; you're going to feel depressed often. A lot of people cry at the end of the day when they realize they're not going to be able to help people. (#144, After Mission Interview)

Some participants spoke about using reflection to cope with moral distress, which did not seem to provide relief.

Within the context of the situation, the dilemmas, and the reality of things, I am constantly evaluating the effectiveness of what I do. Many times, I'm very discouraged and unsettled because I don't feel like I've been able to accomplish all that I wanted to accomplish. And so there's constant talking to myself to stop, look, and see what it is that I have really been able to do, and be comforted by that. (#380, During Mission Interview)

Participants also commented about dealing with moral residue once they returned home, never knowing if they were able to make an impact on the people they cared for in the mission.

I feel ethically split for a month after a mission. It's just sort of this feeling of uselessness. I wonder if I should I even do this. It's a self-centered feeling because you're thinking about yourself and questioning why you do the work, and what difference it actually makes. Again, it's all about you and it's not really about the people because you don't know, and you'll never really know, if you made a difference, or if you helped someone or not, especially when communicating with people is difficult. (#322, During Mission Interview)

Regardless of experience nursing in missions, knowing about the general lack of resources did not help participants to cope with moral distress. Participants stated they were only able to appreciate the full impact of social inequities until they were nursing in the mission, and had established a relationship with patients.

It is tough, sometimes painful, to walk around and people seem to expect things. It's hard to say that you can't help. It gets a little easier over the years but it is still hard. You just have to reposition it in your head and remember that you are there doing some good and

can't help everyone. You need to critically think about how to best help people. (#310,

During Mission Interview)

Therefore, some participants discussed the importance of providing volunteers with

enough information about lack of resources and the possible challenges that may be faced in the

mission.

You need to prepare the people who volunteer for the realities of the situation. I think that

will help people a long way, especially new volunteers who don't know what to expect.

You don't want to be ultra-negative but you need to be able to explain that you're going

to a place where the needs are far greater than what you could ever bring, and there will

be patients for whom there's nothing we can do, which will be difficult to deal with.

(#273, After Mission Interview)

In general, when reflecting about past missions, moral distress and moral residue,

participants spoke about the importance of receiving accurate information about the lack of

resources within the context of the mission to help volunteers prepare for the harsh reality of

people's lives in developing countries. Furthermore, given the lack of resources, volunteers need

to understand the significance, value, and purpose of mission work.

4.3 Group Factors

Table 6 summarizes the three group factors that had an impact on individual participant

clinical decision-making during the mission, and influenced interprofessional collaboration with

colleagues from the mission and local teams. The team dynamics, evidence-based practice and

protocol application, as well as the overall mission team preparation and individual fitness to

practice affected participants' ability to practice in a safe, competent, ethical, caring, and

compassionate manner. Each of the three group factors will be discussed following the table.

Table 6

Factors that Influence a Nurse's Clinical Decision-Making During a Mission

Group Factors
1 Team Dynamics
2 Evidence-Based Practice and Protocols
3 Extent of Preparation and Individual Fitness to Practice

4.3.1 Team Dynamics. Participants recognized that ongoing support and validation from the mission and local teams regarding their clinical decisions to manage patient care outcomes facilitated the delivery of safe and competent nursing care. Honest and open communication with all team members grounded in respect and trust was crucial to meet the mission goals and ensure safe, competent, ethical, caring, and compassionate practice. The ability of the mission and local teams to clarify individual member roles and expectations was essential.

> We come to the mission with different expectations, values and beliefs, which are also
>
> different from our host's. When you're pulling together people who are used to different
>
> ways of doing things, they don't necessarily all mesh right. When you're working with
>
> people you've never met before, you have to trust that they know what they're doing.
>
> You can easily run into trouble because of little things that can turn into a big thing, or
>
> you may have to deal with a situation of ethics, consider right and wrong, and we have to
>
> remember that we're coming from different organizations, countries, and cultures. (#274,
>
> After Mission Interview)

Although the staff in the local team spoke English, participants identified potential barriers in communication, which included misunderstandings between the mission and local teams due to the lack of English fluency, the lack of familiarity with specific health care language among countries that in this mission included Canada, US, UK, Brazil, Pakistan, and Nepal, as well as the lack of familiarity with health care practices, routines, equipment, and

supplies. Therefore, participants identified the critical role of building trust among the teams. Participants relied on the local nurses given the language barrier with patients, differences in care routines, and the available equipment and supplies to provide care. In contrast, the local nurses relied on the participants to learn how to recover patients after cardiac surgery and improve their overall nursing practice.

> We're all on the same playing field in a mission, there's no hierarchy and we're all as important as every team member, patients wouldn't do well otherwise. The development of trust between the visiting and the local team is one of the hardest things to do. Our organization is international and a lot of us haven't met each other before because we're all coming from different places. We must develop trust with each other in or team very quickly, and then try to develop trust with the local team. (#89, After Mission Interview)

Therefore, regarding team dynamics, participants identified the critical need to develop trust and group cohesion grounded on respect for every team member's contributions and role in the mission, which resulted in the team's ability to provide safe and competent care to patients.

> We look for different ways to make things happen but sometimes we can't. We try to make do by getting the resources we need, but if things do not line up and come together then that is another reason why surgery can't be done. Our motto is to respect our team's decision if our team does not accept the risk. (#264, During Mission Interview)

Overall, participants recognized the importance of individual member's ability to work with many strangers from different countries, who practice in different ways, as well as hold different agendas, personal values, and beliefs that impact the overall care provided and capacity to be successful in accomplishing the mission goals. Additionally, members from both mission and local teams provide a way to clarify and validate individual participants' clinical decisions,

patient care treatment and outcomes, as well as facilitate acquiring more knowledge, skills, and expertise.

4.3.2 Evidence-Based Practice and Protocols. Participants emphasized several times, the critical role of assessment and observation to make clinical decisions, implement care, and monitor patient outcomes following evidence-based practice and standard care protocols.

>The other factor in making clinical decisions is trying to maintain standards. We bring all the new research and studies and try to implement those on our missions. All the current guidelines help us in our decision-making on how to care for patients and what we teach the local teams. (#73, After Mission Interview)

All participants recognized critical differences in the health care system, care routines, as well as the local team's lack of knowledge and experience with evidence-based practice and standards of care protocols followed in developed countries. Consequently, everyone in the mission team was vigilant and very cautious about assessing, monitoring, and anticipating potential issues that could negatively impact patient safety in the operating room and the Intensive Care Unit.

As previously mentioned, the mission team volunteers travelled from various countries, and most of them had never met before the mission. Therefore, participants identified the need to clarify individual roles and care routines to ensure that everyone in the mission team followed the same standards of care. They stated that in general, there is a comparable application of evidence-based practice and care protocols in developed countries.

>Guidelines, organizational values, and mission goals are definitely necessary for volunteers to provide care. You're always with a different group of people, in an unfamiliar situation and environment so guidelines and checklists are necessary, and you have to utilize them. That's one way of teaching everybody what to look for and what to

be prepared for, as well as catch the very critical variables that you might not be aware

of. (#159, After Mission Interview)

Furthermore, participants observed a lack of communication and team work among the

local team, as well as the tendency to focus on individual responsibilities, which foster the

absence of check points necessary to promote safe and competent practice. Moreover, the lack of

inter-professional trust, respect, and communication does not support accountability, advocacy,

and the need to ensure clear communication at various times during surgery to assess, monitor,

and evaluate patient care. Following evidence-based practice, a critical change implemented

during surgery in the mission was the responsibility and expectation of each local team member

to speak openly with each other and the surgeon to ensure safe, competent, ethical, caring, and

compassionate practice, as well as the ability to make decisions as a team regarding any

challenges that might arise during surgery.

> Everybody is working in a silo so nobody is thinking about what their colleague is doing.
>
> They're not working as a team so the communication isn't necessarily there. In Europe,
>
> US, and Canada we'll even do time outs to make sure that everybody is on the same
>
> page, all the time, and make sure that all the safety checks are in place. The physician
>
> isn't necessarily the captain of the ship; we don't all stand up anymore when a physician
>
> enters the room. It's not because we don't respect them any less, but sometimes you have
>
> to be the patient advocate to tell the surgeon and inform him of a situation that's going
>
> on. They need to learn to communicate with each other and as a team, so that there's
>
> respect for everybody's roles to always do what's right for the patient. (#166, After
>
> Mission Interview)

Therefore, the education of the local team following evidence-based practice and

standard care protocols utilized in developed countries is a key element to improve practice and

the quality of patient care in a mission. As well as providing constructive feedback to the local

team to help them acquire the knowledge, skills, and experience that will help them to update

their practice, which achieves one of the mission's key goals.

4.3.3 Extent of Preparation and Individual Fitness to Practice. Most of the

participants felt that the mission was well organized, and the organization provided volunteers

with the basic information needed to help them prepare for the mission. Participants had access

to information posted on the organization's website regarding the mission expectations, goals,

hospital location, food and lodging, possible culture shock, as well as various policies related to

basic requirements for travelling and going to practice in Nepal.

Participants discussed the importance of researching the purpose, vision, and mission of

the organization planning the mission experience, as well as any information related to preparing

and nursing in missions. They suggested that talking to people who have participated in previous

missions is very helpful to get organized, and get an idea about what nursing in a mission might

entail. However, regardless of the information that people obtain, as well as previous experience

nursing in a mission, the participants concluded that one cannot truly prepare for the lack of

familiarity with the context and environment. Furthermore, the capacity to be flexible and

realistic about what can be accomplished following the opportunity to carefully observe and

assess the environment during the mission is critical to enjoying, learning, and obtaining

satisfaction from one's ability to provide nursing care in the mission.

In addition to flexibility, participants stated that the ability to have empathy and care

about people was essential to nurse, as well as collaborate and teach the local team.

The hardest part is screening for people that have respect and patience for practice that is

different from what they would normally do at their hospital. You need individuals that

have empathy for people that don't have the same resources, and are willing to figure out

how to make things work within the organization and the resources they have. They need

to have an approach that's very respectful and not overbearing. (#43, After Mission

Interview)

Furthermore, participants discussed the need to meet practice requirements for

volunteering, as well as possessing the necessary knowledge, skills, and experience to provide

safe, competent, ethical, and compassionate care in a mission. Participants did not agree on the

number of years of experience necessary before volunteering to nurse in a mission; however,

they stated that it is essential to have confidence in one's ability to nurse at home, as well as

nurse in an unfamiliar environment with very limited resources, different health care and cultural

practices. Although it is not necessary to organize a mission with expert nurses, exclusively, it is

essential to recruit a team with volunteers who are comfortable making safe, competent, and

ethical clinical decisions under challenging circumstances in unfamiliar environments. A mission

experience in a developing country, such as the one in this study, is not the place to learn to

nurse and become a nurse because the mission and local teams rely on volunteers' knowledge

and expertise. A volunteer's inability to provide safe, competent, ethical, and compassionate

care, as well as educate and make clinical decisions that rely on evidence-based practice will

compromise their practice, as well as the safety of colleagues and patients during the mission.

When you're in the mission, people's lives are in your hands and your team depends on

you. Collaboration, communication and teamwork are critical. You have to rely on

people you never met. It's not a one-man job, everything requires a team effort.

Therefore, you have to trust that the people you're working with know what they're

doing. They have the skills and the knowledge required to be doing what you're doing.

(#249, After Mission Interview)

Overall, participants concluded that although it may not be possible to obtain specific

information about the mission regarding routines and available resources, the information

provided by the organization planning the mission is essential to help volunteers prepare for the

mission as much as possible. It can help them to ensure they are capable and knowledgeable to

practice, and possess the minimum requirements to nurse and be successful helping to achieve

the mission goals.

4.4 Situational Factors

Table 7 summarizes the situational factors that had an impact on individual participant

clinical decision-making during the mission. During and after the mission, participants identified

the need to resolve challenges associated with two critical situational factors related to cultural

norms, as well as the lack of resources and social inequities, which affected their ability to

practice in a safe, competent, ethical, caring, and compassionate manner. Each of the two

situational factors will be discussed following the table.

Table 7
Factors that Influence a Nurse's Clinical Decision-Making During a Mission

Situational Factors
1 Cultural Norms, Hegemony, Hierarchy, and Power Imbalances
2 Impact of Lack of Resources Resulting from Social Inequities

4.4.1 Cultural Norms, Hegemony, Hierarchy, and Power Imbalances. Existing

cultural norms that reinforce an amalgam of factors, namely hegemony, hierarchy, and power

imbalances in any society, and in this study in Nepal, affect the capacity of nurses to practice in a

safe, competent, ethical, caring, and compassionate manner.

In many places, nurses have problems approaching physicians for what they need and are just willing to go with the flow, and maintain status quo. No one is willing to question why. Nurses, and everyone including physicians, keep doing things the same way so patients suffer and 'bite the bullet' with the lack of proper pain control and analgesia post-op, there are no changes made to medication rates and dosages post-op to avoid challenging the anesthesiologist. (#451 During Mission Interview)

At the beginning of the mission, some participants concluded that the local nurses' inability to make clinical decisions was due to an exclusive focus on tasks while providing care, and the lack of independent thinking and theory-practice application, which required physician orders to direct nursing care. However, the careful observation of the local team interactions made participants aware about power imbalances, hegemony, and cultural norms, which required nurses to behave in ways that negatively impacted their practice and patient care.

We need to find out the reality that people face when we're not there, as well as what happens in the hospital and how the hospital works. If you're trying to teach nurses to speak up and encourage them to advocate for patients, you also have to be aware about their reality and whether that is something that will realistically happen. If they risk losing their jobs, chances are they're not going to be speaking up, and that's not something that you would be teaching and encouraging them to do. Instead, you have to understand their reality and tailor your teaching accordingly to work with their needs. (#185, After Mission Interview)

Furthermore, although the local nurses were very motivated and receptive to improving their practice by following participants' suggestions, they were unable to put their learning into practice following the need of a physician's order before implementing any nursing care. In the

surgical room, the local nurses focused exclusively on technical tasks that involved instruments and procedures.

> It's very challenging and frustrating to come on a trip where nurses are very well trained and intelligent but very limited in what they are allowed to do on their own. It is very hard to teach a lot of things when they tell you they can't do many things without a physician's order. (#43 During Mission Interview)

Participants compared the local nurses' practice to the history of nursing oppression and marginalization in the United States and Canada around 1950. Participants became aware of the need to advocate for the local nurses while providing education, support, and facilitating change within the hospital culture to advance nursing practice, which will in turn improve patient care. Like the mission team, most of the local nurses were female, and most of the physicians were male. Although Nepal's cultural norms were not explored in detail, the mission team noted the existence of a patriarchal based-society, and the dominance of the bio-medical approach over nursing practice similar to the history of nursing in developed countries. Hence the power imbalances, oppression, and marginalization of nurses by physicians.

> We had the same challenge at home that nurses in developing countries are trying to manage. It takes a lot of time. It's been a really hard thing for me throughout my entire career. When I go to developing countries, I review any changes and improvement in nursing practice. I don't just facilitate doing procedures. I want to help the nurses improve and help them do things so they're empowered. (#65, After Mission Interview)

Participants acknowledged the most significant difference in nursing practice during the mission being the total lack of autonomy of the local nurses, and the status quo that perpetuated physician-nurse power imbalances. In Nepal, participants retained their autonomy to practice

because of the respect and credibility assigned to them by the local physicians who regarded them as expert foreign nurses. Furthermore, participants were accustomed to exercising critical thinking, practicing autonomously, as well as engaging in independent decision-making following evidence based-practice and available protocols of care. Moreover, the mission physicians trusted and respected the participants, as well as always supported their independent clinical decision-making and autonomous practice, which served to role model effective and successful interprofessional collaboration, and highlighted the need for the local team to change their practice.

Therefore, the mission team physicians, coordinator, and educator spoke to the local physicians about the need to trust their nurses more, and expect them to be their 'eyes and ears' at the bed side, which would leave them free to perform surgery and attend to their patients. Otherwise, having to micromanage nurses by constantly giving them permission and orders to provide care, will require them to physically remain with the nurses 24 hours a day, which is not a realistic expectation for the surgeons to maintain. Such an expectation will negatively affect the time available to perform surgeries and establish a cardiac program. Following the discussion, the mission and local teams developed specific care protocols and standing orders to help the local nurses become more independent in their decision-making, critical thinking, assessment, monitoring, and evaluation of the care provided to patients.

> I think being empowered to do something about situations facilitates critical thinking and clinical decision-making. If the local nurses assess their patient and find something wrong, they don't have anything to facilitate and guide their practice. They aren't empowered to think that they can do anything about unstable situations. (#271, During Mission Interview)

Nursing practice during missions requires awareness and the careful consideration of cultural norms, hegemony, hierarchy, and power imbalances that impact the local nurses' ability to practice, learn, and improve their care. Awareness results in action that requires the necessary involvement of different stakeholders to facilitate and promote change that empowers nurses and facilitates the advancement of nursing practice.

4.4.2 Impact of Lack of Resources Resulting from Social Inequities. Participants acknowledged the second most significant difference in their nursing practice during the mission being the lack of resources due to social inequities, which required them to be flexible and creative as they adapted their practice to the context of the mission. They contrasted this to the abundance and consistency of resources available to them at home, and the unnecessary waste of supplies sometimes due to manufacturers' liability issues.

> Many years ago, we set up our own instrument trays. There's no way we could do that now because of laws about reprocessing. In some regards, I understand it's for a higher level of packaging and improved sterility. On the other hand, it's absolutely ridiculous not to be able to reuse a $100 saw blade that you only used for 3 seconds going through a sternum. It's perfectly good afterwards but at home we cannot reuse that saw blade because the manufacturer says you cannot re-sterilize it, so you have to buy another saw blade. (#130, After Mission Interview)

Most of the resources used by the local staff came from different foreign organizations that made donations to them, so there was a lack of consistency in the amount and type of supplies available. Furthermore, this required the local staff to be very creative combining different equipment together, and sometimes, they were unable to use equipment that required various specific components.

Notably, many participants commented about the lack of universal precautions displayed by the local nurses and the need to reinforce this practice. The local nurses did not wear gloves when drawing blood samples, or when they came in contact with body fluids during certain procedures. The researcher noticed a lack of gloves in the Intensive Unit. Whenever there was a box available, they seemed to be a luxury that materialized from a donation due to their mismatch, color, instructions for use, and often meant to fit either the right or left hand. Therefore, the local nurses were careful to avoid wasting them. Various members of the mission team came into the unit very often to check patients and automatically practiced universal precautions, which require putting gloves on. However, following this protocol every time one came into the unit took away two gloves that a local nurse would need to provide care to a patient. Therefore, whenever possible, the researcher decided to avoid using gloves and found other ways to maintain contact and sterile precautions to leave more gloves available for the local nurses who had to come in contact with body fluids. The researcher also noticed that as the mission went on, various team members wore gloves only when absolutely necessary. There were night shifts when gloves were not available at all, and sometimes, a stack of gloves was neatly arranged somewhere for people to use when they came into the unit.

The lack of resources, which affected sophisticated technology that participants rely on to monitor and assess patients in the Intensive Care Unit, was another element that required the participants' flexibility in adapting their expert nursing practice during the mission to nurse patients in a safe and competent manner comparable to their practice at home. "The lack of resources during missions forces us to rely on fundamental concepts, basic assessment, and intuition" (#74, During Mission Interview). This situation also impacted other essential care routines such as medication administration. Participants adjusted to working with unfamiliar

equipment, as well as routines that typically require the assistance of pharmacy to prevent dangerous medication errors. Therefore, all participants reflected about the importance of ensuring safety while adjusting to different ways of calculating and administering medications.

Additionally, in relation to the different health care practices and lack of resources, participants discussed the critical role of the family in the hospital to obtain the necessary resources to provide care to patients. Families were responsible for obtaining the doctor's prescriptions, getting the medications from pharmacy, and delivering them to the nurses to administer them to the patients. Families picked up and delivered laboratory results, as well as anything related to the care of the patient while their loves ones remained hospitalized. Consequently, participants discussed getting behind in the administration of medications and the care of patients because they had to wait for families to meet their responsibilities, which jeopardized patients' recovery and the ability to provide urgent care as quickly as possible.

Moreover, some participants felt discouraged about the effectiveness of health promotion and teaching strategies in community settings because of communication difficulties and lack of resources due to existing social inequities in the system, as well individual patient characteristics such as cultural beliefs and lack of education. Participants were more optimistic about the success of strategies that required teaching health care professionals and the community workers involved with health promotion activities. Such strategies were identified as resulting in bigger and more sustainable impact following participants' previous participation in mission experiences.

The lack of resources during community outreach clinics caused participants to experience enormous frustration and moral distress due to their inability to provide the necessary care to patients. They spoke about past mission experiences where they ran out of supplies following unexpected numbers of people that showed up requesting care. Therefore, they

reflected about unresolved feelings of impotence and powerlessness resulting from trying to figure out how to care for people without any health care services in place that included referrals, monitoring, and follow-up services, which led to much frustration.

> Nursing in missions makes you think differently about politics and its impact on a lot of social determinants of health. I definitely recommend doing missions but people need to be prepared. It's important to tell people that it's not going to be easy. You're going to work very hard, be emotionally drained, and frustrated but you may get the opportunity to make a difference in someone's life. What we do may just end up being drops in the bucket, but for those who are affected it's a big deal. (#188, After Mission Interview)

Lack of resources had a significant impact on nursing practice in this mission. Volunteer understanding of the impact of lack of resources in achieving mission goals before participating in the mission can assist nurses to prepare for possible challenges when providing care.

4.5 Chapter Summary

This chapter presented the findings in the study. Participants were successful in achieving the mission goal to help the hospital establish a cardiac surgical program. They also provided education to the local staff to help them improve their practice and quality of care. Participants encountered challenges triggered by individual, group, and situational factors, which determined their ability to practice in a safe, ethical, competent, caring, and compassionate manner. In what follows, chapter 5 will provide a discussion of the significance of the findings regarding nursing practice during the mission.

Chapter 5

Discussion

This chapter examines the significance of the study findings, which contributes to our

understanding of the phenomenon of nursing practice during a mission in a developing country.

Each research question in the study is addressed taking into consideration the application of the

findings to support and facilitate safe, competent, ethical, caring, and compassionate nursing

practice in a mission. The chapter concludes with a brief summary that leads into the final

chapter of the dissertation.

5.1 Research Question 1) How do nurses make competent and ethical clinical decisions

during a mission in a developing country?

In this study, participants identified knowledge, experience, evidence-based practice, and

care protocols to be the key factors that influenced and contributed to their clinical decision-

making, which resulted in safe, competent, ethical, caring, and compassionate nursing practice

regardless of the context and setting where they nurse. Critical thinking is essential in clinical

decision-making because it allows the nurse to discern what knowledge, evidence-based practice

guidelines, care protocols, theory, skills, values, principles, attitudes, and behaviors are

appropriate to use depending on the context of the situation and unique patient needs (Benner et

al., 2008). Moreover, it requires the development of confidence, contextual perspective,

creativity, flexibility, inquisitiveness, intellectual integrity, intuition, open-mindedness,

perseverance, and reflection. Critical thinking integrates skills such as analysis, application, and

discrimination of theory, as well as information seeking, logical reasoning, predicting, and

transforming knowledge (Chan, 2013; Scheffer & Rubenfeld, 2000). "The antithesis to critical

thinking is unilogical thinking, or the tendency to see things from only a single perspective"

(Jenkins, 2011. p. 268).

Given the uniqueness of patients' needs, regardless of location and context where nursing

takes place, and especially within the unfamiliar context of a mission, the capacity of a nurse to

engage in critical thinking is vital to make clinical decisions, accurately assess, monitor, and

evaluate the care provided. From a professional regulatory body perspective, nurses must provide

care in a manner that is safe, ethical, competent, compassionate, and caring, which reflects

professional competencies and values in each of these domains (ANA, 2010; CNA, 2015; ICN,

2012). "Competencies are the integrated knowledge, skills, judgment and attributes required of

nurses to practice safely and ethically in any designated role and setting" (CNA, 2015, p. 27).

For this reason, this study was concerned with nursing practice that integrated all five of these

domains during the mission.

Furthermore, the ability of a nurse to practice according to the five domains of

competency and engage in critical thinking requires knowledge from various perspectives and

sciences that impact human life. Fundamental patterns and ways of knowing in nursing include

empirics, personal, ethical, emancipatory, aesthetic, and unknowing (Carper, 1978; Clements &

Averill, 2000; Chinn & Kramer, 2011; Mantzorou & Mastrogiannis, 2011). As was evident in the

fieldwork, nurses must know about physiological, humanistic, social, and various sciences, as

well as evidence-based practice and care protocols. Nurses also need awareness and

understanding of themselves to assume the therapeutic role and establish nurse-client

relationships, which are the vehicle to knowing and understanding patients as unique individuals

within the context of their environment. Ethical nursing practice requires doing good, avoiding

harm, as well as upholding ethical principles and professional values that include respect and

dignity for all patients regardless of background, social status, and personal values and beliefs. Nurses must also understand the impact of social determinants of health, organizational, political, national, and global issues on people's quality of life and wellness, which contribute to inequities. Social justice is therefore a critical concept in nursing practice, which supports and extends to advocacy to minimize marginalization and oppression of vulnerable people.

Furthermore, as demonstrated by the participants in the mission, the ability to integrate fundamental patterns and ways of knowing in nursing leads to the art and science of nursing integration, which demonstrates the individual nurse's aesthetic representation of nursing practice. Moreover, as much as knowing is essential to nurse in a safe, ethical, competent, caring, and compassionate manner, 'unknowing', or the capacity to be humble and recognize personal limitations in what we know about ourselves, patients, and context of situations, is also vital because it demands life-long learning, which is necessary to maintain and improve nursing practice (Altmann, 2007; Clements & Averill, 2006; Munhall, 1993).

5.2 Research Question 2) What factors influence nursing clinical decision-making during a mission in a developing country?

The data analysis of interviews conducted during and after the mission revealed that individual, group, and situational factors had an impact on clinical decision-making during the mission and affected the participants' ability to practice in a safe, ethical, competent, caring, and compassionate manner. The only significant difference between the interviews during and after the mission was the depth of reflection that occurred after the mission. Participants indicated that they appreciated the ability to talk about the mission with someone who was present during the experience. Except for one participant, people had participated in one to 35 missions. However, all of those eight participants stated that they never had a formal opportunity to reflect about their

participation in previous missions. Every participant stated that it was valuable to talk about the

mission after it ended because it was cathartic and it validated their experience (Kettles, 1995),

as well as it helped them to learn from the experience, which will assist them to improve their

practice. Figure 2 illustrates a conceptual model for nursing practice during a mission in a

developing country based on this study's results. Individual, group, and situational factors lead to

challenges that affect a nurse's ability to practice in a safe, competent, ethical, caring, and

compassionate manner to achieve the mission goals. Each type of factor will be discussed next.
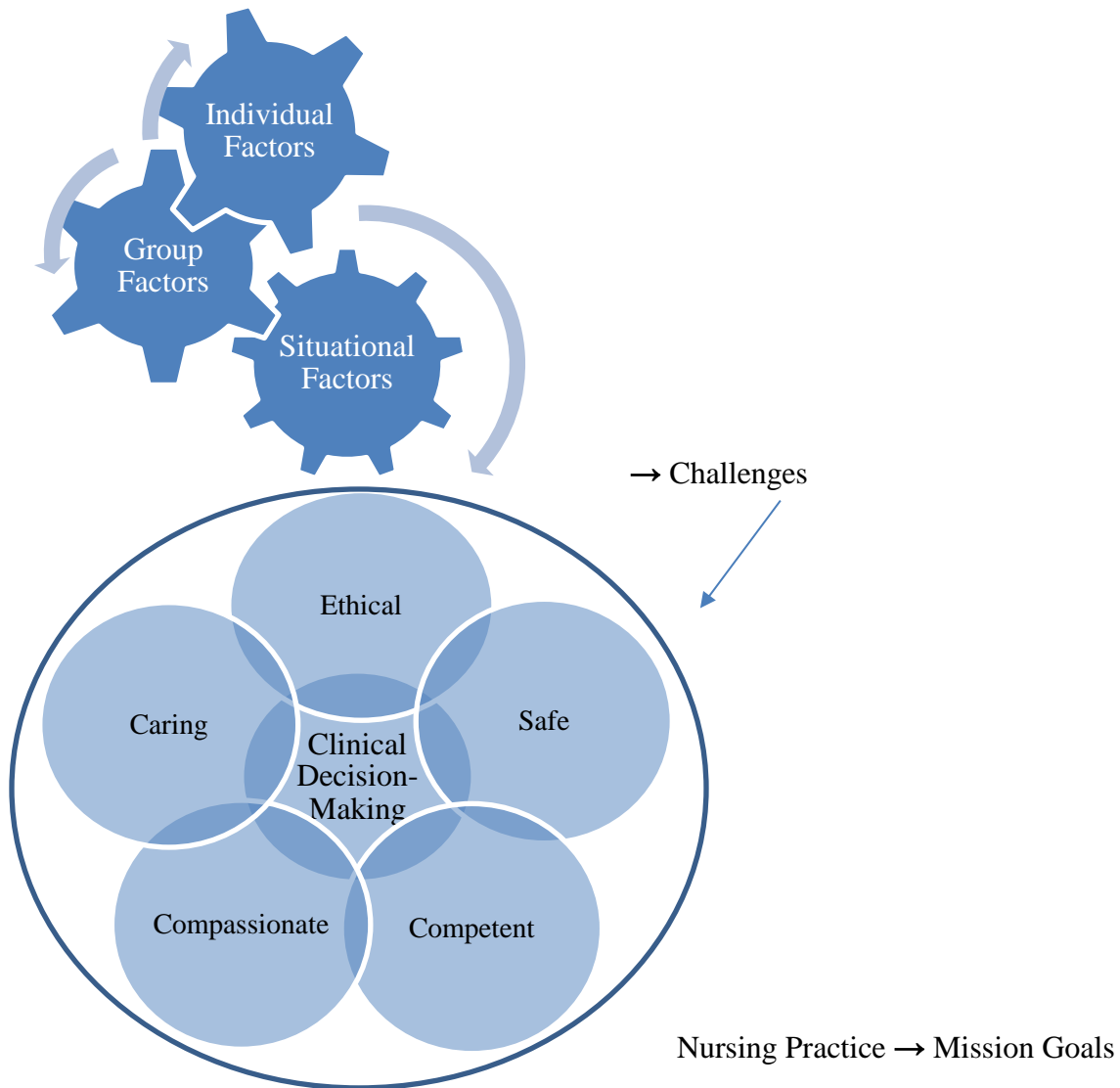
Figure 2. Conceptual Model for Nursing Practice During a Mission in a Developing Country.

5.2.1 Individual Factors. The data analysis in this study identified eight individual

factors that had an impact on clinical decision-making during the mission and affected the

participants' ability to practice in a safe, competent, ethical, caring, and compassionate manner

while coping with the unfamiliar environment and the context of the situations experienced.

Table 5 summarizes the individual factors that influenced each participant's nursing practice in

the mission. Each of these factors will be discussed below.

Table 5
Factors that Influence a Nurse's Clinical Decision-Making During a Mission

Individual Factors
1. Ability to Adapt to the Environment
2. Autonomous Nursing Practice
3. Knowledge, Experience, and Confidence in One's Ability to Nurse During the Mission
4. Flexibility to Problem-Solve and Meet Needs
5. Art and Science of Nursing Integration
6. Making Sense, Finding Purpose, and Doing No Harm
7. Meaningful Work, Vision, and Serving Others
8. Moral Distress Experienced Due to the Inability to Provide Required Care

5.2.1.1 Ability to Adapt to the Environment. Differences in language, weather,

geography, and standard of living between developed and developing countries can often lead to

physiological and psychological challenges in the volunteers' adaptation to their new

environment during a mission (Anonymous, 2009; Black, 2014; Daniels & Servonsky, 2005;

Murray, 1999; Solheim, 2010; Solheim & Edwards, 2007; Titus, 2011). Physiological challenges

include gastrointestinal problems from changes in food preparation, available food and drinks, as

well as sleep disturbances following jet lag, and changes in circadian rhythm due to the shift wok

that can be required during a mission. Altitude sickness occurs when travelling to a high-altitude

environment such as Nepal, which has a low humidity, increased ultraviolet radiation, decreased

air pressure, and cold weather that lead to various problems of which hypoxia, or low oxygen

concentration in the blood, is the biggest concern following its effect on brain and body functions

(Hackett & Shlim, 2017). Consequently, nurses who volunteer in missions must understand the process of physiological acclimatization to a higher altitude environment, as well as general illness prevention when travelling to a developing country, which includes immunization and prophylactic use of medications such as antimalaria pills. Additionally, they also need to monitor potential side-effects resulting from taking prophylactic medications, which can cause physical and psychological illness during and after the mission.

As noted by the participants in the interviews, physiologic and psychologic challenges negatively experienced from the adaptation to the environment can significantly impair nursing practice in a mission. A nurse that is physically and/or psychologically ill cannot meet the demands faced when providing care to people anywhere. For example, experiencing difficulties with altitude sickness and cultural shock will negatively impact the ability to make safe, competent, ethical, caring, and compassionate clinical decisions, as well as relate to patients, the mission, and local teams. Nurses who volunteer in missions must know how to take care of themselves, as well as recognize and manage physiological and psychological challenges they may encounter during missions. During the interviews, participants noted that sometimes, an individual may not recognize their inability to adapt to the new environment, and the team may also not be aware about the changes in personality because most volunteers have never worked with each other before participating in missions.

Therefore, volunteers must know and recognize possible physiological and psychological effects of cultural adjustment and culture shock that can result from the displacement of one's familiar environment. These can include feelings of frustration, loneliness, confusion, melancholy, irritability, insecurity, hopelessness, paranoia, criticism of local culture and oversensitivity to difficulties (Unite for Sight, 2015). However, such symptoms may go

unrecognized by the person, and be misinterpreted as individual personality traits by the mission team, which will lead to increased psychological distress, difficulty concentrating and making decisions, and an overall inability to function during a mission.

Furthermore, participants compared nursing in a mission to the experience of starting a new job that required them to learn and adjust to working in a new environment with new colleagues. As discussed by the participants, this adaptation requires the careful observation of cultural norms, attitudes, and behaviors to be able to 'fit in' and understand cultural norms, which sometimes required them to "walk on egg shells" as they made an effort to be respectful and culturally sensitive of their hosts' ways of life.

> Culture is an abstraction, yet the forces that are created in social and organizational situations deriving from culture are powerful. If we don't understand the operation of these forces, we become victim to them. Cultural forces are powerful because they operate outside our awareness. We need to understand them not only because of their power but also because they help to explain many of our puzzling and frustrating experiences in social and organizational life. Most importantly, understanding cultural forces enable us to understand ourselves better (Schein, 2010, p. 7).

When nursing, regardless of the context and the setting, becoming self-aware and developing self-knowledge through interactions with others is a critical component of personal knowing, one of the fundamental patterns of knowing in nursing practice, which is required for the nurse to engage in the therapeutic use of self (Carper, 1978).

Furthermore, self-awareness requires the nurse to know and recognize personal and professional biases, values, attitudes, beliefs, and behaviors that interfere with practicing in a safe, ethical, competent, caring, and compassionate manner regardless of context and location. In

many respects, we are all products of our socialization within the different levels of culture that

surround us. Therefore, as demonstrated by the participants in the study, nurses who volunteer in

missions must acknowledge and understand the impact of personal and professional cultural

values, beliefs, attitudes, and behaviors on their nursing practice within the macroculture of

different countries and ethnic groups, organizational cultures of the hospitals and agencies they

work with in missions, subcultures of medicine and nursing, as well as the microculture of health

care and other systems that also impact *their* practice and the wellness of the patients who

receive care during the mission (Schein, 2010). Additionally, nurses who practice in developed

countries must be careful to recognize and prevent ethical imperialism, which supports and

perpetuates the values and beliefs of the dominant and privileged cultural groups of developed

countries, and do not necessarily reflect the values and beliefs in developing countries (Davis,

1999; Olsen, 2003).

Therefore, the ability to adapt to the environment in a mission requires physiological and

psychological adjustment, which nurses must be aware about. Cultural sensitivity assists nurses

to carefully observe, understand, and adjust to the context of the mission, as well as identify

personal and professional biases, attitudes, and behaviors that can negatively impact nursing

practice in missions. Participants emphasized on many occasions that they needed to be

respectful of the local team's knowledge, skills, and practice because the way they practice at

home is not necessarily the only way or best way to practice nursing.

5.2.1.2 Autonomous Nursing Practice. Participants expressed a lot of frustration

about the local nurses' lack of autonomy because it impacted the ability to teach, learn, and

advance their practice to establish the cardiac program in Nepal. The local nurses needed to

develop cardiac nursing competency by practicing specific new skills they were not able to learn

and perform with the mission nurses without a doctor's order and guidance. "Professional

autonomy means having the authority to make decisions and the freedom to act in accordance

with one's professional knowledge." (Skar, 2009, p. 2226). The ability to exercise control over

patient care with regards to independent clinical decision-making that is within a nurse's scope

of practice following the assessment, monitoring, and evaluation of patient care outcomes

facilitates safe, competent, ethical, caring, and compassionate nursing practice, and

consequently, the quality of care that patients receive (Kieft, Brouwer, Francke, & Delnoij,

2014).

    As indicated and demonstrated by participants during the mission, autonomous nursing

practice is essential to facilitate quality nursing care because it empowers the nurse to act in a

safe, ethical, competent, caring, and compassionate manner, and advocate for patients' rights.

    Autonomy is the freedom to act on what you know in the best interests of the patient to

    make independent clinical decisions in the nursing sphere of practice and interdependent

    decisions in those spheres where nursing overlaps with other disciplines. It often exceeds

    standard practice, is facilitated through evidence-based practice, includes being held

    accountable in a constructive, positive manner, and nurse manager support. Autonomous

    practice includes both types of decision making—independent and interdependent.

    (Kramer & Schmalenberg, 2008, p. 61).

    Autonomy allows the nurse to adjust and determine the best way to provide nursing care

based on their critical thinking, knowledge, application of evidence-based practice guidelines,

and experience. It allows the nurse to assess, monitor, and evaluate the outcome of care, as well

as make adjustments based on patient care needs. Nursing in missions requires careful

observation of nursing practice to assist local nurses to learn and implement quality nursing care.

5.2.1.3 Knowledge, Experience, and Confidence in One's Ability to Nurse

During the Mission. Participants expressed confidence about their knowledge, skills, and

expertise, which ranged from four to 30 years of nursing practice, and provided the basis for their

critical thinking and clinical decision making. They indicated that they followed the same care

protocols and evidence-based practice they follow at 'home'. Autonomous nursing practice

fosters the individual nurse's confidence on their knowledge and expertise because it supports

critical thinking, as well as the acquisition of knowledge and experience. However, autonomous

nursing practice requires interdisciplinary support, especially where there is a hierarchy system

in place and physician-nurse power imbalances such as the case in Nepal (Carryer, Gardner,

Dunn & Gardner, 2007; Daly & Carnwell, 2003; Kieft, Brouwer, Francke, & Delnoij, 2014). The

ability of the participants to maintain autonomy of their nursing practice was essential and

contributed to their confidence in their ability to practice to their full capacity during the mission.

Participants indicated feeling comfortable and knowledgeable about the nursing care that

patients required. Some participants compared their nursing care to following certain "recipes"

that they were familiar with, knew very well, and just needed to adapt to each patient depending

on individual needs and overall health status. They felt that many of their assessments and

required nursing actions were "obvious" following standard cardiac recovery protocols they

knew well, and fundamental nursing science. Therefore, participants felt concerned and puzzled

about the local nurses' lack of assessments and basic theory-practice integration.

Safe, competent, ethical, caring, and compassionate nursing practice requires the

knowledge and integration of various types of knowledge, which reflects nurses' ways and

patterns of knowing (Carper, 1978; Clements & Averill, 2006). The knowledge acquired through

formal education and practice provides the basis for autonomous, ethical, competent, safe, and

accountable nursing practice. Effective critical thinking and decision-making depend on the

integration of one's knowledge base and practice, which leads to individual expertise and

confidence in the implementation of nursing care (Benner, 2004; Freidson, 2001). As illustrated

by the participants' and local nurses' wide range of proficiency levels in the mission, experiential

clinical knowledge expands over time through practice as the nurse moves from being a novice

to an advanced beginner, competent, proficient, and expert practitioner (Benner, 2001). The

ability to assess situations and implement care without a physician's order or another nurse's

guidance, requires belief and confidence in one's theoretical and experiential knowledge,

courage, and capacity to act. "To act autonomously as a professional nurse in accordance with

qualifications, training and work experiences seems to be connected to the personal courage to

act" (Skar, 2009, p. 2232). Such courage increases with practice that almost invariably builds

confidence in one's expertise.

Safe, competent, ethical, caring, and compassionate nursing practice during a mission

requires the assessment, planning, implementation, and evaluation of care, which depend on the

nurse's knowledge, critical thinking, clinical decision-making, and expertise. These will vary

depending on the level of practitioner proficiency of the individual nurse.

5.2.1.4 Flexibility to Problem-Solve and Meet Needs. All participants stated that

the capacity to be flexible and consider the context of situations in a holistic manner were

essential to resolve challenges, as well as engage in critical thinking and clinical decision-

making. Critical thinking is an essential skill in nursing practice that requires the integration of

knowledge and experience to make clinical decisions that result in positive patient outcomes. As

demonstrated by the participants in the mission, nurses must reflect about the integration of

theory, evidence-based practice, and standard care protocols that may be inappropriate to follow

based on the context of the situation and unique patient needs. Critical thinking requires that the

nurse develops open-mindedness, flexibility, self-reflection, information seeking and analyzing

cognitive skills (Chan, 2013).

As nurses move through the stages of novice, advanced beginner, competent, proficient

and expert, they acquire various skills and reflect changes in three general areas that include:

1. a move from a reliance on abstract principles to the use of past concrete experiences;

2. a change from viewing a situation as multiple fragments, to seeing a more holistic

picture with few relevant factors; and

3. a move from a detached observer to an active performer (Altmann, 2007, p. 115)

As the local nurses and participants demonstrated in the mission, the progression from novice to

expert displays the nurse's evolution from rule-governed behavior to intuitive, contextually

determined behavior (Benner, 2004). The local nurses required the guidance of written orders

and education, in contrast to the participants who either discussed and applied protocols, or were

able to 'intuitively' adapt their knowledge and expertise to each patient situation in a holistic

manner by following a familiar "recipe". However, such progression is not guaranteed; every

nurse does not become an expert, and experience is a requisite for specific nursing expertise

(Altmann, 2007, Benner, 2000). Therefore, nurses considering to volunteer in missions cannot

rely specifically on their years of nursing practice to determine their ability to practice

successfully in a mission. Nurses must carefully consider the type and purpose of the mission, as

well as the role and responsibilities required of nurses, which vary widely given the various types

and goals of mission experiences. Empirical knowledge and specific experiential learning

support nursing practice and contribute to the development of skilled knowledge and perceptual

acuity that help the nurse to sort and make use of relevant scientific knowledge, standard care

protocols, and evidence-base practice that are appropriate to use depending on the context of the situation and unique patient needs.

Additionally, participants emphasized the importance of assessing needs and the context of situations while being aware of personal agendas that interfere with practicing in a safe, competent, ethical, caring, and compassionate manner. Personal knowing, a fundamental pattern of knowing in nursing practice, requires knowledge about patients' unique and individual needs, as well as self-awareness of values and beliefs that the nurse may possess, which can negatively impact the care provided (Carper, 1978; Clements & Averill, 2006). Therefore, the individual capacity to apply this pattern of knowing assists nurses who volunteer in missions to reflect about biases, values, beliefs, attitudes, and behaviors that negatively affect their nursing care.

Depending on their general proficiency level, according to Benner's (2001) novice-to-expert framework and experience nursing in missions, volunteer nurses require support to practice successfully in a mission. In this study, findings indicate that flexibility and the ability to make clinical decisions in a holistic manner depend in part to the level of nursing proficiency, and the self-awareness of personal and professional biases, values, attitudes, beliefs, and behaviors that negatively impact nursing practice in the mission.

5.2.1.5 Art and Science of Nursing Integration. Participants' ability to apply fundamental nursing science, evidence-based practice guidelines, care protocols, and clinical expertise reflects aesthetic knowing, which is the integration of all the fundamental ways or patterns of knowing in nursing practice that include empirics, ethical, personal, emancipatory, and unkowing into an action chosen by the nurse to benefit the patient (Carper, 1978; Clements & Averill, 2006). Aesthetic knowing is complex and depends on the proficiency level of the individual nurse.

As demonstrated by participants, nurse's capacity to think critically is vital to assess patients' unique needs and attempt to meet them within the unfamiliar context of a mission, while considering available alternatives and reflecting about the care provided, "rather than simply accepting [physician orders] and performing tasks without significant understanding and evaluation" (Benner, et al., 2008, p. 92). Recall the situation of the first patient that came out of surgery and regained consciousness while the teams were learning to work together and providing post-surgical care. While everyone was focused on complex tasks to stabilize the patient, one of the expert nurses 'instinctively' knew that providing comfort to the patient was also critical to ensure her well-being at the time, although there were multiple competing critical needs and priorities. Even in an unfamiliar environment, while everyone had to figure out how to provide care to the first patient, the expert nurse knew what to do, how to do it, and why it was a moral imperative to do it without being asked to do it.

A novice nurse has, in effect, just completed basic nursing education, or training in the case of the local nurses in the mission, which affects the ability to integrate the knowledge and experience acquired when providing care (Brown, Alverson & Pepa, 2001; Schin & Schin, 2006). The advanced beginner relies heavily on manuals and care protocols to determine the actions needed. Competent practitioners continuously question what they see, hear, think, and feel an obligation to learn and know more about clinical situations, which fuels their desire and thirst to continue learning. Proficient nurses acknowledge change and its relevance in meeting patient needs based on the context of situations; therefore, they modify and implement care based on how situations unfold rather than preset goals. Expert nurses identify problems precisely and very quickly due to their full grasp of clinical situations, which gives them confidence in their ability to critically think, make decisions, and intervene effectively.

Furthermore, age, life and work experience, length and type of education affect a nurse's

ability to think critically (Benner, 2001; Ericsson, Whyte & Ward, 2007). An expert nurse has

the capacity to think critically because of certain individual characteristics that include

motivation, perseverance, fair-mindedness, as well as deliberate and careful attention to thinking

(Brown et al., 2001; Schin & Schin, 2006; Sheffer & Rubenfeld, 2000). Relevant clinical

experience supports the nurses' ability to make quick decisions, fewer decision errors, and the

identification of salient cues that foster the recognition and action on certain patterns of

information (Aitken, 2000; Benner, et al., 2008; Benner & Sutphen, 2007; Ericsson, Whyte &

Ward, 2007; Higuchi & Donald, 2002). During the mission, participants also relied on the

support from the mission and local teams through the establishment of a collaborative working

relationship, application of care protocols that followed current evidence-based practice,

translators, and the mentoring from expert nurses and educators in the mission team to help them

advance their knowledge and acquire more nursing experience during the mission.

As demonstrated by the participants, nurses who volunteer in mission possess different

levels of expertise; therefore, they require various types of support to help them think critically,

assess situations holistically, and intervene with confidence in a safe, competent, ethical, caring,

and compassionate manner.

5.2.1.6 Making Sense, Finding Purpose, and Doing No Harm. Participants

expressed a need to critically think and reflect about the consequences of their teaching, practice,

and care provided following the various challenges encountered. They were not always able to

integrate evidence-based practice and familiar care protocols due to the context of the mission.

Participants did not have evidence-based practice or care protocols specific to the professional,

legal, and ethical responsibilities of their practice in the mission. Consequently, they experienced

uncertainty and discomfort regarding some of their actions, but always chose to act in ways that prevented harm to patients. Such feelings reflect the impact of the ethical pattern of knowing, which incorporates moral obligations, perceived right and wrong of situations, as well as desired ends (Carper, 1978; Clements & Averill, 2006). Empirical and ethical knowledge are inseparable in nursing practice given the impact of nursing care on patients' lives. Nurses must consider issues that reflect patients' legal and ethical rights, as well as ethical principles such as autonomy, beneficence, non-maleficence, and justice while acting as moral agents and advocating to ensure that patients and their families receive safe, ethical, competent and compassionate care (Keatings & Smith, 2010). Applying an ethics of care approach requires the nurse to habitually question the care that is provided to patients and its implications in their lives.

Nursing practice requires "techne" and "phronesis" (Benner et al., 2008; Benner, 2000). Techne refers to the know-how skill of producing outcomes that is governed by a means-end rationality, and is captured by procedural and scientific knowledge (Benner, 2000, 2004, 2005). Phronesis refers to clinical practice "governed by concern for doing good or what is best for the patient in particular circumstances, where being in a relationship and discerning particular human concerns at stake guide action" (Benner et al., 2008, p. 91). In the therapeutic nurse-client relationship, the needs of the patient and the context of situations shape and develop the nurse's knowledge and experience. Therefore, as demonstrated by the participants in the mission on several occasions, nurses must recognize illness as a life experience that goes beyond organizational and professional priorities and goals. They must develop a head-hand-heart approach that integrates practical know-how with empathic understanding and technical knowledge to provide humane and sensitive care (Hemingway, 2013). Following an ethics of care approach also requires the nurse to consider the context of the situation and act to maintain,

continue, and repair the world, which includes the human body, so that we can live in it as well as possible (Tronto, 1993). Thus, participants opted for "lowering their standards" and finding a "balance" between the application of unrealistic legal and professional expectations of developed countries to the reality experienced in a developing country. Doing so, allowed patients the ability to undergo life-saving cardiac surgery. Furthermore, evidence-based practice, care protocols, and legal expectations of developed countries are based on different ways of life that rely on the availability of a wide range of resources, as well as various socio-political factors that impact health care practices with expectations specific to the context of developed countries.

During the mission, participants practiced in a way that contributed to achieving the goals and purpose of the mission. Doing so, required them to "lower standards" and find "balance" between their practice in a developed country and the context of the mission. However, even if care protocols and standards were adapted to the context of the mission, the pivotal element of clinical decision-making was *always* to maintain and ensure patient safety and do no harm, which meets professional, ethical, and legal responsibilities of nursing practice anywhere in the world.

5.2.1.7 Meaningful Work, Vision, and Serving Others. Despite the many physical and emotional challenges and obstacles experienced during the mission, participants described their work as being "worthwhile", "very rewarding", "meaningful", "life changing", "soul food', "satisfying", "grounding", "fulfilling", and a "transfusion for the soul". They reflected about the opportunity to care for, about, and with people as they provided care that reflected "the true essence" of nursing practice. A mission provides nurses with an opportunity to provide care in a way that aligns with personal and professional values such as respect for people, human dignity, altruism, accountability, social justice, as well as promoting health and

wellness, and providing safe, ethical, compassionate, and competent care (CNA, 2015; Epstein &

Turner, 2015; Fahrenwald, Bassett, Tschetter, Carson, White & Winterboer, 2005).

Participants indicated and were observed to experience joy and satisfaction from being

able to care about, for, and with people by doing what they do best, while fulfilling personal and

professional goals and vision to promote the health and wellbeing of vulnerable and

marginalized patients in a developing country. As well, participants noted that they helped

patients to successfully recover from cardiac surgery, as well as had an opportunity to educate

and mentor local nurses to help them improve their practice and improve the quality of patient

care. Such an opportunity allows "purpose, resolution, and harmony to unify life and give it

meaning by transforming it into a seamless flow experience" (Csikszentmihalyi, 1991, p. 217)

regardless of the many obstacles encountered. Participants affirmed and demonstrated that their

abilities and skills were well matched to the mission goals, purpose, vision, and required actions

to help the local team establish a cardiac care surgical program, and provide care to vulnerable

patients in the hospital and community.

The ability of missions, and therefore volunteers, to benefit the people they serve depends

on factors such as the goals of the mission, established partnerships, and sustainability issues

(Bajkiewwicz, 2009; DeCamp, 2007; Hunt, 2011; Ripp & Scudder, 2011). Therefore, nurses who

volunteer in missions must ensure they have a clear sense of purpose and goals of the mission

that ensure accountability for the work and care that will be provided, which will help to ensure

the ability of volunteers to practice in a safe, competent, ethical, caring, and compassionate

manner.

5.2.1.8 Moral Distress Experienced Due to the Inability to Provide Required

Care. Participants spoke about feeling "unsettled", "uncomfortable", "depressed", and reflected

about the "pain" and "heartbreak" resulting from their inability, impotence, and powerlessness to deal with the awareness of the reality of social inequities, and determinants of health that affected patients' lives in significantly detrimental ways. This type of knowledge reflects nurses' ethical and of emancipatory patterns of knowing. Emancipatory knowing requires awareness about society, community life, culture, economics, politics, and all systems that impact human health and wellbeing. This awareness leads to the recognition of social and political problems of injustice and inequity, which require sustainable change to improve people's lives (Clements & Averill, 2006; Chinn & Kramer, 2011).

In such circumstances, moral distress occurs because nurses cannot fulfill their ethical obligations and commitments, fail to pursue what they believe to be the right course of action, or fail to live up to their own expectations of ethical practice due to an error in judgement, insufficient determination or courage, or other circumstances beyond their control (CNA, 2003). Moral distress is detrimental to the nurse's well-being, patient care, and nursing practice. It can lead to various physical, emotional, spiritual and behavioral responses, decreased interactions with patients and families, and emotional withdrawal. Consequently, moral distress increases the risk of burnout, decreased job satisfaction, and departure from the nursing profession (Rushton, 2016).

An ethics of care approach to nursing practice during missions requires nurses to be willing to make a commitment to care regardless of the challenging circumstances. They must develop a "habit of care" (Tronto, 1993, p. 127), and constantly ask themselves the question "what is the best way to care to care for this patient at this time?" (Lachman, 2012, p. 112). Such a question also requires the consideration of why and how following emancipatory knowing, and can only be answered based on the context of the situation, the patients' unique needs that

depend on how their lives unfold, as well as the relationships that can be established to obtain the

necessary information and resolve challenges (Bowden, 1994; Lachman, 2012; Woods, 2011).

Furthermore, as participants demonstrated during the mission, a strength-based care approach to

nursing practice requires nurses to establish relationships that help them to assess needs and

consider the reality of patients' lives as they work with patients to build capacity, resilience, and

cope with challenges following patients' goals and the reality of resources available to them

within the system and the context of the mission.

During missions, nurses experience moral distress given the social inequities that exist in

developing countries. Awareness about the context of situations, ethical and emancipatory

knowing, as well as an ethics of care approach require nurses to reflect about their practice and

consider the best way to care for patients within the context of the mission. A strength-base care

approach to nursing practice focuses on patients' strengths and building capacity within the

context of the mission to help patients cope with their challenges as they build resilience.

5.2.2 Group Factors. The data analysis identified three key factors that influenced a

participant's clinical decisions and ability to function successfully as a member of the mission

and local teams while providing safe, competent, ethical, caring, and compassionate care. Table

6 summarizes the mission's group factors that affected nursing practice during the mission. Each

factor will be discussed below.

Table 6
Factors that Influence a Nurse's Clinical Decision-Making During a Mission

Group Factors
1. Team Dynamics
2. Evidence-Based Practice and Protocols
3. Extent of Preparation and Individual Fitness to Practice

5.2.2.1 Team Dynamics. Participants emphasized the importance of team support to make clinical decisions, continue to learn, improve their practice, as well as clarify and validate their critical thinking, assessments, and treatment plans. Interprofessional collaboration is vital to ensure safe, competent, ethical, caring, and compassionate practice. It requires that volunteers establish trust and respect as quickly as possible within the mission team, as well as with the local team.

Mission volunteers may travel from different countries; therefore, they need to clarify with each other individual roles and responsibilities. They also must ensure they use the same vocabulary and language to facilitate communication, understand and practice the same protocols of care, and proactively address concerns about patient safety with each other. Communication is key to collaborating and providing quality care (CIHC, 2010). Participants indicated they always felt supported by local and mission team members, which increased their confidence in their ability to practice in a safe, ethical, caring, competent, and compassionate manner, as well as facilitated adapting to the context of the mission. Interpersonal relationships with colleagues have a big impact on individual clinical decision-making. Nurses obtain information from experienced colleagues believed to have clinical expertise and evidence-based practice (Benner et al., 2008). Participants noted a positive effect from working with colleagues that had more experience with missions, and nursing in general, on their ability to provide care, improve their practice, and continue learning regardless of their level of experience.

Participants indicated that trust, respect, and communication were vital to meeting the mission goals in a safe, ethical, competent, caring, and compassionate manner. Effective team collaboration is critical to accomplish the mission goals.

5.2.2.2 Evidence-Based Practice and Protocols. Participants educated the local

staff using evidence-based practice to provide theoretical support for suggestions and help the

local team develop critical thinking. They observed a lack of collaboration among the local team

due to hierarchy issues and physician-nurse power imbalances that leads to unsafe practice,

"working in silos", poor quality of care, and a negative impact on the local nurses' ability to

learn, develop autonomy, and improve their practice.

Interprofessional collaboration reduces duplication of effort, improves job satisfaction,

helps to overcome fragmentation of services, and improves patient safety and quality of care

(CIHC, 2010; Reeves, van Soeren, MacMillan & Zwarenstein, 2013). Therefore, mission

volunteers educated the local team about the necessity to work as a team, communicate, and

advocate for each other and patients to maintain and improve quality of care. Most importantly,

they role modeled effective team collaboration, which made a positive impact on the local team.

Additionally, the mission educator and coordinator worked with the local staff to

develop care protocols for the local nurses based on evidence-based practice and standard care

protocols from the United States to foster autonomous nursing practice and support the local

nurses' critical thinking. Increased opportunities to practice nursing in a supportive environment

promote learning that leads to knowledge and confidence in one's capacity to nurse. During

missions, nursing leaders must support and encourage people to embrace responsibility for their

performance, and commit to take it to the highest level to build self-confidence, confidence in

others, and confidence that the organizational system can deliver on its promises (Kanter, 2006).

Notably, participants did not have written orders to follow from the mission team

physicians, and always discussed and clarified the plan of care with them. Participants did not

document the care they provided during the mission because they were not aware about

applicable professional and legal documentation responsibilities within the context of the

mission. The local nurses had orders from their physicians but did not have many guidelines for

documenting their care, which was also a concern to the participants. Documentation of care is

an essential component of nursing practice in developed countries. It ensures and promotes

communication about patient care outcomes and the care provided, accountability, and can assist

to evaluate the quality of care (CNO, 2008). Ethical, professional, and legally responsible

practice in developed countries requires nurses to do good, avoid causing harm, and demonstrate

the care provided through documentation (Karkkinen, Bondas & Eriksson, 2005; Raholm &

Lindholm, 1999).

The use of evidence-practice and care protocols assists in the education of the local team

and guides the mission team's practice. However, careful consideration is required to adapt them

to the context of the mission, and ensure safe, ethical, competent, caring, and compassionate

practice from both mission and team members that meets applicable professional, ethical, and

legal requirements. Congruency between teaching and practice adds credibility to the mission

team, and demonstrates evidence-based practice to the local team.

5.2.2.3 Extent of Preparation and Individual Fitness to Practice. Overall,

participants felt the mission was well organized, and reflected about challenges in previous

experiences. Regardless of the experience volunteering in missions, they suggested that one

cannot be certain about what will happen, and must be flexible, "go with the flow", "let go of

high expectations and personal agendas", and "be mindful and focus on the moment".

Participants discussed the importance of obtaining as much information as possible

regarding the experience of volunteering in a mission, as well as the organizations that

coordinates missions. Talking to people with previous volunteering experience can help

individuals to evaluate if the experience fits their personal and professional goals, and nursing

expertise. It is important to get an honest view about the negative and positive implications of

nursing during a mission that include physical and emotional challenges related to the location of

the experience. The types and goals of missions will be different depending on the organizations

that coordinate them; therefore, it is vital that volunteers clarify the goals, vison, and purpose of

the organizations, as well as the specific missions they consider attending to make sure they are

ethical, accountable, and the people that will receive care will benefit from the help provided

(Hilhorst & Schmiemann, 2002; Hunt, et al., 2014a; Leader, 1988; Weiss, 1999). Additionally,

volunteers must confirm that the organization in charge will ensure their safety and wellbeing

regardless of the location of the mission. Even in situations of war, crisis, and extreme poverty,

organizations have legal, professional, and ethical responsibilities toward volunteers (DeCamp et

al., 2013; Tschudin & Schmitz, 2003; Slim, 1997).

Participants indicated that is not possible to provide volunteers with specific information

about the mission due to the context and uncertainty of the experience, and they did not receive

any training before going in the mission. The literature also confirms that many health care

professionals do not receive any training or education before they participate in missions (Hunt,

2008; Schwartz et al., 2010). Therefore, as demonstrated in this study, mission organizations

must provide basic information regarding language, country, location, food and lodging, keeping

healthy, and cultural norms to volunteers before the mission to facilitate coping and adapting

during the mission.

During the mission, as happened in Nepal, coordinators and leaders must provide

volunteers with an orientation to the experience, and facilitate group cohesion among the mission

team members, and between the mission and local teams. Additionally, volunteers require an

orientation to the agencies they will be working with and the available resources. It is also

crucial that volunteers have formal and informal opportunities to meet as a team and debrief

throughout the mission to reflect about their experiences, learn, and cope effectively (Daniels &

Servonsky, 2005; Memmott et al., 2010; Solheim & Edwards, 2007; Titus, 2011).

Although there were many opportunities to debrief formally and informally during the

mission, participants indicated in their after-mission interviews that an opportunity to reflect and

make sense of the experiences encountered with a colleague facilitates coping with moral residue

and learning about the care provided in the mission. Additionally, as demonstrated in this study,

mission coordinators must provide volunteers with an official report about the goals

accomplished, care provided, and further plans to expand on the work that took place during the

mission to facilitate closure for volunteers. Furthermore, mission coordinators must evaluate the

effectiveness of the mission by asking volunteers, the local team, and the patients who received

care for feedback to improve future experiences.

Volunteers require as much information as possible to prepare for missions, cope, and

adapt to the unfamiliar environment. Nurses must clarify the goals and purpose of the mission,

responsibilities and expectations to ensure a 'fit' with the experience. Opportunities to debrief

during and after the mission are important to reflect and learn about the experience.

5.2.3 Situational Factors. The data analysis identified two key factors that had an impact

on participants' clinical decision-making and ability to practice in a safe, ethical, competent,

caring, and compassionate manner within the context of the situations encountered in the

mission. Table 7 identifies the situational factors that affected individual participants' nursing

practice in the mission, which will be discussed below.

Table 7

Factors that Influence a Nurse's Clinical Decision-Making During a Mission

Situational Factors
1. Cultural Norms, Hegemony, Hierarchy, and Power Imbalances
2. Impact of Lack of Resources resulting from Social Inequities

5.2.3.1 Cultural Norms, Hegemony, Hierarchy, and Power Imbalances.

Participants reflected on the impact of hierarchy, and various events that illustrated physician-nurse power imbalances during the mission, which negatively impacted the local nurses' practice and quality of patient care. In developing countries, nursing practice is not as highly regarded as it is in developed countries and demonstrates marginalization and oppression (Dubrosky 2013; Paganini & Bousso, 2015; Skar, 2009; Stark et al., 1999; Turner, Keyzer & Rudge, 2007; Young, 1990). Therefore, local nurses experience many difficulties learning and implementing changes in their practice. Regardless of location and context, knowing how to behave is contingent upon the understanding of acceptable customs in the workplace connected to the development of cultural knowledge and adherence to specific norms (Mantzoukas & Jasper, 2008).

As demonstrated in the study, the ability of local nurses to practice autonomously depends on sustainable changes about the perception of nursing practice at an organizational, educational, and health care levels, which include the subculture of medicine and nursing of developing countries. The education, support, and empowerment of nurses on an individual level during a mission is a good start to help local nurses advance their nursing practice and improve the quality of patient care. However, effective and ethical nursing leaders must establish relationships with stakeholders such as hospital administrators and physicians to empower and support volunteer and local nurses' autonomous practice, promote and build self-confidence, as well as confidence that the mission and local teams can successfully accomplish the mission goals.

Furthermore, nurse leaders must be aware about power dynamics between mission nurses and physicians, local nurses, and patients. Ethical and effective leaders are concerned with meeting the needs and goals of organizations, followers, and the people affected by their leadership practices. An ethics of care approach and nursing's core concepts that include advocacy and social justice require nurse leaders to practice from an emancipatory 'peace power-with' approach to leadership (Chinn & Falk-Raphael, 2015). In other words, nurse leaders must be sensitive about the power inherent in their role given their education and social background, which can negatively affect their leadership and further marginalize local staff and patients. In this study, participants engaged in synchronous reflection about their leadership and practice, personal and professional biases, values, beliefs, attitudes, and behaviors to identify and avoid their negative impact on the care and leadership they engaged in during the mission. Participants worked to empower and serve vulnerable patients and local nurses. They developed awareness and sensitivity about themselves and the people they interacted with as they cooperated with the local team to achieve mission goals from a 'caring about, for, and with' perspective. At the end of the mission, participants were able to evolve personally and professionally as demonstrated by their reflections regarding their nursing practice.

Additionally, as demonstrated in Nepal, it is critical that the local organizational leaders provide the local staff with information about the mission before it takes place to ensure collaboration with the mission team, buy-in, and the necessary preparation to meet the mission goals.

> Leaders look forward to the future. They hold in their mind ideas and visions of what can be. They have a sense of what is uniquely possible if everyone works together for a common purpose…but visions seen only by the leaders are insufficient for generating

organized movement. Leaders must get others to see the exciting future possibilities…

[and] communicate hopes and dreams so that others clearly understand and share them as

their own. (Kouzes & Posner, 2012, p.100)

In this study, the hospital in Nepal requested help through a medical mission to establish

a cardiac program and improve the quality of patient care. Participants recognized the

importance of the local staff and various stakeholders' support to accomplish mission goals, as

well as introduce and sustain change. Local staff were given information about the mission's

purpose and goals before the mission, so they were prepared to collaborate with the mission

team. Local staff who do not have much information about the mission will possibly perceive

volunteers as foreign nurses and physicians coming to teach them how to do their job. Therefore,

they will understandably feel threatened and may refuse to collaborate directly or indirectly. This

would, in turn, have a negative impact on everyone's confidence and ability to learn, teach, and

practice in a safe, ethical, competent, caring, and compassionate manner. It may also curb the

leadership contributions that participants can bring to the situation.

Like the participants in this study demonstrated, mission volunteers must be culturally

sensitive and acknowledge the differences in values, beliefs, and behaviors of the people they

serve. They must be respectful as they try to understand people's experiences and the reality of

their situations. An ethics of care approach to cultural care requires awareness about the context

of the patient, the nurse, and the experience to provide cultural safe care that avoids diminishing,

demeaning, and disempowering the cultural identity and wellbeing of individuals (McEldownney

& Connor, 2011). Culturally competent care integrates principles of social justice and human

rights regardless of context. It follows a framework that provides cultural standards of care to

ensure peoples' human rights, dignity, access to quality care, and participation in health care

practices that take place (Douglas et al., 2012). Cultural humility requires acknowledgement of one's limitations, barriers, prejudices, and assumptions, which can affect our interactions with members of a different culture (Yeager & Bauer-Wu, 2013).

Regardless of the cultural approach taken to interact with people during the mission, volunteers need to develop awareness and be respectful of different cultural norms, values, attitudes, beliefs, and behaviors to practice and lead in a safe, ethical, competent, caring, and compassionate manner during a mission.

5.2.3.2 Impact of Lack of Resources Resulting from Social Inequities.

Participants identified the lack of resources, including technology, as the second main difference when nursing during the mission. They had to adapt themselves to nursing without the use of technology. However, the more significant and challenging issues to deal with were the ethical dilemmas encountered due to their inability to provide the necessary care. As demonstrated by participants in this study, the consideration of patients' illness and wellness experiences must be a priority to provide nursing care in an authentically compassionate and humanized manner (Galvin & Todres, 2012; Hemingway, 2013). Fundamental nursing knowledge and the understanding of people's life experiences, feelings, and stories guide expert nursing practice. The profession of nursing has a social and ethical responsibility to address issues that affect the health of people, which includes concerns related to poverty, access to care, and environmental conditions that affect health (Dodson, Piatelli & Schmalzbauer, 2007; Tyer-Viola et al., 2009).

The ICN Code of Ethics for Nurses (ICN, 2012) states that nurses have four fundamental responsibilities that include promoting health, preventing illness, restoring health, and alleviating suffering. To this end, nurses must acknowledge the impact of social justice and address social inequities to ensure people have access to the health care they require. Due to the impact of

social determinants of health and social inequities, it will take international efforts and massive

political will to improve the health conditions of much of the world's population (WHO, 2010a).

As demonstrated by participants in the study, promoting social justice is a priority for nursing

practice ensured by treating everyone with respect and dignity, regardless of the context of

situations, as well as acknowledging and helping to minimize disparities as much as possible

(CNA, 2009).

Participants demonstrated an ethics of care approach to nursing practice in the mission

focused on caring about, for, and with others based on the context of the situation and the unique

needs of individuals. The focus was therefore on the moral imperative to care rather than specific

ethical principles, or a means to end approach. Using this approach requires nurses to recognize

and understand the challenges that people face in life, and consider all the factors that affect a

situation. They must attempt to understand patients' values, beliefs, and life experiences to gain

the insight needed to determine appropriate care choices (Keatings & Smith, 2010).

Furthermore, an ethics of care is a form of political ethics that recognizes power,

dependency, and vulnerability. Therefore, nurses must understand the interaction between

inequity, inequality, and social justice to evaluate the effect of health care policy, and health care

decision-making on individuals and communities. "Broad, systematic inequities, and oppression

are found in all societies as well as an inherent obligation to act responsibly in order to replace

inequities with parity" (Anonymous, 2006, p. 19). As it occurred in this study, justice alone is

not enough to care for vulnerable patients. The ethical issues encountered during missions

require nurses to thoughtfully challenge the status quo while critically thinking about the notion

of human relatedness, and what doing good and doing no harm really means to the vulnerable

patients who receive care in missions.

Moreover, as demonstrated by participants, nurses must support and help people acquire strengths and strategies for improving their health and wellbeing. This helps to build resilience, and the ability to cope and live with illness, which also facilitates providing care in a dignified and respectful manner. A strengths-based approach to nursing care promotes hope through empowerment as people realize they can exercise some control over their lives and create a more desirable future (Gottlieb, 2013).

Lack of resources in missions requires sensitivity and flexibility to provide care that understands and attempts to meet patients' needs within the context of their life experience. Any care provided without careful consideration of people's life experiences and resources neglects to meet their needs, and further increases their suffering (Dodson et al., 2007; Hemingway, 2011, 2013). All humans are vulnerable when confronted with a major illness. A biomedical approach to care focuses on deficits, illness, and limitations that lead to increased vulnerability and hopelessness of patients.

5.3 Research Question 3) How do nurses define and evaluate competent and ethical nursing practice during one mission in a developing country?

Every participant had trouble defining nursing practice and indicated it was a difficult and challenging question because of the different roles, scope of practice, and settings where nursing can take place. Regarding ethical practice in the mission, they stated it was important to involve the team when making decisions about the right and wrong of situations given the context and lack of familiarity with the environment.

Participants noted that health care organizations are responsible for evaluating the quality of patient care provided through various tools that measure factors such as patient satisfaction, infection control, treatment errors, patient falls, and unsafe practice. Therefore, they spoke about

the mission coordinators and hospital keeping records about the care provided, which included

surgery statistics, patient recovery, treatment outcomes, education provided to the local staff, and

other activities that took place during the mission. All the information related to the mission

goals and outcomes was reported in various documents presented to the hospital, mission

organization board of directors, and the mission team volunteers at the end of the mission.

Individual participants evaluated their care throughout the mission according to patients'

immediate responses, overall wellbeing, and the process of surgical recovery throughout the

mission. Participants evaluated the effectiveness of the education and mentoring provided to the

local staff based on the changes in practice that they observed, and the staff's receptiveness to

the suggestions for improving their practice. The mission educator employed formal ways to

assess the education provided to the staff that included quizzes, and the bed side practical

application of the theory learned during workshops, which were planned to meet the educational

needs of the local nursing staff to help them develop competency in cardiac nursing care.

In 2006, The World Health Organization declared the lack of health care competence to

be a significant contributing factor to negative patient outcomes (WHO, 2010b). Therefore, in

2009, it established global standards for entry-to-practice nursing education, which were

recognized to be goals rather than a reality because of the impact of various factors such as

nursing education, health care organizations, nursing practice, culture, and the global shortage of

nurses (APPG, 2016; Numminen, Leino-Kilpi & Meretoja, 2015). Competence in nursing

practice is a requirement of professional regulatory bodies such as the American and Canadian

Nurses Association, and an essential standard of practice (ANA, 2010; CNA, 2015). However,

> …although the competencies or competence assessments are somewhat defined in
>
> practice and education, a widely acceptable conceptualization of competence is not….

Defining competence in practice is an ongoing challenge… there is still not one

thoroughly analyzed and articulated definition of competence and continuing

competencies. (Church, 2016, p. E9, E10)

Therefore, participants were not alone in their inability to define competent nursing

practice, which includes the domains of effective and ethical practice, as well as provide a

concrete way for evaluating their practice. In developed countries, which was also evident in this

study, there is a strong relationship between the quality of care provided and nursing competence

(Axley, 2008; Scott Tilley, 2008; Smith, 2012). Therefore, the assessment of nursing competence

includes the evaluation of other attributes such as knowledge, skills, clinical judgment,

application of professional standards of practice, ability to establish interpersonal relationships,

confidence, experience, safe practice, and holistic care, which employ quantitative tools such as

scales (Nilsson, Johansson, Egmar, Florin, Leksell, Lepp & Gardulf, 2014; Numminem et al.,

2015; Tabari-Khomeiran, Kiger, Parsa-Yekta & Ahmadi, 2007; Takase & Teraoka, 2011). In

general, participants defined ethical nursing practice as doing good and preventing harm to

patients, which also validates the literature findings (Church, 2016; Edwards, 2009; Lachman,

2012). Other concepts mentioned included advocacy, social justice and awareness of inequities,

respect and dignity of all patients, and the consideration of patients' values and beliefs when

providing care, which reflect professional nursing values inherent in professional codes of ethics

(CNA, 2017; ICN, 2012). Although the participants who experienced ethical dilemmas and

moral distress were not sure about their decisions, upon careful reflection, they took some

comfort in the knowledge that they examined lack of resources, context of the situations, actively

explored available services to patients, and engaged in many in-depth discussions with the

mission and local team members about available care choices. Most importantly, they felt they

avoided causing further harm to patients at the time when they experienced the ethical distress. In some cases, their decisions contributed to the team's ability to provide care and improve patients' health at the time.

5.4 Chapter Summary

The study findings regarding each research question in the study were discussed in this chapter. Findings indicated that participants demonstrated Benner's levels of proficiency in their practice (Benner, 2001). Consequently, they used fundamental knowledge about nursing, evidence-based practice, and individual expertise to critically think, make clinical decisions, and practice in a safe, ethical, competent, caring, and compassionate manner. The data analysis indicated that individual, group, and social factors specific to the context of the mission affected the nursing care provided. An in-depth exploration of each type of factors provided evidence for actions to support nurses who volunteer in missions. Moral agency and professional responsibility to do good, prevent harm, as well as uphold professional values such as respect, dignity of patients, advocacy, and social justice provide the foundation for implementing ethical nursing care in missions. Participants encountered ethical dilemmas due to the lack of resources and social inequities; therefore, they experienced moral distress. To end the dissertation, the final chapter that follows will examine the conclusions, implications, recommendations, limitations, and final thoughts about the study.

Chapter 6

Conclusion

This chapter examines the contribution of the case study findings to our understanding of safe, ethical, competent, caring, and compassionate nursing practice during missions in one developing country. To begin, the conclusions, implications, and recommendations for nursing practice regarding the findings of each research question in the study are provided. This discussion continues with suggestions for further research and policy development, as well as the study limitations. The chapter ends with the researcher's final reflection about nursing practice in a mission.

6.1 Research Question 1) How do nurses make competent and ethical clinical decisions during a mission in a developing country? Conclusions, Implications, and Recommendations

Nurses transition through as many as five stages from novice to advanced beginner, competent, proficient, and expert (Benner, 2001), in their quest to develop critical thinking, which is essential to make clinical decisions necessary to practice in a safe, ethical, competent, caring, and compassionate manner. Nurses integrate various ways or fundamental patterns of knowing (Carper, 1978), evidence-based practice guidelines, and their clinical experience to help them assess and monitor patient well-being, implement the necessary care, and evaluate patient outcomes. As they transition from novice either part way or entirely to expert, they move from relying on strict rules and parameters to developing the capacity to perceive situations as complex wholes and patterns while applying theory and abstract concepts depending on salient clues, context, and patients' unique needs.

The data analysis and direct observation of participants during the mission confirmed the five levels of proficiency among participants concerning their mission nursing expertise. With respect to their cardiac nursing expertise, participants were either competent, proficient or experts. Volunteer nurses, in one sense, go through the five stages of proficiency as they quickly adapt to nursing in a mission. In this study, participants provided care to patients and education to the local nurses. Nursing in a mission is a complex phenomenon that requires the integration of knowledge, practice, and expertise within the unfamiliar context of the mission as nurses provide culturally sensitive nursing care in a safe, ethical, competent, caring, and compassionate manner.

Furthermore, depending on their proficiency level, volunteer nurses require adequate support to provide nursing care in the mission and continue developing their mission and nursing expertise (Benner, 2001; Benner et al., 2008). During missions, nurses must develop expertise specific to the context as they critically think and integrate their knowledge and experience in an unfamiliar environment. As noted by the participants, volunteers with mission experience are excellent resources to learn about alternative solutions that are appropriate within the context of missions. The local staff are experts about their culture and their input must be considered when making decisions that attempt to meet patient needs in a culturally sensitive manner. Patients must be a part of the assessment, planning, and evaluation of care. Nurses may volunteer in countries where people speak a different language; therefore, they must find ways to communicate with patients using translators to ensure that patients' needs and goals are integrated into the care that is provided. Additionally, the World Health Organization recommends using a people-centred care approach in the planning, delivery, monitoring, and

evaluation of care to ensure that people's needs, especially those of vulnerable populations, are met (WHO, 2016).

Within the unfamiliar context of missions, volunteer nurses demonstrate various levels of nursing proficiency, and mission nursing expertise. Critical thinking supports clinical decision-making and the integration of knowledge, practice, and experience that results in safe, competent, ethical, caring, and compassionate nursing care. Therefore, volunteer nurses still require appropriate support to practice in a culturally sensitive manner within the context of missions.

6.2 Research Question 2) What factors influence nursing clinical decision-making during a mission in a developing country? Conclusions, Implications, and Recommendations

In this exploratory case study, the findings indicated that individual clinical decision-making was influenced by individual, group, and situational factors, which supports the conclusion that "the manner in which health care is practiced will be significantly different due to a number of important factors" (Hunt, 2008, p. 59). Previous studies were conducted with people who volunteered in various types of medical missions and were contacted six months to five years after their experience (Hunt, 2008; Hunt et al., 2014b; Schwartz et al., 2010; Schwartz et al., 2012; Sheather & Shah, 2011; Zinsli & Smythe, 2009). This particular study however, specifically drew on a sample of nine nurses interviewed during and after a 15-day mission in Nepal where nurses provided care during and after cardiac surgery, outreach services to patients, as well as education to the local staff to help them establish a cardiac surgery program in their hospital. Participants reflected, compared, and contrasted their nursing experience in Nepal and other previous missions.
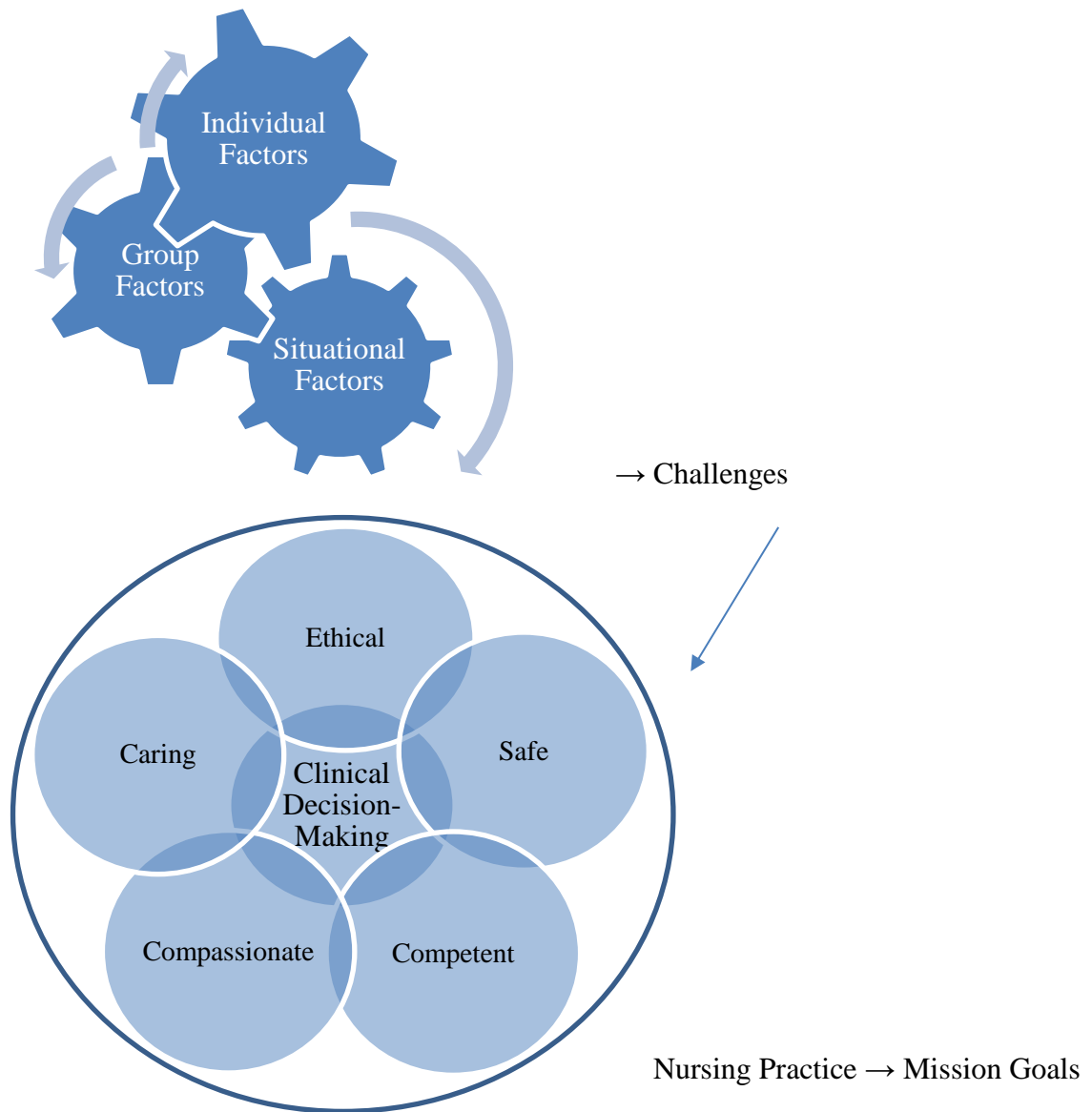
Figure 2. Conceptual Model for Nursing Practice During a Mission in a Developing Country.

The study findings generated a conceptual model of nursing practice during a mission in a developing country, which indicates that individual, group, and situational factors lead to challenges that influence an individual nurse's clinical decision-making. The ability of the nurse to resolve the challenges results in safe, competent, ethical, caring and compassionate nursing practice, as well as achieving the mission goals. Figure 2 illustrates the conceptual model, and

the following sections of the chapter will examine how individual, group, and situational factors

affect nursing practice in a mission.

     6.2.1 Individual Factors. The findings in the study identified eight individual factors,

summarized in table 5, which impact clinical decision-making that contributes to practicing in a

safe, ethical, competent, caring, and compassionate manner, which facilitates achieving the

mission goals. The conclusion, implications, and recommendations for nursing practice and

leadership regarding individual factors that affect nursing practice in a mission will be examined

below.

Table 5

Factors that Influence a Nurse's Clinical Decision-Making During a Mission

Individual Factors
1. Ability to Adapt to the Environment
2. Autonomous Nursing Practice
3. Knowledge, Experience, and Confidence in One's Ability to Nurse During the Mission
4. Flexibility to Problem-Solve and Meet Needs
5. Art and Science of Nursing Integration
6. Making Sense, Finding Purpose, and Doing No Harm
7. Meaningful Work, Vision, and Serving Others
8. Moral Distress Experienced Due to the Inability to Provide Required Care

     6.2.1.1 Ability to Adapt to the Environment. As demonstrated in the study,

nursing in a mission requires individual coping with unfamiliar cultural norms and ways of life

that are part of the country, organization, health care system, as well as the subcultures of

medicine and nursing. Therefore, they must be sensitive to differences in nursing practice, and

avoid assuming that their way of nursing is the best way to practice regardless of the setting and

context of situations. This requires respect of the local team's knowledge, experience, and

familiarity with their environment.

Furthermore, traveling to developing countries changes the familiar physical surroundings, which can lead to problems such as altitude sickness and 'cultural shock'. Ineffective coping with the changes in the physical environment will contribute to physiological and psychological effects in volunteers' bodies that will almost certainly impact individual wellbeing, nursing care, and the ability to function in the mission. Therefore, nurses must know, understand, and prepare for the process of adaptation required to nurse in missions.

Depending on the type of mission, volunteers may need to travel during war and disaster relief situations to provide humanitarian care during crises; therefore, they must consider the added physiological and psychological stress to their bodies. Participants in this case study travelled knowing that the country had suffered two devastating earthquakes; was still experiencing aftershocks; and had a fuel crisis that developed following political instability with neighbor countries, which led to a strike and general tension among citizens (Arora, 2015; Ghimire, 2015; Ravat, 2015). Therefore, the mission coordinator contacted every participant regularly before the mission to update them about the country's status before the mission. During the mission, appropriate measures were taken to ensure the mission team's safety at all times.

In addition to adapting to the environment, as demonstrated in the study, participants must be sensitive and respectful of cultural differences regarding the local team's practice. Therefore, nurses must carefully observe and assess interactions to determine appropriate ways to provide care, educate, and lead during the mission. Regardless of the context of the situation in which missions take place, effective and ethical nurse leaders must facilitate the successful adjustment of volunteers, which promotes safe, ethical, caring, and compassionate practice.

6.2.2.2 Autonomous Nursing Practice. The ability of nurses to contribute to global health efforts by working to their full potential depends on the understanding of nursing

practice and the support provided by governments, organizations, communities, as well as effective and ethical nursing and non-nursing leaders. Nursing practice around the world reflects a history of oppression and marginalization (Dubrosky, 2013; Mooney & Nolan, 2005). As demonstrated by the participants' reflections of their nursing practice and the literature (Elliott, Rutty & Villeneuve, 2013; Wytenbroek & Vandenberg, 2017), nurses continue to work towards changing the global perception regarding the profession of nursing.

In this study, the findings demonstrate the ability to establish a cardiac care program in a developing country following the education, empowerment, and support of local nurses, which was dependent on the support of the local hospital organization and physicians. Participants retained their professional autonomy and were highly regarded for their confidence, knowledge, and expertise by the local physicians, which were obtained through continued education and their respective organizational and cultural support. After careful assessment of the local team interactions, participants understood that the local nurses did not have professional autonomy. They were expected to follow physician orders to be able to provide care, learn, and implement change in their practice, which negatively impacted their nursing practice and the quality of care.

Effective leadership in missions requires that nurses obtain organizational and subcultural support by establishing trusting relationships with stakeholders and followers. Therefore, they must engage in reflection to clarify their values, and understand the rationale of their actions before motivating people to act as they demonstrate commitment to ethical behavior (Sinek, 2009; Turkel, 2014). Through careful observation and reflection of the context of missions, nursing leaders can determine what elements in the organization and health care system require change. The ability to develop insight about the interrelation of things, understand events, patterns, and system structures can help nurse leaders to understand why change is required in an organization (Senge 2006).

Effective and ethical nurse leaders can develop insight about complex problems during missions by looking beyond events to identify patterns and trends occurring in organizations and determine how they fit together to help them clarify existing mental models that are problematic. Effective and ethical nurse leaders must work with the local staff to assess how the organization's goals and priorities affect the development of autonomy, application of evidence-based practice, and patient outcomes. This will also assist to anticipate long-term solutions, future directions, and the integration of the local staff's feedback while ensuring the organization's and its leaders' continued support of local nurses' practice.

6.2.2.3 Knowledge, Experience, and Confidence in One's Ability to Nurse During the Mission.

As demonstrated by participants' reflections, autonomous practice allows a nurse to develop confidence while continuing to build their knowledge and experience through practice. The study findings indicated that regardless of the level of expertise and given the lack of familiarity with the context of the mission, participants relied on their colleagues to consult and validate assessments, make clinical decisions, as well as anticipate, monitor, and evaluate patient outcomes. This approach encouraged everyone in the team to discuss and critically examine challenging situations with each other, as well as increased their knowledge and expertise. Mission and local staff must be encouraged and supported to engage in behaviors that will help them to build their knowledge, experience, and advocate for patients' needs.

During missions, nurse leaders must promote trust and role model the practice of critical thinking while teaching local nurses to establish helping relationships where they feel comfortable giving and receiving help (Schein, 2010). Effective nurse leaders must develop and model the attitude that it is safe, competent, and ethical to clarify, validate, give, and receive information to achieve goals, be successful when providing nursing care, and build expertise.

6.2.2.4 Flexibility to Problem-Solve and Meet Needs. The participants in the study emphasized on several occasions, the critical need to be flexible, open minded, and willing to learn about different ways of life, practice, values, and beliefs to be able to consider situations in a holistic and unbiased manner. They reflected about the negative impact of personal agendas and unrealistic expectations on accomplishing mission goals, assessing and meeting people's needs, as well as triggering feelings of apathy and wanting to give up.

The capacity to critically think during missions facilitates the application of a strengths-based approach to nursing care that focuses on people's resilience while maximizing and helping them to build strengths. Strength-based care focuses on capitalizing and working on areas that help people minimize weaknesses so they can function and achieve their goals. During missions, a deficit approach to educating the local staff reduces them to 'human capital' necessary to meet organizational goals, which shifts the focus to accomplishing medical tasks and functions that preserve power imbalances among local staff and patient-nurse interactions.

Opportunities to reflect about their practice allow nurses to gain awareness of strengths, weaknesses, and ensures continuous learning. Therefore, the reflection that takes place during the mission can help volunteers to develop awareness, understand, and consider the complex social, economic, organizational, and political demands on the care provided by the volunteers and local staff, which determine the ability of vulnerable patients to receive care during the mission.

6.2.2.5 Art and Science of Nursing Integration. As demonstrated by the findings in the study, safe, competent, ethical, caring, and compassionate nursing practice requires the integration of various ways or patterns of knowing, evidence-based practice guidelines, clinical practice, and experience to help a nurse understand the complexities and uniqueness of patients.

Interviews with participants and the findings in this study support the literature (Benner 2001; Benner et al., 2008) in that the length of time nursing does not guarantee expertise, and it also does not guarantee a volunteer's ability to handle the challenges experienced during missions. Some nurses who are not experts adapt well to the context of missions, and some nurses who are experts cannot adapt to nursing in missions. Nursing practice can take place in many different settings and there are many specialties, which require nurses to possess specific knowledge and personal characteristics to be successful when providing care. There are also many types of missions that require nurses who possess specific knowledge and experience.

As indicated by the findings, the realization that volunteers do not have the necessary knowledge and skills required to provide care during the mission creates additional stress and an unsafe situation for volunteers, mission and local teams, local health care institution, and patients. Therefore, mission organizations need to provide a detailed description, as much as possible, of the required volunteer expectations and responsibilities. Nurses must also request information about their responsibilities to consider possible situations that can be encountered during missions, as they carefully appraise their ability to cope with them in an unfamiliar environment. As suggested by the findings, this basic information will assist nurses to determine if they can provide care in the mission, given that most volunteers do not get any training or much information about their responsibilities before the mission (Hunt, 2007; Hunt et al., 2014a; Schwartz et al., 2010; Sheater & Sha, 2011).

A key goal of effective and ethical leadership during a mission is to be successful meeting individual, organizational, and societal expectations by working with the mission and local teams providing care to help vulnerable people achieve wellness and quality of life. As such, one of the most important purposes of education, nursing, and leadership in missions is to

empower people who include volunteers, patients, and the local team to make informed choices.

Volunteers must understand the value of their contribution and the expertise required of them in

missions. It is more effective and ethical for mission leaders to enlist and motivate nurses by

providing accurate information about the challenges that can be encountered during the mission,

including the responsibilities and expectations of volunteer roles, rather than telling them what to

do, coerce, or manipulate them to volunteer and achieve goals in mission (Kouzes & Posner,

2012).

6.2.2.6 Making Sense, Finding Purpose, and Doing No Harm. The study

findings indicate that although participants experienced moral distress and felt "uncomfortable"

about some of their choices when providing care, doing no harm was the pivotal factor that

helped them to clarify the appropriateness of care protocols within the context of the mission.

Furthermore, the lack of knowledge regarding culturally specific and sensitive professional,

legal, and ethical responsibilities applicable to their practice during the mission increased their

feelings of discomfort and uncertainty. Therefore, discussing challenges with the mission and

local teams was always helpful to clarify personal and professional values, holistic understanding

of situations, as well as available alternatives and resources within the context of the mission.

Consequently, nurse leaders need to investigate and provide volunteers with information

regarding applicable professional, ethical, and legal responsibilities within the context of the

mission, which are culturally sensitive and appropriate. This knowledge can facilitate volunteers'

decision-making process and ease the discomfort from the inability to follow standard care

protocols from developed countries during a mission. Alternatively, nurses require preparation to

consider the application of standard care protocols in situations with limited or no resources to

ensure the wellbeing of the vulnerable patients that will receive care in the mission.

Effective leadership is ethical, reflects the moral integrity of the leader, and promotes social justice (Branson, 2010; Branson & Gross, 2014; Garcia, 2014). Consequently, effective nurse leaders must be ethical and work towards achieving the common good of people that receive care regardless of the organization and the country they are in. They must promote ethical behavior in organizations while demonstrating and role modeling ethical consistency in their behavior. Following an ethics of care approach, nursing leaders can help volunteers determine 'the right thing to do' by critically thinking and considering why and how exercising power, authority, and influence may cause and lead to harm (Ciulla, 2014), as well as explore ways to prevent it.

Nursing leadership in a mission requires nurses to push themselves outside their comfort zone in an unfamiliar environment while mentoring and collaborating with colleagues, organizational and community leaders, as well as the people who receive care. Effective and ethical nurse leaders must have the courage to engage in discussion about policy and change. As confirmed by participants in their interviews, effective and ethical nursing leadership requires awareness of how decisions are made by finding the sources of formal and informal power, inside and outside the mission experience, and consistently demonstrate responsibility, moral integrity, and passion to advocate for the wellbeing of volunteers and the vulnerable patients who receive care during missions (Garcia, 2014).

6.2.2.7 Meaningful Work, Vision, and Serving Others.

6.2.2.7 Meaningful Work, Vision, and Serving Others. People need to know that what they do matters (Kouzes & Posner, 2012; Sinek, 2009). The study findings indicate that mission and hospital reports confirmed the participants' work improved the quality of patients' lives, helped to establish the cardiac care program at the hospital, and facilitated the local nurses' improvement of their practice. Regardless of the many physical and psychological challenges experienced, participants stated that their work was congruent with their personal and

professional values, and beliefs. The understanding and identification with the mission goals and

vision, and their nursing experience helped them to be flexible in their approach to providing

care and educating the local nurses.

Mission experiences demand that nurses question and uphold their personal and

professional values and beliefs, as they continue to develop moral integrity and "phronesis",

which requires authentic presence in nurse-client relations and doing what nurses do best, which

is to care about and serve others. Caring and healing are "about relation, not separation, about

meaning, being and finding sacredness in the act of caring itself" (Watson, 1999, p. 15).

Therefore, providing care to vulnerable patients in a mission gives nurses an opportunity to

experience the joy and satisfaction of fulfilling the personal and professional vision to care for,

about, and with others. From an ethics of care approach, nursing in a mission also fulfills the

moral responsibility to care for others through actions that heal our world.

Leaders can be 'born', but leadership capabilities more often develop because of

education, experience, and events that shape an individual's attitudes, values, beliefs, and

behaviors (Dasborough, Ashkanasy, Tee & Tse, 2009; Mattis, 2010; Orozco & Allison, 2008).

Effective leadership is not about popularity, but about doing things to empower humanity

because we possess the ability to do so (P. Bishop, personal communication, November 2, 2013).

During missions, following a strength-care based approach to nursing practice, nurse leaders

must be culturally sensitive and assess the values and goals regarding health and wellness of the

patients who receive care in the mission. They also need to recognize the limitations and impact

of the work that must be accomplished as they try to lead, mentor, and practice in an ethical

manner that benefits vulnerable patients (Siddiqui, 2011).

Effective and ethical nursing leaders have a responsibility to help volunteers clarify, make sense, and understand the impact of their work when serving and providing care to vulnerable patients during missions. Doing so will facilitate supporting volunteer nurses cope with limitations and the moral distress experienced due to lack of resources during missions.

6.2.2.8 Moral Distress Experienced Due to the Inability to Provide Required Care.

The research findings strongly validate previous studies that have identified the moral distress experienced by health care professionals who provide care to vulnerable populations due to the lack of resources and social inequities that exist in developing countries (DeCamp, 2007; Hilhorst & Schmiemann, 2002; Hunt, 2008; Hunt et al., 2014b; Schwartz, et al., 2010; Schwartz et al., 2012; Sheather & Shah, 2011; Zinsli & Smythe, 2009). Regardless of the participants' expertise level of practice as a nurse, volunteers felt powerless due to their inability to provide the necessary care and help vulnerable patients prevent illness, suffering, and improve their quality of life because of social inequities and determinants of health in developing countries.

During their interviews, participants indicated they used the same team-discussion approach they apply at their workplace to problem-solve challenging issues in a competent and ethical manner. Consequently, mission leaders must provide volunteers with opportunities to debrief about challenging situations, manage moral distress, develop moral resiliency, and learn from such events. The literature also recommends ethical training before the mission to help volunteers develop knowledge and experience to resolve ethical dilemmas encountered during missions (Hunt, 2014b; Schwartz et al., 2010). The findings also indicate that volunteers need to debrief after the mission to "reflect", "make sense of the experience", "cope with moral distress", and "continue to improve [their] practice". The ability to do so with mission colleagues provides catharsis and validation of their experiences.

Furthermore, nurses who provide care during missions in developing countries must examine the meaning of values such as privilege, meritocracy, gender, race, ethnicity, health, wellness, and quality of life to determine who says there is a problem, what the problem is, why it is so, and thoughtfully challenge deficit thinking approaches to care (Rusch & Horsford, 2008). They must be able to acknowledge that their practice and leadership behaviors may be based on assumptions that perpetuate oppressive ideologies, which only assign blame to people, ignore their strengths, abilities, and contextual barriers (Weiner, 2006). During missions, nurses must also acknowledge and understand that the health care system in developing countries is not structured to ensure equitable access. As supported by the participants' experiences and the literature, most people in developing countries consider being healthy and receiving health care to be privileges (WHO, 2016).

Additionally, effective and ethical nurse leaders need to consider volunteers' abilities and determine available resources to meet the mission, organizational, and community demands while empowering and encouraging volunteers to achieve goals, and supporting their professional growth. Nurses must also challenge the status quo and deficit thinking approaches to advocate for the right of vulnerable patients to access quality health care services. Senge (2006) proposes that we must learn to see the world as a system of interrelationships so there is no separate other "and everyone shares responsibility for problems generated by the system" (p. 78). Nursing leaders can use of a holistic approach to leadership that incorporates an ethic of care, profession, justice, and critique to promote the development of moral integrity of leaders, volunteers, and organizations, which leads to ethical leadership, practice, and research (Branson, 2010; Shapiro & Gross, 2013).

During missions, nurse leaders must be able to communicate, clarify, and negotiate realistic expectations and goals with stakeholders, which include health care, government organizations, volunteers, community, and the patients who receive care in the mission. Critically reflecting about the purposes and goals of the mission must occur in a way that considers multiple voices and questions whose needs cannot be met. The participation and shared control of the delivery of care among stakeholders must be facilitated, as much as possible, to ensure an ethical and democratic process.

6.2.2 Group Factors. Individual nursing practice requires collaboration with the health care team. The findings in the study identified three group factors, summarized in table 6, which affect the individual participant's clinical decision-making and contribute to safe, ethical, competent, caring, and compassionate nursing practice that allows meeting the mission goals. The conclusion, implications, and recommendations of group factors for nursing practice and leadership in a mission will be examined below.

Table 6
Factors that Influence a Nurse's Clinical Decision-Making During a Mission

Group Factors
1. Team Dynamics
2. Evidence-Based Practice and Protocols
3. Extent of Preparation and Individual Fitness to Practice

6.2.2.1 Team Dynamics. Findings in the study validated the positive effect of team collaboration, communication, trust, and respect on the individual participant's decision-making and consequently, the nursing care provided in the mission. Clinical reasoning is "socially embedded in a nexus of social relationships and concerns (Benner et al., 2008, p. 91). Participants indicated on many occasions that an important goal of the mission was to work with the local team because collaboration is essential to provide safe, ethical, competent, and

compassionate care. Collaboration is the medium that ensures the wellbeing of patients, the team, and organizations. As already discussed, given the context of the mission, nursing leaders must build group cohesion by establishing trust and respect between the mission and local team to ensure collaboration. Nurse leaders must also establish respect, trust, and collaboration with the different stakeholders and the communities involved in the mission, which have an impact on the care that patients receive.

Given their position of power and influence, which can be formal or informal, effective and ethical nurse leaders must inspire others to act. Leadership is about relationships, credibility, and what leaders do to empower, collaborate, and build capacity in others. Therefore, during missions, effective and ethical nurse leaders are concerned with team success, meeting the needs of people, care about social justice, and reflect on the perpetuation of practices that continue to exclude and marginalize vulnerable people. An ethics of care approach to team work requires nurse leaders to consider members as relational, interdependent beings, "with private struggles often rooted in broader sets of social and political contexts that can only be dealt with adequately when those connections are considered" (Lawrence & Maitlis, 2012, p. 649). As supported by the findings, mission leaders must consider the role of the local staff and their contribution in allowing, supporting, and enabling effective, ineffective, ethical, and unethical leadership practices to occur, as well as their struggle with oppressive and marginalizing cultural norms. Therefore, a thoughtful and sensitive power-with approach such as the peace power process (Chinn & Falk-Raphael, 2015) demonstrated by the participants, which is grounded on reflection and integration of information about cultural norms and power imbalances is required to help facilitate, support, and help the local staff to collaborate and create a safe environment based on trust, respect, and inclusion (Griffiths, 2013; Kouzes & Posner, 2012; Schein, 2010).

Furthermore, role modelling occurs intentionally and unintentionally. It is therefore important that the mission team role models effective and ethical leadership practices, communication, trust, respect, and collaboration among its members. Leadership is an essential factor for achieving interprofessional team collaboration (Bennett, Gum, Lindeman, Lawn, McAllister, Richards, Kelton & Ward, 2011; WHO, 2010b; 2013b). Effective and ethical nurse leaders who role model communication, respect, trust, and team collaboration are essential for obtaining organizational support, promoting, and sustaining team collaboration during a mission.

6.2.2.2 Evidence-Based Practice and Protocols. As demonstrated by the participants, novices rely on rules and protocols, which expert nurses have learned to integrate in their care. Evidence-based practice guidelines developed through research have been shown to improve patient outcomes (CNA NurseOne.ca, 2017). Health care professionals around the world (WHO, 2010b, 2016) are expected to use the best available, and most appropriate, evidence to make clinical decisions and provide high quality care based on the context of situations and patients' unique needs. Therefore, evidence-based practice provides the foundation for educating local stuff during missions to help them improve their practice and the quality of care provided to patients in their organizations.

However, regardless of the situational context, the challenge in applying evidence-based practice guidelines requires the evaluation of the validity, reliability, and generalizability of research findings in the clinical setting. Therefore, and individual nurse's critical thinking, expertise, team collaboration, and additional specialized education are required. As the study findings indicate, and as supported by the literature, many nurses do not think they have the education, tools, or resources needed to use evidence-based guidelines appropriately in practice (Benner et al., 2008; Nielsen & Lasater, 2013; Oelofsen, 2012; Pravikoff, Tanner & Pierce,

2006; Tanner, 2006). Hence, regardless of their experience nursing and volunteering in missions, volunteers require support during the mission to apply evidence-based practice guidelines when providing care, as well as to educate local staff within the unfamiliar context of missions.

Clinical education during missions require more than the transmission of knowledge to the local nursing staff (Benner 2001; Benner 2008; Davis, 1999; Muula, Mfutso-Bengo, Makoza & Chatipwa, 2003; Nielsen & Lasater, 2013; Stark et al., 1999; Tanner, 2006). As the findings indicate, volunteers do not receive any training before the mission; therefore, nursing leaders need to ensure that nurses who volunteer are knowledgeable and confident about the application of evidence-based practice guidelines within the context of the mission and can use them to educate the local staff. When education takes place during missions, volunteer and local nurses become co-learners as they teach and learn from each other, and continue to enhance their knowledge and experience.

6.2.2.3 Extent of Preparation and Individual Fitness to Practice. The study findings and participants' reflections about past mission experiences validate previous research's concern that health care professionals do not receive training or education about volunteering in missions (Hunt, 2008; Schwartz et al., 2010). Due to the various types of missions and expectations of volunteers, training before and during the mission can facilitate leadership, team collaboration, individual coping and adapting to context of the mission, the delivery of competent and safe care, the education of local staff, ethical decision-making, and the building of moral resiliency.

Although it is not possible to inform volunteers about what will happen during the mission in detail, mission organizations have a responsibility to provide information that will help people determine their capacity to practice nursing within the mission context and meet the

mission goals. Nurses have a professional, legal, and ethical responsibility to prepare for

missions and take good care of themselves before, during, and after the experience; therefore,

they must obtain the appropriate information to do so. The safety of everyone is always a

priority; therefore, volunteers must ensure they are comfortable with the measures taken by the

mission organization to promote and ensure volunteer safety within the context and type of the

mission experience.

As demonstrated by the study findings, effective and ethical nurse leaders must assess,

monitor, and care about their followers' needs throughout the mission to support volunteers and

their practice. Providing nurses with information about missions helps volunteers to prepare and

carefully examine their ability to provide care in the mission.

6.2.3 Situational Factors. Nursing practice requires that nurses apply their critical

thinking skills as they integrate knowledge and experience relevant to the context of the situation

and the patient needs. The findings in the study identified two situational factors, summarized in

table 7, which affect clinical decision-making that contributes to safe, ethical, competent, caring,

and compassionate nursing practice, as well as help participants to achieve the mission goals.

The conclusion, implications, and recommendations for nursing practice and leadership

regarding situational factors that affect nursing practice and leadership will be examined below.

Table 7

Factors that Influence a Nurse's Clinical Decision-Making During a Mission

Situational Factors
1. Cultural Norms, Hegemony, Hierarchy, and Power Imbalances
2. Impact of Lack of Resources resulting from Social Inequities

6.2.3.1 Cultural Norms, Hegemony, Hierarchy, and Power Imbalances.

According to Frye (1983), oppression occurs when people are caught between forces or barriers

that restraint, restrict, mold, and immobilize them. Young (1990), states that oppression is

structural and embedded in unquestioned norms, habits, and assumptions underlying institutional

rules that include the consequences of following those rules. As described by participants'

reflections, the literature (Izumi, Nagae & Sakurai, 2012; Lago, Nilson & Piva, 2011; Paganini &

Bousso, 2015; Skar, 2009; Tamayo-Velazquez, Simon-Lorda & Cruz-Piqueras, 2012), and

observed behavior in the mission, local nurses experience exploitation, marginalization, and

powerlessness as a result of patriarchy and dominance of physicians (Young, 1990). The local

nurses did not have autonomy and practiced under very strict orders from doctors, which

severely affected their ability to learn and practice to their full capacity as they required

permission to perform most of their care. Therefore, marginalization of the local nurses had a

negative impact on the delivery and quality of nursing care provided to patients. However, the

local physicians expected the local nurses to learn to practice like the participants. Therefore,

after the mission, educator, and operating room coordinators helped the physicians understand

the critical role of autonomous nursing practice and the need for organizational change,

physicians agreed to their help in developing care protocols and parameters to support and

promote the local nurses' autonomy, critical thinking, and practice to improve patient care.

When volunteer nurses assume the role of educators during a mission, they must

understand their leadership role in empowering and promoting change among local nurses.

Societies rely on rules, habits, and beliefs to which people adhere to. Freire (2002) noted that

education is the key to liberation or emancipation that results from the development of self-

awareness, knowledge, and reflection of one's reality. Therefore, all nurses must learn to

thoughtfully challenge and question conformity that promotes social inequities. Organizational

values and goals have a profound impact on the purpose of education, leadership, and the ability

of nursing leaders to meet the needs of patients and vulnerable individuals during missions. As

supported by the findings in the study and the literature (Skar, 2009), the courage to challenge, speak up, and act is a learned habit, as much as remaining quiet and obeying rules are the habitual behaviors taught and expected from oppressed groups (Dubrosky, 2013).

Furthermore, self-reflection requires nurses to be critical about perceptions, worldviews, and develop awareness of biases that are "inescapably centric in one way or another" (Gillies & Alldred, 2012, p. 48). When we talk about oppression, we do it from the point of view of someone who is not living and perhaps has never lived the life experience, which is in itself a form of marginalization. "Our experiences are deeply influenced by what is said about them, by ourselves or powerful others" (Lugones & Spelman, 1983, p. 573). When nurses reflect about their care and leadership, they must be careful to avoid perpetuating ineffective and unethical leadership practices, which contribute to exclusion, marginalization, and oppression of vulnerable groups in society (Anderson, 1990; Armstrong, Allinson & Hayes, 2002; Griffiths, 2013; Lugg & Shoho, 2006; Rush & Horsford, 2008; Weiner, 2006). Therefore, as demonstrated by participants, nurses must be careful assessing the local nurses' 'reality', which in the study led to the realization that local nurses could be fired by physicians for 'speaking up' and advocating for patient needs.

When participants were asked about patient involvement in the decision-making process in the hospital, they stated they were not sure about patient involvement. Participants assumed the local team communicated with patients following their routine health care practices. However, in the intensive care unit, participants became aware that families had minimum contact and information about their loved ones following major heart surgery. In the community, participants communicated with patients through translators, and patients were informed about the clinical decisions made by the participants. Therefore, the study findings strongly validate

and support previous studies regarding the lack of formal patient feedback and their participation

in the evaluation of the care provided in missions (DeCamp, 2011; DeCamp, et al., 2014; Hunt,

2011; Levi, 2009; Oliphant, 2016).

An ethics of care approach requires the consideration of relationships, and the context in

which practice takes place through careful observation, listening, and responding to people's

needs. During missions, nurses must ensure vulnerable patients can be heard and ensure the

ability to talk to them to facilitate the consideration of the consequence of their decisions and

actions on the vulnerable patients who receive care. This includes who will benefit, who will be

hurt, the long-term effect of the decisions made, as well as how to give back to individuals and

society in general (Shapiro & Gross, 2013). Moreover, the consideration of individual human

rights, responsibilities, and maintaining respect for patients' self-agency can assist nurse leaders

and volunteers to determine patients' 'best interest' in situations where health care professionals

need to balance individual and community needs (Hunt, 20122; Shapiro & Gross, 2013).

An integrated people-centred health services approach requires that health care

professionals place the comprehensive needs of people and communities, not only diseases, at

the center of their services, and empower patients to have an active role in their own health

(WHO, 2016). During missions, nurses must ensure the inclusion of vulnerable populations in

the planning, delivery, monitoring, and evaluation of patient care. Therefore, it is critical that

nurse leaders explore the complexities of obtaining patients' feedback about the care received in

missions, which must consider communication barriers such as language and education issues,

avoiding exploitation, and effective strategies to empower vulnerable populations.

6.2.3.2 Impact of Lack of Resources resulting from Social Inequities. The

findings in the study validate previous research that identified the negative impact of lack of

resources and social inequities on the care that can be provided to vulnerable patients during missions (Byrne et al., 2014; Decamp et al., 2014; Memmott et al., 2010; Roye & Nickitas, 2010). A lack of resources has implications on the safety of health care professionals, as well as the quality of care that vulnerable patients receive. For example, the lack of equipment and supplies to promote universal precautions and prevent infection must be explored within the context of missions in areas with minimal or no resources to ensure the safety of everyone.

As demonstrated by the findings, circumstances involving lack of resources and social inequities can lead to many expectations as nursing leaders attempt to meet organizational, team, and patient care demands given the situational challenges of missions. Globally, more than 400 million people lack access to essential health care services, which supports the need for everyone to work together towards meeting the sustainable development goals, and achieve wellness for people everywhere (WHO, 2015, p.2). An ethics of care approach, emancipatory and ethical knowing support action to make the world better for everyone. Nursing leaders must reflect about existing inequities and consider alternatives while collaborating with various stake holders during missions to improve organizational, social, and political systems. However, the ability to transform our world into a more caring global society is everyone's responsibility. An ethics of care approach to nursing practice requires nurses to engage with the context of the situations through relations that require emotional involvement and deep grasp of social meaning by entering the world of vulnerable populations and continue to challenge hegemonic, economic, and cultural realities that patients face to advocate and act accordingly (Woods, 2011).

6.3 Research Question 3) How do nurses define and evaluate competent and ethical nursing practice during one mission in a developing country? Conclusions, Implications, and Recommendations

Participants were not able to provide a concrete definition of competent nursing practice and stated they evaluated their practice based on patient outcomes, the success of the education provided to the local staff, and the accomplishment of the mission goals, which was confirmed by various official mission reports from the hospital and mission organization. These findings support the controversy that exists in nursing practice regarding what nursing competence exactly means (Axley, 2008; Church, 2016; Watson, 2002), and the serious efforts that must be made to define and measure it (Cowan, Norman & Coopamah, 2006). Merely describing competence as a lack of incompetence further supports the ongoing conflict regarding the need to train versus educate nurses, which impacts the quality of care patients receive. As previously discussed, professional regulatory bodies expect nurses to be competent by practicing in a safe, ethical, competent, caring, and compassionate manner. Lack of nursing competency can result in harm or "serious consequences for the patient" from the inability to act as needed (Axley, 2008, p. 214). For example, in Nepal, a nurse who is not familiar with cardiac surgery recovery protocols would not be able to assess and manage patient complication after surgery such as improper drainage of the chest cavity, which puts patients in danger of retaining fluid that leads to ineffective breathing and collapse of the lungs. Therefore, nurses must clarify and understand what is expected of their individual practice during missions to determine the best way to meet their professional, legal, and ethical responsibilities.

Participants defined ethical practice as doing good, avoiding harm, and integrating professional codes of ethics in their practice. They indicated ethical practice requires

compassion, competency, concern for others, the safety of everyone involved in giving and

receiving nursing care, and the consideration of human rights, social justice, and ethical values

and principles such as justice. Participants were not able to concretely evaluate ethical nursing

practice, in fact, they were unsure about their application of care protocols that required them to

"lower their standards" and adapt them to the context of the mission. However, they always

chose to act in ways that appeared to avoid doing harm to patients at the time they experienced

moral distress. Given the absence of mission specific guidelines, care protocols, and evidence-

based practice, they resolved ethical dilemmas through in-depth reflection and discussion of

challenging situations with the mission and local team. Therefore, participants demonstrated an

ethics of care approach, which requires careful consideration about the context of situations,

people's lives, and the relationships that impact the wellbeing of individuals. They also focused

on patient's strengths and building patient capacity within the context of the mission.

Arguably, the phenomenon of nursing practice and leadership within the context of

missions is quite complex given the individual capacities, knowledge, skills, experience,

"techne", "phronesis", and cultural sensitivity required of volunteers, which have been examined

throughout the dissertation. Effective and ethical nursing leaders must work towards the common

good of people regardless of the organization or the country they are in. They need to lead,

educate, practice, and engage in research by being sensitive to people's needs through a safe,

competent, ethical, caring, and compassionate approach. Nurses must understand that the

inability to acknowledge and address social inequities in missions perpetuates fear, prejudice,

oppression, marginalization, and privilege. Given the socio-political, global, and technological

changes occurring in the world, effective and ethical nurse leaders must work towards

empowering and helping people to live in a way that acknowledges and challenges power

imbalances and marginalization. By and large, effective and ethical nurse leaders understand that

education emancipates, opens new doors, and gives people hope and strength to continue as they

learn to make informed decisions that improve their lives. Furthermore, nurse leaders must

support nursing practice during missions through the development of mission specific best-

practice guidelines to support safe, competent, ethical, caring, and compassionate nursing

practice.

6.4 Future Research

Based on the study findings, below are some recommendations to support safe, ethical,

competent, caring, and compassionate nursing practice in missions through future research that

needs to explore:

1. Evidence-based practice and documentation guidelines to support safe, ethical,

competent, caring, and compassionate nursing practice during missions.

2. Effective and ethical leadership during missions, including the education and support

required by leaders before, during, and after missions.

3. The development of documentation guidelines for nurses who volunteer in missions.

4. Effective strategies to recruit and prepare nurses to volunteer in missions, as well as

support them during and after the mission.

5. Effective ways to support the learning needs of volunteer nurses and local nurses.

6. The effectiveness of ethical training before and during the mission to help volunteers

manage ethical dilemmas; moral distress; and develop moral resiliency.

7. Effective ways to support mission and local team development and collaboration

during missions.

8. Effective educational and leadership practices for developing and supporting the

autonomous practice of local nurses in developing countries.

9. Effective ways to establish collaboration among all the stakeholders involved with

missions in developing countries.

10. The perceptions of the mission and the local team about the care provided during

missions.

11. The evaluation of the work and goals accomplished in missions from the perception

of the patients and communities that receive care during missions.

12. The credentialing of volunteers and volunteering activities to ensure professional,

ethical, accountable, and competent practice during missions.

6.5 Policy

Based on the study findings, below are two recommendations to support safe, ethical,

competent, caring, and compassionate nursing practice in missions through policy development.

1. Further studies must continue to explore strategies that engage and empower

vulnerable populations during missions to help inform policy and decision-makers around the

world about how they can improve access to quality health services, financial protection, and

address broader societal goals such as equity, social justice, solidarity, and social cohesion

(WHO, 2016).

2. The ability to refer to doctors' written care orders and care protocols, at any time,

supports the nurse's confidence when making clinical decisions and providing care. Participants

indicated during interviews that written orders and parameters promote autonomous and safe

practice. Nursing leaders worked with the local team to develop written orders for the local

nurses. Therefore, given that volunteer nurses in a mission also require support because they

possess different levels of proficiency, they also require written orders and parameters to provide

care during the mission. Available written care protocols in the mission can ensure and support

safe and competent nursing practice as they do in developed countries. Furthermore, given the

lack of familiarity with the context of missions, written orders and protocols will ensure the safe

and competent practice of all nurses. Written care orders and protocols can also facilitate

teaching the local staff at the bedside, and ensure the consistency of the information taught by all

the nurses volunteering in the mission.

6.6 Limitations of the Study

The findings are specific to the sample size of 18 semi-structured interviews conducted

with registered nurses, and the researcher's reflections in the role of a nurse, who volunteered in

a 15-day cardiac surgical mission to Nepal. There were nine nurses (n=9) who participated in the

mission and were interviewed during and after the experience. The participants varied in age,

nursing expertise, and experience volunteering in various types of missions. There were two

male and seven female nurses.

6.7 Final Reflection

The decision to volunteer as a nurse in a mission provides an opportunity to use one's

experience to care for patients who are amongst the most vulnerable people in the world,

experience marginalization, and live with social inequities. The purpose and goals of missions

might appear to be clear; however, involvement in the experience reveals the profound impact

that organizational, political, cultural, educational, professional, legal, ethical, and social factors

bear on the ability to deliver care to vulnerable populations. Everyone has a right to safe,

competent, ethical, and compassionate nursing care. Therefore, it is essential to ensure that

nurses who commit to volunteering in missions understand the ethical, professional, and legal

implications of doing so, to avoid causing unintentional harm given the context of missions.

Effective and ethical nursing leadership during missions is critical to facilitate the delivery and evaluation of care provided to vulnerable populations. Nursing leadership matters mightily because it supports and facilitates safe, ethical, competent, caring, and compassionate nursing practice. Effective and ethical leadership during missions is everyone's business. Given the context of missions, effective and ethical leaders are vital to protect, support, and evaluate the challenging and complex work of nurses, which promotes global health for people in the world.

Effective and ethical nurse leaders must understand the culture and context of their environment during missions. Leaders and followers are responsible for the effects of their actions, and must carefully examine them against the general good and wellbeing of people affected by them. Self-reflection potentially helps everyone to ensure that nursing practice and leadership are ethical and do not intentionally cause any harm to people. If nurse leaders have a clear understanding about their values, goals, and the impact of their work, they will almost if not always try to practice in an ethical manner that benefits patients, which will eventually accomplish the goal of helping vulnerable populations get much needed access to health care services.

Therefore, nurses who volunteer in missions must ground their nursing practice and leadership on a holistic approach that integrates individual physical, psychological, spiritual, developmental, and sociocultural factors, as well as the impact of determinants of health to practice in a safe, competent, ethical, caring, and compassionate manner, which can help the people they care about, for, and with achieve realistic goals regarding wellness and quality of life within the context of their life experience.

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Appendix A: Western University Ethics Review Board Approval
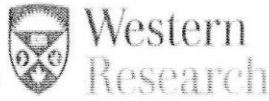
Western Research

Research Ethics

Western University Non-Medical Research Ethics Board
NMREB Delegated Initial Approval Notice

Principal Investigator: Dr. Pamela Bishop
Department & Institution: Education, Western University

Study Title: Nursing Clinical Decision-Making During an International Short-Term Medical Mission
Sponsor:

NMREB Initial Approval Date: September 10, 2015
NMREB Expiry Date: September 10, 2016

Documents Approved and/or Received for Information:

Document Name	Comments	Version Date
Other	References	2015/07/19
Data Collection Form/Case Report Form	Semi-Structured Interview After the Mission Protocol	2015/07/19
Data Collection Form/Case Report Form	Semi-Structured Interview During the Mission Protocol	2015/07/19
Revised Western University Protocol		2015/08/27
Revised Letter of Information & Consent	Appendix B	2015/08/20
Recruitment Items	Appendix 1A-telephone script invite	2015/08/20
Recruitment Items	Appendix 1A-email invite from researcher	2015/08/20
Data Collection Form/Case Report Form	Appendix D Focus Group	2015/08/20
Recruitment Items	Appendix A-email invitation from agency organizing medical mission	2015/08/20

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the above named study, as of the NMREB Initial Approval Date noted above.

NMREB approval for this study remains valid until the NMREB Expiry Date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario.

Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.
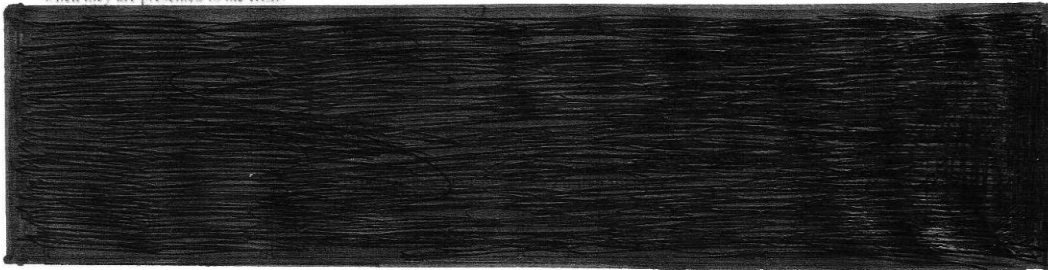
This is an official document. Please retain the original in your files.

Appendix B: e-mail Invitation to Participate in Study
(The Medical Mission Organization e-mailed to the nurses volunteering in the mission)

Date:
Recipient:
Subject: Research Study during and after the [name and location] mission.
Dear [name],

One of the nurses volunteering in our mission, Lorena Bonilla, will be conducting a study to gain more insight about the process of nursing clinical decision-making during a medical mission. This information may help to develop policy and best practice guidelines to support and facilitate safe, competent and ethical nursing care during short-term medical missions in third world countries. Lorena would like to interview each nurse volunteering in the mission for about 1 ½ hours during the mission. After the individual interviews, she will conduct a focus group that will last about 2 hours. Lorena will be talking with you about your nursing experience in the mission, including factors that may facilitate your nursing care or make things challenging. About two to four weeks after the mission, Lorena will contact you again for a final 1 ½ hour's interview via telephone, skype or in-person depending on where you live. ███████████████████████████████.
The title of the study is *Nursing Clinical Decision-Making During an International Short-Term Medical Mission*. Participation in the study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time, with no effect on your current or future participation in medical missions. All of the data collected during the interviews will remain confidential and accessible only to the investigators of this study. All focus group participants will share the responsibility for maintaining privacy and confidentiality. The researcher will protect the confidentiality of the information obtained during the focus group.

If you are interested in more information and participating in the study, please contact Lorena via e-mail at ████████. She will send you a letter of information and answer any questions you may have.

Thank you very much for your time and consideration.

[Name, title and organization logo]

On behalf of:
Lorena Bonilla
Field Researcher
RN, BA, BSN, MN

Pamela Bishop
Principal Investigator
PhD, Associate Dean (Graduate Studies)
██████████████████████████

Brenton Faubert
Co-Investigator
PhD, Assistant Professor
██████████████████████████

Appendix C: e-mail Invitation to Participate in Study
(The researcher e-mailed this invitation to each nurse interested in participating in the study
before the mission, following their email confirmation)

Subject Line: Invitation to participate in *Nursing Clinical Decision-Making During an International Short-Term Medical Mission* study.

Thank you for your interest to participate in a study that we, Dr. Pam Bishop, Dr. Brenton Faubert and Lorena Bonilla, are conducting. The study involves your participation in a one and a half hour interview during the mission, a two hour focus group with the nursing team during the mission, and a one and a half hour interview one month after the mission via skype or telephone. You will be asked to talk about your nursing experiences during the mission.
Please find attached a letter of information about the study and consent form to participate. If you would like more information on this study, please contact Lorena Bonilla at ▮ with any questions you may have. If you prefer, you can also schedule a phone call with Lorena to discuss the study.

Thank you,
Lorena Bonilla

RN, BA, BSN, MN

Appendix D: Letter of Information and Consent Form

Project Title: Nursing Clinical Decision-Making During an International Short-Term Medical Mission.

Principal Investigator: Pamela Bishop, PhD, Associate Dean (Graduate Studies), ████████
██

Field Researcher: Lorena Bonilla, RN, BA, MN. Professor, School of Nursing, ████████
██
████████████████████

Letter of Information

1. Invitation to Participate

You are being invited to participate in a research study to explore clinical-decision making of nurses during a short-term medical mission because you have volunteered to participate as a nurse in the medical mission to {name of mission and location} taking place on {date}.

2. Purpose of the Letter

The purpose of this letter is to provide you with information required for you to make an informed decision regarding participation in this research.

3. Purpose of this Study

The purpose of this study is to gain insight regarding nursing clinical judgment and the contextual factors that affect clinical decision-making and consequently a nurse's ability to provide competent and ethical care during a short-term medical mission in a third world country. Exploring nursing clinical decision-making as it happens during the mission will build on the existing knowledge about this process, and support future research for the development of theory, policy and best practice guidelines for nursing care during short-term medical missions in underdeveloped countries.

4. Inclusion Criteria

All individuals who are registered nurses (RNs) and have been accepted by {name of organization} to participate in the medical mission to {name, location and date} are eligible to participate in this study.

5. Exclusion Criteria
Individuals who are not registered nurses (RNs) are not eligible to participate in this study.

6. Study Procedures
If you agree to participate, you will be asked to take part in an individual interview during the mission. It is anticipated that the interview will take 1 ½ hours in a comfortable and convenient time and location chosen by you in {location of mission}. After the individual interview, you are also asked to participate in a focus group with the other RNs that will be individually interviewed. There will be 15 RNs in the focus group. Two to four weeks after the mission is finished, you are invited to participate in a final 1 ½ hour's interview via skype, phone or in person depending on your location and time.

7. Possible Risks and Harms
The possible risks and harms to you are any emotional discomfort associated with the discussion of your nursing experience in the medical mission.

8. Possible Benefits
The possible benefits to participants is the ability to debrief and reflect individually and as group, about the experience and the medical care provided during the mission that will contribute to your nursing colleagues' and your personal and professional growth. The possible benefits to society may be the ability to increase our knowledge about nursing clinical decision-making and factors that challenge or hinder the process during medical missions. This may contribute to the development of policy and best practice guidelines that support safe, competent and ethical nursing care during short-term medical missions in third world countries.

9. Compensation
You will not be compensated for your participation in this research.

10. Voluntary Participation
Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your current and future participation in medical missions.

11. Confidentiality

All data collected in the interviews will remain confidential and accessible only to the investigators of this study. During the focus group, all participants will be responsible for maintaining the confidentiality of the information that is shared. The researcher will protect the confidentiality of the information obtained during the focus group. If the results are published, your name will not be used. Your responses, identifying information, and any names mentioned will be kept confidential and anonymous. If you choose to withdraw from this study, your data will be removed and destroyed from our database. Representatives of The University of Western Ontario Non-Medical Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of the research.

12. Contacts for Further Information

If you require any further information regarding this research project or your participation in the study you may contact Dr. Pam Bishop (Principal Investigator) at ███████████ ███████████ ……….. and Lorena Bonilla (field researcher) at ███████████ ……

If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Office of Research Ethics ███████████████

13. Publication

If the results of the study are published, your name will not be used. If you would like to receive a copy of any potential study results, please provide your name and contact number on a piece of paper separate from the Consent Form.

14. Written Consent

Please read, sign, scan and e-mail to Lorena Bonilla (██████) the Consent Form included at the end of this letter (page **4** of **4**) to indicate your agreement to participate in the study. When you arrive to [location of mission], Lorena will ask you to sign the Consent form again to keep a record with your original signature.

This letter is yours to keep for future reference.
If you have any questions, please do not hesitate to e-mail Lorena Bonilla ……………

<u>Consent Form</u>

Project Title: Nursing Clinical Decision-Making During an International Short-Term Medical Mission.

Field Researcher's Name: Lorena Bonilla. RN, BA, BSN, MN. Professor, School of Nursing, ██ ████████████████.

I have read the Letter of Information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

Participant's Name (please print):   _____

Participant's Signature: _____

Date: _____

Person Obtaining Informed Consent (please print):   _____

Signature: _____

Date: _____

Appendix E: Semi-Structured Interview During the Mission Protocol

Project Title: Nursing Clinical Decision-Making During an International Short-Term Medical Mission.

Field Researcher: Lorena Bonilla, RN, BA, MN. Professor, School of Nursing, ███████
██
██████████████████████

<u>Semi-Structured Interview During the Mission Protocol</u>

I want to thank you again for your time and consent to participate. The goal of this study is to generate insight regarding nursing clinical judgment and contextual factors that affect clinical decision-making and the ability to provide ethical and competent care during a short-term medical mission in a third world country. Research about nursing practice during medical missions in underdeveloped countries is limited. The available literature clearly identifies the occurrence of moral distress among health care workers, which include nurses, about ethical issues regarding the medical care provided. Most of the studies about medical missions take place 6 months to five years after the mission, so we have a wonderful opportunity to talk about your nursing experience during and after the mission. I would like to hear about any difficult situations you have encountered in the mission, and how you responded to challenges. I would also like to ask for your permission to audio tape this interview. Your responses, identifying information, and any names mentioned will be kept confidential and anonymous. If information from this study is published or presented in any manner, your name will not be used. You may also request that a particular story or information is not included in the study data. Your participation in this study is completely voluntary, and you may withdraw at any time. Please let me know about any questions you find too sensitive to answer, and I will gladly move on to the next question.

Please feel free to look over the consent form and ask any questions that you may have about the process. (Have Letter of Information and Consent forms available, Appendix B)

Length of Interview: 90 minutes.

Do you have any questions before we begin?

1. Is this your first short-term medical mission? Are you enjoying it? Can you briefly tell me what it involves and what is your role? How long have you nursed?
2. What motivated you to get involved in short-term medical missions?
3. Can you please tell me about any challenges you are experiencing while nursing in the mission?
4. Can you share with me any tensions or ethical dilemmas that you have encountered while nursing in the mission?

5. When you encounter a difficult situation, can you tell me what that feels like?
6. Can you tell me what type of factors you think affect your clinical decision-making in this setting?
7. Tell me about any tool(s) (organizational guidelines, ethical frameworks etc…) you are using in your clinical decision-making. Do they work for you and why?
8. How does nursing here differ from nursing at home? Where is home (Country)?
9. How do you evaluate the effectiveness of the nursing care you provide in the mission?
10. Do you think you had enough preparation to nurse in this medical mission? What do you think would have helped you to prepare better?
11. Is there anything else that you would like to add to our discussion today?

Thank you very much for your time. I really appreciate listening to your perspective regarding some of the challenges encountered while nursing during a medical mission in a third world country. I will end our interview by reminding you about the focus group, which will take place on _____, at _____. I will be reminding the nursing team about it closer to the date. About four to six weeks after the mission, I will contact you via skype (or phone, or an interview if the participant lives in/close to ███████████████) for a final 90 minutes interview. I have your contact information on file; can you please remind me again your e-mail address and skype account (or phone number)?

Appendix F: Semi-Structured Interview After the Mission Protocol (via skype or in person)

Project Title: Nursing Clinical Decision-Making During an International Short-Term Medical Mission.

Field Researcher: Lorena Bonilla, RN, BA, MN. Professor, School of Nursing, ███████
██
███████████████████████

<u>Semi-Structured Interview after the Mission Protocol (via skype)</u>

Thank you again for your time and participation in the study. Its purpose is to generate insight regarding nursing clinical judgment and contextual factors that affect clinical decision-making, and therefore the ability to provide ethical and competent nursing care during a short-term medical mission in a third world country. Research about nursing practice during medical missions in underdeveloped countries is limited. The available literature clearly identifies the occurrence of moral distress among health care workers, which include nurses, about ethical issues regarding the medical care provided. Most of the studies about medical mission take place 6 months to five years after the mission, so we have had a fantastic opportunity to talk about your nursing experiences during and after the mission, the two of us and with the nursing team. I would like to revisit with you any difficult situations you encountered in the mission, and how you responded to the challenges. I would also like to ask for your permission to audio tape this interview. Your responses, identifying information, and names mentioned will be kept confidential and anonymous. If information from this study is published or presented in any manner, your name will not be used. You may also request that a particular story or information is not included in the study data. Your participation in this study is completely voluntary, and you may withdraw at any time. Please let me know about any questions you find too sensitive to answer, and I will gladly move on to the next question.

Length of Interview: 90 minutes.

Do you have any questions before we begin?

1. Was this your first short-term medical mission? Will you volunteer again? How many years have you nursed?
2. Can you tell me what types of clinical decisions you made when you nursed in the mission?
3. Tell me about any factors you believe influenced your clinical decision-making process during the mission.
4. How did you make clinical nursing decisions? Did the process get easier or more challenging throughout the mission?
5. Tell me about a difficult situation and how you resolved it.
6. What do you think could have facilitated/assisted you in making decisions?

7. Was it helpful to share your thoughts about the mission with the other nurses during the focus group?
8. Can you tell me what helps you to make clinical decisions at home? Where is home?
9. Tell me what makes it difficult for you to make decisions at home.
10. Can you tell me how you feel about the nursing care you were able to provide in the mission vs. the care you are able to provide at home?
11. Tell me if there is anything you would recommend to nurses considering volunteering in short-term medical missions.
12. Can you tell me how nursing in the mission changed you as a nurse and your clinical decision-making in general?
13. Is there anything else you would like to add about your experience in the mission?

Thank you very much for your time and participation in the study. I really appreciate talking with you about your thoughts regarding some of the challenges you encountered while nursing during a medical mission in a third world country.

Appendix G: Ethics Protocols

The researcher obtained approval from Western University and the organization coordinating the mission following strict ethical guidelines to ensure the safety of participants and everyone involved in the study. The researcher followed the ICN Code of Ethics for Nurses (ICN, 2012), the standards of practice for Canadian nurses (CNA, 2015), and the mission organization's expectations for nurses. Constant reflection about the study and field experiences facilitated the researcher's awareness of values, assumptions, personal and professional biases that could affect data collection, analysis, and findings (Koch & Harrington, 1998).

All the data collected during the study, including transcripts, consent and various forms, were securely stored in a locked filing cabinet in the researcher's home. The data collection and analysis protected participant privacy and confidentiality through the use of pseudonyms. Whenever possible, names of people, places, and organizations were not stated, with exception of the country where the mission took place. Each participant received an information letter describing the project and ability to withdraw from the study at any time, prior to the start of the mission (Appendix C). The researcher obtained informed consent from the participants interested in the study (included in Appendix D) before the mission through email, and in person at the start of the mission in Nepal. The mission coordinator and the mission team, which included the study participants, were made aware of—and understood—the researcher's role prior to the start of the mission in Nepal. The renegotiation of consent in Nepal, and before doing the after-mission interviews ensured that participants felt free to withdraw from the study at any time, and did not feel manipulated or coerced about disclosing information (Miller & Bell, 2012). All the interviews took place in an environment perceived to be comfortable and safe by the participants. They were given information about the dissemination of data and research findings. The data

gathered by the researcher during the mission was kept locked in a suitcase. Electronic data were

encoded, and the researcher protected, stored, and locked equipment in a suitcase kept safe in the

researcher's room during the mission.

This investigation was conducted to partially fulfill the requirements for obtaining the

EdD in Education Leadership degree at Western University. The researcher covered all the

necessary expenses, and participants did not receive any form of compensation for their

participation in the study.

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