

# Essential Nursing Values: Re-Envisioning for the 21st Century

*Editor's Note: This article offers a fuller discussion of nursing history and the future of values-based practice as supplemental content to Grypma's "Nursing in Need of Transformation: What Are We Searching For?" Journal of Christian Nursing, 26(3), pp. 166-173.*

As a nurse educator and historian, I frequently find myself wondering what shaped nursing into the entity it is currently. I wonder what were the issues, who were the leaders, what were the philosophies or paradigms that guided practice, what values drove decisions—and how have these changed over time? As I reflect on what it means to prepare students for an unseen future in nursing, I also wonder what philosophical foundations nursing will draw from, what issues will be debated, and what leadership qualities will be required. In particular, I wonder what the role of the Christian nurse should be. This article, divided into two parts, is a result of these reflections and related discussions with Christian colleagues.



Part 1 offers an overview of nursing history through 2000 years. It considers how factors such as philosophical foundations, leadership, individuals, issues, key events, and values have helped to shape five major eras in nursing (Table 1). Part 2 suggests that a new era of nursing is upon us, and considers how Christian nurses might respond in influential ways. The anticipated shift in nursing over the next decade from an emphasis on “What do nurses know?” to “What do nurses value?” foreshadows a shift from evidence-based to values-based practice. For Christian nurses, increasing attention to the values that

undergird nursing practice should give us pause as we consider the role of values such as compassion, integrity, servant leadership, holism, discernment, honesty, forgiveness, and Sabbath rest. Are these values integral to Christian nursing? Should they be?

## **PART 1: NURSING HISTORY: A SCANDALOUSLY BRIEF OVERVIEW' How Values Shape Practice**

On April 14, 2008 the Canadian newspaper *National Post* ran the headline What Would Eric Liddell Do? In

<sup>1</sup> Title inspired from Jacalyn Duffin's 1999 *History of Medicine: A Scandalously Short Introduction*.



■ **Sonya Grypma, PhD, RN**, is a Nurse Historian and Associate Professor at Trinity Western University at Langley, BC, Canada. She is the author of numerous publications including *Healing Henan: Canadian Nurses at the North China Mission, 1888–1947* (Vancouver: University of British Columbia Press, 2008).

**Table 1.** The Changing Face of Nursing

	A.D. 30 to 1860	1860s to 1940s	1940s to 1970s	1970s to 1990s	1990s to 2009	2009 to ?
<b>Paradigm</b>	Faith-based	Virtue-based	Efficiency-based	Theory-based	Evidence-based	Values-based
<b>Leadership</b>	Religious orders	Nightingale model	Hospital administrators	Theorists	Researchers	Staff nurses
<b>Notables</b>	Sisterhoods	Nightingale—nurses, missionaries	Hospital training schools	Theories	Specialities: cancer, spirituality	Christ-led nurses
<b>Examples</b>	Kaiserwerth, Grey Nuns	Nightingale; missionary nurses	Jean Gunn, Kay Russell	Henderson, Rogers, Parse, Watson	Academics, policymakers	You
<b>Key issues</b>	Social response to illness	Gender (femininity), residency	Hospital-based education	College-based education	EBP, diversity	Burnout, fragmentation, globalization
<b>Key events</b>	Church development, England's rejection of Catholic orders	War, epidemics	Scientific breakthroughs	Move to colleges	Digitalization, litigation, environment concerns	Economic recession, war, increasing rich/poor gap
<b>Key values</b>	Compassion	Character/moral uprightness/integrity	Service, self-sacrifice, humility	Holism	Critical thinking, self-awareness	Integrity, servant leadership, Sabbath rest
<b>Emphasis</b>	Who the nurse represents	Who the nurse is	What the nurse does	What the nurse knows	How the nurse thinks	What the nurse values

it, investment advisor Theo Caldwell (2008) urged governments and citizens debating whether and how free countries should participate in the Beijing Olympics to let “Liddell’s act of consciousness serve as a guide.” Scottish athlete Eric Liddell’s refusal to compromise his Sabbath convictions by running on Sunday not only won him the admiration of audiences who viewed *Chariots of Fire*, the 1981 Academy Award-winning film that dramatized his experience, but also became the defining moment of the 1924 Olympic Games. Theo Caldwell’s juxtaposition of the popularized “What would Jesus do?” serves to highlight not only the tremendous impact one decision made by one athlete had on the history of the Olympic Games, but also the significance of understanding and sharpening the values that shape our everyday decisions.

For Christian nurses searching to

find guidance for their nursing practice, this raises the question: What difference would it make to contemporary nursing if we took seriously some of the most radically underestimated Christian values and incorporated them into our daily practice?

Over the past two millennia, nursing has shifted from the faith-based practice of the Christian church (A.D. 30–1860s) to the virtue-based practice inspired by Nightingale (1860s–1940s) to the efficiency-based practice of the modern hospital era (1940s–1970s) to the theory-based practice of college-centered education (1970s–1990s), and most recently, to evidence-based practice rooted in research-intensive institutions (1990s to the present) through a series of five primary eras in education and practice (Table 1). Nursing as we understand it currently has been influenced by each of these eras.

### Faith-Based Practice (A.D. 30–1860s)

Contemporary nursing can be traced back to the early church, in which Jesus’ instructions to care for the sick and poor were taken up by his followers as both a moral imperative and a living expression of their faith in Christ. Although care of sick, childbearing, and infirm members of one’s family or community have been part of the human experience across time and place, it was Jesus who catalyzed the radical notion of caring for *strangers*. Not only did Jesus heal the sick; he also charged his followers to do the same (e.g.: “Heal the sick, raise the dead, cleanse those who have leprosy”—Matthew 10:8).

Moreover, Jesus taught his followers that to feed the hungry and thirsty, clothe the naked, visit the imprisoned, and look after the sick was profoundly valuable and should



# a Glance

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  - Virtue-based practice inspired by Nightingale (1860s–1940s)*
  - Efficiency-based practice of the modern hospital era (1940s–1970s)*
  - Theory-based practice of college-centered education (1970s–1990s)*
  - Evidence-based practice rooted in research-intensive institutions (1990s to the present)*
- @ **A shift** is occurring toward *Values-based practice (2009–?)*
- @ **Nurses living** out *Christ-centered values can transform nursing*

be carried out as if to Christ himself (Matthew 25:35–37). In other words, it was the Christians' collective duty to care for the sick.

Paul affirmed that illness care was one of the church's main responsibilities. In a letter to James, he urged Christians to go to the community of believers with their illnesses ("Is any one of you sick? He should call the elders of the church to pray over him and anoint him with oil in the name of the Lord"—James 5:14). The role of *diakonos* was established as an organized way for Christians to serve and minister to others on behalf of the Christian church. In Romans 16:1–2, Paul identifies Phoebe, a *diakonos* of the church at Cenchrea, as someone who was a great help to many people, including him. Charged with providing practical help to the needy, the deacons and deaconesses of the early church were the forerunners to a complex, faith-based, organized, practical response to the suffering that accompanies illness and injury—that is, to what we currently know as *nursing*.

Over time, care of sick, wounded,

and poor strangers became a hallmark of Christianity. This provision of care became increasingly institutionalized and formalized as an extension of the diversified Christian church. By the 16th century, religious orders and sisterhoods were leading the way in Europe (and eventually in the colonies) as providers of care for the sick. Pioneering work was done by groups such as Vincent de Paul's Catholic Daughters of Charity in France (founded in 1617), Marguerite D'Youville's Sisters of Charity (Grey Nuns) in Montreal (founded in 1737), Elizabeth Seton's Daughters of Charity in America (founded in 1807), and Theodor Fliedner's Lutheran deaconess movement at Kaiserwerth, Germany (founded in 1838) (Nelson, 2001; Paul, 2005).

In these traditions, nursing was inseparable from Christian faith; one was incomplete without the other. Throughout the centuries, nursing developed in response to social issues of poverty and illness, and one of its key values has been associated with nursing ever since: the value of compassion.

## **The Value of Compassion**

From a Christian perspective, compassion is a Christ-inspired value that involves forsaking one's own desires and acting lovingly toward others, particularly those in distress or need. Closely related to generosity, empathy, sympathy, and mercy, Christian compassion is rooted in Jesus' teachings from the Sermon on the Mount (Matthew 5:3–12): "Blessed are the merciful: for they shall obtain mercy." In 2 Corinthians 1:3, God is described as the "the Father of compassion and the God of all comfort." Hebrews 4:15 describes Christ as a high priest who is able to sympathize with our weaknesses.

Over the centuries, many Christians have been inspired by Christ's example to care for those who are hurt, sick, dying, or disabled. Compassion was the key value upon which Christians developed programs and institutions to care for the sick.

As the Christian church grew and diversified, nursing became increasingly understood as a vocation for single, vowed, religious women. It was viewed as a lifelong calling into Christian service that served as an alternative to marriage and motherhood. In the 1860s, one woman's experience in the Crimean War swept away previously held notions of nursing and paved the way for nursing as a secular, virtue-based practice. The woman's name was Florence Nightingale.

## **Virtue-Based Practice (1860s–1940s)**

Miss Florence Nightingale, the eldest daughter of a wealthy upper class family in England, first turned to the deaconesses at Kaiserwerth, Germany,

to learn what nursing practice entailed. Although she would eventually be credited with radically changing nursing from a fragmented, unorganized, and menial occupation to a standardized, ordered, and well-respected profession, Florence Nightingale's greatest achievement may have been her re-imagining of nursing as a suitable profession for nonvowed women (she also was a brilliant epidemiologist and statistician, roles not generally taken up by nurses for another 100 years).

Nightingale's system of nursing invited a wide variety of women into a highly structured system of caring for the sick. She envisioned a secular (nonsectarian) form of nursing education and practice that relied on a system of hospital-based training, which in many ways combined the commitment and character of religious sisterhoods with the efficiency and hierarchy of the military.

In Nightingale's vision, nursing in post-Catholic England would draw on what was best about the Christian sisterhoods elsewhere in Europe without the requirement of vows into a cloistered community. Although a candidate did not have to be a Christian to enter nurses' training, nurses were expected to display an understanding of and respect for Christian teaching (e.g., through regular Bible reading and prayer) and, perhaps most importantly, an upright moral character.

### **The Value of Character**

Before Nightingale's reforms, nursing in 19th-century England was characterized by the Sairey Gamps of literature, with their slovenness, drunken-

ness, and immorality. Florence Nightingale believed that nurses (all women) should be of high moral character, and set out to ensure systematically that those who entered and graduated from her model of hospital-based nurses' training would be women of competence and character.

As a result of Nightingale's influence, virtue came to be a defining expectation of nursing: The image of nursing became synonymous with virtuous living, purity, and high moral standards. Evidence of good character became an essential requirement for entrance to nurses' training and for becoming a registered nurse.

It should not be surprising that missionary nursing reached its peak during this period. At the turn of the 20th century, religious-minded single young women made lifetime commitments to minister around the globe. Virtue-based nursing practice became the cornerstone of nursing practice and education internationally, and being of "good character" was accepted as an essential requirement for entrance to nurses' training and for becoming a registered nurse.

For Nightingale, being of good character was critical to effective nursing. For almost a century, this ideal remained unchallenged as nursing programs developed ways to predict and measure "good character" (e.g., through references, certificates of character, and behavior checklists). Whereas biblical teachings call Christians into a life that focuses on "whatever is true, whatever is noble, whatever is right, whatever is pure, whatever is lovely, whatever is admirable" (Philippians 4:8), virtue for nurses was measured by a strict code

of conduct that reflected Victorian expressions of feminine virtue such as chastity, cleanliness, obedience, and abstinence from alcohol and other vices. As Anne Marie Rafferty (2005) has noted, nursing education became a "purification process" whereby a nurse's "crystalline character became a beacon of Christian piety and demeanor."

According to Diane Hamilton (1994), this "obsession" with the behavior and character of the nurse helped to solidify the group identity of nurses. It also shaped the public image of nursing as a profession of trustworthy, virtuous women. However, the emphasis on character took precedence over knowledge, something that nursing leaders began to question as scientific advances in medicine began to reshape hospital care.

### **Efficiency-Based Practice (1940s–1970s)**

One of the most significant medical breakthroughs of the 20th century was the discovery of penicillin in 1928 by Dr. Alexander Fleming. By the 1940s, penicillin had become available in medicine form, transforming the care of infection and stimulating a wave of excitement in scientific medical research and technology that has not abated since. As scientists discovered and invented increasingly sophisticated methods for diagnosing and treating disease—including x-rays, iron lungs, anesthetics, blood transfusions, and pharmaceuticals—the need for hospital-based care became more urgent. Not only did the requisite medical technology no longer fit neatly into the doctor's bag to take on home visits; it also was too expensive to purchase. For

the sake of efficiency, patients would have to come to the hospitals.

Nursing education during these years was predominantly hospital based. Nurses typically lived together in all-female residences attached to the hospital training school. They ate, attended lectures, and took care of patients together. And instead of graduating out to private duty nursing care, graduate nurses increasingly were hired to staff hospitals. Caring for groups of patients in large general wards, nurses became masters at efficiency, managing patient routines with military precision as postoperative, obstetric, and rehabilitative care typically involved days, weeks, and sometimes months of hospitalization. Bed baths, bed making, dressing, toileting, feeding, changing dressings, administering medications, and managing technology such as oxygen masks and intravenous lines were routinized and meticulously documented. Specialized areas such as the intensive care unit, emergency department, operating rooms, and recovery rooms required specialized training and provided recognition for the requisite specialized knowledge and skill.

### **The Value of Service**

In the highly organized, hierarchical world of hospital nursing, staff nurses worked as teams, partitioning care into subsections in which one nurse might be responsible for the partial care of many patients (e.g., “the medication nurse”). Nursing was understood as a collective. Individual nurses were expected to provide standardized care according to the decisions made by physicians and nursing supervisors, and their role was to contribute to the

smooth functioning of the ward or unit in which they worked. The values of self-sacrifice and humility were highly regarded. To be self-effacing and meek, striving for the good of someone and something outside oneself, was considered central to nursing care. Nursing leadership was provided by nurses with experience and a lifetime commitment to nursing.

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Leaders often occupied administrative positions in hospitals and training schools. Women such as Jean Gunn, Superintendent of the renowned Toronto General Hospital training school for nurses, and Isabel Maitland Stewart, early Chairman of the Department of Nursing Education at the legendary Teachers College, were highly respected by staff nurses, patients, and physicians alike. Staff and student nurses who showed potential for becoming strong administrators were mentored into those positions with the understanding that their role was ultimately to serve the needs of the community in which they worked—a community composed of patients, physicians, support staff, and other nurses.

As nursing increasingly moved into hospital settings, nurses came increasingly under the authority of physi-

cians. Although their service to patients was valued, nurses began to question why this also necessitated service to physicians (i.e., why physicians had a dominant role over nursing as well as medical practice and education) (Reverby, 1987).

Resisting the notion that nurses were simply physicians’ “handmaidens,” nursing leaders began to explore ways that nursing could be understood and expressed outside an exclusively medical paradigm. One way to do this was for nursing leaders to have more control over nursing curricula, in part by finding ways to articulate how nursing was distinct.

### **Theory-Based Practice (1970s–1990s)**

In the 1970s, an increasing number of nursing leaders began to envision a place for nursing in university and college programs. As unprecedented numbers of nurses entered graduate programs and pursued doctoral degrees in non-nursing fields, they began to perceive a need to articulate the art and science of nursing—to explain, predict, and better teach nursing care.

In 1966, Virginia Henderson famously described the unique function of the nurse as to “assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge” (p. 15).

Some early nursing theorists strove to illuminate the complexities of nursing care in a way that would provide guidance to practitioners, whereas others strove to extend understandings of what nursing is to what it

could become. Nursing was simultaneously deconstructed and reconstructed as early theorists (mostly meta-theorists) struggled with ways to describe its holistic character. Reducing the essence of human nature to biologic, psychological, social, and spiritual components helped to guide nursing curricula as college-based nursing programs found ways to incorporate teachings from other departments. It also provided opportunities to reinforce an understanding of humans as holistic beings who require more than attention to their physical needs.

These new understandings further served to differentiate between medicine and nursing. If the goal of medical care was to treat illness, then the goal of nursing care was to restore wellness. If the focus of medicine was the body, then the focus of nursing was the interrelationship between body, mind, and spirit.

The paradigm shift that characterized Western nursing in the late 1980s and early 1990s was most recognizable in nursing education. Recognizing the value of nursing knowledge (versus knowledge borrowed from other disciplines), a number of Western nursing programs adopted nursing theories to frame their approach to teaching and practice. For example, the University of Calgary (Alberta, Canada) used Sister Callista Roy's Adaptation Model as the organizing framework for their Baccalaureate of Nursing program. Graduates saw value in using frameworks for practice and found ways to incorporate theories and models into clinical practice. For example, Calgary Health Services (public health) used Dorothea Orem's Self-Care Deficit Theory to organize and record nursing

care. Still, it was the nursing theories on holism that most radically changed the way nurses worked and thought.

### **The Value of Holism**

As nursing care became firmly established as a highly technical, hospital-based practice, nurses began to question the reductionist approach to care, which emphasized disease, physical symptoms, and treatments (e.g., "the cholecystectomy in Room 12"). In 1978, the World Health Organization (WHO) issued the Declaration of Alma-Ata, which defined health as a state of complete physical, mental, and social well-being, and not merely as the absence of disease and infirmity. As health and wholeness became the focus of nursing, the WHO definition of health began to emerge in nursing discourse, as did the term "holism."

Perhaps one of the earliest influences on the notion of holism in nursing was the work of Joyce Travelbee (1966) in her book *Interpersonal Aspects of Nursing*. Travelbee defined humans as unique biologic, social, rational, and transcendent beings possessing inherent value and worth. Other preeminent nurse theorists—Martha Rogers (1970), Jean Watson (1979), Rosemary Rizzo Parse (1981), and Margaret Newman (1986)—developed theories to assist understandings of what it meant to pursue wholeness (a state of harmony between body, mind, and spirit) rather than simply freedom from disease.

Christian nurses met this shift toward holism with mixed reviews. Until the 1960s, nursing had been predominantly understood as a vocation (*vocare*) or calling from God. By

the 1980s, the terms "vocation" and "profession" had become antonyms. The former was associated with oppression, patriarchy, and menial labor and the latter with emancipation, education, autonomy, and expertise. As religious ideals were replaced with scientific ideals in the curriculum, Christian nurses became increasingly uncertain about the role of faith in nursing practice as religious practices such as prayer and Bible reading, once central to nursing practice, were rejected and forbidden.

However, the shift toward holism opened new opportunities to explore the meaning of spirituality in nursing. When nursing began to move from theory-based to evidence-based practice, Christian nurse scholars were among the first to take the challenge. Seminal examples are Sharon Fish and Judith Shelly's (1978) book, *Spiritual Care: The Nurse's Role*; Martha Highfield and C. Cason's (1983) article, *Spiritual Needs of Patients—Are They Recognized?*; and Verna Benner Carson's *Spiritual Dimensions of Nursing Practice* (1989). These thinkers laid a foundation for the Christian scholarship that has since followed (Bradshaw, 1994;<sup>AQ3</sup> O'Brien, 1999; Shelly & Miller, 1999, 2006).

### **Evidence-Based Practice (1990s to the Present)**

In both educational and practice settings in North America, nursing research has gained unprecedented recognition and growth. As more graduate-prepared nurses occupy positions in both the academy and the field, research *by* and *for* nurses on topics of relevance to clinical practice is being funded, published, and disseminated

within and outside the profession. At the same time, and in response to an increasing need to provide fiscally responsible, safe, standardized, predictable, and measurable patient outcomes, nursing is taking up the language of medicine by instituting “evidence-based practice” (EBP) as state-of-the-art practice. Fully absorbed into the nursing lexicon, EBP provides a language for communicating “best practice” to students, colleagues, administrators, governing bodies, and funding agencies. Furthermore, EBP provides a standard against which nursing practice in cases of negligence or malpractice can be measured.

### **The Value of Critical Thinking**

In the EBP era, nursing students have been encouraged to be self-directed learners, critical thinkers, interdisciplinary collaborators, and savvy consumers of published research. A rapidly changing body of knowledge has made it necessary for nurses to stay abreast of new developments in the field, and advanced computer technology has made it possible. The key value underlying the EBP era is critical thinking, defined in the 2009 edition of Potter and Perry’s *Fundamentals of Nursing* as an “active, organized, cognitive process used to carefully examine one’s thinking and the thinking of others” (Chaffee, 2002 [cited in Potter & Perry, 2009], p. 216). Within the EBP paradigm, it is important to be self-directed, self-aware, and open-minded toward diverse ways of thinking, knowing, acting, and believing.

### **Limitations of EBP**

Critical thinking is so important

because the success of EBP is partly dependent on the ability to apply evidence appropriately in the clinical setting. One concern is the potential for misapplication when evidence is taken up uncritically by those who do not understand the nature (and limitations) of the evidence provided.

Although few would disagree that nursing practice should be rooted in strong evidence, EBP has some important limitations. For EBP to be accepted as a practice paradigm, certain assumptions must be accepted: (1) that “best practice” knowledge can be quantified and measured (or qualified and described) through research, articulated through reports (verbal or written), and standardized in policies; (2) that the knowledge extrapolated in one setting can be transferred to and used in another, and (3) that this knowledge will provide direction and support to frontline nurses working in broken and disappointing healthcare systems.

To what extent can research provide answers to profound questions about suffering, meaning of life, and life’s calling? Evidence-based practice is an important development in the evolution of the profession. It raises expectations, streamlines resources, and gives nurses an opportunity to influence patient care on a broader scale.

However, when it replaces philosophical, theoretical, historical, or even theological foundations as *the* professionalizing discourse, nurses are left with little direction to the most profound (and deeply personal) questions: Where did we come from? Where are we going? Why am I here? What are we trying to accomplish? Is what I am doing meaningful? These questions

strike at the heart of nursing, inviting us to take a serious look at what *values* should guide our practice.

## **PART 2: A NEW PARADIGM**

A new paradigm is on the horizon. Like each wave of change in nursing history, this one will build on what has gone before, considering old ideas in new ways. One indication of this change is the shift away from EPB terminology in nursing discourse. For example, a 2009 Canadian edition of a nursing fundamentals textbook has replaced the term “evidence-based practice” with “evidence-informed practice” (Potter & Perry, 2009) to acknowledge, in part, the need for nurses to value and synthesize a variety of forms of knowledge. Perhaps more importantly, nursing leaders are starting to question the extent to which the current approach can help nurses respond to a broken world.

In North America, the concept of EBP has been closely tied with patient outcomes. If excellent outcomes are the goal (measured in terms of safety, length of hospital stay, readmissions, patient satisfaction, and staff satisfaction and retention), then EPB is the means. Those of us in Canada have watched with great interest the magnet hospital movement in the United States, in which nursing excellence is pursued and measured in terms of patient outcomes, high level of job satisfaction, and low staff turnover. To receive magnet status, nursing leaders are expected to appreciate staff nurses, involve them in shaping research-based practice, and encourage and reward them for advancing nursing practice. This, to me, appears to be the epitome of all that is good about EPB

practice.

However, according to the Center for Nursing Advocacy (2008), the American Nurses' Credentialing Center has recently started to question the validity of magnet status with a statement: "Frankly, the Center has heard from a number of nurses who are unhappy with the changes at their hospitals since the award of magnet status, and we have not heard from many who are happy." Generally, the complaints emphasize incongruence between the ideals represented by magnet status and actual practice. Reading the Web site discussion board, I am struck by how many complaints are related to relationship, specifically, poor relationships between administrators and staff nurses.

Complaints of low morale, lack of response to staff concerns, and not being heard certainly are not new in nursing. But EBP is not sufficient to address these types of concerns.

For as long as I have been in nursing, an uneasy relationship has existed between nurses in academia, education, administration, and clinical practice. Staff nurses complain that administrators are out of touch with bedside care. Administrators complain that staff nurses do not understand the extent to which decisions are driven by policy and fiscal constraints. Clinicians complain that academics are out of touch with clinical practice. Academics complain about the impossibility of being excellent researchers, educators, and clinicians. Experienced staff nurses complain that novice nurses do not receive enough hands-on training in their education. Novice nurses complain that staff nurses "eat their young." And

## Table 2. Christian Values for Nursing Practice

<b>Compassion</b> —Matthew 14:14; Philippians 1:8
<b>Integrity</b> —Psalm 18:25; Proverbs 20:7; 1 Timothy 3:8
<b>Servant leadership</b> —Matthew 25:21; Mark 10:45; Galatians 5:13
<b>Forgiveness</b> —Matthew 6:12; Mark 11:25; 2 Corinthians 2:10
<b>Critical thinking</b> —Proverbs 16:22, 23:23; Daniel 2:14
<b>Sabbath rest</b> —Exodus 16:23, 20:8; Mark 2:27

passing through the midst of these tensions are the most vulnerable among us: patients and students. Is it possible that values-based practice might improve nursing in settings characterized by relational conflicts?

### Values-Based Practice (2009-?)

What does it mean for nursing to be values based? If we understand "values" to mean principles, standards, or qualities considered worthwhile or desirable in a pluralistic society, we must also ask, whose values prevail? What frame of reference do we use? Is this frame of reference equally relevant for nurses in different geographic, cultural, and professional settings? How do we use good science (e.g., historical, philosophical, empirical) to support values-based practice? How do we use values to support the development of good science?

As Christian nurses, part of our response to the suffering of this age, I believe, is to develop, teach, and role model Christ-centered values including compassion, character (integrity), service (servant leadership), holism, and critical thinking (discernment)—updated forms of the values that, not incidentally, have been part of the development of nursing since the

early church (Table 2). In addition, we must have the courage to seek out ways to incorporate three of the most radically underestimated Christian values into our daily practice: honesty, forgiveness, and Sabbath rest. In this section I revisit values of integrity (including honesty) and servant leadership (including forgiveness), then reintroduce Sabbath rest.

### Integrity

Few would argue that compassion, holism, and critical thinking are essential values in contemporary nursing practice. However, character and service are a different matter. As Bernice Buresh and Suzanne Gordon (2006) argue, historic ideals of self-sacrifice, humility, and moral behavior rooted in the "religious virtue script" served (and serve) to undermine nursing agency and oppress women working in patriarchal institutions.<sup>2</sup> Currently, most nurses, I suspect, would be appalled by a letter to the editor of the *New York Times* on April 18, 1916, for example, which called upon student nurses to "protest against requirements based upon academic achievement, instead of upon character, per-

<sup>2</sup>The notion of "virtue script" is credited to Suzanne Gordon and Sioban Nelson.



sonality, and aptitude to do, rather than aptitude to know" (Stromberg, 1916). Nursing, the writer insisted, did not demand a "judicious mind" but rather a "judicious nature." Currently, resistance to any evaluation of "character" in nursing curricula stems from the Nightingale-inspired era in which an expectation of virtue and virtue alone undermined nurses self-determination and agency.

Sensitized to the power relationships embedded in educational institutions, nursing programs no longer require evidence of "good character" for entrance into or graduation from nursing programs. This is not to say that it is no longer valued, however. For example, the International Council of Nurses recently endorsed the view that students should "first be of good character" if classroom strategies to stimulate moral imagination and ethical thinking are to be effective (Fry & Johnstone, 2002, p. 169). Similarly, in Canada, evidence of good character is required for admission into nursing practice in the provinces of Alberta and Ontario (Alberta, Canada, 2008; McIntyre, Thomlinson, & McDonald, 2005; Health Force Ontario, n. d.). Moreover, in the United States, L. Thomson Adams recently asserted, "Leaders [must] have good character. Good character means they are ethical and moral" (Thompson Adams, 2006).

For the community in which I work, the regional Health Authority developed a list of "leadership competencies" to support the success of employees in formal leadership roles. The very first item was "acts with integrity and trust" (Fraser Health, 2008, p. 1). According to this docu-

ment, leaders are expected to "create an atmosphere that promotes respect, care and trust, act consistently with personal values, and demonstrate sound professional and business ethics." Although nurses must be sensitive to ways that "the virtue script" can undermine professional nursing practice, values such as integrity, honesty, trustworthiness, and moral uprightness are critical to ethical, professional practice.

### ***Servant Leadership***

Contemporary concerns about "service" fall within the same category as concerns related to "character." When placed within a historical context of gendered power relationships in healthcare, the notions of "service" and "self-sacrifice" have (and do) represent a culture that places women's work under the control of men, nurses' work under the control of physicians, and ethnic minority groups under the control of the dominant culture. The Christian struggle to understand what it means to serve must be viewed through this context: there is a dangerously fine line between service/altruism/self-sacrifice and oppression. Yet Christ called his followers to give up all they had to follow him, to lay down their lives for others (John 15:13). What does this mean for nursing?

At the Christian university where I work, "servant leadership" is a core value. Coined by Robert Greenleaf in 1970, servant leadership "serves others by investing in their development and well-being for the benefit of the common good. Thus good Christian servant leaders serve God through investing in others so that

together they may accomplish a task for Gods glory" (Trinity Western University, 2008). The 10 characteristics that describe the essence of a servant leader are listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to the growth of others, and building community. The core idea of servant leadership is quite simple: authentic, ethical leaders, those whom we trust and want to follow, are servants first (Greenleaf Center, 2008).

For those in formal leadership roles (e.g., administrators, educators), servant leadership is a countercultural idea worth embracing. Servant leadership uses power to develop followers rather than control them, is relationship-oriented rather than task-oriented, is willing to be vulnerable by trusting and empowering others, and does not seek to claim credit for success or blame others for failure (Wong, 2003). Servant leadership seeks and offers forgiveness in cases of offense, mistakes, and harm.

Yet the notion of servant leadership is not confined to those in formal leadership positions. In fact, I suggest that in a values-based era, the most significant leadership will come not from researchers or policy makers, but from staff nurses and frontline workers. Most new graduates enter practice as staff nurses. Many of the best educators for our students and new graduates are staff nurses who act in roles as preceptors and mentors. In my experience, there are few whom students regard more highly than experienced staff nurses. I contend that the future of nursing lies not in research breakthroughs, integrated

curricula, or magnet status (i.e., the domain of researchers, educators, and administrators). Rather, it lies in the hands of staff nurses, who are in a position to practice servant leadership with the new generation.

My challenge is to all Christian nurses, particularly those whose expertise lies at the bedside. Do not underestimate the transformative power of living out your “personal values.” For Christian nurses, this means living out values of compassion, integrity, servant leadership, critical thinking, and, perhaps most radically, Sabbath rest.

### **Sabbath Rest**

For a profession characterized by 24/7 shift work, the notion of Sabbath rest seems impractical, countercultural, and even irrelevant. Yet I believe it is essential to the health (wholeness) of nurses and nursing. In particular, it is essential to the development of strong relationships, which lie at the heart of good nursing care: Good relationships with patients, coworkers, and supervisors are key to nursing excellence.

But how does a nurse develop good relationships in a strained and stressful work environment? I have come to believe that part of the key to being relation oriented in the public sphere (a good listener, empathic, compassionate) is to come to work refreshed through strong relationships in the private sphere (i.e., relationships with self, others, and God). And taking Sabbath rest helps to make this a reality.

In this context, Sabbath rest does not mean not working on Sundays. Rather, it is accepting and embracing the principles of Sabbath, recognizing it as gift

from God. Perhaps the reason for inclusion of Sabbath rest as one of the Ten Commandments (Exodus 20) is to challenge those of us who might otherwise not take the time to reflect, recreate, reconnect, and be refreshed. We were created for relationship, and yet the era in which we live makes such high demands on our time, energy, and financial resources that we feel depleted before we even come to work. According to Richard Swenson (2004), we live in an era characterized by all kinds of overload including activity, debt, accessibility, information, and choice. Overload puts a strain on our relationships, pushing us into a form of “hyperliving” in which busyness distracts us from the most profound and deep aspects of being human. Moreover, it distracts us from our calling.

The antidote to hyperliving is Sabbath rest: intentional, scheduled time away from our usual routine. If our lives are defined by activity, Sabbath is a time to sit still. If our lives are characterized by accessibility, it is a time to turn off our pagers, e-mail, and cell phones. If our lives are filled with TV and computer, it is a time to tune out. And if our lives are isolated, it is time to seek out the company of others. Most importantly, Sabbath is a time to reflect on, pray to, worship, and seek the face of God—in both solitude and community. This, I believe, best prepares us to face the challenges of our *vocare*.

### **LIVING OUT OUR VALUES**

As a nurse historian, I am drawn to the story of Eric Liddell for an unconventional reason: his little-recognized marriage to Canadian missionary nurse

Florence MacKenzie. After winning the gold medal in a non-Sabbath race at the Paris Olympics, Eric Liddell moved to China to become a missionary. There he met and married Florence. In 1941, the expectant Florence returned to Canada with her two daughters due to increasing hostilities in China’s war against Japan. Eric Liddell remained in China, where he and 14,400 other expatriates were placed in Japanese prison camps after Pearl Harbor. Eric died of a brain tumor at the Weixian camp in 1945. To both Florence and Eric Liddell, understanding and living out one’s Christian values gave their lives direction and meaning.

Today, Eric and Florence Liddell are commemorated at the Weixian Internment Camp memorial in Shandong province in China. My favorite part of the museum is the caption under the Liddell’s wedding photo, which erroneously identifies Florence MacKenzie as “Florence Nightingale.” Although Florence had not formally practiced as a missionary nurse after marrying Eric Liddell in 1934, her nursing identity remained an important part of who she was and how she was viewed by others.

As Christian nurses, we would do well to recognize that our nursing identity does not stop at shift’s end; nor does it stop when we are off an employer’s payroll. Rather, it extends into our private lives, informing choices about relationships, healthcare practices, and perceptions on issues such as social justice, healthcare reform, and disaster relief. The lines between nurses’ private and public lives are blurred more than is usually acknowledged. Decisions made in one sphere inevitably influence the other.

If being a nurse influences our private lives, it stands to reason that who we are outside our nursing role would influence our nursing lives. That is, the values that inform everyday decisions outside work naturally and necessarily influence decisions and attitudes within work, whether consciously or not.

This article is not a call to individualistic self-examination, however. Nor is it a call to strive toward a self-actualized state. Rather, it is an invitation to conscientious attention to something outside ourselves, something beyond our individual hopes and dreams. It is, in fact, a call to balance self-awareness with self-forgetfulness, to understand our place in the world while simultaneously looking beyond it. Part of that understanding, I believe, comes from paying attention to the broader historical context within which we live and work. By looking to the past, perhaps we will recognize our agency in shaping the future.

Eric Liddell's choice to honor the Sabbath in 1924 is remembered today as an act of courage. Less well known is the courage he showed at the Weixian internment camp from 1941 to 1945, where he had an impact on the lives of hundreds of missionary children from the China Inland Mission boarding school at Zhifu (Cheefoo), imprisoned without their parents. No less important is Florence Liddell's courage in agreeing to separate from her husband by evacuating to Canada with their children.

Florence returned to nursing practice after Eric died. Two of her daughters also became nurses. Whether faced with crises or the mundane, rooting our decisions in

Christ-centered values gives each of us the opportunity to transform the particular corner in which we are called to serve.

## Acknowledgments

The author acknowledges the ideas and contributions of colleagues Sheryl Reimer Kirkham and Rick Sawatzky.

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