Asian Social Institute

Graduate School of Economics, Sociology
Pastoral Sociology, Social Work
Sociology Major in Pastoral Studies
Education (Specialization: Community Development / Transformational Leadership)
Social Services and Development
Ph.D. in Applied Cosmic Anthropology

"HINABING UGNAYAN":
NATURE OF CARING AMONG FILIPINO NURSES WORKING WITH CHILDREN

A DISSERTATION
Presented to the Faculty of
ASIAN SOCIAL INSTITUTE

In Partial Fulfillment
of the Requirements for the Degree
PhD IN APPLIED COSMIC ANTHROPOLOGY

Rudolf Cymorr Kirby P. Martinez
June, 2013

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APPROVAL SHEET

This dissertation entitled ***"Hinabing Ugnayan: Nature of Caring Among Filipino Nurses Working with Children,"*** prepared and submitted by **Mr. Rudolf Cymorr Kirby P. Martinez,** in partial fulfillment of the requirements for the degree **Doctor of Philosophy in Applied Cosmic Anthropology,** is hereby recommended for acceptance and approval for oral examination.

ERLINDA L. NATULLA, Ph.D.
Adviser

PANEL OF EXAMINERS

Approved and accepted during the oral examination held on April 03, 2013 with distinction.

PRISINIA C. ARCINUE, Ph.D.
Chairperson

MINA M. RAMIREZ, Ph.D.
Member

ELSA H. RUIZ, Ph.D.
Member

SUSANA R. REYES, Ph.D.
Member

PROF. FELIPE DE LEON
Member

Accepted and approved as partial fulfillment of the requirements for the degree Doctor of Philosophy in Applied Cosmic Anthropology.

MINA M. RAMIREZ, Ph.D.
President

PRISINIA C. ARCINUE, Ph.D.
VP for Academe-Research
and Academic Dean

June 14, 2013
Date

ACKNOWLEDGEMENT

This research endeavor would fail to actualize without the help and guidance of those who have shared their lives with me in one way or another

To Dr. Natulla, my motherly adviser who journeyed with me till the completion of my research

To Professor De Leon, my mentor who opens my consciousness to the beauty of Filipino culture and inspired me to write about my Filipino caring

To Dr. Reyes, my supervisor in Kahingalay who encourages me to take the ACA program

To my panel members, Dr. Arcinue and Dr. Ruiz who dedicated their time and effort to constructively criticize my paper

To Mam Eve and Mam Amy, who were always there to answer my all my queries

To my ACA Professors, who have guided me all throughout my stay in ASI

To ASI family, my all embracing community who serves as my second home

To my ACA classmates, who share their experiences and have journeyed with me for 3 years

To my family, who have supported me all the way

To my co-researchers, colleagues and friends, who openly share their experiences with arms wide open

To FAPE, whose grant provided me with much needed resources

To the Creator, who always been there to guide me in all my endeavors

And to all those people who directly and indirectly help me fulfill this journey

From the bottom of my soul and being

I extend my deepest gratitude.

DECLARATION OF FUNDING

This research was partly funded by the
Fund for Assistance to Private Education (FAPE) Dissertation Grant Program

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CHAPTER I

The Problem and Its Setting

Introduction

"Can I ask you something?" Mark said as he browsed my Nursing Drug Handbook while I reviewed for my case presentation scheduled that afternoon, for a patient on a far flung ward from where I am now.

Mark was my first patient, the first that I have taken care of beyond the physical aspect. For him, I defied many of the unwritten rules of my clinical instructors, all for the sake of making him as comfortable as possible. I crossed the boundary of the sacred nurse-patient relationship, of maintaining a strict separation of my life and his. He was my patient, I was his student nurse. It was all that was supposed to be.

It was fate that brought us together, the same fate that works in its own mysterious ways of revealing things. He became more than a patient for me, he was my friend and I was his companion. Our lives became an intricate pattern of an elaborate embroidery, deeply intertwined with each other. Unknown even amongst his family, the fact that I unconditionally gave my blood when he needed it most,.

I was there during the most difficult moment of his hospital stay for his leukemia, even excusing myself from class just to be there when his IV was being inserted for chemotherapy. I became part of his family. They confided in me problems unrevealed by the Nursing Assessment, those that only a family member would understand and appreciate. I was given the rare opportunity to help him from inside out. I became part of his world and him part of mine.

"Of course, anything you like". I replied as I slowly brought down the notes that I was reading, gently looking down at him resting on my lap as I sit on his bed.

And as I looked at his young fragile body, I remembered how little by little, cancer and chemotherapy took its toll on him, how he told me one day that his hair was falling out, that he is losing his appetite that he is getting weaker. It was too much for a child to bear. It was even harder for me to watch this unfold right before my very eye knowing that my limited knowledge and experience cannot prevent this from happening.

"Is it painful to die?" He asked as he looked at me with his innocent eyes, seemingly probing for an honest answer.

"Why do you ask?" I responded as fear, anxiety, and shock spiraled down inside me, as if the moment I dreaded the most was becoming a reality. Deep down, I knew this was coming, but I blindly looked the other way, as if denial would do any good. I've read his chart, browsed through books and articles, I knew his time was coming to an end… I just wouldn't accept it.

"I overheard the doctors," he said as he turned his face away from me, gently adjusting it as he rested upon my lap. "They said I was not responding to the chemotherapy, that there was nothing more they could do… I have seen mama crying at night…"

Then there was a deafening silence.

"Maybe it's painful to die, but I don't care," he continued as I was left dumbstruck by his sheer honesty and his way of saying things in a matter-of-fact manner. "I was lonely before you came… I just don't care what the future will bring… all that

changed when you came… you were the brother that I never had… even if I am always in pain, you made it bearable…"

I was speechless, as if this was all a nightmare… wishing hard that I would wake up sooner than later. Denial best described how I was coping during this moment.

"Promise me one thing," he said as if knowing that I was still trapped into believing that everything was all but a dream.

I merely nodded as I tried with all my might that was left, to fight back the tears from flowing. I have to be strong for him, or at least appear to be one.

"Can you take care of other children like me when I am gone? I want them to experience having you as their kuya (brother)… I want them to be as lucky as I am," he said as he slowly gazed at me eye to eye, wanting to hear my sincere response.

"Don't talk like that, everything will be fine, you're going home this afternoon," I lied as I prepared my things for duty, making sure that our eyes never met. "I will always be there for all my patients especially you… See you later before you go."

Then, for no apparent reason, he suddenly embraced me… gently whispering "Thank you…I will never forget you".

This was all that I needed to hear. I was not as powerful as I would wish and think I could be in fighting back those tears. Silence was upon us as I embraced him back, pledging to myself, "I will make your wish come true whatever it takes, I promise".

A week later, Mark died…

Filipino society is generally known to be a caring community. This is believed whether it is among themselves or toward those whom they are not related to by affinity or nationality, Filipinos would generally offer themselves for others' betterment. It is not surprising therefore that within the Filipino parlance and dialects, there exist a multitude of words for care (i.e. *aruga, kalinga, malasakit, etc.)*. Caring is indeed embedded within the Filipino society and culture so much so that in every conscious and unconscious action they make is an extension of their culture of care. It is for these reasons that Filipinos are globally in demand especially in the field of health care particularly nursing.

Though the culture of care seems innate in the Filipino psyche, there seems to be a lack of interest in exploring the uniqueness of what is termed as "Filipino care". Nursing, a pillar of health care in the Philippines and a microcosm of Filipino society, appears to be struck in this apparent lack of interest that even within its basic education, theories of care and/or caring are nothing but foreign in origin. It seems that a greater magnitude is given to the propagation and study of western ideas of care than to discovering the breadth and depth of what Filipinos already possess. It is worth mentioning that though different worldviews exist with respect to care, it is culture that gives context to its appreciation. As such, Filipino nurses trying to grasp the concept of care by utilizing the western lens would have more or less a myopic appreciation of the phenomenon.

To be able to appreciate the uniqueness and intricacies of Filipino care and be able to contribute to the evolving knowledge of Filipino culture, this research was conceptualized. This study is to pursue the vision that it will instill interest in research in

the field of Filipino care and a deeper understanding of what Filipino care is utilizing from the lens of the nursing profession.

Statement of the Problem

This study explores the experiences of caring among Filipino nurses working with children in a selected hospital in Metro Manila and its implication to the Filipino healing tradition and worldview. Specifically, it seeks to answer the following questions:

1. How may the caring experiences among Filipino nurses working with children be reflexively described and explicated?
2. What meanings and insights maybe drawn from their experiences?
3. How may these meanings and insights be symbolically represented?
4. What implications to the Filipino culture of care and worldview may be derived from the essential insight of this study?

Significance of the Study

This research will have significance for the following:

Filipino Healers

Since this research appreciates care through the lens of the nursing profession, it thus instills a new knowledge base from which its practice can be further honed. Through this endeavor, nurses will have a deeper understanding of how they appreciate care as Flipinos and thus a sense of oneness and integrity with their culture. Moreover, this

research can further enlighten Filipino nurses of the uniqueness of their quality of care and help them to appreciate more their own Filipino culture. Though this research is focused on the context of the nursing profession, it can be said that it may have the same effect on our fellow Filipino healers, for the nursing profession is but a microcosm of the overall cultural context of the Filipino view on care.

Filipino Society

This endeavor aims to glean an understanding of how Filipinos appreciate care through the lens of nurses; thus it intends to bring forth a deeply profound understanding and appreciation of how Filipino society perceives care in a holistic, cosmic perspective. It further enriches Filipinos' appreciation of their own culture and their identity. With a profound sense of identity, Filipinos can be more active in nation development and become an active agent in developing our sense of nationhood. Gleaning an understanding of how Filipinos appreciate care through their own lens will enable them to build on their innate resourcefulness and cultural strength thus reinvigorating what it means to be a Filipino.

Researcher

This endevour serves as a two bladed sword for me. Firstly, it answers my personal queries as to what constitute the Filipino kind of care and as such bring our own culture of care to the foreground of my practice as a nurse who works with children. Secondly, and most importantly, it is my continued effort to fulfill my promise to the first patient that I have taken care of during my college years. For me, this paper then is both an academic pursuit and a personal journey.

Scope and Delimitation

This research limits itself to exploring the experiences of care among Filipino nurses working with children at a selected hospital within Metro Manila. Moreover only seven (7) co-researchers, were selected based on the following criteria, 1) They are willing and able to articulate, share, participate, and describe their lived experiences, and 2) They have been a practicing nurse working with children for at least two (2) years and are currently employed as such. This study limits itself to exploring the lives of nurses working with children and not the pediatric client of which they take care of; thus no data will be gathered from them. Also, the varied ways of gathering of the co-researchers' experiences and the process of reflective analysis will be concurrently done within the specified time limit of this study.

This research endeavor further acknowledges my inherent biases, even with the process of epoche, in the process of reflective analysis of my co-researcher's narratives. However, these biases will be minimized by the ongoing process of validation and counter validation with the co-researchers to try to maintain the authenticity of their stories as well as the result of the subsequent reflections.

Lastly, as the results of individual phenomenological researches cannot be immediately generalizable, the validity of the results of this study limits itself to its context where it is done such that the truthfulness of the result can only be ascertained among the co-researchers themselves. Following the principle that understanding in an interpretative phenomenology is a co-constructed reality between me and my co-researchers, the "validity" of this research must be appreciated within our context and

realities. On the other hand, "transferability" of the insights derived from this endeavor can only be established when readers, within their own context, find resonance with the resulting insights. The main aim of this paper is to understand and appreciate the depth and richness of the phenomenon of caring by Filipino nurses, rather than its generalizability and breadth.

Ethical Consideration

After presenting the research proposal and subsequent approval of the panel, this paper had undergone an ethical review via the Beta Nu Delta Nursing Society Institutional Review Boards, a member of the US Department of Health and Human Services (HHS) (IORG #: IORG0006192 and OMB No. 0990-0279) and was subsequently given an approval. The Institutional Review Board ensures that the research maintains all ethical standards throughout the course of the research specially when dealing with human subjects.

Operational Definition of Terms

Nurses Working with Children (NWC) – A Filipino professional nurse employed at a pediatric institution for at least two (2) years

The Institution – A tertiary pediatric hospital located at the National Capital Region

Toxic – A phenomenon characterized by a perceived constraint both in time and space.

CHAPTER II

Review of Related Literatures and Studies

This chapter will include discussion on the nature of a phenomenological literature review, the review of related literature and the justification for the present study.

Literature Review in a Phenomenological Study

Husserl, the father of phenomenology, postulated that in order to appreciate a phenomenon as consciousness would appreciate it, one must be able to suspend preassumptions, so the primacy of listening and interaction and the search for the essence becomes the foreground of the researcher. It is also the same underpinning for the development of bracketing to become central to the phenomenological movement (Husserl, 1970).

Following the abovementioned tenets, some researchers (Carpenter, 1999) claim that the review of related literature must come *after* the process of reflection since an in depth review of literature would provide an avenue for biases to develop. It is worth noting therefore that following the phenomenological tradition of maintaining a neutral stance prior to the process of reflection, it would be rather counterintuitive and counterproductive to bury oneself deep into the review of related literature entangling oneself with presuppositions and foreknowledge, the thing with which one tries to shy away in the first place.

On the other hand, it is also my belief that a literature review is of paramount importance to provide a grounding for the present study as well as situate the gap which the research intends to fill. Therefore, this chapter does not explore the discussion about the theories and explanation of the phenomena under study, for focusing on these topics may affect my, as well as the reader's presuppositions, view and opinions thus impeding in the understanding and appreciation of the phenomena without biases and prejudice.

Thomas & Pollio (2002) further post it that in a phenomenological research, the sole intent of the literature review is to "to survey what is already known, and not yet known, about a phenomenon" thus this literature review only focuses on identifying the gap and providing a justification for venturing into this research endeavor. It does not mean however that an in-depth review studies will not be done, instead it will be undertaken *after* the process of reflection has been attained and will be a significant part (Reflective Resonance) of the process I developed (see Figure 1). With these, only foreign literatures and studies are presented in this section while local literatures that contextualized the resulting reflective insights will be presented in Chapter 4. This middle ground, of providing a literature review to situate the study and doing an in depth review of researches after the process of reflection to provide a context of the resulting insights, satisfied both the philosophical underpinnings of phenomenology as an approach and the rigor of a scientific research endeavor.

Conceptual Considerations on Caring

"To be human is to be caring"

- Boykin as cited by Matsuoka (2007)

Caring, the act of giving care, is seen throught history as an essential part of being human and of humanity. It is considered as a universal phenomenon that cuts across many disciplines by virtue of their disciple's humanity (Cohens, 1991; Heidegger as cited by Matsuoka, 2007; Watson 2009). Care is seen as the ultimate "source of the will" so much that it has been considered as the essentiality of human existence such that when persons becomes "uncaring" they lose their sense of self (Matsuoka, 2007). Caring therefore is appreciated as humanity's essential soul for its survival (Lenniger as cited by Cohen, 1991). Within this context, it is not surprising that caring has always been described through a humanistic perspective rather than viewed through a medical lens.

The concept of caring, though it cuts across varied disciplines, has always maintained its importance in the field of nursing. It is the focus on caring's relationship to health and healing that differentiates and in a way defines nursing from the other professions (Watson and Smith, 2001). It is not surprising to note that authors such as Cheung (1998), Cohens (1991) and Watson(2009) and many others agree that caring is "knowledge based" in the nursing profession it serving to situate and define our profession. Cheung (1998) eloquently puts it that "caring is the ontological and epistemological foundation of nursing". Caring then is the essence of the nursing profession.

Though caring is unanimously considered as the essential tenet of the nursing profession, it has not been fully and exhaustively explicated as a single concept or phenomenon and still there has been no single definition of care that has been accepted both by practitioners and academicians alike. This maybe due to the ever evolving nature of caring such that conceptual definitions seems to be always anchored on the sociophilosophical landscape where it is defined as well as on the theoretical framework where it rests. It is good to note however that the theorist who attempts at conceptualizing caring is to a greater extend biased by his/her own presuppositions. Leininger (1988), being trained in the field of anthropology, sees caring in a cultural context while Watson (1988), influenced by humanist and phenomenologist, appreciates as belonging to the spiritual domain. It can be said that a universal definition of care, which most theorist and academician aim to achieve, is of less importance when it is the "working" or operational definition is what the practitioners utilized in their delivery of care since practitioners agree with Finfgeld-Connett (2006) when he argues that caring is always context-specific. This disconcord on the theoretical and practical definition of caring is a glaring phenomenon in health care setting.

It seems that caring then can be more appreciated if one would accept it not as a single concept but an interlocking complexe of concepts. Since every theory that tries to explicate caring is seen as a lens of understanding, focusing on a single perspective seems antithetical. It is more prudent to accept the different vantage points of appreciation of caring as part of a multitude of realities, a snipet of truth rather than a universal one.

Since a micro definition and appreciation of caring is always contained within the boundaries of the context where it occurs, researches tend to focus their topic on a single phenomenon where care is present as seen through the lens of a certain group of people. Within the domain of health science, literatures in nursing abound with researches exploring care presented in the following section.

Review of Related Studies

Because care is the central philosophy of nursing, there are specific researches which explore the meaning of care in nursing practice such as those of Forrest (1989) and Weiskopf (2005) which focus on the general nurses and prison nurses and that of Chipman (1991) and Beck (1992) which takes the perspective of nursing students.

An understanding of the meaning and experience of care has also been studied by numerous researchers employing different lenses as its entrance to reality. Kim (1998) utilized a qualitative approach to have a general understanding of care among nurses while others like Cheung (1998), Berterö (1999), Liu (2004), Wilkin & Slevin, (2004), Berg et al (2006), Gustafsson et al (2009) specifically utilized phenomenology to gain an understanding of nurses' appreciation of care. On the other hand, there are those who employed content analysis (Boggatz & Dassen, 2006) and grounded theory approach like Chiovitti (2006) and Finfgeld-Connett (2008). Another facet by which an understanding care has been explored is through the lens of the patient per se like that of Smith et al (2004) who focus on stroke survivors and Liu et al (2006) focusing on cancer patients.

There are others who explore the understanding of care through the lens of the family members like Kellet et al (1999) and Whitney et al (2005).

In addition to the above mentioned exploration on the understanding of care, there are researches which focus on the exploration of care within a specific phenomenon like caring for children with special needs (Beck, 1992), with schizophrenia (Tuck et al, 1997) and those on mechanical ventilators (Mah, 2008). At the other end of the spectrum are researches, which focus on caring for the elderly (Fagerberg et al, 2001 and Gates, 2000) specifically those with dementia (Pollit et al 1991) or those residing with their carers (Lewis et al 1995).

On the other hand, care was also explored through researches which focus on a specific diseases condition affecting the body like caring for those dependent on technology (Ray, 1998), with Multiple Sclerosis (Cheung & Hocking, 2004), with cancer (Mohan et al, 2005), and those with ulcers (Lindahl et al, 2008). Furthermore, there are studies on care which focus on caring for those who are inflicted with psychiatric disorders like those of Pejlert et al (2000) and Hellzen et al (2004) which takes the perspective of nurses. McGilloway et al (1997), Lou & Dai (2002), Vellone et al (2002), and McCann et al (2011) utilizing the perspective of the non-medical carers in taking care of those with mental disorder, delirium, Alzheimer and psychosis respectively to explore the meaning and experience of care.

Researches on care do not only lie within the boundaries of the living but also dwells around the dying process. There are studies which explore the meaning of caring for a dying patient in the eyes of the nursing student and that of the family (Beck, 1997

and Perreault, 2004) while others focus on caring for a dying cancer patient both from the perspective of the nurses (Rittman et al, 1997 and Iranmenesh et al, 2010) and that of the family (Mok et al, 2003). Meanwhile some researches focus on the experience of nurses caring for the dying in a specific locale like the hospital (Hopkinson et al, 2003), the ICU (Yang & McIlfatrick, 2001), hospice (Byrne & McMurray, 1997) and the home setting (Iranmanesh et al, 2009).

Justification for the Study

After an exhaustive literature search on the topic of care and caring, I found out that there was no studies yet on exploring the experiences and meaning of care among Filipino pediatric nurses utilizing both phenomenology and ethnography as the approach. Though there are studies which explores care utilizing the lens of nurses, patients and their families, none was focused on appreciating care from a Filipino nurses' perspective. In addition, the nurses involved in the said studies were not pediatrics thus the uniqueness of their appreciation is left unexplored.

Moreover, though care was explored in the studies reviewed above, the context from which these studies were framed upon were mostly European in origin thus the perspective of Filipinos was not explored. Further, most studies focused their attention on the exploration of care among elderly patients and only three focused on care among children.

Finally, though most studies utilized a qualitative approach, mostly phenomenology, none utilized ethnography as an approach to glean a holistic and culturally sensitive appreciation of the caring context.

As supported by the above reasons, there exists a gap in the literature exploring the experiences and meanings of care through the lens of Filipino pediatric nurses utilizing both phenomenology and ethnography as approaches. As such, there is a need for this research endeavor to be undertaken to fill up the above mentioned gap in literature.

CHAPTER III

Methodology

In this chapter, I discuss the research approach that was utilized in the study, the selection of co-researchers, the ways and means on how their experiences were gathered as well as the steps on how these experiences were reflectively analyzed.

The Research Approaches: Phenomenology and Ethnography

This research study was informed by the qualitative methodological approaches of both interpretative phenomenology and ethnography to glean an understanding and appreciation of the contextual experiences of care among Filipino Pediatric Nurses' (FPN). As such, it utilized interpretative phenomenology as the methodological and philosophical underpinning of the study while ethnography serves as another venue by which the phenomenon was appreciated. It can be noted therefore that interpretative phenomenology provides the research's in-depth analysis while ethnography embellished it with a description of the cultural context.

Phenomenology

Before it has become a science and a method, phenomenology was first a philosophical movement started by the German philosopher Husserl (1859 – 1938) as another perspective contrary to the prevailing positivistic view during his time (*See*

appendix A for a brief history of phenomenology). More than an approach, phenomenology is deeply rooted in philosophy (Merleau-Ponty as cited by Speziale & Carpenter, 2007). exemplified by Spiegelberg when he describe phenomenology as

"*the name for a philosophical movement whose prime objective is the direct investigation and description of phenomena as consciously experienced without theories about their casual explanation and as free as possible from unexamined preconceptions and presupposition*" (cited by Speziale & Carpenter, 2007).

Ramirez (1967; 1983), the first social scientist in the Philippines who utilized phenomenology points out that at the core of its philosophy is the belief that the person is a being in the world, a subject more than an object, capable of both sight and insight. It emphasizes that person is always conscious, a meaning giver and a transcendental being. A phenomenon therefore is a shared reality between humans as the world is seen as a "system of relations and meanings" constituted by person himself/herself.

It is from this philosophy that phenomenology developed as a science whose prime intent is to describe and explore the meaning and essence of unconsolidated phenomena as lived experiences. (Finlay & Gough, 2003; Woodgate, 2006; Speziale & Carpenter, 2007; Taylor et al, 2007; Polit & Beck, 2008). As Spiezelberg puts it "it is a special kind of phenomenological interpretation, designed to unveil otherwise concealed meaning in the phenomena" (as cited by Speziale & Carpenter, 2007) by means of entering another's world to discover the practical wisdom, possibilities and understanding found there (Polit & Beck, 2008). Phenomenology specifically uses inductive method to depict a phenomenon as the individual experiences it rather than transforming it into

operationally defined behavior (Colaizzi as cited by Beck, 2004), thus bridging the gap between what is familiar in our worlds and what is unfamiliar (Gadamer as cited by Speziale & Carpenter, 2007). It can be said therefore that there can only be one source of "data" in a phenomenological study and those are the experiences of the co-researchers themselves taken as a fact and another facet of their reality.

Because of its nature as a philosophical movement, many forms of phenomenology have developed (Embree, 1997) but of its many forms, two distinct schools of thought have prevailed, the descriptive, developed by Husserl himself and interpretative phenomenology, proposed by his student Heiddeger. These two prominent schools of thought share almost the same philosophical underpinnings proposed by the founder Husserl himself, i.e. suspending of presuppositions or assumptions, primacy of listening and interaction and the search for the essence (Husserl, 1970), but have important distinctions from each other. While descriptive phenomenology focuses on the individual's consciousness (Husserl, 1970), interpretative phenomenology focuses on the context of consciousness (Campbell, 2001). As such, those who follow the descriptive school of thought must have a "transcendental subjectivity", a state of consciousness where the researchers own reality is abandoned, to be able to describe a phenomenon (Wojnar & Swanson, 2007). To be able to be in the said state, the process of bracketing, consciously stripping away prior knowledge and personal biases, must be instituted prior to the process of reflection (Tymieniecka, 2003, Giorgi, 1999). On the other hand, interpretative phenomenology ascertain that a person is not just a mere consciousness but a being capable of interpretation (Draucker, 1999). Moreover, they ascertain that

individual cannot appreciate the world devoid of its socio-political and cultural context and as such, the importance of the phenomenon's context became central to their philosophy (Campbell, 2001). Interpretative phenomenology post it that there exists an innate preunderstanding (understanding before us) in every person which enables the person to interpret the world around him/her and further believe that a reflection of this preunderstanding is needed in order to understand another person's world (Benner, 1994). Opposed to the idea of bracketing, interpretative phenomenologist affirms that a researcher cannot truthfully strip away his biases (preunderstanding) but rather can accept the fact and be aware of them, for his preunderstanding can be a lens by which the phenomenon can be appreciated (Gadamer, 1975). Moreover, opposed to the linear method of reduction in the descriptive paradigm, interpretative phenomenology asserts that the interpretative process is circular (Hermeutic circle; Heidegger 1962), moving back and forth between the whole and its part to attain a shared understanding, a fusion of both the researcher's frame of reference to that of the researched world (Benner, 1994).

Ethnography

Reimer as cited by Lapan et al (2011) defines ethnography as study of one particular group or phenomenon, documenting the practices and belief of those within the group from their own perspective. Simply put, it is the study of a particular group where culture, the "total pattern of human behavior and its products embodied in speech, action, and artifacts and dependent upon man's capacity for learning and transmitting knowledge to succeeding generations (Webster, 1993) is the main glue that holds the group together.

As Arnould (1998) puts it, ethnography aims to explain the ways their shared system of meanings, i.e. culture and its people co-construct each other as reflected by the behavior and experiences of each member.

Hammersley & Atkinson (1983) opinioned that ethnography can be utilized in three ways; to elicit a cultural knowledge, to holistically analyze a society and to understand social interaction and meaning making. Moreover, ethnography specifically seeks to explain both explicit and tacit aspects of the culture, where the former is an outside awareness and the latter the insiders awareness by utilizing multiple data collection methods such as interview, recordings, videotapes, observation and the like.

For the above reason, the hallmark of an ethnographic study is said to be fieldwork (Boyle, 1994; Mueke, 1994) where the researcher is immerses working with the people in their natural settings. It thus requires that the researcher has a prolonged direct contact within the co-researchers for a holistic appreciation of their world be understood, implying that the researcher becomes part of the world he himself investigates. Altheide & Johnson (1998) further emphasized the importance of such when they claimed that aspect of a culture is “largely unarticulated contextual understanding that is often manifested in nods, silences, humour and naughty nuances”

In the end, the goal of an ethnographic study is to provide a written account describing the culture of a particular group through thick description allowing the voices of the co-researchers to be heard through their narratives. Comprehension therefore can be attained when there is a description of the relationship of the culture and its people

from an insider's perspective (Morse, 1994) where culture serves as the context from which the society revolves.

Combining Interpretative Phenomenology and Ethnography

Interpretative Phenomenology (IP) and Ethnography both came from the qualitative, interpretivist paradigm of research and as such, though they may term it differently, many underpinnings of both methodologies share the same essence.

Both methodologies place prime importance in the utilization of language as the vehicle of understanding and facilitator of many realities. In IP, an intense dialogue through the native language is the way by which understanding takes place. It is through language that meaning is co-created by both the researcher and the researched. It is through language that their horizons fuse to give an insight of the phenomenon. Ethnography shares the same value that IP places on language for in their perspective it is language that serves as the medium by which the emic perspective is gleaned upon. Both believe that language is culturally bound and socially created. It is through language that culture and consciousness are transmitted.

IP and Ethnography both place prime importance of the researcher in the study. IP emphasize the consciousness as the instrument of the study; ethnography emphasizes the interpretation of "data" from the point of view of the subjects of the study and within their cultural context. Both value the researcher's involvement in the lives of the co-researchers. In phenomenology, it is the researcher who does the process of reflection to arrive at the insight, in ethnography it is the researcher who does the emic/etic analysis to

build an explanation of the society's culture. Both then place prime importance in the subjective reality as a source of truth and wisdom. IP tries to co-create meanings based from the realities of the co-researchers, ethnography aims to ultimately seek the emic (insider) perspective of the cultural reality.

Both seek an understanding of a phenomenon through the participant's narratives, where IP focuses on shared meanings of the co-researchers consciousness and ethnography on the cultural context of it. Ethnography looks for patterns, phenomenology seeks for themes, the former is the head of a coin, the latter its tail.

IP seeks to understand a phenomenon by uniting the world of the researcher and the researched, by fusing two horizons through constant dialogue. As such, the researcher is an active participant in co-recreating the experiential meanings of the lives of the researched, permanently dissolving the emic and etic boundaries.

Though both possess subtle differences in their methodologies, it can be observed that taken individually, each has its own limitation but taken in combination, these limitations leads to possibilities. What IP lacks, ethnography possess and vice versa. IP provide the meanings of the co-researchers' co-created consciousness while ethnography endow the context by which these meanings are created, through an analysis of their culture. IP seeks to understand the co-researchers experiential insight, ethnography seeks to understand the cultural knowledge of the co-researchers. It is through the understanding of how the consciousness and culture interacts that provide meaning and a holistic appreciation of the phenomenon is attained. In the end, the insight of the

phenomenon can only be obtained once the researcher becomes the voice of the researched.

Selection of Co-Researchers

This study purposively selected the seven (7) co-researchers that participated in this endevour via preset criteria. The co-researchers were purposively selected by "carefully handpicking of participants that will most likely benefit from the study" (Munhall, 2007).

Polit and Beck (2008) emphasized that in selecting participants in a phenomenological research, they should have experienced the phenomenon under study and be able to articulate what it is like to have lived that experience since it is only through an intense dialogue that a thick and rich narrative could be gathered. The following criteria were then set in the selection of the co-researchers in this study: 1) They are willing to articulate, share, participate, and describe their lived experiences, And 2) They have been practicing pediatric nursing for at least two (2) years and are currently employed as such.

All of the seven (7) co-researchers work as bedside nurses in the Institution, rendering direct patient care to children with varied illness. They are all my personal colleagues and friends since I have worked with them in one way or another. The identities of my co-researchers were withheld by utilizing colors as their pseudonames to uphold both confidentiality and their anonymity.

The table below shows an overview of the co-researchers profile

Table 1

The Co-Researchers' Profile

Co-Researchers	Age	Years of Practice	Areas of Exposure
Moss	29	6 Years	Non-Communicable, Pay, ICU, Newborn, Neurology
Yellow	31	3-4 Years	Communicable, Pay, Hematology-Oncology, ICU & Subspecialty
Blue	25	2-3 Years	Subspecialty, Communicable, Pay, Hematology-Oncology
Purple	31	2-3 Years	Communicable, Non-Communicable, Hematology-Oncology, OPD, Surgery
Gray	23	2-3 Years	Hematology-Oncology, Non-Communicable, ICU
Green	24	2-3 Years	Hematology-Oncology, OPD, ICU
Red	25	2-3 Years	Pay, Neurology, ICU

Ways of Gathering the Experiences

The lived experiences was gathered by multiple means and they are as follows: 1) Interview (Pakikipag-usap), 2) Storytelling (Pakikipagkwentuhan), 3) Participant Observation (Pakikipamuhay), 4) Art (Sining) 5) Group Discussion (Pakikipagkaintindihan) 6) Immersion (Pakikiisa) and 7) Reflective Resonance

(Pagpapakahulugan). Moreover, my personal experience as a practicing pediatric nurse further enriched the gathering of lived experiences.

1. Interviews were done informally to avoid unnecessary stress between the co-researchers and were done outside their line of duty at a time convenient for them. Furthermore, it utilized open-ended questions with the co-researchers and together with storytelling served as the preliminary and primary way of sharing their lived experiences. These interviews also served as the way to gain an entrance to the co-researcher's world and gain full access to their experiences as lived (Wood & Haber, 2003; Todres & Holloway, 2006; Munhall, 2007; Speziale & Carpenter, 2007; Taylor et al, 2007; Polit & Beck, 2008). As Wood & Haber (2003) puts it, the phenomenological method is a process of learning and constructing the human experience through intense dialogue with the person living the experience. These interviews and their subsequent narratives will be recorded via a digital tape recorder, transcribed verbatim and later reflectively explicated for their emerging themes and subsequent essence. I also made use of the respondents' profiles and an interview protocol as personal guide for the interview.

The respondents' profile ensured that the co-researchers within the two discussed criteria. The interview guide, on the other hand, was actually never utilized at any interview proper. It has to be noted that an in-depth interview, involves an unstructured, flowing conversation with the co-researchers (Finlay & Gough, 2003; Henn et al, 2006).

2. Storytelling, as differentiated from the interview, on the other hand, was done by letting the co-researchers narrate their stories without so much my interruption, which not only served as a method of gathering of lived experiences. It also served as a healing session for the co-researchers as this provides an opportunity for them to learn more about themselves as well as their experiences (Braud, 1998). Moreover, based on my experience as a practicing pediatric nurse, nurses generally communicate their feelings through story, thus storytelling helps in affirming, validating and supporting the common elements as well as what is different with regard to the experiences of the co-researchers.
3. Participant observation, a technique to collect primary data both in the tradition of Interpretative Phenomenology and ethnography, meanwhile, was utilized to supplement and further deepen the experiences of the co-researchers. It is a purposeful, systematic and selective way of observing the interaction of the co-researchers with other people in their natural setting. This was utilized from the beginning till the end of experience gathering and was realized by the researcher when observing the rituals, language and interaction of the co-researchers as they performed their role as care-givers.

Furthermore, in order to provide more meaning to the lived experiences of the co-researchers, as well as to the study, my personal experiences and observations was used to provide more depth, validate and counter validate as well as identify what resonates with the co-researchers' experiences.

4. Art, specifically drawing and photography, were utilized as means of providing depth and breadth to the co-researchers experiences as art is a non-threatening way to visually communicate anything that is too painful to say verbally. Moreover, Nadera (1996) emphasized that art is the most beautiful, impressive, and widely effective mode of saying things, as it gives a uniquely elevated mode of saying what one thinks or feels about the surrounding, oneself and the relation of the two. Drawings and photographs represent for the co-researchers things that are either too painful to verbalize or to too complex to describe. It is then another avenue for which the inner world of the co-researchers will be made known to to me.
5. Group discussion was facilitated around the resulting meanings, themes and insights from the study, and was utilized as a form of final validation and counter validation of the co-researchers experiences. During the group discussion, the co-researchers were presented with the themes and insight to ascertain that the resulting themes and insights reflectively resonated with their experiences. This process ensured that what I reflectively explicated resonated with the co-researchers' lived experiences. Moreover, it further complimented and further deepened the meanings in the narratives of the co-researchers by allowing them to listen, share and interact with each other. It was noted that during the group discussion, all of my co-researchers agreed and felt that the themes and insights indeed were a reflection of their lived experiences.

6. Immersion, coming from the tradition of ethnography, was utilized during the whole process of gathering of the co-researchers' lived experience as well as during the process of reflective analysis. Itwas through immersion that contextual insights were attained and a reflection grounded in the cultural ambiance of the co-researchers was done. Since I have been a practicing pediatric nurse working with the co-researchers and have become their close personal friend, the process of immersion was a natural part of gathering their experiences.
7. Reflective resonance was the process of finding echoes of the resulting insights from what was known through the literature studies. This process was done after the reflective analysis have been exhausted since the literature can be both a source of biases and a lens that adds another layer of understanding of the resulting themes. Reflective resonance provided another avenue by which an understanding of the phenomenon gathered was attained. This process, however, neither affirmed nor negated the insights formed from the process of reflection. Rather, it gave the context from which they could be appreciated holistically.

Process of Reflective Analysis of the Experiences

Narratives from the tape recorded interviews were transcribed verbatim on a computer which were then reflectively explicated using an approach I specifically developed (*Figure 1*), inspired by the methodology proposed by Max van Manen and Colaizzi.

Max van Manen's method on how to go about phenomenological research involving six key steps which are as follows: "First, turning to the nature of the lived experiences. Second, investigating the experiences as it is lived rather than how it is conceptualized by the researcher. Third, is reflecting on the essential themes which characterize the phenomenon. Fourth, describing the phenomenon through the art of writing and rewriting. Fifth, maintaining a strong and oriented relation to the phenomenon and last (sixth) is balancing the research context by considering the parts and the whole" (lifted form Taylor et al, 2007). Specifically, the approach proposed by van Manen served as the way to uncover the thematic aspect of the experience. Furthermore, his approach combines characteristics of descriptive and interpretative phenomenology in which the researcher try to grasp and understand the essential meaning or essence of experiences being studied. In gaining the essence and supporting themes, he stresses the importance of becoming immersed in the data by repeatedly listening to the taped interview at least three (3) times (after the interview, after transcription and sometime later on) to gain further perspectives as well as continually reviewing the transcribed interview for significant statements in an attempt to find meaning and understanding through themes. He further believed that the thematic aspect of experiences can be uncovered or isolated from the co-researcher's description of experience by three methods. First, was the holistic approach in which the researcher listened to the recorded tapes or view the transcript as a whole and tried to capture its meaning. The second method, the selective or highlighting approach, involved the researcher selecting, highlighting and pulling out statements, or phrases that was essential

to the phenomena under investigation standing out as themes. The last method, the detailed approach involved the researcher analyzing every significant statement. Once the themes were identified, they became the object of reflection and interpretation and further synthesize until the main essence or the narrative description of the phenomenon is developed. The end result therefore is the development of a narrative description of the essence of the nature of caring among nurses working with children. “data” analysis therefore, occur concurrently with “data” collection. After the themes and the main essence were synthesized and deduced, the researcher returned to the co-researchers for inter subjective confirmation of the essence and themes’ validity (Huberman & Mile, 2002; Finlay & Gough, 2003; Finlay & Ballinger, 2006; Henn et al, 2006; Todres & Holloway, 2006; Woodgate, 2006; Munhall, 2007; Speziale & Carpenter, 2007; Taylor et al, 2007; Polit & Beck, 2008).

On the other hand, the approach proposed by Colaizzi(1978) involves the following steps:

(1) The first task of the researcher is to read the participants narratives, to acquire a feeling for their ideas in order to understand them fully.

(2) The next step “extracting significant statements”, requires the researcher to identify key words and sentences relating to the phenomenon under study.

(3) The researcher then attempts to formulate meanings for each of these significant statements.

(4) This process is repeated across participants' stories and recurrent meaningful themes are clustered. These may be validated by returning to the informants to check interpretation.

(5) After this the researcher should be able to integrate the resulting themes into a rich description of the phenomenon under study.

(6) The next step is to reduce these themes to an essential structure that offers an explanation of the behaviour.

(7) Finally, the researcher may return to the participants to conduct further interviews or elicit their opinions on the analysis in order to cross check interpretation.

Conversely, the approach I developed (Figure 1), describes and summarizes how the experiences were reflectively explicated in this study. Specifically, it showed the process of reflective analysis of the experiences, together with its concurrent level of reflection, essential steps, ways of enriching the experiences and their outcomes.

The yellow shaded boxes showed the level of reflections that was utilized in this study, opposite of which, blue shaded boxes, being the essential steps in the reflective analysis related with each level. In addition to that, the pink shaded boxes represent the ways on how the experiences were enriched, validated and counter-validated, by the co-researchers' experiences. The green shaded boxes represent the outcomes of each essential steps as well as each level of reflections.

The following are the essential step in the reflective analysis of the co-researchers' experiences

1. Interviews and stories of the co-researchers served as the primary way of gathering the experiences afterwhich they were encoded verbatim. This represented the first essential steps termed as the "gathering of experiences". Thereafter, the encoded interviews and stories was given back to the individual co-researchers to validate their content via a reinterview which then resulted in the *narrative*, a validated account of the individual co-researchers' experiences and will be thus considered as the "raw data". The interviews were done outside the hospital premises, in a place comfortable for the co-researchers at a time most convenient to them. It lasted for 1 – 2 hours per interview session and was tape-recorded with their consent. To maintaining strict ethical standards, the verbatim accounts of the co-researchers will only be made available to me for the process of reflective analysis and to the panel members for academic purposes only during the final presentation. This verbatim account will not be included in the final manuscript since it is considered as raw data and to ascertain the anonymity of my co-researchers.
2. After the reinterview, I then identified the essential meanings found in these experiences via identifying their thought markers. This step, known as the first reflection: *thematic representation* was further enriched by my personal experiences as well as my observation of the co-researchers during the period of immersion and of gathering of the experiences. As a result of this first reflection, subsequent enrichment through observation and personal experiences, and further validation and counter validation of the co-

researchers, the enhanced and validated *thought element* of the experiences was produced.

3. Next, after the meaning units of the combined experiences were reflectively explicated, I then reflected on these thought elements to give birth to themes, representing the second level of reflection, the *thematic interlace*, which was further enriched by incorporating the meanings of significant artworks (drawing) of the co-researchers as well as their dreams. In addition to that, significant rituals, beliefs, language and interaction was gleaned upon to add an ethnographic dimension to the resulting themes. These enrichments further provided both breadth and depth to the experience of the co-researchers. The resulting themes were again validated and counter validated by the co-researchers which then resulting in the enriched and validated *themes*.
4. To embellish grounding to the significant insights gathered from the process of reflective analysis, reflective resonance was done by situating the resulting insights from literatures. This process, paralleling the related literature review done in a quantitative paradigm, will neither affirmed nor negated the insights formed from the reflection but merely added a lens by which the result could be appreciated, following the philosophical underpinning of a contextual understanding based on the tradition of interpretative phenomenology and ethnography.
5. The last step, the third reflection or the *thematic embodiment*, I then utilized the themes gathered through the second reflection and integrated these into an

exhaustive description of the phenomenon, which was finally validated and counter-validated by the co-researchers through a group discussion. This process of multiple and on-going validation and counter-validation throughout the process of reflective analysis ensured that the final outcome resonates the co-researchers' experiences as they were lived, producing the *eidetic insight* of the phenomena, the core narrative, visually embodied through its *symbolic representation.*

Since the process that I have developed place great emphasis on the primacy of my co-researchers experience as well as the appreciation that the process of understanding is a co-created reality among our realities, the process of validation and counter validation was done during the different levels of reflective analysis. This process of validation and counter validation was done by presenting the significant outcomes of each step in the process of reflective analysis to the co-researchers for resonance. It was only when they agreed that the outcomes were reflective of their lives and experiences will I continue the next level of reflective analysis. This continuous process of validation and counter validation ascertain that what I would be reflecting upon and be presenting in this study indeed mirrored their lived experiences as Filipino nurses working with children.

Maintaining Ethical Standards

This study upheld ethical standards throughout its process of inquiry. Respect for human dignity was maintained with the highest standard all throughout the study. This said standard has been reflected in this paper by the following methods.

1. Approval of the Internal Review Board of the Beta Nu Delta Nursing Society was solicited prior to beginning the inquiry

2. Informed consent secured from the prospective co-researchers after explaining the objectives of the study, the risks involved, the extent of their participation, assurance of the confidentiality of their identities and/or any identification that can be alluded to the co-researchers on the information that they provide. Voluntary withdrawal anytime along the conduct of the study may be done by the co-researchers without any question, explanation or repercussion was also explained together with the possibility that the research might be published in a local or international journal.

3. Anonymity of the co-researchers maintained by providing aliases instead of their true identity as well as making their narratives (raw data) available only to me and not including it in any part of the final manuscript.

4. Safe keeping of information in the form of notes, tape recorded interview, videos, etc facilitated by keeping it in a locked cabinet and holding the key to such by me alone.

5. Maintaining the integrity of the facts gathered by making accessible only to me.

6. Going back and forth to the co-researchers for the ongoing process of validation and counter validation and final approval of the content of the study and

7. Destroying by burning the hard data gathered through burning, a year after finishing the study

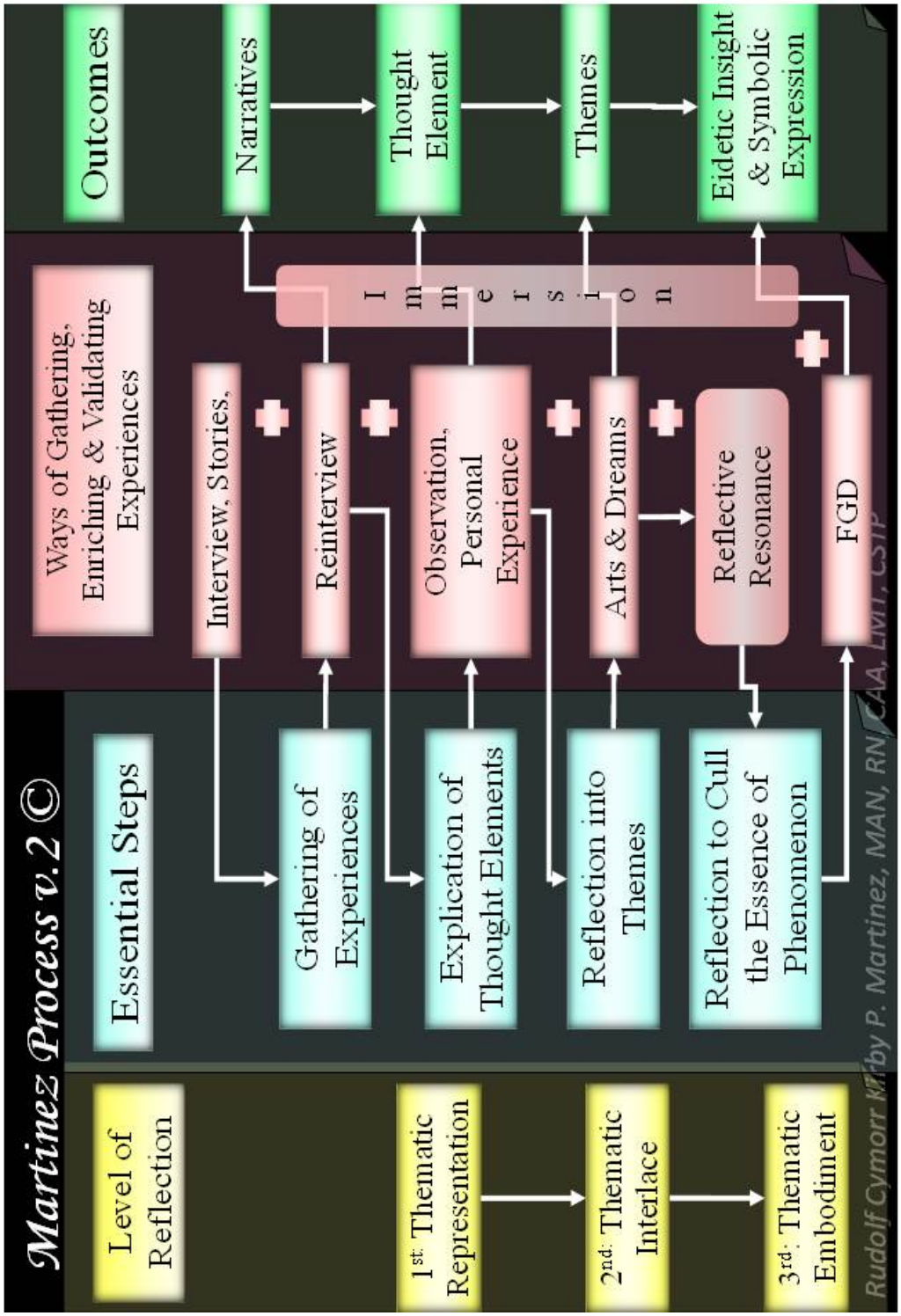

***Figure 1**: "The Process of Reflective Analysis"*
Showing the level of reflections of each essential steps with ways of enriching the experience and subsequent outcome

CHAPTER IV

Setting, Thematic Reflection and Eidetic Insight

In this chapter I describe the setting of the study, the resulting themes from the process of reflective analysis on the narratives of the co-researchers as well the discussion of the themes reflected and appreciated from the available literatures. It will also include my eidetic insight and my symbolic expression of this eidos.

Setting: The Institution

The study locale is a 200 bed capacity tertiary hospital specialized for pediatric clientele located within Metro Manila. It is a government owned and controlled institution under the Department of Health, which caters specifically to ill-children from 0-21 years of age. It is housed in a three storey building with an open space design and non-airconditioned wards for charity patients.

Moreover, the nursing department is composed of both nurses and midwives, which comprised the bulk of hospital personnel employed in the institution. Nurses are assigned to their respective wards based on the classification of the disease of the child; thus there are a specific set of patients that are catered to in a specific ward, i.e. hema ward (for blood disease) and cardio ward (for heart disease). In a sense, there is a "specialization" on each ward but because of the limited bed capacity for each "specialized" ward, some patients are "squatted" on other wards. Because of the limited bed capacity, specifically in the ICU, that patients with very complex needs and are

critically ill are a lot of times taken care of in an ordinary charity ward setting without the benefit of technologically advance machines for sustenance of life (i.e. mechanical ventilator) though provisions for emergency needs are found in each ward. Each ward is composed of a nurses station, a treatment room, a pantry and patient room which caters to 4 to 5 patients accompanied by a watcher at all times. The treatment room, on the other, serves multimodal functions such as the medication preparation room, IV therapy room, "close watch" room and symbolically the dying room.

In addition to that, each ward has a 20 to 30 bed capacity, manned by 2 to 3 nurses on an 8 to 12 hour duty shift. The nurses are rotated in the AM or PM shift on a bimonthly basis (every two weeks). The ward is led by a Head Nurse followed by a Charge Nurse with the Staff Nurse being the foot soldier of the ward. Though there is a theoretical delineation of responsibilities from the Head Nurse to the Staff Nurse, in practice, both do hands on nursing care to patient with the Head Nurses serving a lighter load than the Staff to focus on managerial task assigned to them. It can be said that although bedside care is the main responsibility of the nurse, proper ward management takes part of the time of each of the floor nurses.

While nurses are ward based, physicians are specialty based accordingly with their own hierarchical ladder, with the consultant at the top, followed by the fellow specialist then the residents at the bottom. The amount of time they spent with the patient is directly proportional to their place in the hierarchical ladder. The resident spends most of his/her time in the ward, but exerts the least autonomy to make decisions concerning patient care. Nurses, followed by the resident physicians, therefore, have the most

interaction both with the pediatric patient as well as their significant others (i.e. parents, watchers).

Though familiarization with the ward "culture" is a critical aspect of nursing, nurses are rotated from one ward to another in a 2 to 4 months cycle based on either explicit career ladder programs for nurses developed by physicians or on an implicit knee-jerk response to a presumed "issue" concerning the individual nurses. Promotion among the rank and file nurses are perceived by them to be based not on skills, expertise nor seniority but by affinity to the top officials, by "backers" or by adeptness and participation in some extra-curricular activity totally unrelated to their roles and responsibility as hospital nurses. This highly "toxic" and political world is the world of the pediatric nurses. The Institution, possessing the paradoxical existence of destruction (toxicity, death) and creation (health, healing) in a community reflects a microcosm of Filipino society and the very nature of the cosmos.

Themes: ***Alaga, Kalinga, Malasakit***

After the subsequent reflection from the verbatim interview narratives, the following major themes were identified. They represent the nature of care among pediatric nurses as these are lived through their work. These themes were constructed from the co-created reality of the co-researchers' lived experience and my personal historicality and was rigorously validated and counter validated by the co-researchers themselves. This fusion of horizon was in line with Gadamerian principle of understanding of reality.

The resulting themes from the process of reflection shows the different levels of care as they progress from the simply caring for the body to caring for the person and ultimately to caring for themselves through the person.

Alaga sa Pasyente: **Caring for the Body**

> "*diba si "M" dati, diba nung before siyang iOR anu, diba nakakausap mo, masakit nga lang ulo pero nakakausap mo… after nun (OR) wala, wala na… anu na lang, body na lang*" (Isn't it that you can talk to "M" before undergoing the operation, there is pain in the head but you can talk to him… after the operation, there's nothing, there, just a body)– Red

During the novitiate period, i. e. within the first six months, of hospital exposure, pediatric nurses would tend to see their patient as a complete stranger, as a fragile little child who needs their help. In their own understanding, the one in front of them is a patient, nothing more, nothing less. This was best exemplified when Gray described the patient as

> "*patient sila parang stranger*" (They are patient, like a stranger)

With this view, we tend to see ourselves as separate from our patient, us giving care, the patient receiving it. We tend to perceive ourselves as detached from our patient to fully identify ourselves as their nurse and them as our patient. The I (nurse) and the It (patient) are fully seen as such with this concept of care, where the patient is appreciated

more as a body needing care rather than as a person. This dimension of care is acknowledged by the nurses working with children (NWC) as the "job description" type of care, in which we merely function as what our job description dictates or as Blue would say

> "*sa patient (feel mo mas nurse ka) dahil bakit nga ba, nagcacare ka sa kanila, ginagawa mo yung trabaho mo as a nurse, trabaho ko sa kanila*"
> (You feel you're a nurse with patients because you care for them, you do your work as a nurse, my work for them)

This "job description" as understood by the NWC focused on keeping the patient alive symbolically by keeping the body in its optimal state since the tangible representation of a good nursing care is a breathing patient. With this appreciation, we thus tend to focus more on caring for the body rather than the person inside that body.

Though it is common among novice nurses, it is not uncommon to hear stories among the seasoned NWC on how they would tend to just "do their job" when they are *toxic*. In the context of the NWC's world, *toxic* is an interplay of both time and space, where there is little time to do everything and little space to fit one's "to do list". Thus a *toxic* duty is when there is little or no time for the nurse to sit nor eat his/her meal. The story shared by Red exemplified the word *toxic* when she shared the following incident.

> "*ambilis, angelus, nandun lang siya, wala normal, naglalakad, inadmit ko alas 9, ganito tas may lagnat... maya maya high grade fever, magsasalin ako ng blood, mayamaya wala ng BP! Wala siyang BP … septic shock daw yun e, promise, sa time na yun ang pinapasalin sa kanya, albumin, nagpupush ng voluven isang litro na, pinupush lang ha, hindi*

pinadridrip… epi drip, blood, merop(antibiotic) na hindi ipapaskin test, ipupush ko na lang, anu pa, dopa, lahat na lang, nakahook na… grabe piiiiinakatoxic" (It happen so fast Angelus (my name), she was just there, everything seemed normal, she was walking. I admitted her 9 o'clock then she got a fever, after sometimes the fever intensified then I have to transfuse blood, sometime later her BP was gone! She got no BP… they say it's septic shock, I tell you during that time they were transfusing albumin, giving a liter voluven via intravenous push, not the drip… then there's epinephrine drip, blood, antibiotics (without the skin testing) then dopamine and everything else… it was the most toxic duty!)

For us, the complexity of running the ward, where patient care is just a part of it, often leaves us no space, but to do our "job" as mandated by the hospital, just to finish the shift and keep every patient alive. There is a universal feeling among NWC that like other people, we also experience fatigue and stress such that Red would echo the voices of the co-researchers when she said,

"*naburn out ako dahil, sa work ba, minsan sa work, dun sa environment*"
(I got burned out because of work, sometimes because of work, sometimes because of the environment)

Given the momentous task and multitude of errands to accomplish, we must give way to other things. Given the fact that almost all nurses feel *toxic* once in a while, the *alaga* aspect of care is quite rampant inside the hospital and will definitely stay. Purple's photograph (*Fig.2*) symbolically represents how we experience toxicity.

***Figure 2**: "Toxicity" Showing the varied intravenous lines used in chemotheraphy*

A common *toxic* experience shared by all NWC is taking care of a terminally ill patient, may it be at the ward or at the intensive care unit. To take care of a dying patient is to carry out complicated physician's order coupled by the anxiety of what could happen to the patient and monitoring the child's condition every fifteen minutes as well keeping all the lines and paraphernalia hooked to the patient intact and functioning plus the fact that there are other patient assigned under your care. Green's experience on the ICU embodied the word *toxic* when she shared the following,

> *"One time nainis ako kasi yung patient ko sa ICU as in bagong diagnose na nga sya na lymphoma parang kahit ketorolac drip na siya although inalis yung midas na PRN for restlessness putcha intubated sya na may mga CTT, Foley Cath, lahat ng tubo andun sakanya yun umuubo (nahugot halos lahat)…"* (One time I got irritated because of my patient in the ICU, a newly diagnosed case of lymphoma who seemed oblivious to Ketorolac drip though his Midazolam PRN for reslesness was removed. He was intubated, got a CTT, Foley Cath, and every possible tube then he coughed (every tube almost dislodges)…)

This was but the minimum *toxicity* the NWC experienced when caring for a dying child that sometimes the experience would permeate even their dreams. Green's experience on taking care of ICU patient extendsed even in her sleep

> *"Oo naman te, parang sa ICU lagi akong nananaginip na recall ako pero, hindi, totoo parang parang akala mo yung nagduduty ka akala mo nagaano ka then magigising ka na lang in the middle of the night, hindi pala ayun, yung parang mapapaginipan mo na nasa work kapa yun yung mga panaginip ko inculcated naba ako nun ?"* (Yes, in the ICU I always dreamt that I was on recall to duty but really was not, you feel that as if you are on duty then you'll wake in the middle of the night, you'll dream that you on work, that was my dream, am I inculcated now?"

It is not uncommon therefore that NWC would tend to focus on keeping the patient alive as dictated by their jobs whenever faced with *toxicity*. NWC, during these times would tend to see the patient as a body sometimes devoid of consciousness, the thing that make us human. This view is apparent when Yellow shared her thoughts on ICU patients.

> *"pag nasa ICU ako ang tingin ko sa patient ko anu, mas less ang tingin ko sa… sa ward kasi parang more on attached pa ko eh, sa ICU parang hindi… I don't know why, siguro kasi may kulang, you don't communicate, hindi mo sila nakikita yung emotion nila, hindi mo alam kung nasasaktan sila,"*(when you are in the ICU, I appreciate the patient less… I seemed more attached to those in the ward than those in the ICU… I did not know why, maybe because there was sometime lacking, you did not communicate, you did not see their emotions, you did not know if they were hurting or not) – Yellow

Given the fact that the intensive care unit was always full of patients, it is quite common for NWC even in the ward to take care of a dying child. During these instances, wether the patient be an old patient or new one, NWC will instinctively contain themselves and in the process revert to *alaga* as a modality of caring.

> *"parang wala ng extrang extra care, basta, kunwari magbibigay lang ng gamut ganyan, ganun na lang"* (it seemed I did not give extra care, I just gave the medicine and that was it)- Blue

We would not anymore talk to the patient's relative even if we knew them beforehand nor interacted with the patient unless there were procedures to be done. We would only be there on a *pro re nata* (as needed) basis. There was a common understanding among NWC that one needed to refocus one's energy to keep the patient alive, thus communication, the basis for understanding others, ultimately suffers. Beside this, there is a notion that to place so much personal effort, beyond one's responsibility, to a dying child was a waste since it is hard to revert to caring for other children once the dying child ultimately crosses the boundaries as was reflected on Blue's experience when she shared the following,

> *"pag ganun kasi anu, hindi ako masyadong lumalapit (pag mamamtay na), parang iwas parang ganun, defense mechanism, para hindi ka masyadong masaktan if ever, although alam mo na na mawawala na din yun, para hindi na masyadong masakit… halos lahat din, (ganun) nagmemeds ka na lang"* (its like I did not go near them (when they are dying), I distanced myself, my defense mechanism so I would not get hurt if ever, although you knew that they would leave you… Everybody seemed to be that way, they just gave medicines)

Alaga, seen in this context, though it represents the lowest form of caring, ultimately serves it purpose of keeping both the dying child alive and the NWC's self intact as much as possible. Moreover, the *alaga* concept of care refers to caring that is resource bound. Whether the resources be physical or psychological, i.e. notion of *toxicity*, or emotional, i.e. caring for the dying child, in nature, caring will be affected by the presence or absence of these resources. *Alaga*, caring for the body, in this context is the lowest form of care NWC experience giving, not by choice, but by both circumstances and the natural desire for the NWC and patient to survive.

***Kalinga sa Tao*: Caring for the Person**

> *"kasi doble ying nararamdaman ng pedia nurse, nararamdaman mo yung pagiging ina ng nagbabatay at tsaka yung pasyenteng naghihirap"* (Pedia nurse felt two things; that of being a mother and that of a suffering child) - Red

Even though at times circumstances dictated that *alaga* is more than enough to fulfill one's work, NWC tended to shy away from this and instead find ways to know and really understand the patient. This is where *kalinga*, caring for the person¸ manifested itself as an innately human quality.

NWC knows that in order to care for the child as a person rather than as a body, we must first be one with the child's significant others. This emphasis on the importance

of the significant others, especially the parent, is one of the unique characteristic of NWC's experience and appreciation of care.

> *"pag bata siya (sasabihin mo), "ay kawawa yung pasyente, ay kawawa din yung watcher, kawawa yung parent" kunwari CP, kawawa yung pasyente, tapos maaawa ka sa watcher kasi parang panu nyo nabuhay to, ng ilang taon tapos ganyan, kawawa din siya pero pag adult, pake ko sa watcher"* (when you saw the child you would tell yourself "I pity the child but I also pity the parent". Just like in cerebral palsy, I felt for the patient then you would pity the watcher since they survived the disease for years but when it comes to adult patient, the hell I care about the watcher) - Red

At the hospital, the character of their significant other, especially their parents, largely dictated the interaction between the child and their nurse. If the parents were perceived to be domineering, impulsive and unappreciative, chances are nurses will just "do their job" and interact with the child minimally. Though it was innate among NWC to try to make sense of the patient's landscape and connect with the child's significant others, it is often the significant other's inability to open up that hindered their mutual understanding with the nurse.

> *"kasi pag sa mga bata, hindi ka mismo sa kanila, parang kasama rin yung anu watcher parang ganun"*- (when your caring for a child, you were not actually just focused on the child but on the watcher as well) Blue

NWC knew that no matter how much effort was exerted in trying to build up rapport with the child's significant others, it was his/her decision that would dictate if this

effort would be put to waste or not. Yellow's statement reflected how the interaction between her and the parent undeliberately affected the care she was giving to the child.

> *"so far naman malambot naman puso ko sa mga bata… (nadamay ang bata) kasi walang hiya yung watcher, ang feeling kasi nila ikaw yung nurse bigay mo sakin yung dapat"* (so far I had a soft heart for children… the child was indirectly affected because of the watcher's attitude since they felt the I were their nurse and must give to them what was due to them)

More often than not, it was sometimes the communication between NWC and the relatives that were considered more complicated and toxic than the actual care rendered to the child specially for "well to do" patients. In a sense, the child's significant others served as the bridge into their child's being so much so that if that bridge was kept closed, we could not fully understand the child's life. NWC was fully aware that the child's significant others were the key to properly communicate with the child since some children are not capable of articulating their feelings properly, thus in order to holistically understand a child, NWC must first be conscious of the significant other's perspective of things. The importance of rapport with the parent was best exemplified by Red's experience when she shared,

> *"nageestablish ka rin kasi ng rapport, kasi lalo na kung pedia, protective masyado yung nanay, pero kung nakuha mo na yung rapport, pwedeng hindi nila ipainsertan sa iba yun pero pag ikaw yung duty, papainsertan nila sayo, kasi may tiwala na sila sayo… parang ganun, may pagnakuha mo na yung rapport may trust silang mabibigay sayo"* (You established rapport especially in pedia since mothers tended to be protective but if you would get their rapport they would trust you enough

to let you insert (their intravenous line) if you were on duty because they trusted you… if you got their rapport, you'll get their trust as well)

There were a lot of times though that the child's parent do open up and shared even the very intimate details of their lives, we nurses should not even know about but they willingly oblige to tell. Things like their personal struggle, even their sex lives were shared although we did not ask. This was reflective of the innate trait among Filipinos to easily trust another person especially another Filipino. NWC knew that to tell a complete stranger those life stories entailed trust and when a parent did, it was considered as a great privilege. Red's story below very much reflected the seemingly "openness" of some parents.

"meron sa CNS din, sa CNS nga naalala ko, yung pilot sabi ko, yung pilot, babae, oo kasi sa Cebu sya, e bisaya siya dib a, di nagbisaya kami, kiwento nya lahat ng kanyang profession, lahat ng kanyang love affair, love affair ng husband nya, ang daming girls, basta kinuwento nya lahat, na hindi naman siya palakwento wala daw siayng friends, aloof daw siya eh, sa bahay… kinuwento nya lahat promise… pagkatapos daw nun kasi, ibrebreak nya yung bf nya… sabi nya nga maniwala kat hindi kakadating nya lang, seaman siya di ba (yung asawa), kakadating nya lang prang 3 months nga siyang nandito pero wala pa ring nangyayari sabi nya kasi ayaw na daw nya pero nung dib a minsan pag sila lang dalawa nagkakandungan sila"(There was this instance in the CNS ward, there was this pilot (parent) from Cebu who spoke Visayan like myself so she shared with me all of her previous professions, ber love affairs, her husband's love affairs and girls even if she claimed she feels aloof toward other people… she told me everything even the fact that though her seaman husband was around for 3 months, nothing had happened between the two of them because she didn't want to but sometimes I would see them on each others lap)

NWC felt that somehow he/she was welcome as part of the trusted circle of significant others of the child, that somehow we were not plain nurses, but part of their families and they would call us by our first names. Calling us by our name and not by the generic "nurse" made us feel appreciated.

> *"kasi pati sakin pag tinatawag pag yung pangalan ko na, nurse Blue, ate Blue ganun parang iba, parang iba yung dating sakin, parang may matotouch ka parang ganun"* – (for me, when they (patient) call my name "nurse Blue", "*ate* Blue" it felt different, you would be touched) Blue

It was at this moments like this that we transgress professional boundaries and would welcome the child and their family as friends, that a lot of times we even address their relative as "nay" or "tay". At this same instance, the child was not merely seen as a patient but as a person who needed care.

Reflective of this is the intimacy of calling the child with their first name only after gaining the significant other's confidence and the child's as well. In a way, calling the child by their first name made them more of a person and made you feel closer to them since you had exerted effort to know their first name.

> *"lalu na nung nasa hema na ko parang, kailangan mong malaman yung first name nila parang yun, makukuha mo yung attention nila, pati nung watcher na feeling nila close, close, feel ko ganun ah"* (especially when I rotated on hema (ward), you would need to know the patients first name so you could get their attention and let their watcher feel close to you, that's how I felt) - Blue

This intimate connection with the child's family was often seen in patients who have chronic conditions, such as cancer or kidney problem, who more often than not, treat the hospital as their second home. NWC, once in his/her career, would have a chance to take care of this special group of patients and more often than not it was from this group that they formed a special bond with. Because they saw the hospital as an extension of their home, it was not uncommon for them to treat the hospital staff, including nurses, as part of their family and caring for them is not confined within the four walls of the hospital, it was extended beyond the boundaries of professionalism. Green's experience of being "facebook friends" with one of her patients resonated with all the co-researchers.

> "*kasi kapag sa hema na kasi kapag pabalik balik sila na parang youll get to know their family then sa work nila basta lahat ng nature yung buhay nila makikita mo talaga kaya parang sa labas ng ospital parang friends kayo, magkafacebook oo magkafacebook*" (In hema (ward) the patients were regulars that you would get to know their family, their work and everything even the nature of their lives you would see that was why outside the hospital, my patients were my friends like in facebook)

Yellow would later add

> "*ethically its incorrect (na outside the hospital may connection pa din kayo)pero culturally acceptable, ang pinoy pa kaya nga tayo may mga extended family dyan eh di ba…*" (that's ethically incorrect (that even outside the hospital you'll have a connection) but culturally acceptable, since we Filipinos have extended families)

Though there is an unwritten rule that outside the hospital, our connection with our patient must stop, for some, it is quite next to impossible. Outside the hospital, the child and their parent are not our patients but our friends, textmates even facebook buddies. NWC has felt that it was through this that they could fully understand and came to know the child as a person more than just a patient or as Purple would say:

> *"hindi kasi pedeng pasyente lang yan e, halimbawa ako, long term patient ko yung mga yan eh, hema alam mo yan, matagalan yan, follow up, kabisado mo na nga yung mga pangalan ng mga yan eh kahit nakamask yan, first name basis pati apelyido… kasi kung ang tingin mo sa isang pasyente ay isang pasyente lang, pag labas mo ng ospital wala ka ng pakealam sa kanya, parang ginagawa mo lang na trabaho lang, walang personalan… kasi alam mo yun , magtratrabaho ka ng may puso"* (You could have treated them as your patient, for me, they have been my long term patients, you know that, their treatment was a long one with many follow-ups that you got to know their names even when they were wearing a mask, you knew them on a first name basis, surname included… because when you treated them as just your patient, when you would leave the hospital, you would not give a damn anymore since you were just doing your job, nothing personal… you know, you need to work with a heart)

We hospital nurses would inevitably handle a dying patient whether we like it or not. For some, they saw these times as opportunities to test the boundaries of their skills to keep the patient alive. The golden rule therefore is to do everything to "endorse" the patient to the incoming shift or in the word of Green,

> *"itatawid ko sya or something wala na parang as patient ko nalang sya".*(I would just let them survive or something and treat them as mere patients)

Because of this mentality, focus shifted from trying to understand the child to keeping him alive thus there is always a great tendency to forget that the child is a person. Though this circumstantial shifting of the element of care, from humanely *Kalinga* to plain *Alaga*, is sometimes inevitable, nurses find ways to try and bring back humanity into their care. Things like talking to the patient as if they are conscious during painful procedures or just plainly conversing with them, calling their names even without their response are but ways to let them remember that the child in front of them are not just bodies that demanded curing, but a person that needing care. The experience of Red showed exactly that when she shared,

> *"kinakausap ko siya e… kinakausap ko yung lahat ng tulog mga walang (malay) "magsusuction ako ha… o isa na lang… konti na lang" sabi ni lola "alam mo mam pag yung" kunwari duty ako ng umaga, yung volunteer/ RN heals kung sino sinong duty "yung duty nung gabi, nahirapan talagang magsuction, tinulungan ko pa yung ginanun ng bibig kasi daw kinakagat pero ngayon, buong araw wala, nganga lang siya ng nganga" ""A" (name), ay anu yun "N"(name), suction ako ah" nganga lang siya"* (I talked to them, I talked to my unconscious patient like "I'll suction your secretion one more time". The grandmother would say that others had a difficult time doing suctioning unlike me… I would tell her "N (name) I'll suction again" and she'll just open her mouth)

These toxicity that surrounded the care of a dying patient seemed to act as a vortex that consumed the humanity both of the child and the nurses.

There were times that the child would remind NWC of someone dear to us thus somehow, we were obliged to help and take care of them as if they were family but

consciously we shied away from the idea that the patient *is* a relative or someone dear to us.

> *"I don't see the patient as patient lang ganun… in between (a patient and family) in between siya…"* –Yellow

It has been seen that NWC tended to see the patient on the blurred line that separated a stranger from a family, that the patient simply *reminded* them of their loved ones but did not see them *as* their loved ones as is reflected in the statement of Purple below

> *"hindi ko sila nakikita as (anak ko), for example may pasyente ako o, ilang taon k a na iho, 9 years old, o 9 years old, 9 years old din yung anak ko parang nakikita mo na, sa 9 years old ganito nangyari na sa kanya to, alam mo yun na dapat nagaaral siya, na normal dapat yung ginagawa nya nakakapaglaro pero hindi nangyayari yun, parang ganun, narerelate pero hindi ko nakikita na sila yun"*(I don't see them as my children, for example when I had a patient, I asked them about their age. If they are 9 years old, like my child, I would reflect on the things that happened to him at an early age, that he/she must be studying and doing normal things like playing but you know that would not happen. You would relate them (to your children) but I did not see them as my children.

Figure 3: "*Pamilya*" Showing Purple's son (middle) with her patients

It seemed that caring was but an extension of us Filipinos being family centered and a naturally loving people, that we embraced easily, even

strangers. Purple's photograph (*Fig. 3)* shows how easily she would embrace her patient as part of her family. Moss emphasized this notion when she said that,

> *"sa kultura na din ng pilipino na ma-family oriented diba parang ewan ko yun yung sakin na nadadala ko dito yung pagka makakapamilya ko"* (it seems that it is within our culture as Filipinos to be family-oriented, I did not know but I felt that I brought those trait into my work here)

And Brown would later add that,

> *"feeling ko sa atin kasi mas nakikita nila yung sincerity kaya natin magcare sa isang tao na di natin kamaganak, yung ganun lang kadali… parang ang dali sa atin, maka, kahit hindi natin kamaganak, dib a minsan friend mo pa lang, minsan kakilala pa lang na kaibigan mo, "hoy tulungan mo yung ganun pasyente ko" ayan na agad, tinulungan mo na agad… ganun lang ganun kadali, ng hindi ka nageexpect ng kapalit, yun yung feeling ko naadvantage natin, na kakaiba sa atin, Filipino"*(I felt that among us, you would see more the sincerity that we can take care of other people as if they were our blood relatives and with relative ease… it seemed that we easily could do it even if they were not our relatives that if a friend or a friend's friend asked for your help you would do it that easily… and you never would expect anything in return; that, I felt was our advantage and a unique trait among us Filipinos)

Kalinga embodied the prime importance of relationality when giving or receiving care. It thus exemplified the notion that caring is an innately human faculty, that we care because we are not mere individual beings but are an interconnected people. When asked why she cared for her patient, Red shared the following,

> *"tao, sa tao lang, sa tao (kasi sila), kasi kahit hindi sya dahil pasyente, kunwari may nakita ka dun sa kalye, na nangangailangan din, parang*

nature mo na yung tumulong"(Because they are human, not only because they are patient... for example you saw someone along the street that would need your help, you felt it is in your nature to help)

Kalinga aspect of care emphasizes that caring is an innately human characteristic, we care because of our shared personhood. It places importance on communication, trust and confidence not only of the child but also of their significant persons in order for a care beyond the "job description" to take effect and this could only occur when we would appreciate the child as a person rather than as a mere patient.

Malasakit sa Kapwa: **Caring for Humanity**

"kasi sa atin tulad nyan yung trabaho natin magbigay ng gamut, di naman natin trabaho maghanap ng gamut para sa kanila, di natin trabaho na, minsan may experience ako dyan walang wala yung sa hema, walang wala yung nanay yung nagmomorphine, I think nahandle mo yan, remember sobrang diba, binigyan ko talaga yung nanay, I think 40 pesos lang ata yung morphine diba, binigyan ko talaga "mam bili ka ng gamot pero wag mo sasabihin na binigyan kita kasi bawal to" sabi ko , alam mo yun para lang maibsan yung pain ng bata" – (It's like it is our job to give medicine not scout for them for our patient, it is not our job; there are times that I handle patient who have nothing in hema (ward), the parent of the child who was on morphine had nothing, I think you had handled her, remember? I think a morphine would cost about 40 pesos, I gave the parent that amount and told them "mam buy the medicine but don't tell anybody since this is forbidden" just so the pain would subside) Yellow

Alaga and *Kalinga* are but the norms of care within the four walls of the hospital but there were times when we unconsciously transcend the norms as we cared for our

patient and in these moments we acted more than a professional nurse as we embody caring with innately human and divine traits.

For the NWC, to treat the patient as *more* than a patient is quite a normal sequel of trying to understand the patient and their significant other's appreciation of things. For us, you cannot fully understand where the patient and their significant others are coming from unless you forget that you are just their nurse and start accepting them as your friends and in the process inculcating to yourself that you are part of their family and them as an extension of yourself. Going beyond our "job" as a nurse as we share what we have and what we have not, are the key aspects of *Malasakit*. Yellow's statement reflect this idea when she said,

> *"ewan ko ba kung anung meron dyan sa hema, there something sa kanila, na parang ok lang akong magextend ng care (kahit di ko na trabaho), kasi parang parang you make a difference sa buhay nila alam mo yun, alam mong hanggang dyan na lang siya pero at least in a way in some point natotouch mo yung life nila, prolonged life… kumbaga kung 100 percernt binibigay ko sa iba, sa kanila 105…"* (I did not know what's in hema (ward) that I felt it was alright to extend my care (even if it was not my work). It seemed that you would make a difference in their lifes knowing that their life has an end, at least in a way, in some point I touched their life, I prolonged their life… if I give 100 percent (care) to others, I gave them my 105 percent)

NWC has a trait of maintaining an "emergency kit" in his/her secret place. This "emergency kit" had excess medications or supplies either from discharged patient or from one's own pocket. It is a trend that the more senior the nurse is, the more extensive his/her treasure box. This stash was build on the premise that they could be utilized

during “emergency” needs. Actually, they are voluntarily given to those “special” patients as circumstances often dictate and those special patients are those whom they saw as more than their patient but as part of their family. Often, these patients were those with a debilitating chronic disease like cancer whose treatment cost surpasses their financial means. This was evident in the experiences of Gray when she shared the following,

> *“sa locker ko marami akong stocks e, lalo na kapag gipit na gipit yng parents binibigay ko talaga yung mga stocks ko ganyan, meron din akong mga pinahiram pagnagbabayad hindi ko na pinagbabayad parang tulong ko na din ganun”* (in our locker there were many stocks, especially when the parents were in dire need, I do gave my personal stocks, there were even those that borrow money from me and when they settle for the payment, I usually would not accept it, it was my help for them)

Because NWC were always at the bedside, we tend to know the trivial details of the patients as well as their families’ sufferings. It was quite normal to see parents skipping meals just to buy medications for their child or crying for they have no means to buy such medications. This was where our magical box come in handy, providing them with small things to ease their burden such as free medication or medical supplies. When asked why they keep on stocking their stash, a resounding “someone might need it in the future” would often be heard. Though this phenomenon went against the very grain of hospital rules and regulation it seemed that the NWC have been acting more on their instinctual conscience to help others than what their professional duty calls them to do. This seemingly ethical dilemma was appreciated when Red shared the following,

"ang dami nating naviviolates sa ethic pero kung tutuusin pero pag nandito ka parang normal na lang na ginagawa natin… pero sa totoong buhay naviviolate na pala natin… sabihin natin "mam pano to, walang ganyan" "ay hindi meron pa ko"…"(there were many things in ethics that we violated but in reality when you would be here (in the hospital), its quite the normal thing to do… but in real life, we violate them unknowingly… when some (students) asked me "madam, the patient does not have this (medicine)" I would tell them "I have some")

Purple have this same dilemma when she shared the following experience

"Siyempre hindi (lang pagaalaga) alam mo yung nagmamalasakit ka, nagsisimpatsa ka… malasakit, for example, based on experience to ah, walang wala si patient naipahiram mo na lahat ng gamit pati gamut alam mo yun maiinis ka na dahil mommy pangatlong beses na to ah, magleleonase yung anak mo alam mo ganito alng yan, alam nyong for ganitong chemo ang anak nyo para kayong sasabak sa giyera ng wala kayong sandata, pinapagalitan ko talaga sila pero anu, may magagwa ka ba, wala, papahiramin mo nanaman, " (It was not merely caring, you know that you are compassionate towards them, for example based on my experience, this patient had nothing, you lent them everything, materials and all, even medications, sometimes you would get frustrated and you would tell the parent "mommy, this is the third time that your child will undergo Leonase (chemotherapy), you know that your child would need this medication, it was like you are going to war completely unarmed" I do scold them but in the end you could not do anything, you would lend them again)

Oftentimes, patients who are financially not well off would inevitably miss doses of their medications. During this time, if the "treasure box" would not give the answer, we tended to share supply and medications from the well off patients unconsciously becoming the moral arbiter of equality. Though we did it sparingly and knew that it is not a good practice, there was this mental justification that it was just to share the excess of

what we have to those who have nothing. This universal experience was eloquently told by Moss when she shared the following story

> *"Pag may sobra share mo na lang muna tsaka mo na iopen yung sa kanya para magkasya tsaka yung minsan nagpapabili tayo ng maraming syringe dun sa isa, give from the rich to the poor, parang ganun… pero dinidiscourage natin yun and alam ko rin naman sa sarili ko na ayaw kong gawin yun palagi pero pagkanakikita ko naman na talagang said na yung isa, di ko maiwasan na magshare, although hindi man yun straight na galling sa pocket natin, parang ganun"* (If there were excess (medication), share it to others so their stock will be enough, then sometimes we tell the one parent to buy many syringes then we give it from the rich (patient) to the poor (patients)… but we discourage this practice and you knew that you did not like doing it routinely but if you would see the parent of a patient on the brink of bankruptcy, I could not help but share although not straight from my pocket)

If there was nothing to share from our stash or other patient, we painstakingly would scout the whole hospital utilizing connections we had just to provide for the patient's medication as what Purple shared when she said

> *"manghihingi ka para lang wag mamiss yung dose, pero diba ginagawa mo yun dahil nagcacare ka talaga sa pasyente"* (You would beg (for medication) so you would not miss a dose; you would do that because you really care for your patient)

It was during this time that we began to realize that caring is not resource bound but rather resource sensitive, that resources are not limited but limitless if one has the will to create them. Caring in this context is humanity's way of sharing the cosmic abundance. *Pagkamadiskarte,* (resourcefulness) then is another aspect of *Malasakit.* This aspect of *Malasakit* was seen on the experience shared by Blue.

"Maparaan, sample, pausok, kelangan ng anu, o2 driven, improvised, may ganun kayo, yung sa tubing, o dib a o kelangan ng pausok, mamatay na… yung sa anu, sa chamber nya, dib a napakaresourceful naman, kung wlang o2 driven, yung o2 nipple, napakaresourceful, lalo na sa ISO, ang daming pausok" (resourcefulness, for example someone needed nebulization via oxygen driven, improvise using the tubing, the patient needs the nebulization else he'll die… we are so resourceful especially in the isolation ward where many would need nebulization)

Sometimes, it isn't enough to share other people's resources for if all else would fail, we would share from our own pocket. There were a lot of times that NWC personally bought the patient's medication or share food to the watcher who had nothing left but hope that their children would be cured as what Green and Red experienced when they took care of an "indigent" patient.

"yun yung isa na Dyos ko nakakapulubi, oo ano kaba alam mo yun e, bumibili ako ng gamot, si B (patient) binilhan ko ng gamot si E (patient), si G (patient) binibilhan ko ng gamot yun, ilang libo din yung Ciprofloxaxin IV yun, ilang libo din yun… binibilhan ko sila…napapabili ako ng gamot talagang just one time to live just want them to go home from the hospital alive" (that one thing that made me a pauper, you know it very well, you know that I bought medicines for my patients, patient B, E, G, I bought their medication; Ciprofloxacin IV cost thousands but I would buy them… I bought medicine for I just wanted them to live, to go home from the hospital alive)- Green

"Si O (patient), naabutan mo yun binibigyan namin din ni A (nurse) yun, "A (nurse) walang pang lunch si anu, hati tayo", binibilhan din ni A (nurse) yun ng rice, ng lahat na" (we gave to patient "O", you know her, I will tell nurse A, "A, O have no money for lunch, lets buy him lunch" we would buy him rice and everything else) - Red

It seemed that we assumed the responsibility of the child's treatment, a burden shared from their parents for we came to see the patient as an extension of our own self, as part of our being. We tended to be so much intertwined with caring for the child that the burden of the disease and its treatment was often treated as our own.

This experience extended even when we took care of a dying patient such that most of the time, we felt the pain of the parent watching their child wither away right in front of them. It seemed that to feel what the parent was feeling was one characteristic experience among NWC. Since we share with the parent the holistic pain they suffered caring for their dying child, it was not surprising, however, that we tried to distance ourselves during those very trying times of their hospital stay. This was reflective on the story shared by Red when she said,

> *"pag pumapangit? Nagdedetached ako sa kanila, yun yung akin, kunwari ngayon si nanay barkada ko "mother ganyan, u yang ganda ganda mo ganyan ganyan" tapos nakita ko siya pagpasok ko nasa treatment room na siya, di ko siya papansinin, naaawardan ako, ganun yung coping ko"* (when they were deteriorating? I detached myself, for example I was close with my patient's mother and would tell them "oh your so beautiful so and so" then when I saw her child (my patient) in our treatment room, I could not talk to the mother anymore, there was this awkward feeling, that's how I coped)

It seemed paradoxical that during the very moment that the parent needed companionship, NWC tended to be on guard of their words so much so that they would not speak with them anymore. Asked for the reason behind, there would be a resounding

realization that, in one way or the other, we might aggravate the suffering of the parents when we unconsciously utter words that might hurt their feelings.

> *"nilalagyan mo ng distance hindi dahil sayo, wala kasi mamatay na to wala na kong pakesa pasyente pero hindi ko alam kung anu, kung anu yun mga tamang salita na sasabihin ko sa kanila, kung panu ko sila iaaproach nung time nay un kasi dib a ang hirap tangagapin tapos kahit ikaw iiyak sila sayo actually hindi ko sila macomfort hindi ko kasi alam"* – (you take distance not for yourself, not because they are dying that you would not give a damn, but because you did not know the right words to tell them (parent), how to properly approach them since during those times, it was difficult to accept death. They would even cry at your shoulder, actually I could not comfort them since I did not know how to) - Gray

Since we saw and appreciated the already burdensome existence of the parent, we took the safe route of consciously shying away from situations where interaction with the parent of the dying child might occur unless it was absolutely necessary to keep the child alive (i.e. giving medication, feeding). Here the saying "the less you say, the less your mistake" was very much lived. During these moments, there seemed to be a mask worn by the NWC, a mask seemingly devoid of emotions and viewed from the outside, lacked compassion. However, these same masks worn by the NWC kept them emotionally available to their other patients as well as keep themselves intact if the child eventually dies, which becomes a reality more often than not.

> *"Uhm uhm, dinadaanan ko na lang… to keep your sanity, alam mong lahat sila mamamatay din kasi e, alam mo sad"* (Um, I just passed by them.. to keep your sanity; you knew that all of them would die, it was saddening) - Green

It seemed that this symbolic mask is an epitome of how NWC utilized the process of distancing oneself from the child and their parent as a means of self-preservation. Since the very essence of caring for a dying child was an experience of being unarmed, NWC would not want the same feeling to be shared with the parents thus an emotional mask of seeming callousness symbolic of professional adeptness was worn. Sharing, a key element of *Malasakit,* viewed from the lens of NWC was deliberately selective such that only those that would benefit the child was ultimately shared and those that were viewed as burdensome was set aside to be experienced by the nurses alone.

"siempre di mo pinapakita na, alam mo yun nandyan na yung parang naghihingalo na sa harapan mo, gusto mo ng tumulo ang luha mo pero di mo pedeng gawin dahil kelangan mong maging parang strong sa magulang" – (you would not let them see (you are suffering), though the patient was dying right in front of you, though you were close to tears, you could not cry since you had to be strong for them) Pink

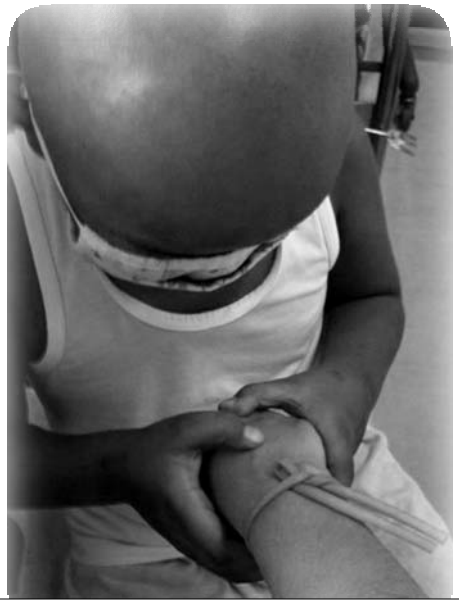

Figure 4*: "Ako ay ikaw, ikaw at ako"* showing Purple's patient acting as the nurse and vice versa

The blurring of both professional boundaries and personal life is very characteristic of NWC's experience of care. We know that it is not the responsibility od a nurse to go beyond what our profession dictates, but there is an unexplained desire to share the burden and suffering of our fellowman and treat it as our own. During these times, we unconsciously feel that those whom

we cared for was not merely an individual but a fellow human being like us, a *kapwa-tao*. Purple's picture (*Fig. 4)* embodied this notion that the patient is a representation of ourselves as nurses. *Malasakit* therefore, goes beyond merely sharing our abundance, but extended to sharing the burden of our patient and their family as our own with an almost natural quality, reflective of Moss's statement.

> *"kasi parang anu satin yun eh, innate? Ewan ko kung innately human o innately Filipino yun yung malasakit na yun kasi pinalaki tayo sa bansang sobrang mahilig sa tsismis"* (It seemed it is innate in us, I did not know if caring and compassion is innately human or innately Filipino since we were raised in a country that love gossip)

For us NWC, *Malasakit,* in a contextual sense, meant unequivocal sharing, be it sharing the personal things they have, to sharing the pains and sufferings of the patients and their significant others, *Malasakit* embodied the belief that to care is to share those things that you have and those that you have not.

The very essence of caring is reflected in *Malasakit*¸ where compassion, love, and sacrifice are embedded. *Malasakit,* goes beyond caring for the child as a patient or as an individual but as a fellow human being. *Malasakit,* encompasses both *Alaga* and *Kalinga*, but transcends these in the belief that we possess not only a shared humanity but a collective divinity as well. Through this, we symbolically care for ourselves through our conscious effort to care for the child. Figure 5 show the schematic mapping of the concepts related to the three (3) themes discussed above.

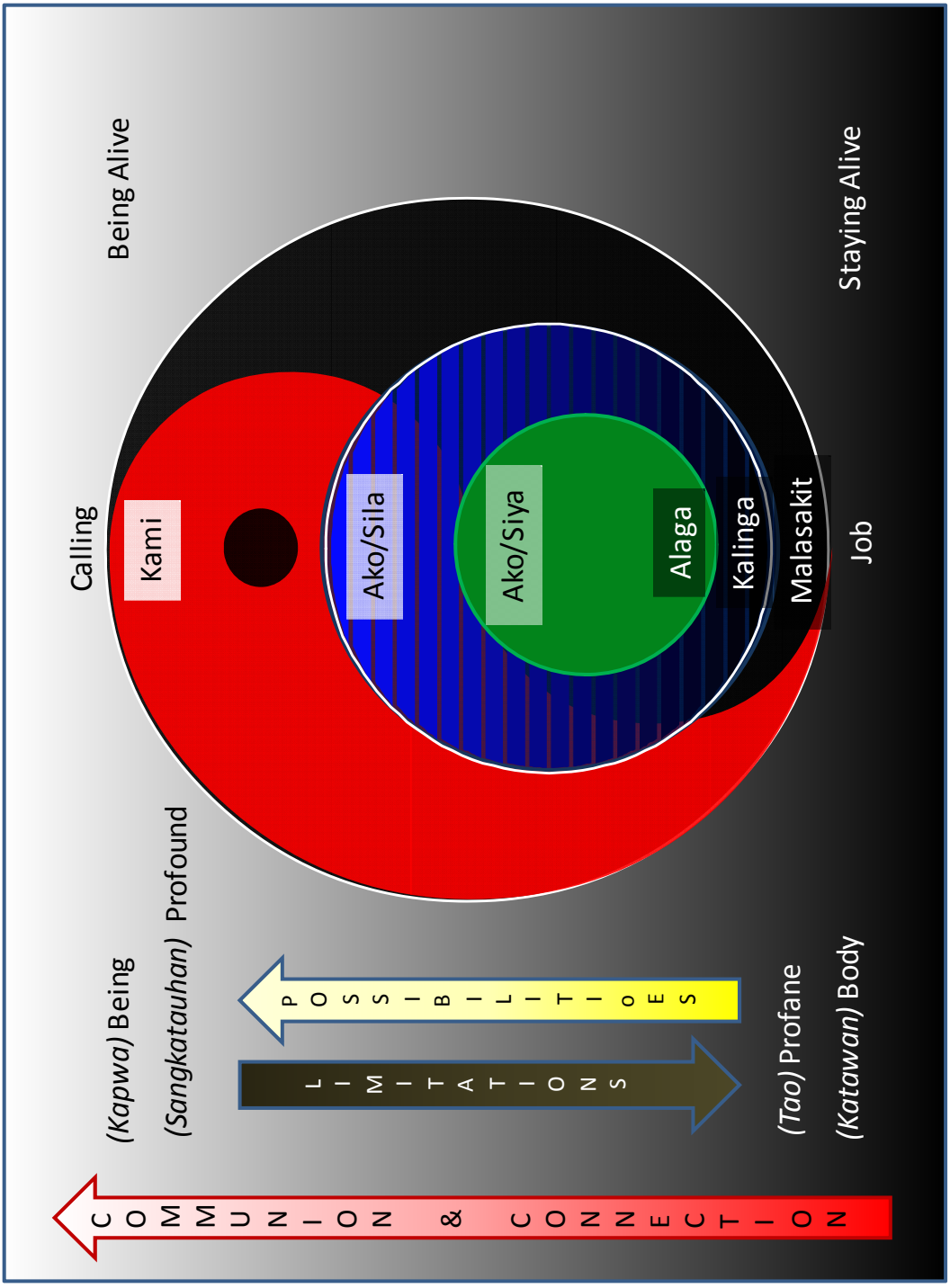

Figure 5: *"Thematic Schema"* showing the interrelated and interconnected concepts of the three (3) themes: *Alaga, Kalinga & Malasakit*

Reflective Resonance

This section puts in context the themes appreciated from the process of reflective analysis thru the lens of the available literatures on the topic. It will focus more on understanding the reflected themes rather than purely comparing the result with other existing studies. The concepts of *Pakikipagkapwa* and *Pakikiramdam* will be utilized to ultimately shed light and add another layer of appreciation to the thematic concepts of *Alaga, Kalinga* and *Malasakit*. Each of the concepts will be explored by first presenting their definition from the literature then by their contextual meaning as they have been lived by us nurses.

***Pakikipagkapwa:* The Others Within Me**

Enriquez (1994) defined *kapwa* simply as "the unity of the self and others" focusing on the prime importance of Filipino "shared identity". He further emphasized that with the appreciation of the other person as our *kapwa*, we place both their dignity and being in the limelight during our interactions. *Pakikipagkapwa* as Guevarra (2005) puts it then means that we see, appreciate and consequently deal with our fellow men as equals.

To be able to fully live the virtue of *pakikipagkapwa*, one must be able to first see the other person as a *kapwa.* This seemingly progressive appreciation of the others from a simply stranger to a *kapwa* is very much reflective of the nurses' appreciation of care. During the first point of contact with the patient, our "professional" self takes the center

stage thus we see the patient as a stranger needing care as we were trained to theoretically separate ourselves from our clientele to define ourselves as their nurses.

The very notion of our patient being a *kapwa* is only evident when we begin to transgress the idea of "professional boundaries", simply by acknowledging the fact that our interaction with them is not only limited by the virtue of our profession but by our innate desire to help a fellow being. It is only when we appreciate the patient as another person that we begin to see them as a *kapwa*.

Because nurses working with children a lot of times interact more with the patient's families than with the patient themselves, our appreciation of our patients' personhood is a lot of times affected by our relationship with their families specially their significant others (i.e. watcher). Symbolically, their watcher serves as a bridge that connects our world and that of the child since they serve as the eyes and voice of the patient. Having a relative at the bedside is another unique characteristic of caring for children since we do not only deal with a person but a community of them as was also reflected in the study of Amrith (2010) on the lives of Filipino medical workers in Singapore.

Here the notion of being part of the family plays a significant role in the continual effort of nurses to understand the context of the patient's family where trust, confidence and rapport needs to develop beforehand. It is only when these values start to surface that the picture of a genuine interest for the child will be appreciated by their significant others. Being a "*kapamilya"*, (being with and one with the family) then is a pivotal point in becoming a part and parcel of the patient's life. Evident to this progressive

involvement of the nurse with the patient's family is how we are being addressed by the family, from simple "nurse" to a more endearing "nurse (name)" to a trusting "ate (name)". It seems that the more we become one with the family, the more that we lose our identity as a professional nurse and bring into the limelight our shared identity as human being, as *kapwa*. It is only when the family sees you on equal footing with them first that they will start to see you as their nurse since as Leoncini (2005) puts it "Filipinos feel more at ease when their relationship with others is personalized, like family"

Family centeredness, another element of the Filipino traits also plays a significant role in the how we care for our patient. Nurses working with children often sees their patient as an extension of their family, a part of their being. Because we see them as an integral part of ourselves, we are more than willing to extend our effort and time beyond what is officially prescribed. It seems that the idea of being a "*kapamilya"* in the eyes of the nurses very well extend beyond the sanguinal or relational affinity but inherently shared to those unrelated to us, another embodiment of our value of *pakikipagkapwa*. Ramirez' (1967) analysis of the Filipino family echoes the notion that Filipino nurses loves those whom they consider as family. Also this notion is evident in one of the reflections of Castillo (2005) study when she emphasized that nurses tend to see their patients as a family member which greatly influence their care for them.

Another intriguing aspect of how nurses working with children is how we appreciate the patient as part of our family but never as a symbolic member of our family. It can be that we do not want to see our beloved family member in our patient's condition

since we know how they suffer. This shows that though we feel one with the patient's family, that though we share a communal existence, we are still a separate being from one another, a notion reflective of Fr. Jaime Bulatao's metaphorical "egg yolk" model of our shared identity that, as quoted by Mansukhani (2005) "although I (we) maintain my (our) identity, I (we) share so much in between". From seeing ourselves as separate from our patient (*ako at siya)* to acknowledging the importance of their family (*ako at sila)* and to ultimately recognizing our shared personhood *(kami)* ,there seems to be an unconscious gradual awareness that indeed our patient's family is *kapwa-tao,* that is only possible through the nurses conscious effort to be one with them.

Seeing the patient and their family as an extension of ourselves and essentially a representation of our being enables us to share both what we have and those that they do not have. Appreciating the concept of caring as essentially sharing makes it a uniquely Filipino phenomenon since it emphasizes the dialogical nature of caring placing importance on the family's participation in the care of the child. Since the essentiality of caring is the idea of sharing, the belief that care is resource bound will eventually be reaffirmed that it is only resource sensitive. Sharing enables us to utilize the cosmic abundance by rethinking the idea of "professional boundary" and turn it into "humane possibilities".

Pakikipagkapwa in all its essence brings humanity back to our appreciation of caring as it instills the reality that our patient , like ourselves, is a community of living persons, a *kapwa-tao,* whose divine core is the same as ours. Fox (1991) in his seminal work on creation spirituality emphasizes this core notion of the profane

interconnectedness of all beings as an inherent gift from the Divine. The nurse's appreciation of care based on our notion of *pakikipagkapwa* is an embodiment of Fox's core value of creation spirituality.

Pakikiramdam: Of Connectedness and Relationality

Enriquez (1994) defines *pakikiramdam* as "shared inner perception", that which "heightened one's awareness and sensitivity" toward another person. It permeates the very essence of being a Filipino and is lived in the humane everyday lives of the person, upon which layers and layers of meanings are attached to this value (Mansukhani, 2005). We, being Filipino nurses working in the microcosm of Filipino society (the Institution), it is no wonder that the value of *pakikiramdam* permeates the different aspects of our care as was seen in our everyday interaction with our patients and their families.

The dialogical interaction between the nurse and the patient with their family takes its root on the value of *pakikiramdam* as a mode of communication between them. As was experienced by the nurses, we tend to feel the meanings of words uttered and not solely understand them in the literal sense. Taken as a concrete example is the way we address the patient. How we address them seems to be unconsciously determined by our closeness both with their relatives and their parents, such that when they are new and unaccustomed to us, we call the patient with their surname and address the watcher as "ma'am" or "sir". It is only when we feel a mutual deep awareness with them that we start to address the child with their pet names and call the relative "*nay, tay, ate or kuya*". It seems that our very nature of being family centered again is reflected by this

phenomenon. *Pakikiramdam* is at the very core of trying to understand and feel if we really have this "connection", transcending the very western idea of rapport where connection is based on individuality and not on shared personhood.

Pakikiramdam also enables the nurses to try to reconstruct the world of the patient and their family to appreciate the context where they are coming from. It is only through this that we can fully have a feel of their suffering and the start of us giving *malasakit*. The notion that we must try to be conscious of their lives is again anchored on the idea that they are a *kapwa-tao* capable of feeling the same anguish that we have felt in our lives one way or another. Because we know the feeling of hardship (*nararamdaman)* and appreciate their being a *kapwa*, sharing their burden as our own and stepping outside the boundaries we set upon ourselves is quite a normal sequence of caring for them This is the very idea of *malasakit.*

It seems that the Filipino trait of being an expert in indirect communication has influenced our ability to finely tune ourselves to non-verbal cues in our relationship with our patients that even when we take care of an unconscious child, we talk to them as if they are awake and are as much as possible gentle to them since we feel (*nararamdaman)* that they still are alive though they are devoid of full consciousness. Through *pakikiramdam*, the family also sees the mere existence of the nurse as an avenue of caring, that though we do not do anything with the patient, our simple presence during painful procedure sends signal that we have a *pakialam,* a stake in the matter (Manauat, 2005). Again this dialogical recognition that we care lies in the very idea of *pakikiramdam* and not on direct verbal communication with the patient and their family.

Embodying *pakikiramdam,* nurses learn to be cognizant of the lives of the patient relatively free from boundaries and constraint of professional roles by pure association grounded on the humane and divine aspect of our shared being. Coupled with the notion that those whom we cared for are our *kapwa*, *pakikiramdam* then is a way to profoundly understand oneself through connecting with the personhood of our *kapwa tao*.

Pakikiramdam in the lives of the nurses echoes the belief that *pakikiramdam* is a deep interpersonal connection (Mansukhani, 2005) with our patient and their family. It is in this sense that a mutual association and understanding always needs to be a ground from which caring is shared and lived by nurses.

> *"di ba ayaw mo naman ng may sakit na bata pero iniisip ko rin kung walang pediatric nurse, panu na lang yung mga patient natin? Kasi lagi na yan tinatanung ng mga mothers e, "buti anu kayo, buti hindi kayo nasasaktan pag nakikita mo?" "hind mam, naaano rin kami, naaapektuhan din kami pag nagtutusok kami ng pasyente kung pede nga lang wag naming gawin yun, pero nasa utak naming kung hindi naming gagawin yun panu na lang yung pasyente mismo?" sino na lang ang gagawa"* – (we don't want a sick child but if you'll come to think of it, if there would be no pediatric nurse, where will our patients be? There are a lot of time the mothers often asked, "you're lucky you don't feel hurt when your patient is in pain" I will tell them, "we do get affected when we inject them, if not for their own sake, we won't inject them at all" but in our minds we keep on thinking that if we won't do this, what will become of our patients?) – Moss

Eidetic Insight: *Paghahabi't Pagkakaisa* (Of Weaving and Oneness)

After the process of reflective analysis of the themes of my co-researchers' narratives and taking into consideration the contextual understanding of the themes from the literature, the following insight have been culled out.

For NWC, to care for a child is to symbolically weave the very fabric of the child's life into their own being, sharing both the joy of their divine existence and the burden of their mortal frailty. Caring for a child is an interplay of our multidimensional interconnectedness both with the profound and the profane embodied by the primacy we place on relationality (*Fig.5*). It is a phenomenon characterized by paradoxical closeness, of consciously trying to be one with the child and their family toward healing the child while unconsciously distancing oneself when the child becomes critically ill and is dying. It is an experience where *pagmamalasakit* and *pakikiramdam* are values lived in caring in a context where healing and suffering are intertwined realities of life.

***Figure 6**: "Kamay" Purple's representation of oneness among our patient*

Nurses working with children appreciate caring as both a human trait and a divine gift that is meant to be shared through our deep connection with our shared personhood. It can be said that essence of caring among NWC is oneness, of being able to share and intertwine one's life with the child's and in the process appreciate their existence as a professional nurse, remember their gift of humanity and be aware of their capacity to be divine.

Symbolic Expression:

Figure 7*: "T'nalak" showing Lang Dulay with her work of art, a weave of dreams and culture*

Interpretative phenomenology postulated that art serves as another avenue by which the insight of the phenomenon can be appreciated since art in itself expresses more unconstrained possibilities of understanding that description alone may not contain in itself. The following are the artistic expression of my insight on the phenomenon of caring among Filipino nurses working with children

Symbolic Representation: *Paghahabi* (Weaving)

As an avid collector of woven artwork among our indigenous brothers, I have felt that the process itself is symbolic of our appreciation of caring for the children. Weaving, amongst our indigenous brothers, is both a profound and profane art, where a tangible output from the human hand and an intangible connection with the unseen and the Cosmos are dualistically achieved. Shadowing the art of weaving, caring is always seen as both our profane profession and our profound calling as nurses. Moreover, it has been understood that woven art, the product of weaving, serves as the symbol of the community's culture and is deeply rooted in their collective consciousness. Figuratively, healing, the aim of caring serves as the symbol of our lives and culture as nurses. This is also rooted in our collective consciousness. Weaving demands time, effort, concentration, hardwork and determination from start to finish as we do when we care.

Symbolically caring for NWC is akin to *paghahabi* (weaving) where the threads represent the lives of both the nurses and the child sharing both their intrinsic nature of humanity and divinity, symbolically enmeshed with each other by the hand of the Cosmos (*Fig. 6*). During the weaving process, the essence of the weaver is transformed into the cloth and as such, the weaver and the weave become one. Symbolically, when NWC care for the child, their transcendent divinity as rays of the Creator, comes one with their humanity as a professional nurse, which fulfills their essence of becoming a being-for-others. Weaving, as well as caring, is both a conscious process of creating order amongst the individual threads while unconsciously giving meanings to their interconnectedness. The more closely woven, distinct and complex the design of the

weave, the more closely knit and caring is the society that creates it. Appreciation of community interconnectedness is then an essence of both weaving and caring.

The weaving design can only be aesthetically beautiful if the threads each retains its individuality and at the same time be part of the whole pattern. It is this pattern of tangling and untangling of their existence that gives meaning to the nurses' appreciation of care. At the end of the weaving process, the hand that created it must symbolically cut its continuity for it to be useful for other purposes and to start making other designs with other threads representing both the conscious and unconscious effort of the NWC to distance themselves away from the dying patient. Interconnectedness, the basis of the woven design and the core of caring, is symbolic of the Filipino idea of shared personhood, symbolic of our culture, rooted in our consciousness.

Artistic Expression: *Hinabing Ugnayan*

The following poem was birthed resulting from the continual reflection of the insight of the phenomenon. It reflects my own appreciation of the nature of caring among us, nurses working with children and was agreed upon by my fellow co-researchers upon seeing it. This poem thus reached a resonance between my appreciation and my co-researchers' experiences.

Hinabing Ugnayan

Kerubing tumatangis ako'y iyong tingnan
Mata sa mata, kalooban ko'y pakiramdaman
Dampi ng aruga iyo nawa'y maibigan
Dalamhati ng buhay akin nawa'y maibsan

Mumunting anghel ng aking katauhan
Nadarama ang iyong lungkot at pagdaramdam
Pagkaiba nati'y ating ng talikuran
Pagkat kaisa mo ako sa diwa't kalooban

Kerubing tumatangis ako'y iyong kapwa
Nilalang at diwa nati'y lubos na Binathala
Kaya't kalingain ka'y isa ng kapamilya
Lakbay ng yong buhay sabay nating itamasa

Mumunting anghel sa ating katauhan
Malasakit at pag-unawa ang nasasa kaibuturan
Bigkis ng tadhana nawa'y laging maunawaan
Pagka't ating buhay ay isang hinabing ugnayan

Akda ni: Rudolf Martinez

CHAPTER V

Creative Synthesis, Implications and Possibilities

In this chapter, I synthesize my dissertation through a creative synthesis and discuss the implications based on the insights that could be drawn from the study as well as the possibilities and direction of this research endeavor.

Creative Synthesis

Using the methodology I have developed, anchored on the philosophy of phenomenology embellished with ethnographic techniques, I, together with my co-researchers, have reflected upon our collective experiences on the nature of caring among us, nurses working with children. Build upon the continuous process of resonance and counter resonance, we had reflected that caring was woven upon layers and layers of meanings revolving around the three (3) thematic concepts of *Alaga*, *Kalinga* and *Malasakit*, where *malasakit* echoes the very core of caring, that is sharing. Trying to find resonance from the existing literature, I had found that the Filipino concepts of *Pakikipagkapwa* and *Pakikialam* shed another layer of meaning and vantage point of understanding our experiences of caring. Upon further reflections, I had found the *eidos* of the phenomenon; that to care for a child is to symbolically weave the very fabric of the child's life into our own being. The essence of caring among NWC therefore is oneness, of being of being able to share and intertwine one's life with the child's and in the process appreciate their existence as a professional nurse, remember their gift of humanity and be

aware of their capacity to be divine. This insight was symbolically represented by the process of weaving (*paghahabi*) where the threads represent the lives of both the nurses and the child sharing both their intrinsic nature of humanity and divinity, symbolically enmeshed with each other by the hand of the Cosmos. To summarize the insights I have reflected upon, I wrote a poem entitled "*Hinabing Ugnayan*" echoing the nature of caring among us, NWC.

Implications

"True transformation of health care ultimately has to come from a shift in consciousness and intentional actions of the practitioners themselves, changing health care from inside out" – Jean Watson (2009)

At the core of a phenomenological inquiry is a deeper understanding of the phenomenon one wishes to explore and following its philosophical roots, it does not claim to generalize the insight gathered from the process of reflection nor aim to give recommendations based on the reflected-on realities gleaned from the approach. Instead, phenomenological insights are utilized to make suggestive implications grounded in the insights drawn solely from the phenomenon. I wish to follow this philosophical grounding.

Based on the insights I have gathered from the process of reflective analysis, I can say that indeed, we Filipino nurses working with children appreciate care in a different

context from what we were taught to practice which is basically western in perspective. There seems to be an unconscious continuous effort within our educational system to strip off our own perspective and replace it with western lens. Though caring is a universal phenomenon, it is also a cultural reality, where the cultural consciousness of the community determine the context of our appreciation of caring. We need to understand and be connected with our own culture for us to fully understand other cultures as well. It is through our awareness of our uniqueness that we will be proud of ourselves and shy away from viewing our culture through the lens of the west and in the process alienate ourselves, belittling are our own complexities. Reflecting back on my undergraduate years of schooling as a nurse, I remember that we only focus on the topic of Filipino consciousness in passing in a minor three (3) units subject while most, if not all, of my major subjects rely solely on resource books either from the US or Europe. It seems that the more we learn and inculcate within ourselves our profession as a nurse, the more alienated our being becomes from our own culture. There is a dire need to rekindle within our future health care providers the beauty, elegance, uniqueness and complexity of our own culture so that they know they are at ar par with the best in the world.

Though this endeavor adds to the paucity of research on our appreciation of care, I feel that there is still a need to continue to discover our phenomenon of caring. This research may serve as a starting point of these future endeavors of knowing and appreciating our own culture. This is specialy important to those who work in the "caring" profession such as medicine, nursing and social sciences since understanding how we appreciate care through our own lenses will inevitably let us understand

ourselves as professionals. Since caring is the central value of our professions, it is but logical to fully and deeply understand the phenomenon of caring through our own experiences. Research on the phenomenon of caring utilizing the lens of nurses in the other fields (i.e. cancer), of those receiving care (i.e. patients), or of other caring discipline (i.e. social work) are some endevours that can and need to be further explored.

For those nurses who are already in practice, there is a need to continually reflect on our lives as nurses, stressing that ours is not just a job nor a profession but a calling. Due to the constant "toxicity" that nurses experience, we unconsciously resort to giving care on a per demand, job description basis. Stress debriefing, unwinding and reorienting ourselves of why we took this noble profession often helps in shaking those "toxicity" off one's self. There is need, in my opinion, for health care providers to be more reflective of their work, in their day to day communication and interaction with their patients for I and my co-researchers feel that there are rare occasions where we consciously bring into our awareness the hardships and possibilities of our work. This research became instrumental for my co-researchers since it is one of those moments where they become reflective of their mundane lives as nurse working with children. Our being a family centered society, the value we place on *pakikipagpakwa* and our intrinsic desire to connect ourselves to others through our shared personhood was deeply instrumental on how we appreciate the nature of care thus this same values should always be emphasized when we interact and give *malasakit* to our patients and their families. Also, there is a need to rethink what we perceived as "societal and professional boundaries" of giving care and start looking at them not as boundaries but possibilities just like our ancient forefathers appreciates the

waterways (i.e. rivers, seas) not as hurdles but as connectors of their community to the world. Emphasis on our being interconnected with the world and the cosmos should be placed at the forefront (and not the value of individuality that the west has mastered) to be developed. It is about time that we start to be proud of our own system of values for it is what makes us Filipino and which make us sought after even in other countries.

Supervisors of nurses and other health care professionals can give continual education as well as in-house training for their staff on topics like stress management, Filipino values, modalities of caring among Filipinos to further equip their staff to fully understand why we are the way we are as well as minimizing stress on the workplace, the sole reason for the degradation of our way of caring. From my experience, I see a lot of in-house training on stress management, but none on Filipino customs and values since some managers believe that because we are Filipino, we already and instinctively know those things. However, I do believe that because we are so accustomed to those practices and way of thinking, they remain invisible in our consciousness. Professor Felipe de Leon Jr once said “What is constant, remains invisible”. Therefore, there is always a need to resurface those Filipino values and way of thinking into our own awareness. It is always a good thing to focus on the value of *malasakit* as an aspect of our caring since it brings humanity back to our patient, our profession and our being. The intrinsic value and importance of reflecting on our mundane daily experiences as health care workers must be truly recognized since it serves as an avenue on how we make sense of our experiences and our world. This serves as a way to understand and appreciate our jobs further as our calling, our mission, and part of our being, part of who we are as persons.

There is a need to instill into our awareness our own cultural strength by rediscovering our roots through research, relearning our culture by education and dissemination and by rethinking our practice by means of reflection, reorientation and responding to the need of our community. This we need to inculcate in our KAPWA (Knowledge, Awareness, Practice, Wisdom, Attitude) as health care providers or simply Filipinos.

Possibilities

Through this study, I was able to deeply understand the way we, nurses working with children, appreciate our intrinsic nature of caring as was reflected in how we interact with our patients and their families, practice our profession and live the values of being a Filipino. This research was both a revelation and an affirmation of what I have always believed in, that we understand caring in a different light. It has enabled me and my co-researchers to bring further into our consciousness the realization of the uniqueness of our care. Utilizing phenomenology has again proven itself not just as a methodological process but also as an approach, a discipline, a way of life, a way of being, and a path to knowing oneself more through understanding oneself and others.

From this process and journey, I was able to present parts of this paper in a number of research conferences, talks, seminar, speaking engagements sharing the beauty of phenomenology and of being a Filipino through our collective experiences of being a nurse. I have presented a number of talks tackling the intricacy of phenomenology, exploring the lives of cancer nurses, understanding the experience of death and dying

among Filipino nurses as well as the journey of combining phenomenology and ethnography, all of which stems directly and indirectly from this research endeavor. From these simple talks, I was able to rekindle the spirit of research among participants as well as bring into their consciousness the beauty of our own culture as Filipinos. Some were even interested to pursue their graduate thesis to be along my efforts and I got the privilege to have guided some of them in completing their respective topics such as the nature of caring among Tausug nurses, meaning of caring among the Dumagat of Zambales, meaning of being a father of a critically in newborn, caring among prison nurses, elements of caring among nurses working in war-torn places in Mindanao and the phenomenon of compassion fatigue among renal nurses. I believe this is but the start of my journey in helping others start theirs with phenomenology as our guide to understanding ourselves through others' lived experiences. This work has surfaced into my consciousness the vast phenomenon that need to be explored to further appreciate our understanding of care vis-a vis our nature as Filipinos. Topics such as the nature of caring among oversees Filipino nurses, nature of caring among nurses working with adult patients, caring among indigenous Filipinos, touch as a healing modality, nature of *pakikiramdam* among nurses are but a few of the phenomenon that I wish to further explore.

Those who have journeyed with me as my advisers got interested in phenomenology after my lectures since it was also an eye-opener for them to know that such an approach exists or what they know as phenomenology is not grounded in philosophy. I believe that in one way or another, I would wish this paper to be published.

That is the reason I decided to write this dissertation in a publishable format, for a wider dissemination and to appeal both to nursing scholars and bedside nurses. Though I have written it in a relatively "modern" format, the philosophical underpinning of phenomenology, its grounding on the primacy of experiential realities and the focus on the dialogical nature of understanding was never set aside but rather placed under the spotlight. Looking back at my journey, I did feel that an Asian, especially Filipino, perspective on phenomenology is a necessity for us to be connected with the approach, but exploration in this field is very sparse in literature. I intend to contribute to this paucity in the field as what was done by the works of Dr. Mina Ramirez to hopefully develop further this fluid and open approach of understanding human experience. This work enabled me to further enhance my practical approach in phenomenological understanding and reflection through practice, mentorship and *pakikiramdam*. After this paper, I intend to produce at least a monogram on my understanding on the practice of phenomenology so others might be inspired to take their academic journey with a phenomenological attitude.

I am humbled by the sheer opportunity that this research has given me and continuity to shower me with limitless abundance as this research showed me many avenue of possibilities in academe, in research and in practice.

EPILOGUE

Journey within a Journey: Reflexivity in Practice

As part of phenomenological reflexivity, I would like to share my personal story as I journey with my research endeavor from the very conception of the topic until the process of writing the paper. This personal reflection on my experiences was explicitly explored and placed in the latter part of the paper for two main reasons, 1) to give the primacy of my co-researcherss experiences the spotlight and center stage of my research 2) to give the reader a feel of where I am coming from. However, it does not mean that I have been only self reflective and critical after I have finished my paper .On the contrary, it has been a continuous process throughout my journey and even after I have finished my paper. Another reason I placed it as the last chapter of my work has to do with Heiddeger's idea of the importance of one's historicality in the process of reflection as well as Gadamer's notion of a co-constructed world and a fusion of horizon in understanding the phenomenon. These serve as my philosophical grounds for coming up with this chapter. I do not intend to spell out all my experiences in caring in this chapter since it would be counter-productive and would consist another study (that of being an autobiographical one). To explore points I deemed important to shed light on the context where I am coming from, a dialogical approach with self-reflexive questions were utilized.

What made me choose my topic?

I originally intended to do a dissertation on the lives of families with children undergoing chemotherapy as a continuation of my masteral studies on the lives of adolescents undergoing chemotherapy, but my attention shifted from knowing the lives of families to knowing the lives of the carers, the nurses themselves, specifically their experiences of giving care. From there I began to see more possibilities of this work from simply providing a profound understanding of why we are what we are to rekindling the Filipino consciousness of Filipinos in one way or another. When this "shift" in interest happened, I am unsure of; but I do attribute this to my professors in PhD ACA in reawakening both my interest in Filipino culture and appreciation of the arts, and not only the science, of care. Professor Felipe de Leons' lectures coupled with our cultural immersion among the northern indigenous people, especially among the people of Bontoc Mountain Province (among whom I felt I was very much welcomed) secured in my consciousness that I will indeed explore more on our Filipino ways as I write my dissertation.

My experience as a bedside nurse for two and a half years, I think was another reason why I chose to explore the nature of caring. During "break time", or simply idle moments during non-toxic duties, we would often cover varied topics and always one of them would be our uniqueness as pediatric nurses. This is, I think, one of the many reasons why I began to be self-reflexive on how I live my life as a bedside nurse. It is wonderful to find though that all of my co-researchers' experiences was a reflection of my own. There was never any discrepancy in our experiences but rather merely variations

on such. Attaining a co-constructed understanding of our reality and experiences was never a difficult task since I was one with them and they are my colleagues and friends before they became my co-researchers. Our trust and rapport go a long way from just a simple "research relationship".

Lastly, I did remember fondly as if it was only yesterday when I promised Mark, my first patient, that I would continue to be a part of healing children like them. This, indeed, I have done for I took that path and became a pediatric nurse; but it seems I have not fully understood why during those times and up until now that I am a professional nurse, I tend to cross the boundaries of being a student and professional nurse. I think this was again instrumental why I chose this topic to work on since I do believe that not until I become fully conscious of our nature of caring can I fully give the authentic care to my patients, to those I consider my friends.

Why am I so much interested in phenomenology?

Phenomenology was instrumental in my growth as a qualitative researcher since I was exposed to "phenomenology". I have a feeling that what we did was not phenomenology at all during my undergraduate years. I remember back then that I was my group's "analyzer" since I took up the position myself to avoid doing the laborious work of interviewing and transcribing the text. Psychology being my first choice, I was very much interested in analyzing the narratives of our respondents and the idea of reflection was at that time alien to me. From then on, I hang on phenomenology as a way of understanding people's experiences, but I felt even before that some things are lacking

in the approach that I knew then was phenomenology. Being trained in the framework of qualitative inquiry, it is quite difficult for me to understand the philosophy (which was the root of phenomenology) and would rather choose a methodology with prescribed steps, i.e. the Collaizi's Methodology, to guide my work. Looking back, it seems like I was trying to understand phenomenology from its fruits rather than its roots and this I think is the reason why I did try to develop my own understanding of phenomenology rooted in interpretative philosophies of Heidegger, Gadamer and Merlue-Ponty. Trying to dig the root of phenomenology was not an easy task nor was I able to do it overnight. It took me years just to scratch the surface of this approach and up until now, I am humble enough to accept the fact that I could not know everything there is about phenomenology. This is the main reason I shy away from labeling myself as a "phenomenologist" or a "phenomenological expert", but would rather introduce myself as its disciple. Having the attitude of unknowingness serves as my motivation to continually learn, unlearn and relearn phenomenology as realities unfold and transform the approach and myself in the process.

When I took my graduate studies (Masters) I started the process of developing and refining my approach to phenomenology infusing it with methods that I feel is in line with its philosophy of understanding the world and meaning through a dialogical fusion of horizon. I place philosophy at the core of my approach and inculcate practical methods in what seems to be a highly cerebral (from what I understood before) process of analysis. Both my experience from the field as I utilized my own approach and feedback from students whom I was blessed to meet who utilized my "practical" approach serve as

an invitation to realign phenomenological methods with voices of the grassroots practitioners. My journey in trying to make phenomenology sensitive to the needs of its disciples, both in theory and practice, is still an ongoing process. This is one of the reasons, besides being the most appropriate methodology for my inquiry, why I chose phenomenology for my dissertation.

Being exposed to the complexity and beauty of our Filipino culture, through the ACA program, I dreamed of instilling this Filipino values in the development of my phenomenological process of reflection thus I "borrowed" elements of ethnography to add another lens by which my intended phenomenon can be gleaned upon. My reason for "combining" phenomenology and ethnography then is two-fold, for surfacing a clearer and deeper picture of the phenomenon and the refinement of the methods. Philosophically speaking, interpretative phenomenology and ethnography can be combined since they share many assumptions on the nature of reality and being. Theoretically I did successfully combine the two approaches with phenomenology being the central philosophy and ethnography at the periphery but in practice I have a feeling that what I was doing is purely phenomenology with some elements of ethnography put in it. There are times however, that when I reflect on my journey, it seems that I was using phenomenology all throughout the process and the elements of ethnography that I have inculcated in the process can be appreciated as "unconventional" methodology to understand realities if one takes the phenomenological stance. I feel that because I have chosen phenomenology to be my central philosophy, my attitude and consequently my way of life and being, I see the elements of ethnography in the light of phenomenology's

inclusive nature thus as another aspect to view reality. I remember when I presented my experience in combining phenomenology and ethnography in an international convention last November of 2012, a well-respected international speaker asked me, “What it is that you want to find out?” I answered back, “I want to understand the nature of caring among Filipino nurses working with children”. Reflecting back on my answer, it seems that though I believe that phenomenology and ethnography are ways to “understand” social realities, when I try to combine them phenomenology unconsciously surfaces as the inclusive approach and the other was simply appreciated as a facet of its developing methodology. This is my personal bias that I am now well aware of.

The resulting process of a combined interpretative phenomenology and ethnography (though it is very rigorous and insightful) may not be so practical to some qualitative researchers, specially the budding one. Since it combine two approaches, it is very easy to get lost in the process if one is not fully philosophically grounded in at least one or both of the approaches being combined. The technique of immersion, the process becomes time consuming and time is considered both as a luxury and privilege by some researchers. I do believe that there will never be a perfect approach or method and if one aims to be more rigorous, time and effort will always be sacrificed. I never intend to “bastardize” phenomenology, I only aim to develop and refine the process for myself so it would be philosophically rooted and methodologically practical.

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C. Thesis and Dissertations

Martinez, Rudolf et Al. (2010). *"Falling Hair and Drilling Bone": A Phenomenological Inquiry into the Lives of Adolescents Undergoing Chemotherapy*. Unpublished Graduate Thesis. Trinity University of Asia.

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Appendix A: Brief Development of Phenomenology (Adapted from Martinez, 2010)

Phenomenology began during the first decade of the 20th century with 3 distinct phases, Preparatory, German and French (Speziale, 2007:78-81).

The *preparatory phase* was dominated by two philosophers, Franz Brentano (1838-1917) and his student Carl Stumpf (1848-1939). Their work demonstrated the scientific rigors of phenomenology and paved the way for further development of phenomenology as a scientific discipline. Moreover, during this period the concept of *intentionality* was clarified and was the primary focus of this time. Intentionality is described as the consciousness of being always conscious of something such that one cannot hear without hearing nor believe without believing something (Cohen cited by Speziale, 2007:78).

The second phase, dominated by Edmund Husserl (1857-1938) and his predecessor Martin Heidegger (1889-1976), was known as the German phase. Edmund Husserl, known as the father of phenomenology, believed that philosophy should become a rigorous science that would restore contact with deeper human concern and that phenomenology should become the foundation for all philosophy and science. He further emphasized that in order to understand a phenomenon people should "go back to the things themselves" (as cited by Speziale 2007: 79). It is during this time that the concepts of essence, intuiting and phenomenological reduction were developed. Essence derived from the Greek word *Eidos* means image, form or shape (Moustakas, 1994). It is the element related to the ideal or true meaning of something and represents the basic unit of

common understanding of any phenomenon. (Huberman & Mile, 2002; Macnee, 2003; Munhall, 2007). On the other hand intuiting is described as an eidetic comprehension of what is meant in the description of the phenomenon under investigation. It results in a common understanding about the phenomenon under investigation requiring the researcher to imaginatively vary the data until a common understanding about the phenomenon emerges. (Moustakas, 1994; Munhall, 2007; Speziale & Carpenter, 2007; Mccance & Mcilfatrick, 2008). Conversely, phenomenological reduction is described as returning to original awareness regarding the phenomenon and begins with a suspension of belief, assumptions and biases about the phenomenon under investigation. It is further argued that the only way to really see the world clearly is to remain as free as possible from preconceived ideas or notions. Moreover, phenomenological reduction involves the process of *bracketing*, defined as remaining neutral with respect to belief or disbelief in the existence of the phenomenon. (Moustakas, 1994; Todres & Holloway, 2006; Munhall, 2007; Speziale & Carpenter, 2007).

Since the prime aim of a phenomenological study is to understand and interpret the lived experiences of people, it is crucial that the researcher identify and hold in abeyance his preconceived assumptions, beliefs and opinion about the phenomena under study via the process of *bracketing*. Only by this can the interpretation and insight drawing about the phenomena be solely based upon primary experience and makes the confrontation of data in its pure form possible (Huberman & Mile, 2002; Wood & Huber, 2003; Fely, 2005; Henn et al, 2006; Todres & Holloway, 2006; Munhall, 2007; Speziale & Carpenter, 2007; Taylor et, al 2007; Polit & Beck, 2008).

With the above development of phenomenology during this phase, two prominent schools of thought emerges - one by the founder himself, Husserl and the other by his student Heidegger.

Descriptive phenomenology was influenced by the teachings of Husserl and placed heavy emphasis on the description of the meaning of human experience. It tries to answer the question "What do we know as a person". On the other hand, Interpretative phenomenology was developed by the ideas of Heidegger and stresses the interpreting and understanding, not just describing, the human experience. As such, it focuses on the meaning of people's experience in regard to a phenomenon (descriptive phenomenology) and how these experiences are interpreted (hermeneutics). (Huberman & Mile, 2002; Wood & Haber, 2003; Carpernter & Soto, 2008; Mccance & Mcilfatrick, 2008; Polit & Beck, 2008).

Wood & Haber (2003:233) present a summary of the main difference between the two schools

Table 1: Summary of difference between descriptive and interpretative phenomenology

Descriptive Phenomenology	**Interpretative Phenomenology**
Husserlian	Heideggerian
Epistemology (question of knowing)	Ontology (question of experiencing and understanding)
Person considered as a separate mind-body person living in a world of objects	Person exist as a "being" in and of the world

Data speaks for itself	Interpreter participate in making data
Techniques and procedure to aid rigour (adaption of analysis structures)	Own criteria for trustworthiness
Bracketing defending objectivity	Hermeneutic circle (background, preunderstanding)
Useful in uncovering the “essence” of a phenomena	Useful in examining the contextual features of experience – values uniqueness and diversity

On the other hand, the French phase was dominated by Gabriel Marcel (1889-1973), Jean Paul Satre (1905-1980) and Maurice Merlaue-Ponty (1905-1980) and it was during this phase that the concepts of embodiment and being-in-the-world, refering to the belief that all acts are constructed on foundation of perception on original awareness of the phenomenon (Speziale & Carpenter, 2007). Taylor (2007) further elaborated that the concept of being-in-the-world means that instead of trying to lay presupposition to one side, explore them as a legitimate parts of finding out the nature of a thing of interest, for humans live in a body and that the experience of living in the world could give them clues to the nature of their existence. Munhall (2007) further explained that through consciousness humans are aware of being in the world for it is through the body that human gain access to the world.

Munhall (2007) refers to the above-mentioned philosopher as the first generation phenomenologist for they are more attuned to the philosophical underpinning of phenomenology. On the other hand, those she termed as the second generation phenomenologist, which include Georggi, Colaizzi, van Kaam and van Manen, have proposed their own way of data analysis thus the methodology of the phenomenological approach was refined. The first three were the most influential methodologist for nurse researchers in the 1970's and 1980's while van Manen, the contemporary phenomenologist most cited in nursing circle today (Taylor et al, 2007:336), was instrumental in combining the philosophy and methodology using a human science approach where his views were often consistent with many first generation phenomenological philosophers. His method was not only utilized by nurse researchers but by known contemporary nurse theorist such as Paterson and Zderad (1976, 1988), Watson (1985), Newman (1986), Parse (1987), Ray (1990), Benner (1994). (Tomey & Alligood, 2004; Meleis, 2005; Munhall, 2007:160).

Locally, the development of phenomenology as a research method was spearheaded by Dr. Mina Ramirez (1967; 1983), the first documented to utilize phenomenology in the social sciences as well as expound on the application of phenomenology in the Philippine research setting. Moreover, like van Manen, she views phenomenology as a philosophy as well as a science and a research method which is parallel to the understanding of the methods by Spiegelberg (as cited by Ramirez, 1983) involving seven interrelated steps: 1. Investigating particular phenomenon, 2. Investigating general essence, 3. Apprehending the essential relationship among essences,

4. Watching modes of appearing, 5. Watching the constitution of phenomenon in consciousness, 6. Suspending belief in the existence of the phenomenon and 7. Interpreting the meaning of the phenomenon. These processes where aimed at discovering the "nucleus of truth" of a phenomenon (Ramirez 1967; 1985). It can be noted, therefore, that through her, the *Filipinization*, a process by which Filipinos become aware of themselves as creators of meanings and shaper of their culture of phenomenology took place (Ramirez, 1967; 1985).

Appendix B

Beta Nu Delta Nursing Society

3rd Block Zone 2 C Bula
General Santos City 9500
Philippines

INSTITUTIONAL REVIEW BOARD

CERTIFICATION

Certificate Number: **IRBBND-0001**

This is to certify that the research proposal of

Mr. Rudolf Cymorr Kirby P. Martinez

entitled

" Nature of Care Among Filipino Pediatric Nurses:

An Ethnophenomenological Study "

has been reviewed by the Institutional Review Board of Beta Nu Delta Nursing Society. The research proposal has fulfilled the requirements to conduct ethical research investigations involving human participants.

Issued this ***17th*** day of ***June, 2012.***

Raymund John Y. Ang
Chair, Institutional Review Board
Beta Nu Delta Nursing Society

Beta Nu Delta Nursing Society Institutional Review Board is registered with the United States Department of Health and Human Services (DHHS), Office for Human Research Protections (OHRP) Registration Number: **IORG0006192**; Institutional Review Board Registration Number: **IRB00007451**.

Appendix C

Informed Consent Form for Participants in Research,

"Nature of Care among Filipino Pediatric Nurses"

Principal Investigator: Rudolf Cymorr Kirby P. Martinez

Affiliate Institution: Asian Social Institute

Contact Number: 09484238189 Email: vanidorgildor004419@hotmail.com

Information Sheet

I am Mr. Rudolf Cymorr Kirby P. Martinez, a PhD in Applied Cosmic Anthropology candidate doing research on the nature of care among us Filipino pediatric nurses. With this, I am humbly inviting you to be part of this research endevor exploring the lives of us Filipino pediatric nurses. You do not have to decide today if you will participate in this study, feel free to ask additional information, or clarification if there are words that are in this consent form of which you do not fully understand. You can ask me as we go through the information or later if you have any more questions.

The lives of us Filipino pediatric nurses are a less likely explored phenomenon. Few, if there are any, have tried to explore the nature of care in our own perspective. This is the main reason why this research was actualized. I want to find out how we make sense of care in our daily practice as a pediatric nurse as well as our own appreciation of the idea of care.

This study will involve you in a series of interview and group discussion that will take about an hour or so of your time per session.

You are being invited to take part in this study because I feel that your vast experience as a practicing Filipino pediatric nurse can contribute much to our understanding of the appreciation of care by Filipino pediatric nurses.

Your participation in this research is entirely voluntary. It will be your personal decision whether to participate or not. You may withdraw anytime during the course of the study even if you agreed earlier.

If you agree to participate in this study, I will be asking you to share your experiences as a Filipino pediatric nurse on how you practice care in your daily live as a nurse as well as together explore its nature within our own views. This will be done via a series of interview lasting an hour or so of your time at you own convenient time and place where you would want to conduct it. During the interview, I will be asking you to tell stories and experiences relating to how you practice and see care within your practice as a nurse. Only the two of us will be present in the room during the conversation but if you wish to have company during the interview, you may do so. You may not answer follow up questions when you do not want to and I will continue with another question. The interviews will be tape recorded for later reflection and will be strictly confidential. No one except me will be able to access the records and the tapes will be kept in a locked box to secure confidentiality. Moreover, the tapes will be subsequently destroyed after a year of finishing the study. Your identity will be strictly secured and a pseudoname of your choice will be in place of your name and will be reflected in the body of the study as well as in a possible publication, local or international. You have a choice to either include you stories if this paper will be published or may decline. If you wish to be included, your chosen pseudoname will be shown and your identity be held in confidentiality.

After your individual interview and my reflection on your stories, a written output will be shown to you for validation purposes. There will be three (3) times that you will read and

agree or disagree with the authenticity of the written output. If there are things that you do not agree with in the written output, you may say so and the paper will be edited accordingly.

At the end of the study, you will be asked to participate in a group discussion, which I will facilitate focusing on the result of the study. It will be done during your free time and if you wish not to participate, you may do so. This will provide a final opportunity to clarify results that you feel is not correct as I want the research to be validated by you as part my participants. This group discussion will be held for an hour or so.

This research will take place over a period of six months in total. During those times, I will be conducting at least three (3) follow up interviews lasting an hour or so.

There is a risk that you may share some personal, confidential information about yourself during the course of the study by chance. I do not wish for this to happen and so if during the course of the study you feel that a topic or question is sensitive or make you feel uncomfortable, you may not answer them. You may not give reason for not answering them at all. However, if you wish to share intimate information, this information will only be made available to me.

By you participating in this study, you will help shed light into the lives of Filipino pediatric nurses and how they appreciate care in their practice. It will greatly add to the body of knowledge of our nursing profession.

You will not be provided any incentive to take part in this study. However, all expenses incurred during the interview will be shouldered by me and a token of appreciation will be given after the study have been finished.

All data that will be gathered in this study will be kept private and strictly confidential. Data will only be available only for my personal reflection. All records, information will be kept in a locked box during the whole course of the study and later destroyed a year after finishing the research. Your name will be replaced by a pseudoname to maintain your anonymity.

If you have any more questions, you may contact me at 09484238189 or email me at vanidorgildor004419@hotmail.com or my adviser Professor Erlinda L. Natulla, PhD at (632) 523 8265 to 67 loc. 219.

This research have been reviewed and approved by the IRB of Beta Nu Delta Nursing Society which make it point that the research's participants will be free from harm. If you wish to know more about the IRB you may contact them at to secretariat@mail.betanudelta.com or at IRB Chair, BND 3rd Block Zone 2C Bula, 9500 General Santos City

Certificate of Consent

I have read the above information and have the opportunity to ask questions and clarifications which have been satisfactorily answered. The study's goal, procedure, risk and benefits have been explained to me and I have understood them fully. I consent freely, voluntarily and without coercion to be a participant in this study.

Print Name of Participant_____

Signature of Participant _____

Date _____

Day/month/year

A copy of this ICF has been provided to the participant.

Print Name of Researcher taking the consent_____

Signature of Researcher taking the consent_____

Date _____

Day/month/year

RUDOLF CYMORR KIRBY P. MARTINEZ
PhD, MA, RN, CAA, LMT, CSTP

Assistant Professor 1, UST College of Nursing
Advance Member, Philippine Nursing Research Society
Research Coordinator, Beta Nu Delta Society of Nursing
Complementary & Alternative Therapy Practitioner

[redacted]

PERSONAL DATA:

- [redacted]

EDUCATIONAL BACKGROUND:

Graduate School:	**Asian Social Institute** 1518 Leon Guinto Street Malate, 1004 Manila ***Doctor of Philosophy in Applied Cosmic Anthropology*** *Dissertation: "Hinabing Ugnayan": Nature of Caring Among Filipino Nurses Working with Children*
	Trinity University of Asia 275 E. Rodriguez Sr. Avenue, Q.C. ***Master of Arts in Nursing Major in Clinical Nursing*** *2007-2010* *Thesis: "Falling Hair and Drilling Bone: A Phenomenological Inquiry into the Lives of Adolescents Undergoing Chemotherapy"*

Tertiary:	**University of Santo Tomas, College of Nursing** España, Manila ***Bachelor of Science in Nursing*** *2003-2007*
Secondary:	**Quezon City Science High School** Misamis St. Bago Bantay, Q.C. 1999-2003
Elementary:	**Tomas Morato Elementary School** Kamuning Q.C. 1992-1999

LICENSURE/ CERTIFICATION:

- ***Nurse Licensure Exam Rating: 84.80***
  - ***Registration #: 0445344***
  - ***Expiration: 04-14-2016***
- ***Certification in Renal Nursing***
  - ***Date: July 27, 2008***
- ***Certification in Acupuncture***
  - ***Date: Dec. 3, 2008***
- ***Licensure Exam For Massage Therapist***
  - ***Date: Dec. 19, 2008***
- ***Certification in Somatic Therapy Practitioner's Course***
  - ***March 8, 2009***

ACHIEVEMENTS

Extra-Curricular	▪ ***Volunteer Nurse in Various Medical and Surgical Missions by UST – MMI and other Organizations***
Graduate School	• **With Highest Distinction on Dissertation (PhD)** • **GPA = 1 (MA)** • ***Best Thesis Writer* (MA)** • **Trinity University of Asia Graduate School Association (GSSA) External Vice-President (2009 – 2010)** • **Trinity University of Asia Graduate School, MAN Organization's President (2009 – 2010)**
College	• ***Cum Laude*** • **Consistent Dean's Lister**

High School	1st Placer, Regional Science and Math Competition
Elementary	***Valedictorian*** 1st Placer, Regional Sci-Math Competition

PAST WORK EXPERIENCES:

1. **University of the Philippines, AKKAP Healing Arts Center**

   Complementary and Alternative Therapy Nurse Practitioner

   (Pain Management, CAM [Acupuncture, Ventosa, Moxibustion, Massage, Somatic, Soft Tissue Manipulation, Positional Release Therapy])

   November 2008 – Present (On Call Basis)

2. **Home Service: Case Manager**

   Complementary & Alternative Therapy Provider

   Nursing Care Provider

   TMJ Therapist

   November 2008 – Present (On Call Basis)

3. **St. Augustine School of Nursing, QC Branch**

   Part Time Lecturer & Team Leader

   (Health Assessment Course)

   November 2008 – March 2010

4. **Tomas Morato Elementary School**

   Volunteer School Nurse/ Complementary & Alternative Therapy Nurse Practitioner

   June 2009 – April 2010

5. **Asian Social Institute, Kahingalay Center**

   Complementary & Alternative Therapy Nurse Practitioner

   June 2009 – Present (On Call Basis)

6. **Philippine Children's Medical Center**

   Staff Nurse

   September 2010 – May 2013

7. **University of Santo Tomas College of Nursing**

   Assistant Professor 1

   June 2013 - Present

RESEARCHES DONE/ PRESENTED:

A Phenomenological Study on the Lives of Non-Adherent Type 2 Diabetics

"Falling Hair and Drilling Bone": A Phenomenological Inquiry Into the Lives of Adolescents Undergoing Chemotherapy

"Journey Through the Seasons": The Adolescents Journey with Chemotherapy

"Masked, Needled and Ruled": Self Concept Among Adolescent Undergoing Chemotherapy

"It Penetrates Your Being": The Experience of Bone Marrow Aspiration in the Eyes of a Child

"Healing Through Suffering, Suffering Through Healing": A Glimpse into the Lives of Pediatric Oncology Nurses

"Unarmed": Experiences of Death and Dying Among Nurses Working with Children

Sight and Insight: A Personal Journey Merging Interpretative Phenomenological and Ethnographic Approaches

"Hinabing Ugnayan": Nature of Caring Among Filipino Nurses Working with Children

SPEAKING/ RESEARCH ENGAGEMENT:

CO-Convenor

- *Evidence Based Practice in Nursing,* Arellano University Little Theater, July 3, 2012

Chairperson

- Panel of Judges: *152th Founding Anniversary and 5th Pagbiagan Festival Cultural Presentation,* Solano Nueva Vizcaya, October 11-13, 2012
- Panel of Judges : *Cultural Presentation, "8th Lang-Ay Festival & 45th Founding Anniversary"*, Bontoc, Mountain Province, April 7, 2012
- Poster Evaluation Panel: *4th National Nursing Research Conference,* Angeles City Pampanga, November 18-19, 2011
- *"Emerging Concepts on Influenza A H1N1: Demystifying the Disease*", Trinity University of Asia, May 22, 2009

Judge, Poster and Oral Evaluation Panel

- *"Nursing Research and Innovation", 5th NNRC's Poster Presentation,* MTC Gymnasium, Dona Tytana Tower, Manila, November 28, 2012
- *UST College of Nursing12th Annual Research Competition,* UST Medicine Auditorium, March 7, 2012

Resource Speaker

- *"Unarmed: Understanding the Phenomenon of Death and Dying Through the Lens of Filipino Nurses' Experiences"*, AVR Hall, Concordia College Manila, April 27, 2013.
- *"5 Qualitative Approaches: An Introduction"*, Building Capacity in Diabetes Education Research: Strengthening Competencies in Quantitative and Qualitative Research, Abbott Laboratories, EDSA Mandaluyong City, April 15, 2013

- *"Meaning Making, Making Meaning: Exploring Phenomenology in Nursing Research"*, AMS Auditorium, Our Lady of Fatima University, March 6, 2013
- *"Shadows and Butterflies: Phenomenology in Critical Care"*, Critical Care Nurses Association of the Philippines, Inc. 2013 Annual Convention, Diamond Hotel, Roxas Boulevard Manila Philippines, February 22, 2013
- *"Unweaving the Intricacies of Phenomenology"*, Little Theater Arellano University, December 8, 2012
- *"5th National Nursing Research Conference"*, MTC Gymnasium, Dona Tytana Tower, Manila, November 28, 2012 (Concurrent Session Moderator)
- *"Re-approaching Phenomenology and Ethnography: A straightforward Guide to Praxeology":* Vincent de Paul Hall, Concordia College Manila, September 1, 2012
- *"Needle in Haystack: Thematization in Phenomenology":* Asian Social Institute, August 18, 2012
- *Grounding Phenomenology: Enmeshing Philosophy with Methodology*, Alfredo Ang
- Lecture Room, Silliman University Dumaguete City, Philippines, July 7, 2012
- *Research Presentation*, Negros Occidental State University, July 6, 2012
- *Acupuncture: An Introduction*, Department of Science and Technology STTI, June 29, 2012
- *"Unweaving the Intricacies of Phenomenology*", Asian Social Institute, October 28-29, 2011
- "*1st Regional Health Research Summit*", Zamboanga City, Philippines, August 17-18, 2011
- "*1st Summer Research Workshop: Phenomenology*", Mindanao State University, May 13-14, 2011
- "*Intensity 50: 50 Years of Dedicated Thomasian Services*", UST Nursing Auditorium, St. Martin de Porres Building, June 30, 2011
- "*7th Lang-Ay Festival & 44th Founding Anniversary*", Bontoc, Mountain Province, April 6, 2011

- "*Introduction to Acupuncture*", Asian Social Institute, June 17, 2009/ March 3, 2010
- "*Pain Management: The Nurse's Way*", STI Fairview College of Nursing, January 27, 2009

Podium Presenter (Research Presentation)

- *2nd International Conference on Qualitative Research in Nursing and Health Sciences*, Bayleaf Hotel, Intramuros, Manila, November 29-30, 2012
- *4th National Nursing Research Conference*, Angeles City Pampanga, November 18-19, 2011
- *Inter-Graduate School Research Colloquium*, UERMMMCI, Philippines(Best Podium Presenter), August 8, 2011
- *International Research Conference for Nursing Students*, University of Santo Tomas, Philippines, March 10-11, 2011
- *National Health Research Skills Workshop*, Cebu Normal University, Cebu Philippines, November 20-21, 2010
- *3rd National Nursing Research Conference*, Philippine Nursing Research Society & PNA Iloilo Chapter, Grand Hotel, Iloilo City, November 18-19, 2010

AREA OF SPECIAL INTEREST AND EXPERTISE

- ***Nursing Research/ Qualitative Research Approach***
- ***Phenomenological Research Method***
- ***Anthropological and Cultural Studies***
- ***Complementary & Alternative Medicine (Focus: Pain Management & Acupuncture)***
- ***Pediatric Nursing***

PROFESSIONAL ORGANIZATIONS with ACTIVE MEMBERSHIP

NURSING ORGANIZATION

1. ***Philippine Nurses Association (PNA)***
2. ***Philippine Nursing Research Society***
3. ***Beta Nu Delta Nursing Society***
4. ***Samahan ng mga Nars ng UST***

ALLIED HEALTH ORGANIZATION

5. ***University of SantoTomas Medical Missions Inc (UST - MMI)***
6. ***Philippine Academy of Acupuncture***
7. ***Philippine Association of Massage Practitioner (PHILPRAC)***
8. ***Somatic Health Care Providers Association Inc, UP-AKKAP***

CHARACTER REFERENCE:

MICHAELA LLAPITAN
Nurse Supervisor (Nurse IV)
Philippine Children's Medical Center
[redacted]

FELIPE DE LEON, JR
Chairman, National Commission for Culture and the Arts
Professor Emeritus, University of the Philippines
[redacted]