CATHOLIC NURSES' GUILD OF THAILAND

1997

CICIAMS

THE PROCEEDINGS OF THE 7th ASIAN REGIONAL CONFERENCE OF CICIAMS

CARING

A PATH TO HEALTH AND HEALING

NOVEMBER 9 -13, 1997

VENUS : ASIA HOTEL, BANGKOK

EDITOR :

The Academics Committee of CNG of Thailand

ORGANIZED BY

The Catholic Nurses' Guild of Thailand

C.I.C.I.A.M.S.

Origin and History: It first started in 1928 at Brussel, where the Presidents of the Catholic nursing associations of several countries decided to create an international professional Catholic organization. A first Congress was held in Lourdes in 1933 and a committee was elected. By 1946, its activities had spread rapidly in the majority of countries, faced with the complex development of preventive; social medicine; and the appearance in every country, by the side of those engaged in nursing care, of persons qualified in the medico – social sphere, the International study committee adopted the title "C.I.C.I.A.M.S.". Towards 1956, CICIAMS entered into relationship with a great number of international organizations.

Objectives: CICIAMS proposes these aims among others; GROUP professional Catholic Nursing Associations with a view to ensuring their technical perfection according to Christian moral principles, REPRESENT Christian thought in the general professional field on an international level, COOPERATE in the general development of the profession and promote a healthy social action.

Organization and Administration: CICIAMS is directed by;
General Council: This is composed of Presidents of official delegated of the Adherent Member Guilds,
General : The office elected by the General Council
Consultative Status: CICIAMS has been a member of many international orgnizations: International Catholic Orgnization (I.C.O.), Pontifical Councils of Pastoral Assistance to Health Care Workers, The Family and Cor Unum, International Labour Orgnization (I.L.O), World Health Organization (WHO), Council of Europe and Others.

Meetings and Conference:
The Regional Committee Meeting is held once every 2 years during the Asian Regional Seminar and during the World Congress.
The Asian Regional Meetings are held during CICIAMS World Congress and also the Asian Regional Seminars.

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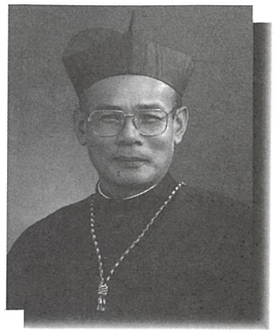
We are thanking the Sisters, instructors and staff of St. Louis Nursing College especially Library and Information Department, Rector's Office and also Saint Louis Hospital particularly Louis Media Department and all our sponsors who gave their generous help and support to make this conference and book meaningful and fruitful.



Message from

H.E. Michael Cardinal Michai Kitbunchu

It gives me great pleasure to address all participants of the 7th Asian Regional Conference of CICIAMS.

Sickness , suffering and pain are the mystery of human life. They are inevitable reality and part of human condition which have perplexed whole humankind since the beginning of the world. Sickness , suffering and pain are closely connected with humankind's sinful state and yet they are not to be seen as punishment from God. By Christ's suffering, death and resurrection , he gave meaning and value to sickness , suffering and pain as a preparation for and as means to achieve salvation and an eternal life in glory. Through his incarnation and his life on earth , Christ came to know and experience human sorrow. He loved and had deep compassion towards the sick and those who suffered all kind of illnesses. He healed them all.

The task of caring and healing the sick persons has been handed down to all christians who believe in Jesus Christ. Such duty, however , is the main concern of doctors and nurses who devote their life to combat this human misery.

As catholic nurses are now convening in the 7th Asian Regional Conference of CICIAMS, it is a great opportunity for all personnel in this medical expertise to put all effort to find out ways and means to succour the sick and to help them for the relief of their pain and suffering both physically and spiritually. I pray for the success of this conference. And may the Lord Jesus be present among you throughout the sessions.

M. Card. Michai Kitbunchu

M. Cardinal Michai Kitbunchu
Archbishop of Bangkok

CONTENT

CONTENT

Foreword

The following document presents the proceedings of the 7th Asian Regional Conference of CICIAMS, Bangkok, Thailand.

It includes: the background information of the CICIAMS; important speeches, including the presentation on conclusions and summaries of each topic.

All materials in the report have been compiled and edited by the Academics Committee of the Catholic Nurses' Guild of Thailand with the assistance of Sr. Marie Reine Lekprasert, SPC, A. Sriprapa Piyasirisilp, A. Suwannnee Laopaksin, A. Jeerawan Rod-una and the General Secretariat, led by Sr. Loretta Joseph Sambo, SPC along with the Instructors of St. Louis Nursing College, contributed greatly to the success of the international conference. Lastly, the guidance and support of Fr. Joseph Chamnien Kitcharoen, Chaplain of CNG Thailand, Sr. Adela Phisutsinthop, SPC, and Mrs. Theresa Angoon Vacharatith, the President of CNG of Thailand were critical to the proceeding.

This publication has been a product of the various journeys of the nurses, midwives, medical assistants, religious Sisters and priests from different countries.

Sr. Magdalena Supaporn Daodee, SPC
Head of Academics Committee,
The Catholic Nurses' Guild of Thailand

Perspective

A Global Agenda for Human Caring

Sister M. Simone Roach

The author

Director of Heritage Project,
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Abstract

Care and Caring have been the focus of study and research in nursing over several decades. This paper is based on a philosophical inquiry into the nature of human caring and is in place in nursing

*Grounded in an ontology of caring, nursing is defined as the professionalization of the human capacity to care, through the acquisition and application of the knowledge, skills, attitudes and values mandated by nursing's prescribed roles. A person cares not because he or she is a nurse, but because he or she is a human being. Caring, therefore, is deemed not unique to nursing is that it distinguishes nursing from other professional or occupational groups. Rather, caring is unique **IN** nursing; all attributes used to describe nursing have their focus in care.*

Also addressed are the specific ways in which caring may be expressed in the FIVE C's : Compassion, Competence, Confidence, Conscience, Commitment. Human caring is caring from the heart, caring from the core of one's being; moved by an awareness of being in relationship; inspired by an intuition that there is something in each of us, greater than ourselves; each human being is a Temple of God. God dwells within us, and caring acts are a manifestation of God's love among us.

Introduction

Any discourse on human services presumes, to some degree at least, the importance of human caring. This is particularly the case in health sevices. Despite the fact that different conceptualizations of caring are proposed in nursing studies, and a variety of opinions about its place as an organizing concept in nursing are presented, there is a growing consensus among nursing theorists about its importance and centrality. It is impossible for me to even highlight literature in the field of human caring in nursing, but I would be remiss if I did not acknowledge a few major sources.

Dr. Madeleine Leininger, Founder of the International Association for Human Caring, nurse anthropologist, writer, educator and researcher has been an international leader in this movement, with her reflections around the theme, "Caring is the essence of nursing and the unique and unifying focus of the profession" (1981, 1984, 1991, 1995). Dr. Jean Watson (1985), internationally renowned educator, researcher and writer, has also contributed much to the philosophy and science of caring, including the establishment of a Center for Human Caring at the University of Colorado, Denver, USA.

The nineteenth Conference of the International Association for Human Caring was held in Helsinki, June 14-16, 1997. Each of these Caring Conferences has generated a wealth of literature on caring from researchers, educators and practitioners representing countries across the globe. Many of the presentations have been published in volumes by the National League for Nursing, New York. In the Spring of 1997 the Association embarked on a new production, the International Journal for Human Caring, providing a

rich source of reflection by persons committed to the ideal as well as to the practical application of human caring theory.

The theme of this conference, "Caring: A Path to Health and Healing", a theme which reminds us of the need for healing in a broken world, is timely. In my presentation this morning, I should like to share with you a reflection on my journey in trying to understand the meaning of human care and its relevance for all who are committed to the science and art of nursing and to the helping professions in general.

My purpose, this morning, is not to lecture, much less is my purpose to read a paper. I trust this privileged time together will be a process of engagement and participative listening. To keep on track, I will use the following outline:

1 The Universe of Caring; Naming the Questions
2. Toward an Ontology of Caring
3.Caring and the Nursing Profession
4. Caring Entities: The Five C'S (Onticology)
5. Conclusion; A Nursing Exemplar

The Universe of Caring; Naming the Questions

The concept *caring* is a complex one with many meanings, raising numerous questions. I have found it helpful to assign these questions to the following five categories:

1. Ontology: Ontology is an inquiry into the *being* of something and its range of possibilities. Ontology raises the question, What is the *being* of caring? What is caring in itself?
2. Anthropology: A study of both the nature and the mystery of the human being, asks the question, What does it mean to be a human person?
3. Onticology: A study of an entity in relation to another entity (Schmitt, 1969), includes the question, What is the nurse doing when he/she is caring?
4. Epistemology: Concerned with ways of knowing, focuses on the question, How is caring known?
5. Pedagogy: Involved with the art and methods of teaching, raises the question, How is caring learned and taught?

This presentation will focus on two of these categories--ontology and onticology.

Toward an Ontology of Caring

Caring is the human mode of being

Caring is not an exceptional quality; nor is it the response of an exceptional few. It is the most common, authentic criterion of humanness. Caring is humankind at home; being real; being his or herself. I care, not because I am a nurse, social worker, chaplain, physician, or parent; I care because I am a human being. To the extent or to the degree I am uncaring; to that extent or to that degree I am less than fully human. In the core of our being, we know this to be true.

Caring is essential for human growth and development

One is fulfilled through caring, and becomes fulfilled as one's capacity to care is called forth, nurtured, and expressed. We have to care for something; in some way to let the other grow, whether this other be a project, a hobby, another person or oneself.

That caring is essential for human growth and development is shown in the relationship between caring and dependency (Gaylin, 1976).
…the most unique aspect of human development is the total helplessness of the human infant and the uncharacteristically long period of time in which it remains floundering in this helpless state (p.31).

The dependency period, notes Gaylin, is "crucial to the development of the person who loves and is lovable, who has

emotions and relationships, is capable of altruism and hope" (p.32).

One of the most tragic examples of the inability to care or to allow oneself to be cared for is depicted in the character of Javert, the policeman, in victor Hugo's *Les Miserables.* In one scene Javert, held captive by the rebels behind a blockade, is turned over to Jan Valjean. Jean Valjean takes Javert outside the blockade, fires his pistol in the air, then unbinds Javert and lets him go free. In the second scene, when Jean Valjean has successfully reached the exit of a Paris underground system with an injured friend, he encounters Javert waiting for him. Knowing he has to turn himself in for arrest, Jean Valjean asks Javert for permission to deliver a message to a friend on the way to police station. Javert grants the permission but, when Jean Valjean returns, Javert has already gone. The third and tragic scene shows Javert pacing back and forth over the bridge, above the most turbulent rapids of the River Seine. In what appears to be an agonizing struggle with his conscience, Javert, in utter darkness and desolation, throws himself into the rapids below. All that is heard is a splash in the night. Victor Hugo makes the observation that "The ideal for Javert was not to be human, grand or sublime: it was to be irreproachable, and now he had broken down" (Vol.III, p.205). Javert could be only a policeman; he could not be a human being. Not to care is to lose one's being.

The capacity to care is almost indestructible

The capacity to care may be suppressed or its expression inhibited, but caring in some way seeks to express itself. Rollo May (1969) illustrates this in his reference to "a strange phenomenon about the photographs taken of soldiers in combat. These pictures show soldiers taking care of injured comrads; the bewilderment on the face of a child caught in the middle of the conflict, and the momentary exchange between two human beings (supposedly enemies). This human exchange in May's language, reflects "on this elemental level, *care*." (p.284).

Other moving accounts of persons involved, for example, in the holocaust reveal attempts for the natural capacity to care to express itself (Speer, 1971); as well as reports of acts of human decency of a few guards in the prison camps. By writing directly to Aleksandr Solzhenitsy, I have tried unsuccessfully to track signs of conversion of guards involved in the atrocities described in the *Gulag Archipelago.* I still have enough faith in humanity to believe that somewhere, someone acted in a humanly decent manner, but sadly we do see evidence of attempts to repress the capacity to care so that individuals charged with the torment of others will not "weaken."

All too frequently in Western society, the premise that caring is the human mode of being is called into question. Caring appears to be more obvious by its absence than by its presence in human affairs, and our exposure to local, national and global conflict convinces us of this on a daily basis. Nonetheless, is it not because we have a natural capacity to care; that we are naturally endowed with a moral call to care; that we have an intuitive grasp of the need to care and be cared for that few can recognize non-caring as anti-human and wrong in the first place?

Caring is a *total way of being*. It is the most authentically human way of acting, of relating. Caring is a quality of investment and engagement in the other. Milton Mayeroff (1971) speaks of caring as providing meaning and order in one's life:

"Caring has a way of ordering his [her] other values and activities around it. When this ordering is comprehensive, because of the inclusiveness of his [her] caring, there is a basic stability in his [her] life; he [she] is "in place" in the world instead of being out of place, or merely drifting or endlessly seeking his [her] place. Through caring for certain others, by serving them through caring, a man [woman] can ever be said to be at home in the world, he[she]

is at home not through dominating, or explaining, or appreciating but through caring and being cared for (p.2)."

Within a theological perspective, we see caring epitomized in Sacred Scripture in the God of the covenant. In the Old Testament, God is revealed as the one who enters into a covenant with God's people; as one who restores and fulfills the covenant. God is a faithful God; and God's fidelity or faithfulness is an invitation and response born of love for the people of the covenant. Faithfulness to the covenant conditions faithfulness to one another. When the human person is not faithful to God, faithfulness to each other disappears; no one can be relied upon (Deut.32:4;1 Kgs. 8:56ff; Ps.85:5,11ff; Jer.9:2-8). In the New Testament, the fidelity of God is exemplified in Jesus, the totally faithful one (1 Cor.13:4-7).

Dubay (1973), in a theological reflection on caring as the basis for community, presents caring as a synonym for love. One loves when one cares. He notes: Love and caring are primal…Loving is caring, deep love is deep caring; passionate love is passionate caring…to care is to jump into the other's skin. It is to become the other in mind and heart, to love the other's interests. To care is to become one's brother, one's sister (p.23).

There is a convergence between caring as the human mode of being and spirituality (Roach, 1997). Spirituality, the search for meaning, an attraction to the source of being, seeks to integrate itself, not in self-absorption or isolation, but in self-transcendence. Spirituality is more than an abstract ideal. One writer notes: "It manifests itself in our human responses to the brokenness of our world, the threats to our planet home, the crisis points in our lives, and the please and plights of human beings around us" (Puls, 1993, p.2).

Spirituality is a movement into relationship, manifesting itself in caring, in a healing encounter with others. Grounded in relationship, spirituality is actualized in the net-works and patterns of human care; it is disclosed in caring acts, in one's way of being in the world.

McCarthy (1992), in her research in relational ontology, shows how the spiritual dimension of human existence provides a foundation for " envisioning the fundamental relatedness of human beings and this [she notes] is a philosophical foundation for nursing practice envisioned as relationship" (p.127).

Human care has been a preoccupation of philosophers, theologians, poets and artists for centuries. The following Roman myth, cited in Heidegger (1962), attempts to portray the primary relationship between the notion of care and the meaning of human.

Once when "Care" was crossing a river, she saw some clay. She thoughtfully took up a piece and began to shape it. While she was meditating on what she had made, Jupiter came by. "Care" asked him to give it spirit, and this he gladly granted. But when she wanted her name to be bestowed upon it, he forbade this, and demanded that it be given his name instead. While "Care" and Jupiter were disputing, Earth arose and desired that her own name be conferred on the creature, since she had furnished it with part of her body. They asked Saturn to be their arbiter and he made the following decision, which seemed a just one: "Since you, Jupiter, have given its spirit, you shall receive that spirit at its death; and since you, Earth, have given its body, you shall receive its body. But since 'Care' first shaped this creature, she shall possess it as long as it lives. And because there is now a dispute among you as to its name, let it be called 'homo,' for it is made out of humus (earth)" (p.242).

According to this myth, while we live on this earth, our truest name is care, that is, we essentially are care. "Care" shall possess us as long as we live. When we cease to care, we cease to be human.

Caring and the Nursing Profession

A person cares, not because he or she is a nurse, but because he or she is a human being. Caring, as the human mode of being, is at the core of all healthy relationships, whether personal or professional. All health care practice as healing ministry presupposes a caring presence. Hence, for example, the care-cure distinction, sometimes used to distinquish medicine and nursing is flawed. Nouwen (1974) reminds us that care is the precondition of all cure…"cure without care is as dehumanizing as a gift given with a cold heart" (p.32).

That one cares does not distinguish one professional or occupational group from another; how one cares, using the unique knowledge and skills of physician, social worker, nurse, housekeeper, pastoral minister, parent, does differ. We share in common that call to be for others.

Caring, then is not unique TO nursing; but unique IN nursing, that caring embodies all the characteristics used to describe nursing roles. All attributes used to describe nursing have their *locus in care*.

A Definition of Nursing

Conceptualized within an ontology of human caring, nursing may defined as *the professionalization of the human capacity to care, through the acquisition and application of the knowledge, skills, attitudes, and values mandated by nursing's prescribed roles.* Over time it has been demonstrated that individuals choose nursing because they want to care for people, to make other people's lives better. Baring few exceptions, whether one begins a nursing career immediately after basic education, or selects nursing as a second or third career. I have noted that the desire to care for people is a primary motivating factor in each person's choice. This observation is consistent with the basic premise of this paper that *caring is the human mode of being.*

How is caring expressed by the nurse?

Exploring Onticology

What is a Nurse Doing When He or She is Caring?

An exploration of the question, What is a nurse doing when he or she is caring ? elicits many responses-- : simple and complex skills, observations, clinical judgements, levels of decision making, formal and informal communications, teaching, research and management skills. The range and specificity of such activities becomes unmanageable in raw form. The model of the FIVE C's, C*ompassion. Competence,Confidence, Conscience, and Commitment*, was designed as one way of organizing manifestations and expressions of nurse caring in meaningful categories. The FIVE C's are not mutually exclusive, one presupposes the other. Reflecting on each C, however, translates caring as ontology into the practical ways in which caring may be expressed in our daily lives, personally and professionally. A brief discussion of each of the FIVE C's follows.

Compassion is a way of living born out of an awareness of relationships. Made in the image and likeness of God, we live in a community of relationships with all living creatures, and in connection with the whole universe. This communion engenders participation in the experience of another; a sensitivity to pain and brokenness; a quality of presence which allows one to share with and make room for the other. As Nouwen (1983), passionately insists, compassion involves us going …where it hurts, to enter the places of pain, to share the brokenness, fear, confusion, and anguish. Compassion challenges us to cry out with those in mistery, to mourn with those who suffer loneliness, to weep with those in tears. Compassion requires us to be weak with the weak, vulnerable with the vulnerable, and powerless with the powerless. Compassion means full immersion in the condition of being human (p.4).

Yet, as Nouwen further reflects, compassion is not a skill mastered with years of study or training, but a Divine gift.

At a time when many programs are designed to help us become more sensitive, perceptive, and receptive, we need to be reminded continuously that compassion is not conquered but given, not the outcome of hard work but the fruit of God's grace. In the Christian life, discipline is the human effort to unveil what has been covered, to bring to the foreground what has remained hidden, and to put on the lamp stand what has been kept under a basket…Discipline enables the revelation of God's divine Spirit in us (p.90).

Competence, the state of having the knowledge, skills, energy, experience, and motivation required to fulfill one's professional responsibilities, expressed itself in one who, not only achieves a beginning foundation for nursing, but also in one who continues to learn; to acquire that level of expertise demanded by one's role as teacher, manager, researcher or practitioner. Competence provides for a caring energy; it is uncontaminated power. Caring competence is a power, not motivated by a compulsive reaching for the top, nor driven by competition. Competence and compassion are inseparable in a caring relationship. Compassion without competence can be fraught with clinical neglect; competence without compassion can be an act of violence.

Confidence, used in this model, refers to a quality that fosters trusting relationships. It is an expression of caring that promotes trust without dependency; that creates an environment enabling the other to grow. Caring confidence communicates truth without violence, sensitive, not only to the other persons' right to know, but to the person's readiness to receive the truth under his or her unique circumstances. It is way of caring that communicates respect without parentalism; that recognizes the other's capacity and need for freedom, enabling a response not born out of fear or powerlessness.

Conscience, in its exercise, embodies one's state of moral awareness; a sensitive, informed sense of what is right or wrong. Conscience may be considered one's personal compass directing behavior according to moral standards or the moral fitness of things.

A caring person acknowledges the need for a fine tuned compass, alert to the knowledge and skills of moral reasoning required for responsible ethical decisions. MacNamare (1997), reflecting on the moral journey makes the observation. Becoming moral is a long delicate and difficult journey inward. It fans out into the great demands of action--the tough, gutsy virtues of respect, justice, equality, fairness. But it begins here in that spiritual space where we take responsibility for ourselves, for others and for the world we share. To listen to this God-given thrust within us, to want to be moral is a fundamental conversion. (p.7).

The impact of continuing developments in science and technology on health care decision making requires health professionals who have inquiring minds, the ability to make astute clinical judgments, skill in moral reasoning needed to apply relevant moral-ethical principles. Above all caring grounded "in the moral strand or our experience" (MacNamara, p.7), presupposes a desire to be moral, a desire to embrace that fundamental conversion or call within the depths of our hearts.

Commitment is a complex response expressing a convergence between desires and obligations. It is a convergence between what one ought to do and what one wants to do. Commitment is usually invisible in the everyday responses of parents to the needs of their children; to the frequent and repetitive gestures and actions of nurses in the run of a typical day. On other occasions, commitment calls for a difficult decision, a choice sometimes between two goods, but a choice, nonetheless, not made without cost.

In Mayeroff's work, (1971), caring is considered to subsume the quality of devotion, denoting a convergence between what one wants to do and what one ought

to do. According to Mayeroff, devotion [commitment] is essential to caring; if devotion [commitment] breaks down, caring breaks down. Commitment, therefore, is a quality of investment in a task, a person, a career choice, a project, a quality that becomes so internalized as a value that what one is obligated to do is no longer regarded a burden.

Are The Five C's An Impossible Demand?

In sharing these reflections on the FIVE C's, my intention is to present them as challenges, ideals, and goals to which, as caring persons, we aspire. At times we fail. In the work previously cited, Mayeroff makes the observation that there are *a limited number of caring objects to which we can commit ourselves at any given point in time*. We cannot be all things, to all people, all the time. Caring involves caring for the self as well as for the other; and most importantly, it involves caring for ourself to the point of accepting one's limitations.

Persons in health care today are frequently stretched beyond reasonable boundaries. If it is sometimes claimed that nurses do not care anymore. Perhaps the most critical question is, Why? Before responding to this question, it is helpful to review the profile of a hospital staff on a typical day and examine who they are--wives, husbands, mothers, fathers, teachers, students and often, because demands are made by school, community and church, involved in these activities as well. To compound the pressures of over-extension, care-givers are inclined to suffer from what I prefer to call *the guilt syndrome;* often because they do not feel like caring. It is often the case, when persons who are stressed out acknowledge there are a *limited number of caring objects to which they can commit themselves at any given point in time,* that their feelings are justified and normal, they are freed of their false guilt, and the guilt is diffused. They subsequently get the energy to care more. Attention to the need of caregivers to care for themselves, and to receive care and support from others, is perhaps one of the most urgent requirements of our health care system in the West. It may not be a priority in the East. In any case, care for the caregiver may be a topic for another conference.

V. Conclusion: an Exemplar

I looked after a man whose address was the bus shack outside the mall hotel. I sat there and I held his hand and I watched him die, through the whole night. It was Saturday night and I thought to myself, this is a very strange job I have. You know, you're looking outside and seeing the stars and you know people are out and it's Saturday night and I'm sitting there holding a man's hand...because he's going to die. He has nobody to be with when he dies. It made me feel very rewarded. I felt in some ways pleased that I could be with him. He did not have to be alone. He opened his eyes occasionally and he knew someone was there and I held his hand (Fentor-Comack, 1987, p.195).

This exemplar was shared by a nurse working in a critical care unit in a large, university teaching hospital in a Canadian City. The nurse shared this exemplar because she easily remembered it as an experience of moral-ethical importance. The patient was a man of unknown address; he had no family or friends with him, and none could be contacted because there was no record of who they were or where they lived. This nurse would normally have completed her assignment at 11:00 p.m. She stayed with him through the night to be with him until he died.

Hi-tech, the norm within a hospital critical, intensive care unit, is not visible in this examplar; rather hi-touch, an equally intensive form of care, defines the nature and quality of the nurse's ministrations. In the short, sacred space of one night in a hospital ward, a human relationship is created, and caring as the human mode of being shines forth as one human person cares for another. The nurse may have never heard of the word ontology, but, in her ministry, she shows us what it means. She does not lecture on caring attributes but demonstrates each of the FIVE C's as she responds to the unique personal needs of her patient.

Human caring is not guaranteed by one's possession of knowledge or a high degree of technical skill; it is not driven by head or the scientific principles of hygiene or even comfort, as important as these are. *Truly human caring is caring from the heart; caring from the core of one's being;* moved by an awareness of being in relationship; inspired by an intuition that there is something in each of us, greater than ourselves, for each human being is a temple of God; God dwells within us.

Each of us has the capacity to care [to love], because God has first loved us. To care for one another, personally or professionally, is to spread this GOOD NEWS; to share with others this spark of Divine love within us.

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Perspective

The Caring Nurse Administrator

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For the past 20 years, I have taught nursing administration at the master's level. For several years, I taught standard management theory and attempted to incorporate the human care philosophy. That was not easy as management theory is broken down into planning, organizing, directing and controlling, while human caring emphasizes intuition, societal obligation and equity between the caregiver and one who is cared for. I wrestled with the issue over one semester when I had an opportunity to design a course with these concepts, management and caring in mind. I told the students what I wanted to do. Together we committed to learning how the theory of caring could impact management theory.

Using standard management theory, we critiqued how a caring philosophy affected a manager's behavior. We decided that the duties do not change, but how one goes about those duties can be different. Much of our discussion focused on values: values of nursing, value of administrators, and value of human care. We discovered that "generic" management could be differentiated from "caring" management. For example, management stresses the use of power, while caring emphasizes empowerment. The management concepts of superior and subordinate is altered by consideration of collegiality and self governance. We composed lists of terms that, while not all foreign to business management, tend to be more highly developed and valued by the caring administrator. As we worked our way through the course, there were six areas that were particularly important in considering how caring can impact nursing administration. These six areas are 1) management theory; 2) theory of caring; 3) healthcare industry; 4) ethics; 5) women's issues; and 6) organizational effectiveness.

Definitions of Caring

In defining the term "caring" one can identify three different uses of the word. "Care" can be defined as a burden, as a responsibility and as a feeling toward another. In medicine, caring for a patient primarily involves taking responsibility to cure illness or solve health problems. Nurses are involved in the responsibility of the curing part of care, but they also practice caring in the emotional sense. As a whole, nurses care for and care about patients. They provide technical and physical care but they also establish relationships with their patients as individual human beings. In nursing, caring for patients is something if a burden, sometimes a responsibility and sometimes a feeling toward the patient.

Noddings (1984) focuses on caring as a feminine approach to ethics and moral understanding. This author views "ethical caring" as an extension of "natural caring" (e.g., a mother cares for her child). To practice the "caring ethic," one must maintain a preparedness to care, and in caring must focus on the welfare, protection, or enhancement of the cared-for. To care is to act, not by fixed rule, but by affection and regard. Caring involves feeling with the other, receiving the other unto oneself, sensing with and understanding the other. It also involves the commitment of energy to the service of the other. Caring is primarily relatedness and connectedness. And as one cares for others and is cared for by them, caring for oneself is possible as well. Basic reality is

defined in terms of caring relationships (Nodding, 1984).

Mayeroff (1971) suggests that "to 'care' for another person in the most significant sense is to help him grow and actualize himself." He describes caring as a process that emerges in time through mutual trust and a deepening of the relationship. He maintains that a person may care for many things, such as people, ideas and communities. The common pattern is helping the other grow. In caring for someone or something, we must be able to sense other's potential and need to grow; we must also believe in our ability to help the other to grow.

Watson (1985) has described caring as a "human science". This author broadens the perception of nursing beyond scientific principles toward a culturally defined process that emphasizes caring as central to its existence.

Leininger (1984) states that caring is the "essence of nursing" and advocates the study of caring in order to understand its meaning in nursing. Gaut (1984) performs a conceptual and theoretical analysis of caring and develops an action-based description of caring as an intentional human expertise directed toward the goal of bringing about a positive change in the one who is cared for. Ray (1984) develops a philosophical analysis of caring within nursing, identifying the recurrent theme of growth or mutual self-actualization and the concepts of co-presence and love.

From this variety of authors the central characteristics of caring can be identified for the purpose of defining the term. Caring being as an interest in someone, which expands through knowledge to a feeling and a commitment to assist the person to exist and grow. As one experiences the satisfactions of an individual caring relationship, caring becomes a part of one's philosophy and approach to life. Caring is a way of thinking and acting that determines more and more of the individual's behavior as they allow the intuitive, relating part of themselves to invade their awareness. As knowledge of caring is attained, each nurse applies this knowledge to his or her own area of practice. For the nurse administrator, caring is not confined to a patient-nurse relationship. It can be very useful in dealing with staff nurse and others in the context of the organization. The nurse administrator can exemplify caring and thus enrich the patient care environment by insisting on the development of an emphasis on caring behaviors throughout the nursing division.

The Element of Caring in Nursing Administration

For the nursing administrator, five attributes enable one consistently to exhibit caring behaviors: commitment, self-worth, ability to prioritize, openness, and ability to bring out potential. By understanding and developing these attributes, the nurse administrator can be the role model who exemplifies caring and encourages it to become an institutional form.

Commitment

The first attribute, commitment, consists of three components: interest, knowledge, and commitment. Caring begins at the time a person first takes a special interest in someone. For an object of interest to evolve into an object of care, there must be a time of learning about the person that leads to a level of understanding and a desire to get involved more personally.

If the relationship evolves into one of understanding and trust, and if the potential caregiver feels willing and able to contribute to the growth of the other, a commitment may be made to care for the other. The last part of the phase of establishing the caring relationship is that the one who is cared for must be receptive and willing to be cared for.

The attribute of commitment is essential to the caring relationship. To care for someone, one must be committed to a

continuing relationship. It can be very damaging for a person to be cared for briefly and then to be shut off from that caring. Subsequent trust in people may diminish, making it difficult for that person to accept care from others. Trust is a large part of caring relationship, and it is established through the strength of the commitment of the caring person.

Self-worth

The second attribute that promotes caring emphasizes the need for the nursing administrator to achieve feelings of self-worth, self-understanding, and self-confidence. Many of the behaviors that detract from a caring manner are connected with anxiety about one's own security and place in life. If there is constant concern about meeting one's own needs for achievement, being accepted by others, or obtaining personal rewards, it is impossible to find energy and time to address the needs of others.

This area is one of the great importance in organizational life. Many people become administrators because of an inner need to achieve a position of power and prestige that allows them to feel secure in their identity. A healthy need for achievement can be useful if it leads to feelings of personal success that can be shared by others. An inordinate drive to get to the top, however, can lead to disregard for others and the organization.

Rather than dealing privately with issues of self-worth, some administrators make the organization an arena in which to play out their personal issues. They may withhold rewards, be overly critical, or demand to be in charge of every situation. They often court the favor of people in the organization who they believe can help them get ahead. It is not unusual for insecure administrators to have favorites on their staff who maintain the nurse administrator's power and control by never questioning or challenging him or her. Such administrators may stifle creativity and growth in others because the others are perceived as competitive and threatening to the nurse administrator.

Another common issue regarding self-worth is that of placing importance on meeting one's personal and social needs. Unfortunately, the norm in many organization is that the administrator works longer and harder than anyone else. Personal needs for outside friends, leisure activities, and growth are subordinated to work priorities, and administrators become progressively dependent on organizational success to maintain their sense of identity and worth. Then, if something goes wrong in the organization, the administrator feels personally devastated, self-doubt is reinforced, and the cycle continues.

Attention to personal needs is very important for nursing administrators. One should never feel guilty about maintaining healthy activities outside of work. The reality is that only by doing so can one feel the inner instability that leads one to be caring as an administrator. The concept of caring requires that caring persons have developed a strong sense of self-worth, feel cared for in their own lives and see themselves as having something to offer others through the caring process.

Ability to prioritize

The third attribute that enables one to be caring is the ability to prioritize and order life's activities in a way that allows time and energy for the caring process. Mayeroff and Noddings talk about the need to limit caring relationships to a few significant others, in order to have time and energy to pay attention to one's own needs as well as the needs of others. This becomes a very difficult task for the nursing administrator, who has an abundance of people in the organization who need to be cared for. Some nursing administrators handle the situation by retreating into businesslike behavior and a bureaucratized method of managing by rules and policies. It is impossible to care for everyone, so they care for no one. While such a posture may help to insulate

the administrator, the environment it produces is often rigid, impersonal, and flexible. Nursing managers feel uncared for and pass this feeling on the staff nurses, who pass it on to patients.

The nursing administrator can prioritize his or her job to encourage caring opportunities and reflect a caring approach. He or she can structure time so as to keep in touch with the feelings of staff nurses. That generally involves making rounds, holding open staff meetings, dealing directly with staff nurse committees, and occasionally getting involved in patient situations. As the nursing administrator displays caring behavior in meetings, conversations, and dealings with nurses, patients, families, and physicians, the caring norm begins to coalesce in the institution. As employees see and feel expressions of caring, the attitudes of caring are reproduced in patient situations.

Developing caring relationships with nursing managers and leaders also requires direct contact in which to display caring behaviors. As the nurse administrator makes rounds, he or she is able to interact with nurse managers on their own turf. Being alert to the atmosphere on the unit, talking to the staff and visiting patients create opportunities to learn about the nurse manager's world. Allowing time to visit with the nurse manager on the nursing unit is often very productive. The manager, typically more open in a familiar environment, will be able to share successes and problems more readily.

In relation to nonmanagement nurse leaders (e.g. educators, clinical specialists, and quality assurance and discharge planning personnel), opportunities for caring interactions are facilitated by keeping up to date on their programs and taking a few minutes to interact with them informally whenever possible. In the case of all nurse managers and leaders, consulting with them individually when issues arise in their areas of expertise constitutes caring through validation of their sense of worth.

While we should encourage nurse administrators to develop caring relationships wherever possible in the organization, caring for their close associates (assistant nursing directors and others reporting directly to the administrator) must be accorded top priority. In these relationships the nurse administrator must create time and opportunity to develop one-to-one caring. Those directly supervised become the significant others in the organizational setting. Setting up small group retreats and regular administrative meetings enhances cohesiveness and caring. In moments of private counseling, the nurse administrator should focus energy on the growth of the individual being counseled.

Openness

The fourth attribute contributing to caring in the administrative role is the development of personal values and behaviors that allow those cared for to risk being honest with the one who cares. This sets the stage for openness, which develops into trust and growth in the relationship. Being open is much more difficult than it sounds. Being open means being willing to disclose your own humanity, your unflattering thoughts as well as your nobler ones, your hopes and your feeling, your priorities and your problem areas. As others see the administrator more and more as a "real person," they are able to reveal themselves with some sense of safety. The attitude that must be exhibited is that openness leads to growth for both people in an interaction.

Rather than projecting the image that "no news is good news" (i.e., problems not expressed are not problems at all), the nurse administrator must foster open discussion to all issues. Problems that are always easier to deal with than those that have festered long. The behaviors involved in openness include listening, soliciting comments, watching nonverbal communication cues, asking the right questions and waiting patiently for answers. Another behavior that portrays

openness is requesting feedback concerning all major changes. All identified issues must be carefully processed if obstacles to achieving change are to be overcome.

An important aspect of developing openness relates to the ways in which nurse administrators respond to feedback. If they express anger or alarm at negative or controversial comments, openness will be suppressed. If they express appreciation for the information provided and confidence about solving problems, people will be willing to continue to risk being open. Developing positive approaches to problem solving contributes greatly to enhanced caring behaviors. The attribute of openness is more than just a willingness to hear; it is a willingness to perceive, to understand, to empathize and to respond. For nurse administrators, openness includes the ability to focus quickly and completely on the reality of many individuals and groups with whom they interact each day. Often the tendency is to split one's attention between the current interaction and the many other items needing attention, discussions, and actions. Certain measures can be instituted to aid the nurse administrator. For example, meetings or appointments can be scheduled to end 15 minutes before the next one is to begin. During each 15 minutes break, having access to an efficient and personable secretary or administrative assistant is invaluable.

In addition to several short breaks, whenever possible the nurse administrator should schedule a period of time each day with a colleague who can provide caring for the nurse administrator. An opportunity to empty one's mind of the needs of others, to share concerns, and simply to enjoy not having to be a caregiver can be immensely rejuvenating.

Ability to bring out potential

The last attribute that promotes caring behaviors is the ability to bring out potential in others. As several authors have pointed out, the outcomes of caring relationship is growth in the one cared for. This element has as its foundation the belief that people have abilities and talents that can be enhanced through the care of others. The person who would care for another must be able to search for these abilities and develop skills in encouraging the other to strive toward self-growth. The arena of nursing administration offers many opportunities to enhance the growth of others. Recognizing these opportunities requires a deep appreciation for the potential of people around you. Some nurse administrators, threatened by the abilities of others, tend to put people down rather than build them up so that their own needs for power and control are met. Other administrators view people, in accordance with Hertzberg's Theory X (1988), as basically lazy and self-centered, thus requiring close control and strict rewards and punishment. The caring nurse administrator views people as valuable and is interested in helping them develop to their full potential.

It is possible, given the basic belief in the potential of people, to develop particular skills that motivate others. Liberal use of positive feedback is very useful, particularly if used in conjunction with gentle honesty about areas where growth should occur. Inquiring about people's hopes, dreams, and goals for the future can make nurse administrator more alert to opportunities that may help others to meet individual goals. Both publicly and privately, the nurse administrator should always acknowledge the successes of staff nurses or nurse managers. During difficult times for a nurse manager for example, conflicts between staff nurse on different shifts, the nursing administrator must remain accessible to troubled manager and continue to follow up with him or her until the situation is resolved. Throughout the crisis, the nurse administrator must offer help and suggestions, and must also clearly communicate faith in the manager's ability to handle the problem.

When a project must be delegated, the nurse administrator should take time to

assess who might be interested and able to handle it. Delegation is not only a way of redistributed work loads, but also a tool for allowing others to exhibit their potential through successful handling of special assignments. The person receiving the assignment must feel that the nurse administrator will trust and support his or her work and provide the freedom to grow through the experience. Motivating others is basically the process of knowing people well enough to identify their potential, providing opportunities for their potential to be realized, and giving meaningful praise and rewards for jobs well done. The nurse administrator must always strive to convey faith in his or her people's potential. When one communicates a positive expectation that people can achieve great things, they usually do. Communication by the nursing administrator that people are expected and will be assisted, to develop their full potential is a strong message of caring.

The meaning of caring:

These five attributes-commitment, sense of self-worth, ability to prioritize, openness, and ability to bring out potential in others-enable the nurse administrator to direct caring behaviors toward the growth of others. The preferred definition of caring then, *is an interactive commitment in which the one caring is able, through a strong self-concept, ordering of life activities, an openness to the needs of others, and the ability to motivate others, to enact caring behaviors that are directed toward the growth of the one cared for, be it an individual or group.*

Caring is an ethic that affects all of life's relationships. It is a way of relating to people that involves special skills of openness and responsiveness to the needs of others. It is also a specific responsibility of the nurse administrator in his or her formal role as one who cares for nurses in an organization. Caring is both a philosophy and a milieu created in the organization for the purpose of encouraging caring relationships among staff members and between nurses and patients. The responsibility of the nurse administrator in relation to caring is thus threefold : **1**. to understand caring as a philosophy and an ethic to be established by particular organizational processes and structures. **2.**to develop skills related to caring behaviors that are utilized in formal relationships with individual and groups; **3.** to be alert and responsive to opportunities to participate in situations involving nurse managers, nurses, administrative colleagues, and patients or families who have specific needs that allow the nurse administrator to behave as caring person.

The goals of caring are meaningful relationships and the growth of people in the organizational environment. Patients benefit by enhancement of the healing process, and employees benefit by finding added meaning and rewards in their work. While the pressures of the increasingly business-like environment of health care continue to mount, the nurse administrator can have great impact by ensuring that the element of human caring remains an organizational priority.

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Perspective

The Actualized Caring Moment : The Essence of Caring Nursing Practice

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Abstract

The actualized caring – healing moment is a conceptual model of caring developed from 2 studies. This model demonstrates authentic caring in nursing practice. It elucidates invisible aspects which characterize nursing. Caring moments occur during patient care, "The Actualized Caring-Healing Moment." ACHM is the moment at which the nurse and the patient realize their intersubjective connectedness in transforming healing-growing in a specific dynamic changing situation. The nurse herself has a therapeutic presence and the patient's self-caring and self-healing processes are enhanced.

Components of The Actualized Caring-Healing Moment (ACHM) Conceptual Model

1. Caring precondition – include " given" of both the nurse and the patient. The nurse's personal and professional qualities as well as the patient's uniqueness and health – related
1.1 the nurse's caring preconditions include conscience, compassion, commitment and clinical competency.
1.2 The patient's attributes are uniqueness, vulnerability and need for assistance.
2. The actual caring process – is the interactive process between the nurse and the patient, having a trusting relationship, participating in meeting needs, having empathic communication and balancing knowledge- energy- time. Balancing knowledge- energy- time considers the six elements of assessing, interpreting, priority setting, anticipating, maintaining dynamic complementarily, consulting and episodic continuity of spending time.
3. Caring situational context - is the situation which promotes the occurrence of caring process in a specific time and place. It considers the circumstances of the nurse-patient interaction and care facilitating conditions.

The actualized caring- healing moment evolves from caring preconditions and caring situational contest. It allows the nurse and the patient to realize the fullest expression of their innate psychological, emotional, spiritual and intellectual capacities. It is the best moment in nurse-patient interaction and the very reason for considering nursing as a caring and healing profession.

Recent nursing literature highlights the concept of caring as the essence and unifying domain for the body of knowledge in nursing (Leininger, 1981; Roach, 1984; Watson, 1988; Benner and Wrubel, 1989; Boykin and Schoenhofer, 1993). However, there is no universal definition of caring. There is an urgent need to develop a clearer conceptualization of caring including middle-range and practice theories (Morse et al, 1990; Bottoroff, 1991). This paper presents a conceptual model of caring developed from two studies which used qualitative approaches (Euswas, 1993, 1994). The model demonstrates how authentic caring occurs in nursing practice. In addition, it elucidates invisible aspects which characterize nursing.

In their professional life, nurses experience special meaningful moments with their patients. However, there are very few detailed accounts of these moments as they are usually brief and invisible. Nurses, although they know these moments occur, find it difficult to relate about them. As a result, this important aspect of nursing is not usually made explicit in efforts to communicate the essence of nursing both to nurses and others. This author will

demonstrate how these moments occur and have named them "The Actualized Caring-Healing Moment".

The actualized caring-healing moment is the moment at which the nurse and the patient realize their intersubjective connectedness in transforming healing-growing as human being in a specific-dynamic changing situation. It empowers the nurse in using herself as therapeutic effect and empowers the patient in initiating self-caring and self-healing. It is proposed as a conceptual model of the nurse caring process for it explains how the nurse translates caring into nursing actions.

Components of the Conceptual Model

The model of the actualized caring-healing moment is composed of three main components: the caring preconditions, the actual caring process, and the caring situational context. See Figure 1.

1. The caring preconditions are the prerequisites for the caring process to occur. Nurse and patient are ready to be in contact, and each brings unique capacities and expectations into the situation. The nurse brings her personal and professional qualities of caring. The patient brings his or her personal uniqueness and a specific life situation of health-related problems.

1.1 The nurse: Personally and professionally prepared to care, is described and possessing the qualities to be caring. These are conscience, compassion, commitment and clinical competency.

Conscience is the nurse's moral standard arising from her humanistic-altruistic value system. It directs her behaviors.

Compassion is the nurse's moderate love toward others which allows her to participate in the other's experience.

Commitment is defined as the affirmation of an individual nurse to put a human care value into her professional practice. Human care is a professional value and moral obligation.

Clinical competency is the ability of the nurse to integrate various kinds of knowledge and apply the knowledge in her practice with skilled performance. To be able to care for the patient with particular health-related problems, the nurse must have experience in clinical practice in that area. The clinical experience must be for a period of time sufficient for the nurse to develop clinical knowledge and technical skills.

1.2 Patient: Person with compromised health and well-being, is defined as a person whose health and well-being are threatened so that he/she is in need of assistance from nurses.

Uniqueness is defined as the whole being of a person--physical , psychosocial cultural and spiritual aspects. This whole being cannot be divided into parts or reduced to an object.

Vulnerability is defined as the state of a person exposed to danger or liable to be hurt.

Needing assistance is defined as the patient needing assistance from the nurse to satisfy his/her situational needs as they are perceived by both the nurse and the patient. These needs include all aspects--physical, psychosocial and psychospiritual--which are changing dynamically in the response to illness and medical treatment.

2. The actual caring process represents the continuous interactive process of an interpersonal helping relationship between the nurse and the patient. The nurse translates her human care values and knowledge into the action of helping the patient to meet situational health needs. The actual caring process consists of six elements:

2.1 Being there is defined as the nurse making herself available to respond promptly to the patient's needs.

2.2 Being mindfully present represents the nurse's constant awareness of her thoughts, feelings and actions when being involved with the patients in any situation.

2.3 Having a trusting relationship is represented as the nurse and the patient engaged in a relationship to build trust. The patient, because of limitations in self-knowledge and self-help, needs assistance from a professional nurse. The patient is ready to trust in professional knowledge and the nurse seeks to establish interpersonal trust. The nurse opens herself and allows herself to come close to the patient, respecting the patient as a uniquely valued person with dignity. The nurse shows her genuine willingness, attention, and her

competence in knowledge and skill to help the patient. Therefore mutual trust is developed.

2.4 Participating in meeting needs is defined as knowledge and experience shared between nurse and patient. Both the patient and the nurse work together discovering and setting goals to achieve the patient's needs. In any situation of nurse-patient contact, the nurse uses her specialized knowledge to identify all patient needs (physical, psychosocial or psychospiritual) and with the patient's participation, to meet these needs at that time. The nurse gives the patient control and choice. She endeavors to work with the patient to meet those needs.

2.5 Having empathetic communication is defined as the nurse conveying caring through the congruency of verbal and non-verbal behavior to the patient. It is human-to-human contact between nurse and patient via touching: physical touch through body contact; emotional touch through eye contact and facial expression; verbal touch; and other body language. Three patterns were identified to demonstrate verbal/non-verbal communication: facing, listening and engaging in dialogue.

2.6 Balancing knowledge-energy-time is defined as the nurse exhibiting four modes of knowledge (i.e., ethical, personal, empirical and esthetics) to maintain complementary working with the patient to gain harmony in a dynamic changing situation. Balancing knowledge-energy-time consists of six elements.

Assessing-interpreting: A cognitive process in which the nurse uses her intellectual skills and nursing knowledge to identify the patient's problems and needs by observing, monitoring, analyzing, translating, synthesizing and making decisions.

Priority setting: The nurse compares and orders the patient's problems and needs based on the criteria of survival, safety and welfare of the patient. The nurse acts on the most important first.

Anticipating: With her knowledge and experience, the nurse knows what is likely to happen to the patient. Therefore, she prepares for what will probably need to be done.

Maintaining dynamic complementarily: The nurses take actions to assist the patients in meeting their needs. She evaluates whether these needs are achieved by incorporating her compassionate intention, technical procedures and tasks in synchronizing performance with the patients on moment-to-moment basis.

Consulting: In some situations, the nurse acknowledges her skills and knowledge limitations in helping the patients. She therefore seeks help from other resources.

Episodic continuity of spending time: The nurse expend an appropriate amount of time in establishing a trusting relationship with the patient as well as identifying and meeting the patient's needs in an irregular although continuing pattern

Conserving-replenishing energy: The nurse expends energy in assisting the patient meet his/her needs in the more effective ways. The nurse replaces this energy utilization by taking a time break during the work period; carrying of self-care in everyday living; and being supported by colleagues.

2.7 Actualized caring-healing moment is defined as a point in time when the nurse and patient know and realize the giving and receiving of care. They share warm feelings, positive regard, satisfaction, achievement at participating in meeting the patient's needs or coping with sadness. It is an intersubjective connectedness between the nurse and the patient of their best as human beings in the situation. This moment is a moment of empowering and transforming healing and growing.

3. The caring situational context is the situation of the nurse-patient contact within a specific place and time, in the environment of health care settings which promote the occurrence of caring processes.

3.1 Circumstances of the nurse-patient contact: This encompasses situations of nurse-patient contact (eg., a nurse admitting a patient, a nurse giving chemotherapy). Two patterns were identified to explain the conditions of the nurse-patient meetings: planned meetings and unplanned meetings.

3.2 Care-facilitating working conditions represents the environment in the health care service which allows nurses practice caring. Four components were identified: Private space valuing continuity of patient-centered care; supportive collaboration; and continuing clinical teaching and learning.

Explanation of the conceptual model

The caring preconditions are the prerequisites for the caring process to occur. The nurse and patient are to be in contact, and each brings unique capacities and expectations into the situation.

The caring situational context is the situation of the nurse-patient contact within a specific place and time, in the environment of health care settings, which promote the occurrence of caring process.

The actual caring process evolves from the caring preconditions and the caring situational context. It is the process of the nurse-patient interaction in a continuously changing pattern. The nurse is fully aware of her commitment to give herself to assist the patient in achieving personal health need within the reality of the patient's situation. She is physically present with the patient and promptly responds to the patient the immediate, present moment. That is to say the nursing in the state of caring mindfulness. She develops a trusting relationship with the patient, and co-participates with the patient, to identify needs and to meet these needs.

The nurse conveys empathetic understanding to the patient through verbal and non-verbal communication. In this process of caring, the nurse is aware of integrating all patterns of knowing (ethical, personal, esthetics and empirical) in order to use an appropriate approach, and spends the amount of time that is appropriate for a particular patient in a particular situation. Ethical knowing motivates the nurse's state of moral awareness of helping the patient as a valued dignified person. Personal knowing facilitates the nurse's entry into the patient's personal world. Esthetics knowing allows a nurse artist to create a unique approach to the individual patient in a specific situation. Empirical knowing allows the nurse to reflect on scientific knowledge to understand the particular caring situation and to make decisions that will help the patient. The nurse maintains her complementary position by working with the patient moment-by-moment, by imparting her compassionate intention and physical energy, and by spending time with the patient. She is always aware of preventing over-emotional involvement.

The process of caring is continually moving forward. At any moment during the interactions, both the nurse and the patient realize their intersubjective connectedness. "The actualized caring-healing moment" is changing dynamically and occurs within the wholeness of the three components converging together. The diagram representing the conceptual model is illustrated in Figure 1.

The moment of actualized caring-healing represents the growth and healing potential that allows the nurse and the patient to realize the fullest expression of their innate psychological, spiritual and intellectual capacities. It is their best moment as human beings in this situation. The actualized caring-healing moment does not occur in a regular pattern of the nurse-patient interaction. It may occur once or more in an episode of a nurse-patient encounter or it may occur only once in many episodes. However, once it occurs, there is a likelihood that it will recur.

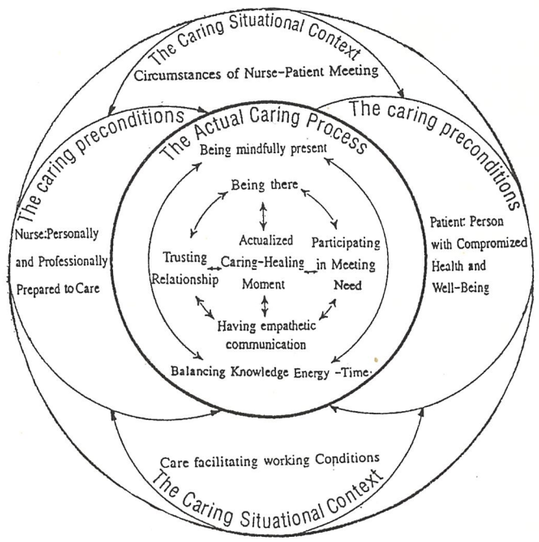

Figure 1: The Actualized Caring-Healing Moment: A Conceptual Model of the Nurse Caring Process (Euswas, 1994, p.72).

Caring Episodes

Following is a group of poems on episodes of caring in everyday nursing practice. This author has transformed them from the data. Her reflection on the essence of caring in nursing is portrayed in the analog diagram in Figure 2.

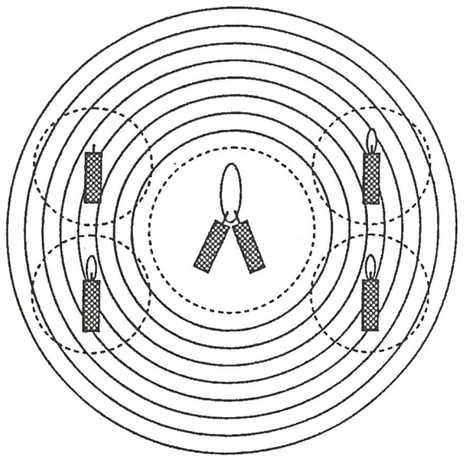

Figure 2
An Analog Diagram of the Actualized Caring-Healing Moment
(Euswas, 1991, p.238)

In the Hospice: Bedtime

Mr. K lies stretched in bed
His wife sits close by
Waiting for the nurse to come

Two come with a smile
Close to him, his wife
Eyes touch, soft speech, they listen

"I... ....I... ...feel... ....al... ...alright"
Slow speech, stuttering, he speaks
The nurses listen, talk, wait

Cleansing touch, soothing hand, they minister
He talks about his garden, his wife shares
The nurses share talking, and all laugh

Comforting him with pillows
Puff the pillows...No, he says, Add a pillow....No, he says, Tilt the pillow to the left....Yes.....That.....that's right

"I....I....heard.....you....you....sing....this...
...this.....morning
Could....could...you....sing....sing
.....please," he asks one nurse
She smiles, eyes touch...silence

Close to him, arms around his wife, they move
"Edelweiss song" begins, they sing
A circle of four in oneness
He smiles... ... eye close

Taking Temperature

Having lymphoma, Mr. B
Computer engineer is his career
He needs explanation of things

Temperature high for two days
Staying in a ward for investigation
Moment of worrying, he experiences

A nurse comes for temperature taking
Chatting away with him, his worries
Telling him her finger hurt, she shares

Reading the scale 37.5C
"I don't think it's long enough, " he says
"Could you put it in longer?," he asks

The nurse smiles, "Alright, we'll do it again"
Three minutes thermometer is in his mouth
Silence, eye touch, she waits

The scale shows 37.8^{0}C
"Oh, it is not high as the other times," he says "Have you had a cold drink?," she asks
"No." He smiles; she smiles

Having a Shower

A big operation, I had

They helped me slowly down to the stool
And gently let me down

They could feel what I felt
"You are doing well," they reassured
I felt good and tried harder

When I went into the shower
I told them I could do by myself
They listened to me and believed me

They let me do it
They're always there
"Are you alright? Are you alright?," kept checking
I felt really confident in myself
I felt I'd achieved a really big milestone
"I can do it"

Implications for Nursing practice

The model of the actualized caring-healing moment contributes to the understanding of the actual caring process, which provides guidance, and a means by which nurses can transform the qualities of caring into a therapeutic effect for the patient. By increasing the intensity of the interaction with the patient, nurses would be able to provide an even greater therapeutic effect. To do so, the nurse must increase her awareness. She focuses on the patient at the immediate present moment and integrates within herself all patterns of knowing to impart the appropriate energy and spend an appropriate amount of time. In this way, the nurse achieves a therapeutic harmony of verbal and non-verbal behaviors, and technical competency.

Nurses provide health services for individual client, family and community throughout life span, and clients need care from nurses. Within health-illness experience, clients experience moment of, or encounter, stressful situations.

Nurses can use this caring model as a tool for nursing intervention to create the caring-healing moment and help the patient cope with their life situations. These actualized caring-healing moments assist the patients in gaining physical comfort; finding inner peace; feeling a liveliness within; learning about oneself; and having the opportunity to reflect on the meaningfulness of life. The following are caring situations where nurse and the patient experience the actualized caring-healing moment.

A situation of a patient being told of cancer

Christine, a 42-year-old female patient had a lump in her left breast and came to the hospital for an investigation. A biopsy was performed and a doctor told her about having cancer. A nurse was with her at the time she was told about having cancer. The following are poems, which this author elicited from both the nurse and patient's description of their experience of the caring interaction.

Nurse

Caring is my value
I am willing to help people
For me, Christ is the model of life

When I care for my patients
I always keep my feet firmly on the ground
All my attention is with them

At the time of bad news
I am always with them
like one lady "Christine"
I could feel what she felt
When the doctor told her
Tears welled in her eyes
Her whole body was shaking

I came close to her
Held both her hands
Put my arms around her

An inner voice said "Take the warmness of my heart"
I looked into her eyes and spoke softly
"I'm very sorry that it has to be this way"

My arms still around her
We were close in our oneness
We let time pass in silence

"I feel better now," she said at last

We talked and talked
Her daughter came to share
Sad and joyful moments I did experience
I felt a little drained
Though, at the end of it all
I gained something more.

Patient

A lump was in my breast
The biopsy was done
I could not sleep well

Two forces pulling apart
I might get it... my mother had it
I hoped..I prayed..It would not happen to me

One morning I heard the word "cancer"
It ran into my body, my mind
Like a thundering storm....a shock

Nothing could I hear or see
Cold and darkness
My life was ending

Suddenly..a warm touch was creeping inside me
Like a light spreading out
A whispering of soft voice at my ear

She shared and guided me round
When I went home
I reflected on what she said to me
"Try to think of one thing at a time"

She told my daughter
"Your mother needs more love and caring"
I gained the strength to have my breast off
The caring from that nurse I remember

A situation of a patient waiting to have chemotherapy

Dang was a 49-year-old Thai female who had ovarian cancer. Her ovaries and uterus were removed and chemotherapy administered. She came to the hospital for her full chemotherapy course. She mentioned that every time she came for chemotherapy she felt nauseated, vomited and couldn't have food for one to two days before coming to the hospital. This time she felt unwell and had pain at her neck. The following was a caring situation experienced by a nurse and Dang.

Nurse

When I walked into the room
I saw Mrs.Dang lying in the frog position
With one hand placed on her neck

She then sat up quickly
Spitting saliva into a basin
Her face looked anxious and unwell

I walked to her and sat on the chair close to her
I touched her and looked into her eyes
I gave her a little smile and she smiled back

"How do you feel? Is there anything I can help?" I asked
She expressed her worries
I listened to her and gave her time

She said to me with tears in her eyes
*"It is my Kam"**
We talked about our Buddhist faith

*"Is your Sati** OK now?" I asked*
"I need someone to wake me up" she replied
We shared our Buddhist practice

I thought of the compassionate Buddha
Looking to my inner heart
*Sending my Metta***to her*

I touched her neck where she had pain
We started breathing meditation
Sending Metta to ourselves, each other, and others

Twenty minutes passed
Someone said "It's time for dinner"
And so we stopped

"I'd like to try some", she said
She ate slowly
A quarter amount she finished

Throughout the time we were together
She did not salivate at all
No nausea, no vomiting
She relaxed and I felt great

**Kam- A Thai word derived from Sanskrit Karma. Karma is a Buddhist law of cause and effect, of action and reaction.*
***Sati- A Thai word derived from Pali language, which means mindfulness.*
****Metta- A Thai word derived from Pali language, means loving kindness.*

Patient

Coming for chemo is hard
Just step on the hospital ground
I've got to be sick...I cannot eat

I've so many worries
Losing weight...could not sleep...could not eat
This time here ...it's much worse
I felt sick all the time
And there's the pain in my neck
My mind is cloudy

I have tried to meditate by myself
But I could not make it
I've wanted to talk to someone

A nurse came to me
She was really good
I could feel her kindness, we talked a lot

We shared our Buddhist practice
Mindfulness breathing..Buddha
Sending Metta to myself, to her, and to all beings I have done bad to them

She came at the right time
Without her I could not have Sati (mindfulness)
She woke me up from worries

I could see things clearer
I felt peace inside
I felt good to have her with me

What made me most happy
Is that I can eat
Which never happened before

No nausea and vomiting that night
I slept well
My neck was O.K.

Conclusion

The conceptual model of the actualized caring-healing moment attempts to demonstrate the essence of caring which is an invisible aspect characterizing nursing. This moment represents the growth and healing potential that allows the nurse and the patient to realize the fullest expression of their innate psychological, spiritual and intellectual power. It offers nurses and other health professionals in any practice area a tool to achieve excellent health services.

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Perspective

Caring : A Core of Nursing Education

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Abstract

Believing, like Leininger, Watson, Gaut and Roach that caring is the central core of nursing knowledge and practices of nurses, the author examined how caring constructs by used in guiding actions in nursing education activities.

At the first step of curriculum development process, nursing educators who have the responsibility to prepare future nurses for caring-based practice must engage themselves in defining care, the caring constructs and subcontracts required to formulate a curriculum philosophy and conceptual framework. This efforts may take very long time. Then, curriculum objectives and level objectives: Caring concepts and behaviors are introduced and expanded with increasing depth as the student progressed through the curriculum. Practicum courses should allow the development of caring tools. Complexity of care should be increased and setting be changed to allow the student to have learning experience in hospitals and in community, particularly home care, until the completion of the program.

Major activity of curriculum implementation is teaching-learning process. Course syllabus must be carefully designed. Teaching and learning of caring is the way to accomplish the curriculum objectives. A caring community or caring groups in which nursing faculty and students could engage each other in a reciprocal dialogue of sharing and support must be emphasized in all curricular and extra-curricular activities. Within a caring community, students are expected to gain the awareness and able to conceptualize the meaning and importance of caring in their personal and professional lives, become more accepting of others, and valuing caring model of nursing practice.

Believing that for the student to learn caring, the faculty must first exhibit and practice caring. Also, students search for a nurse-model in the teacher, one they can feel comfortable imitating and respecting. They need and want a teacher who can inspire them and let them grow in their own caring ways. That is, the student must be taught to be a caring person by a caring nurse-teacher. Using Roach's concept of caring and Watson's ten curative factors, and the concept of empowerment, the author proposed a "caring teacher model". The proposed model explained caring behaviors of a caring teacher which were categorized into 6 groups: 1) Professional Competence; 2) Genuine concern for the student as a learning person; 3) Acknowledge freedom and facilitate personal and professional autonomy; 4) Professional commitment; 5) Mutual trust, and 6) Facilitate personal and professional growth and motivation. The comparison of the proposed model findings from other studies will be discussed.

Perspective

Caring: A Healing Gift of Nursing

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Abstract

The purpose of this chapter is twofold. First, to provide an overview of death in modern Western society, origins of hospice of care, a model of hospice care. Secondly, to explore, analyze, and summarize selected literatures related to the phenomena of caring. The literature is drawn from the fields of philosophy, psychology and nursing perspectives related to caring.

- *A discussion of the meaning of caring form a nursing perspective.*
- *Exploratory critical analysis of relevant literatures drawn from the field of philosophy and psychology offering an understanding of the meaning of caring in the nursing context and,*
- *The changes occurring in the health care industry in this decade are of paramount importance to the future of nursing.*

Now is the time to validate the importance of the role of caring in nursing. Bureaus (1986) addressed the economic impact of establishing the cost factor for patient's perception of nurse caring interactions and determining the worth to the patient of the interaction. The quality of nursing care, with the main attribute "simple human caring", is the most important asset a hospital has. It is the nurse who is most intensely and constantly focused on the whole patient. It is essential that nurses take command on this indispensable commodity and safeguard the economic future of nursing. With increased emphasis on accountability in nursing and the move to project costs for nursing services, there is difficulty in measuring the nurse's full role. While those activities involving technical skill and procedures are more easily qualified, the inter-human dimension of nursing is harder to measure. As part of a more complex subtle, albeit valuable phenomenon, the interpersonal aspect of nursing related to caring does not lend itself to quantification. It is important that the study be implemented to promote understanding of the full scope of nursing (Bottorff and D'Cruz, 1984).

While caring has been identified as the essence of nursing, there are many factors which discourage the caring process in nursing. Ray (1981) cited the predominant organizational system of rewarding those who follow orders, the bureaucratic system in health care institution, and increasing reliance on technology as blocks to the caring process in nursing. For the caregivers, expression of true professional caring with its potential for growth in the patient can raise job satisfaction and increase motivation.

This paper will cover some aspects of caring that facilitate healing within the context of nursing. A brief overview of philosophical, psychological and theological perspective's of caring within the context of nursing will be explored. Finally, caring as a way of facilitating healing for both nurse and patient will be presented.

Caring as a life force and its challenges

The concept of caring is a profound expression of being human. It is the life force that moves and sustains the quality of nursing care delivery. Its expression embedded in nursing actions unfold the beauty of human qualities that facilitate healing for both recipient and giver of care.

However, scientific, sociopolitical and economic changes in health care management globally inevitably challenges the way caring is perceived by health care providers. From a theoretical perspective, caring has been described as a fundamental value that guides the nurse in ethical decision making and provides a basis for nursing actions (Brody, 1988).

Historically, nursing and nursing care have been adversely affected by unprecedented progress of science and technology. High tech expansion in today's health care marketplace, cost conscious bureaucracies, and understaffing have created a vacuum in caring relationships among members of the health care community and the recipients of their care. These glaring issues raised great concerns among leaders and theorists of nursing. Indeed a call to consciousness, to caring and healing for nurses is imperative.

Watson (1988, p. 175) believes that we are moving "out of an era in which curing is dominant into an era in which caring must take precedence. The morality of treatment and cure at all costs is breaking down financially, morally, scientifically, and spiritually" (p.176).

Caring is important in health care for several reasons. Leininger (1978, p.2) who studied transcultural caring throughout time and culture argues from an anthropological perspective that :

caring for self and other human beings is a universal phenomenon that has endured beyond specific cultures, and has brought forth important humanistic attributes of care-givers and care-recipients.

Leininger (1986, p.9) states that "the current diagnostic related groups (DRG's) are mainly focused on making medical diagnoses, providing medical treatment regimens, and giving basically physical curative acts as the "quick fix" means to award and receive reimbursement". The devaluation of personalised care and quality care services to help clients beyond their physical needs and the limitation to an allotted number of days in the hospital (depending on disease condition) are the greatest deterrents to holistic and humanised care practices. The economic value observing, comforting, and remaining with clients is receiving considerably less attention and less financial value compared with high technology in medical services.

The scientific model, can eliminate a disease, but "the process of curing can and frequently does take place in the complete absence of healing, often with devastating consequences" (Quinn, 1989, p.554). Healing occurs within the person, and is explained by what Quinn calls the 'haelen effect.' Haelen is the Anglo-Saxon root of the word heal, and means " to be or to become whole" (p.553). The 'haelen effect' is the "total, organismic, synergistic response that must emerge from within the individual if recovery and growth are to be accomplished" (p.554). This healing response is characterised by wholeness, harmony, and fundamental relationship or connectedness. "When true healing occurs, relationship is restabilised, relationship to and within self, to others, with one's purpose" (p.553). Nurses have the potential to help establish a feeling of relationship or connectedness within the patient, as opposed to alienation and fragmentation.

Although nurses have been encouraged to integrate caring and healing perspectives, much of nursing education and practice still continue to uphold the medical model and mandate to cure.

The meaning of the word 'gift'

First, let us examine briefly the meaning of the word 'gift.' A gift is a present or offering. It refers also to talent, aptitude, capacity, ability, faculty or genius (The Doubleday Roget's Thesaurus, 1977, p.289). Titmuss (1970, p.117) in his book entitled 'The Gift of Relationship', which is a study of the voluntary donation of blood, explains that the freedom to give, to be free

to choose to give to unnamed strangers is the best way of ensuring that society 'cares for strangers.' It reduces the atmosphere of competitiveness generated by treating health and welfare as commodities to be bought and sold, and to create structures for the enhancement of giving to others and furthermore, creates new structures for the expression of altruism (p.118). The argument of Titmus (1970) presents a challenge to the notion of caring as a gift since health is seen as a commodity in the present health care system. Every nursing action if not all has a price tag attached to it. Indeed, this is a dilemma for nurses caught in a tug-of-war- between these two worlds - that of altruistic caring and economics of caring.

The art and process of gift giving

Firstly, when I am giving a gift, I think of the person who I intend to give a gift. I think also of the circumstances why I want to give a gift and what would be the best gift. If the person is known to me, then I might ask the person what she would like to have as a gift relating to the occasion. There is a process involved in gift giving. The first step is an assessment relating to what would be the most appropriate gift. There is planning involved relating to what would the person most likely appreciate to receive as a gift. What resources are available to me such as time, finance, availability of the gift, its quantity and quality. One can see that there is almost a talent required when giving a gift. The timing of when to give the gift is important. It is heart warming when we know that the gift is well received. In gift giving, we also give a part of ourself if it is done thoughtfully. Similarly, when nurses care about their patients, it is done with the same thoughtfulness and sincerity.

Among members of the health care team, nurses are in a privileged position of being able to offer the gift of caring to facilitate healing and wholeness to those who are recipients of their care. Nurse are always there with patients, constantly experiencing awareness of patients human needs, being able to respond compassionately and competently as they complete skillful nursing interventions appropriate to those needs twenty four hours a day. Every encounter between nurse, patients and their family members are enriched with opportunities of human expression of caring. Yet, there are times when the curing needs of patients become significantly paramount at the expense of caring. Consequently, the patients missed their opportunity to heal due to lack of caring.

What is this gift called caring?

The etymology and meaning of the words care and caring

There are few words in the English language which are more ambiguous than "caring". The words "care" and "caring" conjures many meanings. The etymology of the Middle English word "care" came from the Old English word "caru, cearu". (Universal Dictionary 1988, p.249) The Gothic word is "Kara."(The Macquarie University, 1881, p.298).

The noun "care" implies mental distress, uncertainty, worry, grief, an object or source of worry, attention, or solicitude. The verb "care" means to be concerned, have regard, mind, heed, watchfulness, vigilance, interest, caution, carefulness. Further meanings given are charge, custody, keep, control, protection, ministration, management, supervision and responsibility (The Doubleday Roget's Thesaurus 1977, p.91)

The Doubleday Roget's Thesaurus (1977, p.91) described the noun 'care' which included mental distress, uncertainty, worry, and grief. Each description could be the consequence of nursing intervention devoid of 'caring'.

The descriptions of care and caring from Macquarie Dictionary (1981, p. 298) would seem to support Griffin's (1983)

claim that care refers to a general set of meanings:

- concern or regard for someone
- responsibility or ministering for someone

(Macquarie Dictionary, 1981, p.298).

The meaning of care are difficult to discern from words that are identified as synonymous. Love, empathy, altruism, compassion, support and positive social behaviour have been equated as either the same as caring, similar to caring characteristics of a caring relationship or caring process. Each of these words provoke profound emotions and feelings and thoughts when they are used. It is difficult to describe and separate the feelings, thoughts and meanings that are associated with caring and caring behaviours. Although it is inherently known that when one is cared for and are caring for others, it is with great difficulty that one is able to name either the feelings or the thoughts. When one "cares", one "knows" what that is. There is, then, an intuitive understanding that is communicated between the caregiver and the recipient of care. However, frustration and discouragement are the usual outcomes when one attempts to describe caring in more concrete terms without losing the feeling tones of what caring feels like what is "caring," and how is "care" provided.

Leininger (1981; 1984 ; 1990; 1992) a leading proponent of research into caring phenomena, has consistently discussed caring as the essence of nursing and the most central and unifying focus for nursing decisions, practices and goals. In her view, no construct could be more central or more promising for teaching, research, and practice than ideas related to care and caring in the nursing profession.

Caring as a concept has a significant influential role in the development of nursing theory, research and practice of nursing. Many nursing theorists claim that caring is the essence, the core, the focus, and a central concern of nursing (Leininger, 1980, 1981, 1984; 1990, 1992; Bevis, 1981; Gaut, 1984; Watson, 1985, 1988; 1989; Ray, 1981, 1984, 1985, 1987; Benner and Wrubel 1989).

Philosophical, psychological perspectives of caring within the context of nursing.

- **Caring as a primary mode of being human**

Most philosophers tried to comprehend the breadth and depth of the concept of caring by attempting to describe and explain it. Their analytical writings viewed caring as an essential way of being and have found it embedded in discussions of other topics such as the problem of being and related issues concerning human relationships.

Caring denotes a primary mode of being in the world, which is innate in humans and is significant in their relationship with oneself and others. This notion is clearly described in an ancient Roman myth quoted by Heidegger in his book 'Being and Time (1987, p. 242).

Once when "Care" was crossing a river, she saw some clay; she thoughtfully took up a piece and began to shape it. While she was meditating on what she has made, Jupiter came by. "Care" asked him to give it spirit, and this he gladly granted. But when she wanted her name to be bestowed upon it, he forbade this, and demanded that it be given his name instead. While "Care" and Jupiter were disputing, Earth arose and desired that her own name be conferred on the creature, since she had furnished it with part of her body. They asked Saturn to be their arbiter, and he made the following decision, which seemed a just one. "Since you, Jupiter, have given its spirit, you shall receive that spirit at its death; and since you, Earth, have given its body, you shall receive its body but since "Care" first shaped this creature, she shall possess it as long as it lives. And because there is now a dispute among you as to its

name, let it be called 'homo,' for it is made out of humus (earth)."

The myth highlights the point that in essence, the primary mode of being in a life time of human existence is to care. Heidegger (1992) emphasised the practical dimension of human existence by defining the very being of Dasein as "care." To be human means to be concerned about things and to be solicitous toward other people (p.238). Roach affirmed Heidegger's point when she stated that when we cease to care, we cease to be human (1992, p.17). Caring is also viewed as a way of being and doing nursing (Roach, 1992; Watson, 1985).

• Caring : a way of relating with others

Mayeroff (1971) is one of the few philosophers who provides direct discussion of the concept of caring. He sees care as an important way of living which can be distinguished by several features. It is first, the development of a way of relating to someone or something specific, not some generalised other, through a long process. He says caring develops as a relationship with changes in the one who cares and the one cared for. The response of caring is one which requires that the caring person recognise the person cared for as separate and apart but at the same time as one with the caring person.

Through the caring process the carer participate in the reality of the other. The carer sees the other as having the potentialities which are expressed through the other's need to grow. The caring process is at once an extension of, yet separate from, the carer. In this way the other is not dependent on the carer, for the other is a participant in that caring. Mayeroff (1971, pp. 19-35) asserts that this process exhibits eight major components. These are: knowing, alternating rhythms, patience, honesty, trust, humility, hope, and courage.

• Caring as knowing

The carer must know the other before one can render caring. Knowing the other enables the carer to help that person to grow (Mayeroff, 1971, p.12). Once the carer knows the other, both immediate and long termed needs are examined. This is the process of alternating rhythms. It is characterised by backward and forward movement. This movement occurs across both in a narrow, or short -term, and wide, or long-term, framework. The carer must use past experiences in order to determine which framework best fits the other's need at a given point in time. Such a framework requires patience if "the other is to grow in its own time and in its own way" (p.12). As an active process, patience requires the carer to appropriately interpret the need for caring (Mayeroff, 1971).

Carper (1978, p.22) emphasises the significance of using the patterns of knowing when she stated that "nursing depends on the scientific knowledge of human behaviour in health and in illness, the aesthetic perception of significant human experiences and a personal understanding of the unique individuality of self" (Carper 1978. p. 22). Nursing knowledge and intervention within the context of caring recognises humanistic and holistic approach to health and healing. This kind of approach enables nurses an awareness of 'self' and the recipients of their care as holistic beings. Operating from a holistic framework, nursing care addresses the physical, emotional, mental, spiritual needs of patient care.

Caring as action is not apparent unless the assessment indicates that the action are both appropriate and meaningful. This process requires that the carer is honest in openly confronting one's motive in caring. Honesty facilitates genuiness in the carer. Honesty is a prerequisite to trust. Such trust enables the carer to allow the other to grow towards independence in one's own way and time with a sense of trust that the other will achieve self-actualisation. The presence of trust in human relationships nurtures the carer and enhances his/her self

confidence. Thus the carer's caring ability grows (Mayeroff, 1971).

• Caring as a dialogue

Buber (1970) and Marcel (1964) take a subject-object view of caring in the human relationship. Each sees the "I - You" relationship in a dialogue. Empathy occurs only as a between people phenomenon in the presence of genuine dialogue. This dialogue requires that a degree of openness between oneself and the other person. Marcel (1964, p.89) describes this as a process of one's "making room" within the self in order to communicate empathically with another. In other words, the carer must penetrate the other's reality, becoming a co-presence with that other. Thus the 'I-Thou' encounter is transformed into a transcendent co-presence of carer and recipient (Marcel, 1964: 1981).

Here is an exemplar of this situation taken from an interview with a nurse from Pakistan when she shared with me her thoughts on caring in nursing. She was reflecting on a situation from her nursing practice. She said:

" I can feel what this mother is going through. Her baby is dying of cancer. I am a mother who has a daughter of the same age. I may not exactly feel and fully know what she is going through but as a nurse, based from my professional experience, her facial expression is a picture of someone going through tremendous suffering. Being a mother, I can identify with her fear of losing her child. As she spoke of her fear, listening to her emotional pain, how can one not be touched by the pain of this mother. I feel wounded as well. Here am I as a nurse but I could not separate myself from being a mother reaching out to another mother in distress. In caring, we bring all of ourself into the human situation beyond our role as a nurse. We give the best of ourselves to creatively provide a safe environment for our patients and their family to heal. This is more than caring, it is really a way of loving another being. As she expressed her gratitude for being able to understand her feelings, she kissed my hand. I remember uttering a prayer of surrender to 'Allah' for everything."

In this exemplar, caring and loving are invisible force of healing. The nurse being there and with the mother of her young patient facilitated a comforting presence for the distressed mother and ultimately the child.

Buber (1970) asserts that co-transcendent communication requires that one both see and experience the other from one's own as well as from the other's perspective. This notion moves beyond empathy, wherein one experiences the other's reality as the other experiences it. Co-transcendence requires that the self experiences something from both one's own as well as the other's reality. Such an experience is a concretization of the notion of genuine love or 'agape' (Friedman, 1976).

• The use of self in caring

Mayeroff's notion of caring is not that of a casual or transitory interest in another. Rather, caring is the use of self in order to help another to grow toward self-actualisation. It is the caring process rather than its action that bestows self-meaning and, hence, gives meaning to one's life. The gift of self speaks strongly of the art of nursing that originates with who engages the patient in understanding. Through a process of giving and receiving each other, the art of nursing unfolds. By creating nursing, the nurse herself, is a creation that enfolds the moment. Through giving self, both nurse and patient co-create a loving experience expressed as the art of nursing. Nursing as art creates a spirit of understanding that allows for caring in a way that truly helps patients (Appleton, 1991, p.88). The gift of self lovingly given empowers both nurse and patient as they transcend beyond their role, overcoming their separateness in a highly structured world of bureaucratic health care system.

Creatively, in a loving safe and secure presence of the nurse, even the highly mechanised and sanitised environment of the hospital become a 'home away from home.'

Love begins with a feeling of care

The concept of 'caring' is connected with the concept of 'love.' The English word 'cherish' (which means to hold dear, feel or show love for) originates from the Latin word 'carus' (in English: care,' 'caring') which means love. The history of ideas states that the foundation of the caring profession through the ages has been an inclination to help and minister to those suffering (Eriksson, 1992, p.11).

Fromm (1985, p.15) a prominent psycho-analyst stated that man's deepest need is to overcome separateness, to leave the prison of his aloneness, and to establish relationships. Humans have tendency to be concerned for other humans. Interactions are caring interaction when they help to overcome separateness and achieve union. Caring is an art requiring knowledge of the person, incorporating effort as well as respect and responsibility.

His book entitled "The art of Loving" (1985, p.28) has as its focus, the simultaneous development of one's personality and the capacity to love as a characteristic of that personality. Attainment of satisfaction in individual love is tied to one's "capacity to love one's neighbour which can not be attained without true humility, courage, faith and discipline." He identifies certain basic elements common to all forms of love, "these are care, responsibility, respect and knowledge". Both care and concern imply an aspect of love that is found in responsibility. Responsibility is a voluntary act of response to the expressed or unexpressed need of another. To act responsibly then is also to act with care and concern. There is an unexpressed based of deliberation that precedes acting responsibly. To act responsibly one has to have both the capacity and ability to do so. To act in a caring, concerned and responsible manner is to have forethought and to place another's needs deliberately on one's mind (p.29).

Love is an attitude toward the world. Love is neither object related nor symbiotic attachment. Love determines the relatedness of one's person to the world as a whole (Fromm, 1985,p.43). To live in this orientation to all the world is to share one's humanity among people with a "sense of responsibility, care, respect and knowledge" (Fromm, 1985,p.28). The implications of loving, caring, respect and responsibility are all interdependent.

Although Fromm uses the word "care" often in some of his writing, he does not provide a definition of "care" that is separate and distinct. Loving and caring are interdependent. Productive love always implies a syndrome of attitudes; that of care, responsibility, respect and knowledge. (Fromm, 1985).

Rollo May (1969), in his book entitled "Love and Will," said that relationships of love begins with a feeling of care or concern for another. His views is that:

love means to open ourselves to the negative as well as the positive to grief, sorrow, and disappointment as well as to joy, fulfilment, and an intensity of consciousness we did not know was possible before or May (1969, p.99).

Love is purposeful because it is guided by will, the capacity to organise oneself so that movement toward a goal may take place. Love and will are interdependent. A careless relationship is based on manipulation, it is taking care of others without caring for them; it is the person who can give material things, but not his heart, and can direct others but not listen to them. In a caring relationship one reaches a state of recognition of another, a fellow human - being, like one's self; of identification of one's self with the pain of

another; of guilt, pity, and the awareness that we all stand on the base of a common humanity from which we all stem (p.285).

Varnier (1988, p.88) explains that in the fragility of this experience lies also its pain. He added that, in awakening our capacity to love, it awakens what is deepest in us which includes our vulnerability and sensitivity. Love is gentle and beautiful but here comes with it a terrible fear. Fear of the future and of the risk of getting too involved; fear that it will lead only to the death of our so-called freedom, fear too of being hurt, for to love is to become vulnerable; to love is always a risk.

St. Paul, in his letter to the Corinthians, tells us that if we do big and beautiful things and speak with all the tongues of angels and of people, have all knowledge and even a faith to move mountains and have not love, then we are nothing. Then he goes on to explain:

Love is being patient and kind, not jealous or boastful, not arrogant or rude. Love does not insist on its own way; it is not irritable. Love finds its joy in truth.

Love bears all things, believes all things, hopes all things, endures all things.

Yes, love is manifested in the small things concerned with another person (1 Corinthians 13: 4-8: The New Jerusalem Bible, 1990, p.225).

May (1969) identifies other works that might be confused with caring such as concern, compassion, dedication and patience. A basis of care is emphasised in feeling for another human being. "Feeling commits one, ties on to the object, and ensures action" (p.300). This type of feeling is more than a subjective sensation. The beginnings of human relationships are through caring expressed as concern for the other's existence. There may be progression to dedication and eventually a willingness to delight in the others good fortune and even to suffer for the other.

Human relationships are characterised by waiting, "waiting is caring, and caring is hoping" (p.300). He asserts that the meaning of one's life is related to the world in which one lives. The concept of care provides one's meaning in that "in care one must be involved with the objective fact. One must do something about the situation" (p.18). Care is a necessary part of humanness. His notion of care is one of action.

Worrall and Worrall (1965, p.123) state that the energy of love itself in compassionate healing -love is a paramount factor. These are not mere words, sentimentality, pretty phrases; the chemistry of compassion is the most powerful factor in religion and most of all in religious healing. One must love, one must enfold one's patient in compassion, one must yearn for him or her to get well, to be whole, to be without suffering or pain. Without this driving force of compassionate love nothing whatsoever is likely to happen.

- **Love and health**

Love is intimately related with health. One survey of ten thousand men with heart disease found a 50% reduction in frequency of chest pain (angina) in men who perceived their wives as supportive and living. The power of love to change bodies is legendary, built into folklore, common sense, and everyday experience. Love moves the flesh, it pushes matter around - as the blushing and palpitations experienced by lovers attest. Throughout history "TLC" has uniformly been recognised as a valuable element in healing (Medalie and Goldbourt, 1976).

David McClelland, PhD., of Harvard Medical School, has demonstrated the power of love to make the body healthier through what he calls the "Mother Teresa effect." He showed a group of Harvard students a documentary of Mother Teresa ministering lovingly to the sick, and measured the levels of immunoglobulin A

(IgA) in their saliva before and after seeing the film. (IgA is an antibody active against viral infections such as colds). IgA levels rose significantly in the students, even in many of those who considered Mother Theresa "too religious or a fake". As a result of his personal experiences and research, he became an advocate for the role of love in modern healing (Borysenko, 1985). He also informed his medical colleagues that:

I can dream a little changing hospital environments, one that relaxes you, gives you loving care, and relieves you of the incessant desire to control and run everything. A healthful environment. All of us- can learn that being loving to people is really good for their health. And probably good for yours too.(Locke and Douglas, 1985).

• Empathy is integral to a caring relationship

Empathy is an important aspect of a caring therapeutic relationship (Rogers, 1961, Carkhuff et al., 1966 and Jourard, 1971). Relationship is one that develops and grows over time. Within the therapeutic relationship, the client is an 'incongruent person' who senses that the therapist, a 'congruent person,' accepts and values the client unconditionally. The therapist is emphatic. The feeling of empathy of the therapist enables the client to develop insight into the incongruence. The client begins to more fully and completely accept the self (Rogers, 1966, p.9). This view is consistent with the emphatic genuiness of the notion of "I-You" relationships as described by Buber (1970) and Marcel (1964). Because of empathy, the client is helped to grow (Roger, 1961) towards the notion of self-actualisation (Mayeroff, 1971) and is able to benefit from caring.

Carkhuff et al (1966, p.725) states that professional helping relationships are ineffective should one's counsellor be uncaring. He believes that a counsellor's therapeutic impact is more "deteriorative" rather than "constructive" if "the levels of empathy, positive regard, and genuiness are not demonstrated."

Jourard (1971) sees the concept of behavioural change postulated by Rogers (1961) as that of achieving "worthwhile objectives." The emphatic, caring, genuine behavioural attributes of the therapist is what Jourard referred to as "authentic behaviour." Such behaviour " is essential in the practice of caring for patients" (Jourard, 1971, p.201).

• Compassion is the force that motivates a person to care

Compassion is the force, which motivates a person to care. "So much compassion - so much care." True caring is based on compassion. Compassion will emerge in the meeting between suffering and love. The nurse's ability to feel compassion emerges from personal experiences of suffering and love (Eriksson, 1994, p.14). Roach (1992, p.58) defines compassion as a way of living born out of awareness of one's relationship to all living creatures; engendering a response of participation in the experience of another; a sensitivity to the pain and brokeness of the other; a quality of presence which allows one to share with and make room for the other. Compassion involves a simple, unpretentious presence to each other.

Love, empathy and compassion seem to form a real bond - a resonance or 'glue' - between living things (Dossey, 1993, p.112). These three elements of caring are vital in the facilitation of healing.

How can caring be a healing gift?

Florence Nightingale (1969) expresses the view that "nursing ought to assist the reparative process" and that the goal of nursing is to enable the "patient in the best condition to act on him"(1969). It is clear from her statement that the nurse is there to

enable the process to take place that calls for consideration of the concept of healing and caring within the context of holistic paradigm. She added further that:

But when you have done away with all that pain and suffering, which in patients are the symptoms of their disease, but of the absence of one or all of the above - mentioned essentials to the success of Nature's reparative processes, we shall then know what are the symptoms of and the sufferings inseparable from the disease (1969, p.9).

Healing can also be the outcome of caring intentionality and action. Leshan (1966) states that caring , or 'caritas,' is essential to what he terms "type 1 healing," as differentiated from "type 2 healing." This latter type is consistent with healing energy transference, such as by the laying on of hands in Therapeutic Touch.

LeShan (1966) asserts that "type 1 healing" occurs when the healer "views himself and the healee as one entity" (p. 106). LeShan (1966) states that the Christian approach to healing in particular sees such healing as one connection with the "Divine Universe" by means of a healing process. In this sense, caring is therapeutic.

Ashbrook (1975) describes four common features of the healing or therapeutic approach to caring.

• First, a relationship is established. The caregiver expresses empathy with the other's pain. The caregiver demonstrates respect, values and accepts the other without being judgemental. The caregiver recognises the other's potential.

• Second, he asserts that a healing approach to caring requires a special place physically/ emotionally removed from the source of the other's pain. This removal of self is consistent with a male caring identity, for as such it is dialectical rather than female dialogical according to Noddings (1984).

• Third, he states that a "rationale for caring "must exist." He calls this rationale "the grammar of therapeutic approaches."

Finally, procedures must be designed that are "consistent with the rationale designed to help (the other)." The enactment of these caring procedures for healing necessitates genuine involvement, or relatedness, by caregiver (Ashbrook, 1975, pp. 54-62). He believes that caring is therapeutic when a "rationale for caring" exists, possessing multiple "therapeutic approaches." He does not address whether these approaches are necessarily deliberate. Nonetheless, he implies that such is the case. His approaches to healing are employed in a formal rather than informal therapeutic relationship.

How may we be instrument of healing?

By entering into what Buber (1970) called, "I-Thou, relating"; by focusing on the otherness of the person cared for and on the wholeness of her personhood. I cannot be subjective and stumble into the trap of identification when I am focused on the patient's otherness, and, at the extreme, I can't depersonalise when I focus on the wholeness of his/her personhood.

Depersonalisation occurs when the person cared for is always on the receiving end like the object of nursing care. Are patients seen as 'givers' or 'receivers of caring?' Do we foster their giving? Do we hear the plea of a patient experiencing physical pain exarcebated by emotional and spiritual suffering? Do we see only what we want to see and hear what we want to hear?

One nurse in hospice care recalled the gift of wisdom about life and death that she received from her patient who died of HIV. She said:

He was an intelligent young man far advanced in his wisdom about life for his age. We had some wonderful in - depth discussions about life, illness and death. I would write down in my diary thoughts

from our discussion that seemed to hit home to me about my view of life and death as a nurse. When things get on top of me like having more than one death in one day, I would go through some of the thoughts I have written down that he shared with me about the finiteness of life and how dying is a rebirth to a spiritual dimension. It helps ease the sadness. It brings a glimmer of hope in a relationship where the thread of life is so fragile and yet strengthened by the appreciation of joy and pain. It also brings a sense of peace as you honour the memory of the one who have just gone. Looking back, I have received more than what I have given. Today, I celebrate his memory by sharing this thoughts with you.

Here is a journal entry of a nurse caring for a patient newly diagnosed with a life threatening condition. What does this exemplar convey to you about healing?

Today a situation in the ward hit home to me what it means to be first as a person and second as a patient. Today is one of those very hectic shift. I just did not have time to stop and be with some of the patients needing more than physical care. The telephone never stops ringing. Dressings, medication, drips, doctors round, relatives complaining, patients wanting to discuss their treatment and on and on. Dear old Mr.H., everytime I pass by his bed, he always says "I am alright luv! but his facial expression revealed he is worried about something. I think that 'look' communicated to me a sense of loneliness. It was almost as if he was saying to me, "Show me that you take me seriously but don't support my acting out or the games that I play to cover up my true feelings and who I really am. I feel this way because I am hurting. I am more than the disease that I present. I am a human being. You are a human being who happens to accompany me in this sensitive and trying journey of my life. Be here with me. I need comforting. I am here and I am in pain. Come here. Touch me gently for I am aching all over. My spirit is down and wanting to soar out of this place of pain. Help me to see hope in my world that is crumbling. I feel helpless and hopeless. Stay. I need reassurance. You are doing really well. I feel comfortable with you. Help me to see that I have a place, a role, that I have something to give to you, to my family or my fellow patients, and you will heal something in me.

The exemplar presented a situation of a patient reaching out to the nurse, needing his/her presence to facilitate the natural healing process, to focus attention on and encourage the patient towards recovery. The exemplar reveals to us nurses that the active ingredient in the healing process is not surgery, antibiotics, or other technological methods. Rather, it is the caring compassionate presence, love; the impulse towards unity, non separation, and wholeness.

The patient in the exemplar has so much to lose and his future is so bleak. What can one say or do to make a difference? I would submit that we can make a difference by recalling that his experience of quality in life depends on his recognition of a personal context of meaning. Frankl (1984) speaks to the thing that gives quality to our lives. He suggests that the variable which makes us rich is not prestige, is not fame or fortune, the almighty dollar or the sexual drive. It is the search for meaning. We will experience quality in our day today, if our personal experience of meaning is enhanced.

We can sit down and ask the patient about the meaning of his illness to him. We can ask him about things he has done, created or accomplished; the things he has loved, such as places, people, music, ideas, sights, sounds and smells; the things of meaning that he is leaving behind, and the things he believed in. Such thoughts may rekindle a spark of feeling engaged, a sense of involvement, purpose, and identification. However, as transient that experience may be, it carries with it the message that life, even now, can be meaningful.

Relevance of art in caring and healing

Moore (1992, p.174) describes the relevance of art in the caring for the spirit that facilitates healing of the whole person. He explains:

Our hospitals are generally not equipped to deal with the soul in illness. But it wouldn't take much to change them, because the soul doesn't require expensive technology and highly trained experts. Not long ago a hospital administrator asked for some ideas about improving the hospital's operations. I recommended a few simple things. Their plan was to let patients read their own charts everyday and also be given pamphlets describing the chemical and biological aspects of their diseases. I suggested that rather than being given a chart of temperatures and medications, the patients be encouraged to keep track of their impressions and their emotions during their time in the hospital and, most important, to note where patients could paint, sculpt, and maybe dance their fantasies during treatment. I was thinking more of an art studio than of an art therapy in the usual sense. I also recommended a time and place where patients could tell stories about their illnesses and hospitalisation, certainly not with an expert who would reinforce the technical medical format, but maybe with a real storyteller or someone who would know the importance of letting the soul speak and find its images.

By helping patients to see the realistic things to hope for in their day, to recognise, as that hope does not lie in a way out, but in a way through, the healing of spirit may be accompanied by an awareness of quietness, a sense of solidity, quiet stability, security, or a sense of being held. This may occur apart from the context of religious belief.

According to Munley (1983) the essence of spiritual care giving is not doctrine or dogma, but the capacity to enter into the world of others and respond with feeling with appropriate spiritual awareness.

Healing occurs naturally, love heals (Laskow, 1992, p.1). In a healing equation, love is the common denominator. We can use our thought, our hands, our ears, our higher consciousness to facilitate healing.

Watson (1985) describes caring as a transcendent experience; a mutual flow of energy that allows both parties access to a universal source of psychic energy. Watson (1989) explains how one who is cared for *an experience a release of subjective feeling and thoughts that had been longing and wishing to be released and expressed. Thus, both provided and care receiver are co-participants in caring; the release can potentiate self-healing and harmony in both. The release can also allow the one who is cared for to be the one who cares, through the reflection of the human condition that in turn nourishes the humanness of the care provider. In such connectedness they are not capable of transcending self, time, and space (p.132).*

Thus caring is not a one way flow of energy from caregiver to receiver, but a mutual flow that enhanced both parties. Gilligan (1982), in her theory of women's moral development, suggests that the need to care is a universal human truth, and implies that caring is a necessary form of self-expression. Quinn (1989), in describing the work of as the healer, states that "there is increasing evidence that positive emotions are health producing, and what is more positive than the experience of love and compassion which "healers" attempt to communicate to their patients" (p. 556).

The research that most directly supports the positive effects of caring is Benner's (1984) descriptive study of skilled performance in nursing. After contacting 1200 nurses Benner concludes that caring does not cause burnout, rather it is the energy required to defend oneself against

involvements that is emotionally exhausting.

According to Benner and Wrubel (1988) caring is necessary to manage the stress of nursing. These authors criticise popular stress management theories that emphasise distance and control strategies as a way to cope with work stress. They maintain that "caring is the essential requisite for all coping:" (p.2). Because caring organises a person's involvements, it "sets up what matters," and creates possibilities that would otherwise not be realised. The opposite of caring in this senses meaninglessness or anomie. As an example, Benner and Wrubel point out the endless nature of the tasks involved in child care. These tasks would be demoralising, and the risk of child abuse would be high if the patients did not care and allow themselves to be engaged and be involved in the child's cries and laughters. When there is caring, parents find ways to manage, even in extreme conditions of multiple births or chronic illness (p.3).

Yet "health care workers are repeatedly exposed to breakdown, tragedy and death" (Benner &Wrubel, 1988). Sally Tisdale (cited in Benner and Wrubel, 1988, p.375) in her book entitled 'The Sorcerer's Apprentice: Medical miracles and other disasters' describes the narrow path nurses on a burn unit must walk between over-involvement on the one hand, and detachment on the other:

Along the narrow road where the nurses scrape little Michael's nerves (she refers to a caring approach to the debridement of a burned child) is a simple acceptance. Here is now, this is happening, keep walking. To project another's experience onto one's self how would I feel; what if this were my child?) is not terribly necessary and terribly dangerous. Burn nurses work here year after year, anonymously, cutting off skin and treading lightly. It is easy to slip. They must help each other up when they fall (Benner, 1988, p.376).

How can those work with such intense pain protect themselves? Benner and Wrubel (1988, p.373), explains that the common denominator, the golden thread that runs through all forms of healing which allow nurses to walk that "narrow path may be called healing relationship".

Solfin (1989,100) describes the healing relationship as a way to communicate the love and concern of others that gives us strength and reason to heal. It communicates our worth as an individual. It communicates the irrational, just as love is irrational, and gives us hope that everything is possible through love. The healing relationship communicates high expectations for ourselves, our bodies, minds, and spirits, and motivates us to respect ourselves. The healing relationship communicates the love and concern of others that gives us strength and reason to heal. It communicates our worth as an individual. It communicates the irrational, just as love is irrational, and gives us hope that everything is possible through love. The healing relationship communicates high expectations for ourselves, our bodies, minds, and spirits, and motivates us to respect ourselves.

For health professionals, the healing relationship is important because it holds the potential for reacquainting oneself with their own self-healing abilities. It is a special form of communication that reassures our faith in the so-called miraculous, just as our parents taught us through their comforting kiss how quickly wounds can heal (Solfvin, 1989, p.101).

According to Prather (1989, p.16) to truly heal, to deeply and permanently affect the mind, a healer must have no goal but innocence - to see it and to be it. To accomplish so great a feat, the mind has to shift away from mere pictures and beliefs to the quiet, still knowing that is love. Harmlessness, absolute and complete, is the ultimate power. When healers immerse themselves in harmlessness, what to say

and what to do is gently known. It means "get real."

I think Margery Williams said it well in the Velveteen Rabbit. Do you remember the scene between the Rabbit and the Skin Horse?

What is real? Asked the Rabbit one day, when they were lying side by side near the nursery fender, before Nana came to tidy the room. "Does it mean having things that buzz inside you and a stick-out handle?"

"Real is not how you are made," said the Skin Horse. " It is a thing that happens to you. When a child loves you for a long, long time, not just to play with, but really loves you, then you become real."

"Does it hurt?" asked the Rabbit. "Sometimes," said the Skin Horse, for he was always truthful. "When you're real you do not mind being hurt."

"Does it happen all at once, like being wound up," he asked, "or bit by bit?"
"It does not happen all at once," said the Skin Horse. "You become, it takes a long time. That is why it does not often happen to people who break easily, or who have sharp edges, or who have to be carefully kept. Generally, by the time you are real, most of your hair has been loved off, and your eyes drop out and you get loose in the joints and very shabby. But these things do not matter at all because once you are real, you can't be ugly, except to people who do not understand."

Authentic interactions with patients have potential to be healing. Healing is a natural potential within all persons which becomes actualised when the intention to help or to help another is present, transforming a routine interaction into a healing, therapeutic opportunity (Kunz, 1985).

Prather (1989, p.16) argues that the mind that sees itself as whole and another as sick unquestioningly requires healing. True healing is thus expressed within the mind of the healer and not within the body of the patient. When a healer sees that he or she is not separate from the patient - and not only love holds this vision - healing is already accomplished. The mind that no longer struggles to contrast itself with another, but looks happily upon its oneness with all living things, has moved into that level of reality where healing is a constant. The healer has now received and accepted the only thing that can be given away (Prather 1989, p.16).

A caring approach cannot result in a set of prescriptions or universal principles, unless respect for others' beliefs may be considered a universal principle. Here are some guidelines I would like to share with you based from nursing practice.

- Perhaps the most important tool is self-examination. As nurses, we need to critically and continually examine our own beliefs and meanings about life, illness, health, caring, healing, death and dying. As we scrutinise these beliefs, some may be rejected, some transformed, and others celebrated. Only by knowing one's own beliefs and values about life that we can be ready to learn and appreciate the values of others.

- We must attend to our patients' physical needs. The foundation stones of the edifice of whole person care are competence in careful assessment built upon a good foundation of knowledge in physical, emotional and spritual assessment and appropriate care. Competent physical care demands skilled listening of the whole person. We must work as a team in a spirit of cooperation not competition, since we can't possibly meet that broad range of goals alone.

- The challenge of listening asks of us to learn to listen attentively to both what is said and to what is left unsaid. We must listen for non-verbal cues from the patient.

• Do we hear the non-verbal communication from ourselves? How clearly do we monitor our own relating? We must begin to recognise the message we give when, for instance, do we let them wait when they ring the bell. We must understand our own need for power. Do we sit down at the bedside so that eye contact occurs without them having to look up to meet my gaze. If I remember to sit down, might this convey involvement, without a greater expenditure of time? We must note when the patient has become an object rather than a person; when privacy needs are being ignored; when we are invading the patient's space. We must use touch thoughtfully to convey caring, but avoid it when it might be an intrusion to privacy. We must also avoid ambiguous gentle touch that becomes a caress, using instead the gentle, yet firm contact that sends clear supportive messages.

• By establishing realistic goals in each case we have to accept the fact that we will not always succeed. They will not all be likeable, easy to deal with, interesting and grateful. It will help if we can develop a personal philosophy that can respect their right to be different, their right to appreciate what a great nurse I am, their right not to thank me and to meet my ego needs. We can not always make it all better. We can not ever make it all better. The most and the least we can do is to do our best - nothing more - nothing less.

• For each of us, whether patient, family member or caregiver, healing is marked by making a little progress down the path toward wholeness.

• Find out what the client knows and expects about the illness and its treatments. Evaluate whether the client's health beliefs are congruent with your own or the dominant health care system. If they are incongruent, determine whether there will be negative consequences for the patient's health.

How do we care and heal oneself?

Nurses are known to be givers. We give and give and never allow ourselves to take the time to be quiet, to heal. As much as we are healers, we are not immune from being wounded. We need to learn to give and to receive, to heal and to be healed. We need to learn how to forgive ourselves when we cannot meet our highest ideals. We need to always check that our cup of caring for ourselves is overflowing so we can give our best of caring for and about those who trusted their life in our care. If we ignore this situation, it might be too late to tip the scale to a position of balance. Adversely, it is then that we are truly exhausted and absolutely burnout. We have nothing to give and we can not care. Dossey et al (1995, pp.4-7) describe how to create rituals of healing. According to them, an important aspect of relaxation is to create a special time for the art of ritual in daily living. Creating a sacred space to be alone and to reflect on healing awareness deepens one's understanding of being alone and being able to reflect on healing. It also deepens one's uderstanding of being connected with self, others, and a Higher Being. It can reduce anxiety and fear, lessen feelings of helplessness, and become more capable of dealing with daily stressors. By creating a healing ritual, we can benefit more from the holistic strategies that will help us become better healers. Facilitating the experience of caring for our mind, body and spirit enables us to be whole and more open to the needs of others.

Dossey et al., (1995, pp.4-7) describe the path to a healing place of peace.

- *Know yourself as a spiritual being by experiencing your spirituality. You are both whole and becoming. Be aware of the need to be, to be with, and to hear painful feelings as you grow in your ability to be present with another. You are part of the other's journey and becoming.*
- *Encourage and share in reminiscing.*
- *Encourage and share in life review, a time when persons can remember and sometimes resolve or understand conflicts and pain from a new perspective.*
- *Experience the present moment - whatever joy, pain, grief, struggle, or laughter it may hold. It sometimes helps to name what you are experiencing as you share a moment with another.*
- *Listen for the meaning of this moment with another.*
- *Remember that being aware of the presence of God does not depend on being able to define or describe God.*
- *Remind your self that experiencing your spirituality often means experiencing ambiguities, struggle, and searching for rather than finding 'answers'.*
- *Remember that each person is the expert of his or her own life's journey - we (as nurses) can help clients recognise, explore, and experience their uniqueness.*
- *Consider viewing silence as an opportunity and space to listen or to be still rather than as an emptiness to be filled (Burkhardt and Nagai-Jacobson, 1985).*

To conclude, we need to acknowledge the importance of caring as a way of facilitating healing not only to the recipients of our care but also to ourself. We need to have a good understanding of the meaning of caring in facilitating our well-being. It is only in doing so that we will be able to reach out to clients/patients, their family members and or significant others experiencing physical, emotional and spiritual distress. The greatest gift we can give to those we have been fortunate to join in their most sensitive journey of life is our own personal, living, spiritual richness. This gift of one's self given compassionately to our patients, their family members and or significant others and to our colleagues experiencing crisis will inevitably encourage them towards a healing journey of wholeness and wellness.

As I come to the final point of sharing my thoughts on caring as a nurse healer, I would like to share this poem with you about the dance of the spirit to the tune of caring and healing for each other. May the spirit of the Dance be with you.

May the Spirit of Awakening touch you, and that you in turn may touch one another, in your celebrations and your woundedness, in your going out and your return.

May the spirit of Dis-Covering find you, that you in turn may find one another, in your listening and remembering, in your brokenness and your connection.

May the spirit of Creating fashion you, that you in turn may fashion one another, in sensitivity and in gentleness, in artistry and awe.

May the Spirit of Dwelling quiet you, that you in turn may be quiet resting places for one another, in the desert and the garden, in the city and at home.

May the Spirit of Nourishing feed you, that you in turn may feed one another, in your hungers and your yearnings, in your neediness and your losses.

May the spirit of Traditioning inspire you, that you in turn may inspire one another, as lovers and teachers, as mentors and models.

May the spirit of Transforming re-create you, that you in turn may give new life to one another, and to all of Earth's creatures, and to the Earth itself (Harris, 1991, p.205).

I wish you many caring moments and an experience of a peaceful healing journey in this conference. Thank You.

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Perspective

Human Caring in Multicultural Societies

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abstract

Human caring in multicultural societies has reflected the importance of coming to grips with reality in providing culturally congruent patient care based on the values, beliefs and life styles of people form the rather diverse cultural groups within our society. When nurses decide that the way to improve and advance the quality of care of people is through the deliberate and creative use of transcultural knowledge, we can then expedite a nursing process aimed at ensuring that our culturally diverse client is empowered to achieve the desired outcomes as well as meeting the expectations of all concerned. Today's society is unavoidably in the midst of change brought about through a number of processes. The nature of these changes makes for similarities and diverseness in society that influences the way that patients perceive their health as well as the management of the illness. Also, these social changes influence the way by which nurses carry out their practice. If nurses accept that human caring is the essence and core of their profession and make provision for the understanding of the cultural differences among themselves, their patients, and others in society, then the key to the real issue is at hand.

Introduction

In countries which have historically hosted predominantly monocultural societies a wave of change has brought about a more open way of thinking and through the integration of culturally diverse groups, have become more pluralistic in recent decades. Most nations have indeed recognized the importance of understanding cultural backgrounds in terms of health issues. As well, many health care professionals have now published reports on the need for greater involvement by members of ethnic minorities in health care. In these reports there are calls for the implementation of measures to improve quality care for all minority cultural groups. Whilst this may seem an encouraging sign for minority groups, it does however, place a great deal of pressure on health care professionals and other carers to develop a better understanding of the needs of the various cultural groups during episodes of care.

In anticipation of this worldwide need, nurses must shift their thinking and actions from unicultural to a multicultural focus, and in so doing, reflect ways to serve human beings in distinctive and meaningful ways. Nursing is a discipline that views human care as the central focus and is the true essence of nursing, for what it is to be a nurse cannot be separated from what it is to care for and about others. Eriksson saw that: "Nursing as a profession is mandated by society to care for patients in order to alleviate their suffering, and therefore, the nature of nursing care is to promote health and healing" (Eriksson, 1994). The question now for us is: How does the nurse apply these principals in a way that promotes health and healing in multicultural societies? In this article, an attempt is made to provide information which is useable within the clinical setting and focuses on human caring in multicultural societies.

Culture in today's society

Culture is a relatively specialised life-style of a group of people, consisting of their values, beliefs, artifacts, way of behaviour and communication (DeVito 1992). This meaning of culture suggests that peoples' lives are influenced by their culture in the

way that they view the world and how to behave in it in relation to other people. Culture is not something that is inherited genetically but rather, passed from one to another in the social group and transmitted from one generation to the next. The culture of a society tends to be similar in many respects from one generation to the next and is generally one of continuity. In part, this continuity in life ways is maintained by a process known as enculturation (Harris, 1987).

However, it does not take much to realise that enculturation cannot account for a considerable portion of life-styles of social groups. It is clear that replication of cultural patterns from one generation is never complete and old patterns are not always faithfully replicated in successive generations and new patterns are continually being added. As well, we see that even with respect to continuity, enculturation has important limitations and that every replicated pattern is not necessarily the result of one generation's being programmed by another. Many replicated patterns are the result of the response of successive generations to similar conditions of social life. The programming received may even be different from the actual; in other words, people may be enculturated to behave in one way by being obliged by conditions beyond their control to behave in any other way.

It is generally recognised that culture in today's society is not stable and that the original culture or any group will be influenced and changed according to its exposure to the media, schools, institutions, the community and even direct contact. We see then, a modification of the original culture, and to some extent, a sharing of the values and beliefs of the other as it comes into contact with other cultural influences. This process is known as acculturation (DeVito, 1992).

The passing of cultural traits from one culture or society to another is common, so that today we find the majority of traits found in any society can be said to have originated in some other society. This approach can be seen in popular attempts to explain sociocultural differences and similarities as there are many examples to show that the closer societies are to each other, the greater will be the cultural resemblance between them. But this resemblance cannot simply be attributed to some automatic tendency for traits to change. It must be kept in mind that societies that are geographically close are likely to occupy similar environments, hence similarities between them may be caused by the effect of similar environmental conditions. On the other hand, there are numerous cases of societies who have been in close contact for hundreds of years and still maintain radically different ways of life.

The dynamic nature of cultural change through enculturation and acculturation is an accepted global phenomena as the diversity and the ethnic mix of the population of all but a few societies is increased.

These assumptions or views hold true today, albeit for a world that is at peace and which enjoys climatic conditions that supports an environment where national, ethnic or cultural boundaries remain static and do not take into account the forces that can be exerted by man and nature to make sweeping changes to traditional areas of cultural differences and similarities. We know that past generations encountered times of global and national unrest, times where "quick changes" in ethnic balances have, in some cases, irreversibly changed the cultural outlook and identity of nations. Today we are living in a time of "super change." The world is now one of instant communications, it is alive with technology never thought possible just a brief decade ago, and we, as part of the "global village." are faced with forces that are sweeping aside traditions, beliefs and values as well as the cultural boundaries of many of our "global villagers."

It is a time when the saying that ***the only constant is change*** holds much truth. It is a time also when we, as carers, cannot

afford to hold stereotyped views about any given culture. To do so would make us rigid, unrealistic and unaccepting of people's individuality, thus increasing groundless assumptions about cultural group(s) in question. Therefore, we should keep to principles that value people's cultural choices and permit their beliefs to flourish.

Health and Illness in Multicultural Societies

In any society, the experiences of health and illness are strongly influenced by culture, because it is an intimate part of the social system of meaning and rules for behaviour (Kleinman et al., 1978). It is seen therefore, that health and illness are culturally shaped in that how the individual perceives, experiences and copes with disease and maintaining health is based on the individual's explanation of sickness within his or her own socio-cultural setting. These explanations are specific to the social position that people occupy and the system of meaning they employ. Because health and illness behaviours are derived from an individual's culture, it is not surprising that there can be marked cultural and historical variations in how disorders are defined and coped with (Long and Long, 1982). The variation may be equally as great across ethnic, class, or family boundaries in one's own society (Suchman, 1965). As well, health care providers' explanations and activities, as are those of their patients, are cultural-specific (Freidson, 1970), consequently there are many views to explain the behaviour of health and illness.

The results of Kleinman's study (1978) of patient and professional interpretation of disease and management indicated that patients and professionals behaved under different rules, values and structures, even though they were in the same culture or society. Clinicians searched for technologies "fixes" to control disease problems, whereas patients (who also often searched for technological fixes) seek solutions to illness problems that were more given to psychological than to technological interventions. Patients tend to evaluate treatment success as "healing" of illness, for example, the provisions of personal and social meaning and the management of life problems, rather than the "curing" of disease.

In any encounter between practitioner and clients, cultural differences may occur as each have different understandings and expectations. As well, with understanding between practitioner and client often merged as the terminology used and understood by practitioners may differ from the terminology that is understood by clients. Furthermore, even though clients may use the same vocabulary as practitioners, this does not always imply that they share similar interpretations of events.

As nurses working in that area between the understanding of the practitioner and that of the patient, they must learn to identify with and understand the interpretation coming from both worlds. This author suggests that any approach which centres on a cultural perspective would be most valuable and important in bridging these two worlds.

Working with clients from culturally diverse backgrounds in the multicultural society should be a shift from the practice based on natural science to human science. The paradigm from which nurses practice determines how they view human beings and health. Nursing practice within the natural science setting views the body, the mind and the spirit as separate entities and focuses on assessing, diagnosing and categorising clients into pre-established, problem-oriented categories. Within human science, the human being is the sum of the whole of body, mind and spirit.Individuals are not viewed as biological, psychological, social and spiritual parts who cope with and adapt to situations, but rather, they are seen as living entities who are greater than and different from the sum of their parts and who can create their life experience. Persons are acknowledged and respected as intentional, free willed, unitary beings who

make their own choices and assign their own meanings to situations.

Caring in Nursing

Whilst nurses can never claim to be the only health professionals who care, they can claim to be the only group whose central concern is that of human caring per se. Since Nightingale, the idea of caring as the essence and core of the profession of nursing has remained constant. It is a defining characteristic of nursing's past and the key to its future.

Much has been written concerning the provision of nursing care from which three major theories have emerged. These theories are presented here to show that there is debate on this core essential element of nursing.

Dorothea Orem's Self-care Deficit Theory of Nursing (Orem,1985), proposes that all humans engage in self-care, although in times of illness, they may not be able to meet all of their self-care needs. It is here that the nurse becomes involved in providing help and through specific actions assist the individual to meet their self-care requirements. In this "helping system" Orem identifies acting for, guiding, supporting (psychologically and physically), teaching and providing suitable environmental conditions that supports personal development as the main caring functions. However, the values inherent in this self-care theory reflect those of western society and may not be appropriate in other societies, including multicultural ones (Morse, et al., 1990).

Another caring theory, developed by Jean Watson and known as the Theory of Human Care (Watson, 1985), explicates the kind of relationships and transactions that are necessary between the caregiver and care receiver to promote and to protect the patient's humanity, thereby influencing the patient's healing potential. In describing the processes involved in caring, as well as outcomes of care, Watson emphasizes the psychological, emotional, and spiritual dimensions of care almost to the exclusion of other characteristics of everyday tasks inherent in nursing care, such as bathing or procedures involving technical expertise. Combinations of interventions related to the process of human care are presented as curative factors such as a humanistic altruistic system of values that are enacted in the context of the relationship. In reality, these ideals may not be attainable as we see a deficiency between what is envisaged as the nursing process and what is clinically possible. As well, there are many nursing situations in which nurse-patient contact is limited, or the length of the hospital stay is short and would negate an in-depth nurse-patient relationship.

Leininger's Theory of Transcultural Care Diversity and Universality (Leininger, 1978) concentrate on the relevance, meanings, and uses of cultural care and has been used with different cultures in specific ways to be beneficial to clients. The central purpose on the theory was to discover, document, interpret, and explain the phenomenon of culture care. The goal of the theory was to provide culturally congruent nursing care in order to improve or offer a different kind of nursing care service to people of diverse or similar cultures. Leininger concluded that knowledge on transcultural care differences and similarities is essential to understand and to guide practices as nurses work with people of different cultures.

Today, nursing and society alike are now recognising that the dominant diagnosis, treatment and cure model of medicine is inadequate and unlikely to achieve the goal of universal access, cost containment and preservation of quality. This is because the medical-scientific technological enterprise lacks the expertise or skills to meet the human caring and health needs of the population that is increasingly aged, chronically ill, poor and without access to reimbursed health services (Watson, 1990). Nursing professionals view this dilemma another way with emphasis on caring within a humanistic process of concentrating on the individual as he or she responds to a health problem, rather than

simply looking at the person as a collection of physiological symptoms or laboratory tests.

In nursing, the caring practice of "mutual realisation" encompasses many specific caring practices such as supporting life functions, promoting health, care of the body, focused attention, systematic reasoning, coaching, fostering a healing relationship and/or a healing environment and healing community, decreasing the sense of alienation and restriction of world that often accompanies illness, and bearing witness to human experiences that range from everyday activities of living to suffering, recovery and death. Because caring practices are integral to everyday actions of nurses and because they are being extended and developed in everyday practice, an exhaustive list of caring practices cannot be compiled. However, there are many examples and references showing that caring practices can be described and exemplified.

Nursing must respond to the human situation with a caring intent that either contributes to the patient's health, leads to full recovery or allows a peaceful death and above all, must be appropriate within community groups and/or cultures with differing concerns. By providing caring practices that are shaped or tailored to fit specific community needs surely negates the idea of basing a caring practice on abstract formal rules.

We see therefore, that even though caring practices cannot be made explicit by rules, procedures or technique, they can be described and interpreted as they exist in the public world of nursing practice. The only way to know how to act in a caring manner is to do so in such a way that is consistent with the patient's culture. Some patients, for example, may consider a consoling touch on the hand to be inappropriate given their cultural background, whilst others may believe that touch is the way caring should be communicated. It is suggested that the task of nursing is to provide care in such a way that is not in conflict with the patient's culture. If the nurse acts in a way that is incongruent to the particular culture, it could add to the patient's distress.

Caring in a Multicultural Society

Health care providers working within multicultural societies must be aware of cultural differences and be accepted by the client whether it be an individual, family and groups, or the community as a whole. To provide culturally competent health care, providers must not only be aware of health beliefs and health seeking behaviours of their clients, but also of how culture influences the individual's behaviours, perceptions and evaluation of the world. In the process of learning from another's culture, health care providers cannot help but learn about themselves. In every culture the uniqueness of the individual cannot be overlooked. Culture cannot be stereotyped, nor can the importance of individual differences be excluded.

Leininger, in recognition of cultural factors as being valuable for nursing practices stated, "We are entering a new phase of health emphasis as we examine the impact of cultural factors upon human caring, health and illness behaviours" (Leininger, 1978, pp. 123). In her continuing works, Leininger (1984) emphasised the historical, cultural, and social context of human beings in order to explain and predict the broad dimensions of human care behaviours. The major objective of her theory was to improve and advance the quality of care of people through the deliberate and creative use of transcultural knowledge that reflected culturally congruent care based on the values, beliefs and life styles of people from different cultures. Culturally derived nursing care actions and interventions were predicted to maintain clients health, improve clients satisfaction and to help clients recover readily from illness or disabilities. With the improvement of care for human kind at the focus of her belief, nursing was defined as "a learned humanistic art and science that focuses upon personalised (individual and group) care behaviours, functions and

processes directed toward promoting and maintaining health behaviours of recovery from illness" (Leininger, 1984, pp. 4-5).

The theory of cultural care diversity and universality to influence and guide nursing as seen by Leininger has been realised and with the increase in cultural identity bringing an increased demand for cultural sensitive and specific care and practices to assist patients of diverse cultures in multicultural societies, this theory holds great potential for enhancing quality humanistic and holistic care for all cultures.

Working with clients from culturally diverse backgrounds should be a rewarding challenge for nurses and I again stress here, that through cultural assessment, planning, and implementation of a well defined, culturally sensitive care, the nurse can expedite the nursing process and ensure the culturally diverse client is empowered to achieve the desired outcomes.

Conclusion

Health care is in the midst of dramatic, all encompassing change and in order to provide high quality care and to meet the expectations of patients and their families, health care providers are being challenged to rise up and find new ways to provide patient care that truly honours individual values, choices and decisions.

I reiterated here, that if nurses accept that human caring is the essence and core of their profession and make provision for the understanding of the cultural differences among themselves, their patients, and others in society, then the key to the real issue is at hand.

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Perspective

Human Caring

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1. Human Caring in a Multicultural Society

The title of this panel discussion is deliberately challenging. How can care with a human dimension be provided in a world which is moving forward at an ever-faster pace in all areas, where people from all corners of the world are able to keep in close contact with each other, and where individuals from many difference races and cultures live alongside each other? If nothing else, a close examination of this theme will prompt us to ask what is meant exactly by "human caring" and how can we gain an understanding of the concept "multicultural society" in a definable and operational entity.

The aim is not to give a blow-by-blow account of "care" as a compoment of nursing, but to examine what is meant exactly by human care and what is the underlying vision. A number of ethical issues will no doubt come up for discussion.

Other speakers will consider this matter at even greater length. Clearly the idea is not to provide a world view of the multinational society but to act against a specific European background, to place signposts for now and in the future.

How is "human care" interpreted in this presentation? In many industrialised countries, care hovers between what is called the distant and proximity model, or the Euro and care model. In the form in which it is now being practised nursing as a science has its origins in Europe, or to be more precise Britain. The English nurse, Florence Nightingale has become a model for the whole world, a basis for the development of the modern nursing profession. From the very outset the emphasis was on care. Florence Nightingale sought to care for and attend to the sick and this attidude towards suffering is also reflected in the model exemplified by Mother Theresa.

However the principles of obedience and authority soon developed, along with more emphasis on scientization, technical skills, knowledge and learning. In this sense, the nursing profession followed in the footsteps of the medical profession, and professionals were those who practised "nursing". Care was stressed by nurses as caring arms of doctors. In the meantime, care could be or was made the responsibility of the less qualified, in Christian areas to nuns.

Outside Europe, "care" continued to be a model and was even the primary concern for many Westerners. To ensure the reintegration of care, now as a model, alongside the involvement-based one, with proximity as key-note.

Integrated care systems began to take shape in the 1960's to be implemented in the 1970's and 1980's. The models of the 1990's were characterised by the key aims of effectiveness, efficiency and performance.

In the Western world, care is supposed to be customised, yet there is also a balance act going on between what "needs to be done", "what can be done" and "how much it will cost". The focus of attention is the patient, as underlined the development of palliative care, also involved is the question of cost and the strength of Western social systems.

In African countries, there is less focus on technology, care is given on the basis of the quite natural and spontaneous attitudes of the care providers.

All nurses now take care as their starting point, but we continue in hover between the medical Euro model and the care model involving the

proximity principle. For most nurses, this balancing act is considered to be harmful and wasting a great deal of energy. This is where the ethical dilemmas come in. Not only medical and biological ethical questions but above all the ethics of day-to-day practice. For example, can a nurse refuse to obey a doctor's orders if this is deemed to be in the patient's interest? For the purpose of the introduction, human care may be considered to mean nursing care with a human dimension, within the context of the tension between the Euro and care model and the ethical questions related to day-to-day activities.

The second vital concept reflected in the title; the multicultural society, requires some explaining. Depending on the language and the interpretation, this can be understood as multicultural, multiracial, multi-ethnic differences within a specific society, or differences guiding the global society. With countries being required to operate in an increasingly international environment more than ever different cultures are coming into contact with each other.

As far as Europe is concerned, there are significant ethical differences within the European Union. Cultural disparities continue to exist in Europe. The researcher H.Wursten divides Europe into five cultural models: The pyramid model where hierarchy and power differences are significant: this is seen mainly in France and Belgium. The family model with "paternalism" as the key concept, mainly in the Mediterranean region. The market model with small power differences and a winner-takes-all mentality, mainly in the United Kingdom and also on the European continent and the United States.

The normative model where society functions primarily on the basis of rules, as in Germany and Austria. The network model where shared responsibility and compromise are the key concepts, as in the Netherlands and Scandinavia. Within these cultural models equally different health care systems are found. Of course a health care system is coloured by a country's specific social and cultural characteristics and limited by its economic opportunities.

With a certain amount of creative thinking, the classification of the European continent according to different cultural models could certainly be applied to the United States and to Asia. It is up to the conference members to decide which one, or which combination of the aforementioned models best reflects the situation in Thailand.

This fairly lengthy introduction is intented to highlight the need to pay requisite attention to human care in a multicultural society and for cultural differences to be taken into account.

2. Human Care

What is care? In our modern times, care is a concept as well as a practice. Care qualifies the relationship between the patient and the provider. Care is a way of relating to each other under specific circumstances .

Consequently to approach "care" in terms of a market product and to speak about "patients" in terms of clients or consumers is besides the point. Health care is different practise compared to business. Receiving care is different from buying new care. Care is a complicated process. The needs of the patient are central in this process and the patient participates activity. The goal is not a product or a profit, but the alleviation of suffering and if possible the restoration of health. That means that there are in the delivery of modern health care fundamental characteristics and changes namely :

1) The fundamental ambivalence :
On the one hand we consider care for those in need as an essential and vital moral value; indispensable for a human society. On the other hand since the 18th century in Europe where care was first a moral benevolence practice then a charity well organised practice and now a professional care, that such care-giving has one fundamental negative side effect; the care reciever is in a position of less self-respect and dignity. How can we overcome this above mentioned ambiguity?

2) But first the changes in human health care.
a. Changing attitudes of the provider and the reciever.

In many European countries (for ex Belgium and the Netherlands), the care-receiver decides what kind of care he/she wants against a well known price. Contract health care is more involved than some years ago. Patients and their families, especially in the geriatric field, buy care in institutions and homes of their choice. Times the doctor knew best are over.
Specialization and professionalization of all kind of health workers made that a large number of care givers can cooperate at making visions, planning and evaluations of care giving. The step to work in a contract type of care giving is quickly made.

b) Changing the health care enterprise in Europe.
In Europe the hospitals, institutions, homes, etc. are working with market based mechanisms. Giving care respond to the demands and needs of patients . Although the client is the center of the approach.

c) Changing notions about care.
Not only has the attitude of patients changed but all care givers traditionally applied to health care services are no longer adequate. The moral vocabulary of health care workers has changed; religious notions: for example, love- charity-gratefulness are no longer part of that moral vocabulary. These notions are individualized and become part of the personal motivation for doing the health care job
Political notions have changed; what about quality and solidarity? This moral vocabulary and notions in politics are no longer applicable. This effects the attidude of health care workers towards their patients. The patient's submissiveness and gratitude have evaporated. Today's norms and values are a complicated affair, mostly the resolution is found in "doing ethics". In that way, for many nurses/ midwives/ health care workers, the leitmotiv of NVKVV (member of CICIAMS) is applicable; for example, the difference between vocation and profession.

Profession starts with the obligation to do your paid job as well as possible, vocation is doing your job based on love-charity and the faith of The Holy Bible.

One can say that NVKVV's leitmotiv is based on the vision of the former Nobel-price winner Mother Theresa; with this difference: All CICIAMS-Members are professionals. It is obvious that love-charity-faith are not in contradiction with professional caring but make the platform of the basic values and attitudes of a catholic health care worker.

Before closing this chapter with some coping possibilities and proposals of challenges for human caring to the difficulties and changes in human care, I would like to come back to the above mentioned ambiguity: for example care giving and decreasing self respect and dignity of the patient. To clarify this ambiguity we have to make a distinction between two dimensions of care: care as an activity and care as attentiveness to the meaning of a human being. So, health care workers deliver human care, as meant in the title of this panel presentation. Care as an activity appeared the last centuries in Europe. In many cultures caring is an holistic and integrated part of life, mostly related to sacral activities. In many societies care as an independent activity is not on the spot. Care is a family affair, so it is a matter for family members and sacred persons. I refer here to almost all black societies in Africa, former systems of health care in the Western World, in Latin-American and as far as I could study also in Asia. Since the last century health care systems as developed in the Western World define care as an activity; giving care is a paid job.

The social sector, including health care is the third work area in Western World. Some figures and trends seem to indicate that it will climb up to second place at beginning of the next millenium.

Studies carried out in the Netherlands indicate that 11% of its population is working in the health care sector. This represents 10% of their national income. In the Netherlands and Belgium, two neighbouring countries with the same language and similar culture, 60% of

women deliver care. Of all women between the age of 30 and 60, one in three delivers care. These figures include professionals and voluntary care givers, 20% of voluntary care givers recieve some sort of wage depending professional work facilities, regulations of the social system etc.

We can conclude that care, as an activity is accepted as well known frame reference in the West.

What about care as attentiveness to the meaning of human being. Care as attentiveness finds its roots in sociatic tradition. In fact it is the elaboration of the ontological dimension of care: that means

a) human existence is an embodied existence;

b) the embodied existence manifests itself in two ways for example, vital-passionate, powerful, energetic versus fragility-dependency-vulnerability. This all characterizes human existence;

c) process of care as attentiveness to meaning is not resolved to the individualistic self. Care as attentiveness is the mutual way of responsiveness, dialogue and communication.

Care as attentiveness is fundamentally a social process, because it is based on superior interests in the other.

We can say that Mother Theresa understood so well the fundamental base of care for example, never ending and everlasting interest in the other, for Mother Theresa the poorest of the poor.

How can we, modern health care professionals all over the world interpret the dimension of care as attentiveness of meaning in the concept of care as activity?

1) Targets of care activity.

Mostly health care workers orientate their care activities to dependency, vulnerability, illness or poverty. Christian health care workers relate care to people's activity to give meaning to their existence, their illness, misfortune and poverty. With Mother Theresa I refer to the Pastoral Letter: Salifici Doloris of His Holiness Pope John Paul II.

2) The responsibility of the care receiver.

Through receiving care the patients can formulate the meaning of independency and non-government of others and they can interpret illness, handicap, age, even death as part of life. Dignity and patients responsibility should be incorporated in the practice of care

3) Possible option: ethical care elaborated by the philosopher Friedrich Nietsche

4) Little health: a human being resists illness, handicap, suffering and death .

All energy is invested in preventing such attacks on life .

5) Great health: this attitude does not glamourise suffering but refers to let itself be controlled by it. Overcoming the fear of suffering sets the condition to test the value of life in all its expresssions. What, medically speaking, is a handicap can in this perspective lead to great health.

When this view on health finds acceptance in medical and nursing practice, then there will be room for an approach that links the meaning of care to the meaningfullnes of life .

Conclusion on the chapter on human caring: every health care worker should become aware of his/her own professional identity and that the catholic idea is made to stand act in profile by the health care workers. I refer to what His Holiness Pope Paul VI and later on Pope John Paul II called: civilisation of love.

Refering to catholic professional health care organisations such as CICIAMS there is an extraordinary mission as to being the driving force of professionalism based on christian principles. Catholic professional organisations offer the posssibility to let the religious dimension have a valid place and to integrate this into the total package of health care .

3. Multicultural Society

Societies all over the world are in the pipe-line of continued changes. Many factors can be focused to define the multiple changes such as: the very fast increase of technology possibilities. TV brings the whole world into one's living room.

- the availability of a tremendous boost of every possible information at any time
- unknown possibilities to travel fast easy and very far
- telecommunication is on the menu
- constant discovery of new sources of life-supplies, etc.

Due to the above mentioned changes societies have become more and more multiracial. For example: in all European societies a large scale of the population is native.

In 1990, Amsterdam town, the capital of the Netherlands, counted a population of 427.143

Dutch origin	365.941
from Surinam	25.814
from the Atilles	3.638
Other ethnic origin	31.750
	427.143

Correlated caring will be faced with the increased character of a multicultural society. It is well accepted that culture has a deep influence on behaviour, as well on internal motivation as on physical expression. This means that treatment and caring must take into account the cultural and biological backgrounds. One must not forget that ethnic groups with different backgrounds living together within a society experience a cultural transmission.

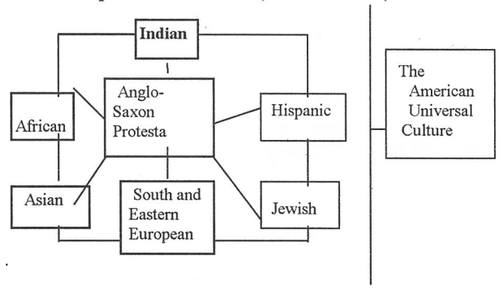
In the case of oblique cultural transmission one can learn from other adults of institutions, either in one's own culture or from other cultures. If the process takes place entirely within one's own culture, then the terms enculturation and socialisation are appropriate. If the process derives from contact with another culture, the terms acculturation and resocialisation are used.

It is useful at this point to clearly distinguish enculturation from acculturation. Enculturation is the process by which the group generally incorportates children into the culture and by which the child acquires the appropriate behaviour. In contrast, acculturation refers to cultural and psychological changes brought about by contact with other people belonging to different behaviours.

For example: many groups in India and Africa become acculturated to aspects of the British Empire and of British life-style (changing social structure, economic and institutions but also behaviours such as their religion, language, dress and health care).

Acculturation creates new problems for the individual. Many societies evoluate from mono-cultural society to a multi-ethnic society, such as most West-European countries but also many Asian countries. For example, Singapore-Hongkong-Philipinnes-Indonesia.

Some researches state that the model of the American universal culture will be followed by most of other societies; that means a universal development through a process conceptualized as multiple acculturation(Banks 1981).



Concerning health behaviour, a multiple acculturation, on a world- wide scale tooke place. In the 1970's and 1980's there was a revolution in the way many people thought about health.

A clear indication is the unanimous acceptance of the Alma Ata Declaration by the the WHO"Health for all by the Year 2000" (1978) and the Attawa Charter (1988) There has been a shift from curing disease to the prevention of disease.

During the same period health was redefined by the WHO (1988) as a state of complete physical, mental and social well being, not merely the absence of disease or infirmity.

In the light of this movement many approaches from different specialities occured such as anthropology,sociology,cross-cultural, psychology, etc. Health became a matter for local population such as sanitation, safe water,

health education, control of parasites and infections all important elements both in cure and prevention .

Cross-cultural studies showed that the way populations deal with health are different and that many well meant ways of caring have not the expected outcome, sometimes they are even bad for local population.

Let me shortly describe some examples of cross-cultural health care in different ethnical groups within multicultural societies.

1) WHO studied in 1980's 9 centers for psychiatric care with trained staff in standard diagnostic instruments. (Colombia-Chechoslovakia-Denmark-India-Nigeria-Taiwan and different groups within one country, such as Nigerians in the UK) A "care of common symptoms" in social and emotional withdrawal, delusions and flat effect appeared in all of the patients diagnosed as schizophrenic. The profiles of symptoms did differ substantially from center to center. For example: The U.S. schizophrenics differed from the Danish and Nigerians on symptoms of lack of insight and auditory hallucinations, while Nigerians had more frequent "other hallucinations" than the other two groups. Nigerians living for a long time and in second or third generations in the UK had still the same hallucinations as Nigerians in the motherland. The study concluded that schizophrenia is a universal disorder, present in all cultures, but that it appears to respond to different cultural experiences in prevalence rates and modes of expression

2) Culture-bound syndrome in cultural psychiatry "exotic" mental disorders have been described and interpretations given in local terms often with the indigenous name for the disorder entering into medical literature. Amok involves wild, aggressive behaviour of limited duration (mostly among males) in which there are attemps to kill or to ingure people. Amok is a Malay term meaning "to engage furiously in battle" It is obviously related to the Viking term berseker (in Dutch beresterk) practised just prior to entering battle. Terms as running amok and going berserk are in common usage. In the Dutch language amokmakers is a usual term for difficulties with boys on the street -sports events, etc.

Koro (West-Africa) involves the sensation that one's penis is retracting into the abdomen and the belief that when fully retracted death will result. Panic attempts to keep the penis from retracting can lead to severe personal physical damage. Lynching events took place in Senegal in March-April 1997 concerning Koro. Senegalese french educated people living for a long time in France went to hospital after consulting Senegalese traditional health carers to be protected from Koro. They wanted drugs from French doctors for preventing and curing Koro.

Brain fog involves problems of academic learning, headache, eye fatigue and an inability to concentrate. It appears widely in West African students often prior to school and university examinations, unknown outside that culture area. It appears in West-African students often at US and European universities.

Kwashiorkor is a spectacular illness. A child becomes apathetic, looks miserable, gets oedema on his legs, arms and face, abscesses develop at a later stage and the ears become red or yellow. Western doctors describe kwashiorkor as a dietary illness, a real form of PEM (protein-energy malnutrition). In Africa, where the illness is common, it is called Ngang. Ngang has no relation with nourishment.

Kwashiorkor and Ngang only share the same external symptoms. Bfaa is the old word for Ngang and means Fault. Mainly serious faults such as incest, murder, suicide and injury. Bfaa affects children and adults.

Western doctors help kwashiokor patients with a diet rich in proteins. African healers treat it through ritual cleansing of the child. Witchcraft has an indirect role with Bfaa, and the causes should be traced within the family and group. African healers prescribe "strong" food such as: chicken ritually slaughtered, goats milk, etc. They do not claim that healing occurs through the food but by the right and proper way of ritual handling.

Zairian health care workers in France and Belgium help their fellow countrymen suffering from kwashiorkor with Bfaa and then with

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Zairian health care workers in France and Belgium help their fellow countrymen suffering from kwashiorkor with Bfaa and then with

acquired western methods. They also prescribe protein rich foods before advising them to consult the medicin man.

It is clear that in the Western world, where many societies evolved from mono-cultural to multicultural ones, there is tension between the Universalists and the culture linked health carers. Universalists say that illness (including psychiatric diseases) can affect everybody anywhere in the world. Culture-linked health carers are of the opinion that illness cannot be separated from the culture in which they occur. Lots of western health carers tend to agree with biological state of mind specific to the human being free of his culture.

Western health care workers have a tendency to "ethnocentricity" meaning that traditions and words of one's own culture are the most if not the only correct ones.

3) Depression-Guilt

An extensive survey in the field of psychiatry has been conducted in The Netherlands (1990) by RIAGG and TB. Research has shown that Dutch people express their anxiety through depression and the Surinams their apprehensions and relational problems.

The basic difference lies in the way aggression is expressed. A Dutchman will aim his aggression at himself(depression -guild) .
A Surinam will project his aggression on his environment and be fearful that his environment will harm him. The plausible explanation might be:
a) That in the relation between white and black the history of slavery and colonialism might play a role
b) Dutch people will seek help a lot sooner and the Surinams have the inclination to bring their health problems to a feath healer and turn to witchcraft.
Surinams live in close-knit society and will sort their problems out within the family and/or social group. Health workers and the police have a different approach when dealing with Dutch than when dealing with Afro-caribbean people. Afro-caribbeans will be arrested quicker and not considered as psychiatric patients as would the Dutch people.

4. Conclusions

The world has changed during the last 50 years, certainly in Europe. Also substantial gains in health are on the spot; people are living longer, the impact of infectious diseases (leprosy, polio, etc.) has declined tremendously.

Unfortunately, more people live on poverty today than 20 years ago. Poverty has a dramatic impact on health. Since gaps are widening both in income and wealth, the health status of populations will reveal increasing disparities. Demographic trends like ageing and urbanization are accelerating particulary in developing countries. In Middle-and Eastern Europe urbanization has been accompanied by the collapse of social structures, by overcrowding, spread of diseases and violence.

The role of health has to be established, saying that health is central to development. In Western Europe psychological diseases such as stress, depression, alienation, etc. have to be focused. Health systems have to be developed that are able to meet the challenges of the 21st century.

As CICIAMS functions in multicultural societies action to future practice have to be established. In order to meet the challenges of the year 2000 it is necessary to react to the problems encountered by the health care workers.
a) The individual health care worker has to react and it is, therefore, very important that the health care worker becomes aware of his/her own professional identity and that the catholic idea is made stand out in profile by the health care workers, midwives and the medico-social assistants. As a starting point one can refer to what H.H. Pope Paul VI; and later on Pope John Paul II, called: the civilisation of love.
b) The joint reaction can be dealt with by catholic professional organisations; in this case by CICIAMS.

More than ever before the catholic professional organisations have an extraordinary mission as

to being the driving force and/or the pilots of the professionalism of the members of the profession, all this being based on christian priciples.

During the CICIAMS' 15th World Congress in September 1994, all the speakers strongly emphasized that through groups cohesion and joint acting, the ideas ought to be more asserted via the professional activities of the health care workers, midwives and medico-social assistants. Catholic health care workers, midwives and medico-social assistants are no different from other colleagues as far as professionalism is concerned. According to society and culture, health care quality and nursing differ. In industrialized countries nursing and midwifery are of high quality. Catholic professional organisations offer the possibility to let the religious dimension have a valid place and to integrate this into the total package of the health care.

Although it seems rather difficult to motivate colleagues to become member of a catholic professional organisation, the need to unite is greater than ever before, because of the increase in laicism and the loss of basic values. Members of a catholic professional organisation find the strength to carry on in the organisation, but equally find the strength to support others. This is the essence of nursing and midwifery.

It is evident that all CICIAMS members realise that the organisation is a living part of the Church. The strong traditional bond which exists between CICIAMS, the local Church and the Vatican, ought to maintained and should even be strengthened. The challenge for CICIAMS is to differentiate from non-confessional professional organisations, for CICIAMS is based on catholic principles. Our vocation as catholic professional organisation is based on the evidence of believing and on the attachment to the Church. From this CICIAMS gets its significance in the world now and will get it in the future.

CICIAMS should also accomplish the expectations in the case where individual members expect a joint and public breakthrough regarding the hushing-up of difficult ethical problems, and in this manner be a human witness in the face of God's magnitude.

The Gospel says that love, affection and caring can have a healing effect. Maybe this is what christian health care workers, midwives and medico-social assistants experience and that this give them the courage to carry-on. This will also be applicable in the next area.

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Perspective

Human Caring in Multicultural Society

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Introduction:

Nursing is a learned humanistic and scientific profession which is focused on human care phenomena and activities in order to assist, support, facilitate or enable individuals or groups to maintain or regain their well-being. Therefore, human care is central to nursing as a discipline and profession.

The central issue in nursing is human life as a unique creature. Nurses need to understand various aspects of human, so they can give qualified nursing care. Nursing field, as those health fields or other professions, now face various development of science and technology. The quality of health service is often identified as the used of sophisticated health equipment. To increase the growth and development of health service, everyone is demanded to work effectively; therefore, manpower is sometimes changed by machines or other equipment. These could cause the decrease of humanistic approach to the patient.

Nurses take care of patient according to the hospital schedule and order, as though all patients have similar habitual. On the other hand, patient as a human wants to be treated as himself who is different from others. Frequently, nurses are able to respond quickly to the accidents and disaster, and to handle physical needs of people, but they are somewhat slower to respond to the major emotional crises, cultural and social problems. If the nurse can not understand the patient with all his uniqueness, patients could feel that they are treated inhumanly. If so, nursing service which is stated as a human service is questionable.

"Care" which is in fact as the core of nursing is an act or activity in order to assist, support individuals or groups to improve or regain their health, way of life and to face death. "Care" should be done sincerely, therefore, "Care" should be based on the "sense of love;" love to our fellowmen and willingness to participate in reducing their suffering. "Care" is every human's need in everywhere he would be; thus; "human care" is a universal need, but it can be expressed differently. The difference is extremely relevant to the background of the culture.

Health is a well being condition which is interpreted and done according to one's culture. Health reflects the ability of individuals (or groups) to perform their daily activities in cultural expressed, beneficial and patterned lifeways.

Each culture has a generic or folk health care facilities that vary across cultures. In some cultures, there are similarities and differences between the care receivers and professional caregivers.

Comprehension of the culture tradition and different faith of the patients will extremely be helpful for nurses to work effectively. To do these, they need:

- to prevent "ethnocentrism" the faith that their own culture is the best and better than others.

- to prevent "stereotyping" the inaccurate assessment because it is based on the opinion which has formerly been shaped.

Nurses as health care professionals who emphasize on the aspect of "human caring", should integrate universal professional nursing and health service and the individual culture values of the patient. The integration will be expressed in nursing decision and action in giving care to the patients.

Beside the nurses' capability to integrate the universal and specific aspect of the patients, "communication" includes verbal and nonverbal is also very important as a tool in expressing nurse's care to the patient. If communication is done with attention to the cultural background, patients will feel humanly and nursing care will be more qualified.

2. Some Cultural Customs and Traditions in Indonesia

Indonesia is an archipelago country which has more than 13,000 big and small islands with 200 million population and divided into 27 provinces. As a nation with many population and dispersed location in various islands and archipelagoes, Indonesia has more than 300 ethnic groups with their various culture traditions. In each ethnic group there is tradition which is practiced according to their values. The concepts of health and the ways to maintain their health and to respond to sick condition in various ethnic groups have so many variations.

In this article we only discuss three traditions from three ethnic groups (Javanese, Balinese and Senggi) in Indonesia, which are relevant to health care pattern. Although these traditions have not been fully practiced by local society, it still influences the attitude of local community. Therefore a nurse need to know it in order to look after the patient as a unique person.

2.1. Javanese Culture

Java Island is the most densely populated island in Indonesia. There are five provinces in Java: West Java, Central Java, East Java, Municipality of Jakarta, and Special Territory of Jogjakarta. However, talking about Javanese ethnic group it usually means Jogjakarta and Solo. These two areas are still very much influenced by the royal tradition in the era before Indonesian independence.

2.1.1. Religious and Belief System

The life of Javanese Society is very much influenced by the unification of various beliefs, which are Animism, Dynamism, Hindu, Buddha, and Moslem. Combination of these various beliefs bring out Javanese's way of life.

2.1.2. The Impact of Their Beliefs to the Concept of Sick and Illness

They believe that if someone dies his spirit can be everywhere; up on the trees, stone, or statues. If a person is sick especially if the doctor can't heal him, they tend to say that it is the spirit who makes his sickness. The only person who can heal him is "Psychic or Traditional Healer (Orang Pintar)" who is able to ask the spirit out of the body of the sick. On the other hand, to blame the spirit as the cause of the sickness is a profitable projective effort because it doesn't cause any social conflicts, hatred, and suspicious to his fellow.

In Javanese culture there is a ceremonial meals, which is held in marriage ceremony, first pregnancy, delivery, and circumcision. Javanese culture as those other cultures in Indonesia have various taboos in certain conditions. For example, pregnant woman can not come to visit the dead person because she could miss her baby. The negligence in having ceremonial meals or the violation of this taboos can cause sickness, suffering or

even death. The advice to have ceremonial meals is often used as a way to give therapeutic comfort.

2.1.3. Philosophy of Life

There are philosophies of life that can be taught hereditary and integrated in the family education to form the attitude and behavior accepted by the society. The accepted attitude (*Nrimo*) is an attitude of accepting sincerely one's fate as God's will. However, it doesn't mean that Javanese people just give their fate. They struggle as strong as their in to ability to accept their fate and they try it again if they fail. Their submission to the "Almighty God" is often said as "God doesn't permit yet" or "It is not the time yet." This attitude will prevent them from frustration and prolonged sadness.

Nurses' understanding of Javanese culture will enable them to communicate effectively with the patients. For example, a woman who suffers from missed abortion, usually has "sad and guilty" feeling because she thought that she is the cause of the abortion. The patient from this culture will be believed from their grieving if the nurse gives "pastoral care" by saying that it is the will of the Almighty God or God doesn't permit yet; He may have a better plan for the woman.

2.1.4. Social Life

Javanese social life is full with various unwritten rules and it is a belief as a moral obligation to be obeyed. Javanese person who has inappropriate attitude to the rules is assumed impolite. The polite rules include the position of the body, gestures, expression, dressing style, and speech.

Javanese society consists of various layers, which make the polite principles become more complex. The language used in communication with others very much depends on to whom we speak. Although all of the people speak Javanese language, there are some different words for persons of higher rank or the younger to older persons, or among friend colleagues. For example, to say "eye" can be said "Mata or Tingal or Soca;" it depends on to whom we speak. Mata is used with a friend while Tingal or Soca is normally used when speaking to the parent or to the higher levels. Faulty in choosing the words can cause the anger of some people and the speaker could be assumed as impolite or uneducated.

In addition, some Javenese people like to see psychics because they know very well the culture of the society. Therefore the psychics can behave as the patient's will. They could choose polite words, polite attitude and put the patient in comfort feeling. They could become as a parent if the patient expects protection and advice. They could also become as a servant if the patients want to be served.

2.2. Balinese Culture

Bali is an island located in the middle of Indonesia. This area is 5,632,860 square kilometers.

2.2.1. Religious and Belief System

The majority of Bali population is Hindu (93%). The rest are Moslem, Buddha, Protestant, and Catholic.

2.2.2. Means of Lifehood

The majority of Balinese people are farmers and craftsmen. This island is popular with its arts and handicrafts. Its beautiful scenery and its interesting culture make Bali an interesting place to the foreigners and other Indonesian people.

2.2.3 Customs And Traditions

Balinese society gives special attention to a pregnant woman. There is a particular

ceremony for a woman in the fifth month of pregnancy. The aim of this ceremony is to clean the baby who is still in the mother's womb. Clean means free from bad impact and it is expected that only the cleaned spirits of their ancestors would affect the safety of the baby's reincarnation process. Moreover, this ceremony is also wanted to ask for soul and body so that the baby will become perfect and useful person in the society.

In order to maintain the health of mother and her baby, Balinese have taboos for pregnant women and their husbands. The women are not allowed to speak rude/impolite (Wak Capala), to humiliate people (Wak Puruja), to pray for the dead, and to hold the Holy water for "Ngaben ceremony" (burning the dead body). Also the husbands are not allowed to be jealous. He has to be calm at all times.

In the delivery process in certain community of Bali, they asked for traditional birth attendance assistance in delivering their babies. Normally the traditional birth attendance sees the mother since her pregnancy until the end of her childbirth. To cut the umbilical cord, they use bamboo made - knife. Under the umbilical cord they put three leaves of frowning trees of erythrina and three turmerics. After delivery, the placenta is not thrown at random. The placenta has been as important as the baby, so it has to be cleaned and buried with a ceremony. Its aim is for the baby's safety, long life and no deformities.

Balinese generally assume that their head to be superior and sacral. Therefore they are not allowed others to touch their head without their permission. Additionally, Hinduists generally assume that the cow is a Holy animal. Since mostly Balinese are Hinduists; therefore, most Balinese don't eat beef. However, some Hinduists don't abstain from eating beef. In fact, they don't get any effects of eating beef.

2.3. Senggi Culture in Irian Jaya

Senggi society lives in East Irian Jaya, about 35 kilometers from the boundary of Irian Jaya and Papua New Guinea. The area is about 1,912,500 acres with 1,400 population.

2.3.1. Means of lifehood

Like other inhabitants in Irian Jaya, Senggi people live from gathering sago (kind of flour), cultivating plants, hunting and sometimes fishing.

2.3.2. Religious and beliefs system

The majority of Senggi society is Christian. However, they still believe in magic and eternity world. Like any other ethnic in Irian Jaya, they generally believe that magic world is resided by gods and goddesses, the spirit of their ancestors, and the good and bad spirits. They believe that the power of magic is productive, protective and destructive particularly for Senggi people who believe that God created human and universe.

They believe that the spirit of living people is shaped into breathing. If they sleep, their breathing is still in their body. When they are shocked or surprised while they are sound sleep , their soul will be gone because their breathing was disturbed and therefore they will die. If someone dies, "songatai" (the soul of living people) will change to "depas" (the soul of dead people) and it will roam around people's residence.

2.3.3. Knowledge of well-being and sickness

Senggi people know the concepts of well - being and sickness. Well - being is a condition where the body is strong, well built, and able to work well. The illness is assumed to be caused by "the bad spirit" or because the person offended the cultural rules and therefore, he gets bad black magic.

So, if they want to enjoy well - being, they shouldn't cause any anger to the gods and goddesses and shouldn't offend the rules of their tradition.

Health care is learned by Senggi society from the Health Center. However, Senggi society still turn back to the traditional treatment and see psychic who is also traditional healer (orang pintar) if they haven't recovered from their illness yet.

3. Nursing Implications

As professional team, nurses who particularly handle human caring need to understand the sociocultural background of individual, family, and society. Leininger (1991) in her Sunrise Model says that nurses, in her decision - making and action, need to integrate professional nursing system and values believed by individuals, families, and society. If we look into the society culture, there are values and customs, which are supported by the pattern of healthy life and are not the cause of negative effect to the health. In this case, nurses need to do "Cultural Care preservation/ maintenance."

From the examples above, we can see that in Javanese culture there are ceremonies for important events such as marriage, pregnancy, and delivery. These show that they respect the important events very much and pay attention to one's life. Nurses need to understand their attitude of submission to the Almighty God in order to prevent them from frustration and prolonged guilty feeling as an effective therapeutic communication.

In Balinese culture, we need to preserve the ceremonies for babies' health and babies' safety because it can decrease the mortality rate of mother and baby. The custom of Balinese society in giving special ceremony to the placenta after delivery is also similar to other cultures in different parts of Indonesia. Nurses should respect this so they won't throw out the placenta after assisting delivery. Nurses should also need to know whether their patients are abstaining from beef or not. If they are, nurses need to determine patient menu and diet advice and not to give beef as a source of animal protein.

In deciding and giving nursing action, nurses need to do cultural care accommodation/ negotiation beside cultural care preservation/ maintenance. This can be done if there are systems or ways believed by individuals, families, or societies which are dangerous or unsupported to the healthy life pattern and it needs to be changed with a better and healthier ways.

From the examples above, we can see that in some cultures in Indonesia, the society still believes in the psychic (orang pintar) than in health care team. If nurses want to negotiate a new custom to replace an old one that is less supportive to the healthy life or is dangerous to one's health, they need to make approach and cooperate with orang pintar. The beliefs or customs that need to be negotiated with better customs are:

- in Javanese culture, there are some societies who still believe that the illness is caused by "bad spirit" which enters into the patients' body.
- in Balinese culture, Traditional Birth Attendance (TBA) cut placenta with bamboo made-knife on some leaves and turmeric's. Nurses need to teach TBA about the sterile techniques in assisting delivery.
- in Senggi culture, the beliefs that the illness is caused by "Bad spirit" or because someone offends the cultural rules, should be changed and be introduced to the original cause of illness and how to lead a healthy life.

If the new values and ways based on professional system is known and accepted by individuals, families, or societies, nurses need to do cultural care repatterning or

restructuring which are assisting, supporting, facilitating or enabling professional actions and decisions that help patients reorder, change or greatly modify their lifeways for new, different, and beneficial health care pattern, while respecting the patients' cultural values and beliefs, and still providing a beneficial or healthier of life way than before the change were coestablished with the patients.

By viewing all of there, nurses care to give humanistic care need to assess precisely and comprehensively her patients - individuals, families and community. In making plan of action, implementing and evaluating, nurses need to involve their patients and cooperate with them.

4. Conclusion

By understanding the culture and the beliefs of one's society, nurses can make humanistic approach to the patients. The belief of local society about "well-being" is a good entrance for the nurses to build the attitude of healthy life. Since this society have their own language, nurses are best to learn and practice their language for them to be accepted by the local society.

The illustration above is only a small part of subcultures in Indonesia. Some of these traditions are still practiced fully by local society but some are practiced partly. However, as an integrated country, Indonesia has universal norms and it becomes an Indonesian culture. By the population of 85% Moslem, the norms and ways of Moslem very much influenced the society life, particularly in the big cities. For example, people don't serve pork meat or food containing pork products. Moslems practice their religion by praying five times daily.

As a nurse who gives humanistic services, she should respect her patients' values. She should be wary of the difference of values between hers and the patients. If the nurse isn't wary of this matter, she will probably misinterpret the patient's attitude or even force her action based on her cultural values.

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Perspective

Ethical Issues in Caring

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abstract
Ethical Dilemmas in Nursing: The advancement of medical science and technology and wider public concern with medical issues have made medical ethics and nursing ethics an increasingly important subject. Life is more complex with each passing day, more people are involved in the delivery of health care, and there are more and more options for choice, both for the providers of health care and for the consumers of that care. The situation and event today challenges nurses to reflect and answer the questions; how we see ourselves and our patients and nursing. We need "a paradigm shift" or distinct new ways to think of old problems. It is a time for nurses to come to their own conclusions about what is right and wrong, about what should and should not be done for and to patients.

Introduction

We are living in a modern technological, rapidly changing society. The advancement of science can help, promote, and guide modernization, but at the same time, people's way of life are being changed. Life is more complex with each day passing . The Health care system is keeping up with, even for outstripping, the pace of life's increasing complexity. More people are involved in the delivery of health care, and there are more and more options to chose from, both for the providers and receivers of health care .

According to Fromer (1981), there are usually several treatment modalities (and the choice of no treatment) for each problem; deciding on the best and most effective one often creates an ethical dilemma. Nurses are becoming involved in helping patients make, these of choices, and in order to be of the greatest service to the client they must have a thorough understanding of the ethical issues involved. Based on the situation described, knowing to identify moral and ethical issues, to raise questions, and to propose possible answers of inquiry is important.

What are Ethical Issues?

When we talk about "ethical issues" it means making a choice between two equally desirable or undesirable alternatives. We may use another word "Dilemma" which comes from a Greek word meaning an argument which forces an opponent to accept one of two propositions both of which contradict his former intention, for example sometimes in nurses every day routine we have to make decisions between telling the truth or keeping confidentiality. Let's consider the following case.

Malee, fourteen years old, has just completed a six - month check-up for a fractured ankle. The fracture has healed completely without complications, but her hemoglobin level was in the low - normal range. As a precautionary measure she was sent to Saichai, a nurse practitioner, for diet counseling. Before long Malee confided that she thought she was pregnant and that she did not want anyone else to know, especially her mother. Upon brief questioning, it become evident to Saichai that Malee had no clear idea of what she was going to do about the suspected pregnancy. Before Saichai could begin to help her think the situation through,

however, Malee' s mother came in. The mother said that Malee had been nauseated and very tired lately, and she asked Saichai if she had any idea of what could be causing it. As Saichai prepared to respond, Malee remained silent and glared at her. (Benjanin, Mortin and Curtis Joy, 1986)

From the case described, we can see although there is a presumption that nurses should maintain confidence. There is also a presumption against deception. Saichai's dilemma in this case is due to a conflict between these presumptions: How does Saichai decide what should be done? What is right and what is wrong? What does the nurse do if there is no right or wrong answer ? What if both answers are right or both answers are wrong? And what reasons should be ground for answering these questions?

Discussion about ethical issues or dilemmas, clear understanding about characteristics of ethical dilemmas and systematic approach to resolving is needed.

Leah Curtain (1982) maintained that a problem must have three characteristics in order to be an ethical dilemma:

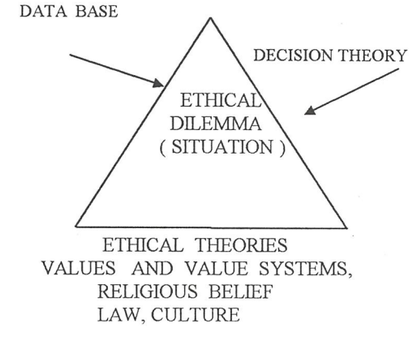
1. The problem can not be solved by using only impirical data;
2. The problem must be so perplexing that it is difficult to decide what facts and data need to be used in making the decision; and
3. The results of an ethical problem must effect more than an immediate situation. It should have far - reaching effects.

Because the ethical dilemma poses a conflict for the nurse as she must make a choice between alternatives, learning a systematic approach to resolving ethical dilemmas can help the nurse make better decisions and even, more importantly, feel comfortable about the decisions she has made. The following systematic approach to ethical decision making was proposed by Murply and Murply (1976) as follows :

1. Identify the problem
2. Identify why the problem is an ethical problem.
3. Identify the people involved in the ultimate decision .
4. Identify the role of the decision maker.
5. Consider the short - and long - term consequences of each alternatives.
6. Make the decision.
7. Compare the decision with the decision maker' s philosophy of patient care ethics.
8. Follow up on the results of the decision in order to establish a base line for future decision making.

Besides the systematic approach which will help the nurse reach a decision it is important, however to remember that all the steps of the process are clouded and influenced by the individual's values and basic beliefs about the rights, duties, and goals of all human beings. Due to these facts ethical frameworks are needed as a ground for making decisions. Ethical frameworks do not solve ethical dilemmas, but they do suggest ways of structuring and clarifying them.

The process of structuring an ethical dilemma for proposes of clarification, decision, and ultimately, action may involve a variety of forms. However, Mila A. Aroskar (1980) suggest a useful way in working with nursing groups is to break the dilemma into three elements-situation facts' decision - making questions, and underlying ethical theories, and to view these elements within the context of time and value systems. We may illustrate this elements :



In thinking about these dimensions, time is another fact concerned with clarifying dilemmas. Some dilemmas demand immediate action. These in which time is less critical offer more opportunity for evaluating information as well as identifying and weighing options prior to action.

To clarify the elements as described, we must consider step by step:

1. Ethical Dilemma or situation according to the case "Malee, fourteen-year old girl" confidentiality, and advocacy. And Saichai the nurse's dilemma is due to a conflict between confidentiality, advocacy vs. deception, trust and nurse - patient relationship.
2. Data base to gather the data base for ethical inquiry, the following questions should be answered as complete as possible :
2.1 Who are the actors involved? What are their histories and involvement in the situation.
2.2 What is the proposed action or actions?
2.3 What is the setting or contest of the proposed action.
2.4 What is the intention of the propose of the proposed action ?
2.5 What other alternatives or choices are available?
2.6 What are the probable implications or consequences of the proposed action? Aroskar (1980) explained that this is different from the data base that nurses are accustomed to gathering, but it contains such familiar concepts as assessment, and it - extends the reflective thinking process to an identified ethical dilemma however, even though the data base provides an essential component in the consideration of an ethical dilemma, decisions do not simply spring from heaps of data.

3. Decision theories dimensions. The second element of the triad for structuring an ethical dilemma is to consider the following questions which come from decision - making theories :
3.1 Who should decide? the physician, nurse, patient, family, committee? Why?
3.2 For whom is the decision being made? self, proxy, other?
3.3 What criteria should be used? Social legal, physiological, economic, psychological, other? Why?
3.4 What degree of consent by the client or subject is needed? Freely given, coerced, none?
3.5 What, if any, moral principles are enhanced or negated by a proposed course of action? self-determination, truthfulness, beneficence, justice as fairness?

In thinking about these questions, nurse and nursing students should also examine the concept of paternalism, or maternalism, as the case may be. On the other hand, when is the nurse interfering with a person's liberty and autonomy for the good of that individual in order to free what he or she, the health professional, considers to be a reasonable choice ?

4. Ethical Theories. When a conflict of values arises, for example, when, if ever, do considerations for social good override the rights of the individual to make his own decisions about health care? These decisions may be easier in such situations as an epidemic of communicable disease where the community is clearly in danger. But they become particularly difficult and ambiguous when children, the mentally ill, or others determined to be incapable of decision making are involved: for example, in alleged child abuse situations or commitment of the mentally ill. Malee, a young girl of fourteen who is too young to make a decision and to be responsible for her life and her baby, what should be a proper criterion for decision - making? Moral Judgement based on ethical theories should be considered.

Before we talk about ethical theories the first thing we should review is understanding about "Ethics". What is ethics?

Ethics (the Greek word Ethos) is a branch of philosophy (Axiology) dealing with values relating to human conduct in respect to whether certain actions are right or wrong and whether the motives and ends of such actions are good or bad. According to Dictionary of Philosophy (Angeles, Peter A. 1992) the meaning of ethics described as follow :
1. The analysis of concepts such as ought, should, duty, moral rules, right, wrong, obligation, responsibility.
2. The inquiry into the nature of Morality or moral acts.
3. The search for the morally good life.
Here in this paper we'll discuss ethical theories which will be used as a framework for decision making. There are four ethical theories Utilitarianism, duty - based reasoning, right - based reasoning and intuitionism.

Utilitarianism is a theory encourages the nurse to make her decision based on the common good; on what would be the best for the most people. This ethical framework diminishes and wants, of the individual. An example might be a patient with a living well. If the patient's family opposes the physician following the patient's request the physician may use a utilitarian framework to decide that he should meet the requests of the family over the patient.

Duty-based reasoning is an ethical framework which says that some decisions must be made because it is "there are things that a person is bound to do because it is "right". There is a duty to do something or to refrain from doing something. A nurse may use duty-based reasoning in deciding that a patient should be discharged back to the home rather than to a skilled nursing facility because she believes there is a duty to care personally for our elderly.

Right-based reasoning is based on the belief that some things are a person's just due; that each individual has basic claims or entitlements which should not be interfered with. Rights are different from wants, needs, or desires. Examples of rights might include the right to privacy, the right to health care, the right to life, and so forth.

Intuitionist, the intuitionist framework for ethical decision making is to review each ethical dilemma on a case-by-case basis comparing the relative "weights" or goals, duties, and rights. The goals, duties, and rights are not weighed the same in each case. The weighing is determined primarily by intuition, what we know and feel to be right for the situation. For example, the intuitionist may decide that the basis for selecting heart transplant recipients on one occasion should be based on the length of waiting time, and the next time that it should be based on potential value of the individual to the community.

We should remind ourselves again that, ethical theories and reasoning do not solve ethical dilemmas, but they do suggest ways of structuring and clarifying them. Beside knowing and understanding ethical theories, to know and understand culture, cultural values, beliefs of people in society is also significant, and helpful for providing holistic care for the patient. For example in Thai society. The culture of Thailand could be summed up in one word, religion. Thai culture tended to become secular in the progressive parts of the country; but that to the people as a whole, religious culture was still a living force (Rajadhon, 1968). This is nearly half a century ago and major changes have taken place since but there is a fundamental truth in his words because Theravado Buddhism, as the religion of the country professed by 95% of the total population, undoubtedly has directly or indirectly exerted a strong influence on the people's everyday life (Komin 1991). We can see the overall approach of Medicine in Thailand tends to be paternalistic: Patients and relatives trust the doctors and nurses completely and are convinced that whatever treatments they prescribe or nursing care they provide, will be for the best interest. The image of

doctors and nurses according to Thai people is a Trustworthy one .

Significant ethical dilemmas

Ethical dilemmas which arise in today society are numerous; Veracity-truth telling, Abortion, AIDS, Religious belief, Death and Dying, Organ Transplant, Euthanasia, Nurse-patient relationships, etc. In Thai society, nurse-patient relationships, Veracity, Advocacy, Spiritual healing, and Death with dignity are concerned.

Tschudin (1990) mentioned that: the increasing technology and sophistication of treatments and machines; and the patient's increased knowledge of medical matters, and their willingness to both take part in treatments, and also to question such treatments makes us reflect. The influence on nursing from increased technology as described is not only practical and technical, but also moral and ethical.

I would like to end this paper with Tschudin's words :*Because the nursing process, the rapid social change, the advancing technology, and the patients themselves make it impossible for us to accept everything and believe that ours is not to question why we can not avoid taking a stand on matters which concerns nursing deeply:What about the wonder of care? Do we as nurses accept every possibility of life - saving or prolonging, or do we not - and on what grounds do we not?Do we condone treatments or condemn them?What are our bases for such judgements? Do we have enough knowledge to decide?Are we in fact free agents who can decide for ourselves?*

Society should expect that the nursing profession will prepare and regulate advanced nursing practice for the good of patient care and society as a whole. As an Asian patient I do believe, human life is

Pain, Hope,
Sadness, Joy,
Through it all ..... there are the nurses decent, dedicated human beings with a strong commitment to right and wrong ..... and they act on those commitment. Nurses are good friends in need, and are people for all seasons of human life.

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Perspective

Caring Inquiry in Nursing : Phenomenological Research Method

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Caring is an essential component of nursing practice, nursing education and nursing administration. In the past, caring has been overshadowed in nursing practice. Only in the last two decades caring has been recognised by a number of nurse leaders as a topic of scholarly and practical importance (Leininger, 1978, 1986; Watson, 1985; Benner, 1984; Roach, 1992). Since then, caring has become a focus area of investigation in nursing and caring knowledge has emerged. However, it is still in need of further clarification and expansion. This paper introduces phenomenological research as a method of caring inquiry in nursing. It demonstrates how to use phenomenological method in studying caring. The examples of selected caring research are also included.

Phenomenological Perspective

Phenomenology is a philosophy and a research method which attempts to study the human experience as it is lived. "The goal of the phenomenological method is to describe the total systematic structure of lived experience, including the meanings that these experiences have for the indiciduals who participated in them" (Omery, 1983, p. 50).

Munhall and Oiler (1986) state that the perspective of phenomemological philosophy "focuses on phenomena as they appear in recognition that reality is subjective and a matter of appearances for us in our social world. Subjectivity means that the world becomes real through our contact with it" (p.62).

The entire phenomenological attitude is one of understanding the meaning of the subject's experience from their perspective. In order to penetrate the world of the subject, the researcher must suspend or bracket the preconceptions or assumptions about the phenomena under study. "This process of recovering original awareness is called reduction" (Oiler, 1986,p.72).

The phenomenological method is concerned with the transformation of human experience as it is lived into validated knowledge. Reinharz (1983, pp. 78-79) lists five steps in the phenomenological transformation. These are:

1. A person's experience is transformed into actions and language that are available to him/her by virtue of a special interaction she/he has with (an) other person(s). In this case the other is a phenomenological researcher who creates a situation or context in which the person's inchoate lived experience becomes available to him/her in language. That's the first transformation;
2. The researcher transforms what she/he sees or hears into an understanding of the original experience. Because we can never experience another person's experience, we rely on data the subject produces about that experience, and we produce from that our own understanding. That's the second transformation;
3. The researcher transforms this understanding into clarifying conceptual categories which he or she believes are the essence of the original experience. Without doing that, one is simply recording, and recording is not enough to produce understanding;
4. The researcher transforms those conceptual categories into written documents (or other products such as a she/he has thought about the experience picture or poem) which captures what that the person has talked about or expressed in

some way. That's another transformation. In lost and something can be gained;
5. The audience of the researcher transform this written document into understanding which can function to clarify all the preceding steps and which can also clarify new experiences that the audience has. This is where the inductive principle leads.

Phenomenology has been an integral field of inquiry across philosophical, sociological, and psychological disciplines. In nursing, phenomenology has recently gained recognition as a qualitative research approach applicable to study of nursing phenomena. The purpose of phenomenological research in nursing is to describe nursing phenomena as lived experience of the world in every day life. The important points of phenomenological research as presented by Oiler Boyd, (1993: 126-128) are:
(1) Phenomenological research is the study of lived experience;
(2) Phenomenological research is the explication of phenomena as they present themselves to consciousness;
(3) Phenomenological research is the study of essences;
(4) Phenomenological research is the description of the experiential meanings we live as we live them;
(5) Phenomenological research is the human scientific study of phenomena;
(6) Phenomenological research is the attentive practice of thoughtfulness. Oiler Boyd (1993: 127) describes this: "The impetus, for doing research is the researcher's everyday practical concerns in her or his orientation as a nurse for example;"
(7) Phenomenological research is a search for what it means to be human; and
(8) Phenomenological research is a poetising activity. Oiler Boyd (1993: 128) summarises this: "phenomenological description is then characterised by inspirational insight won through reflective writing. Research and writing are thus closely related."

Structure of the Research Method

There are five basic elements of phenomenological research. These are: identifying the phenomenon; structuring the study; gathering the data; analysing the dada and describing the findings (Parse,et al, 1985: 16-19).

1. Identifying the phenomenon
A phenomenon worthy of study in nursing is a human experience related to health and caring for example: being comfortable, suffering, being cared for, experience of surgery; experience of providing care.
2. Structuring the study
This includes specifying a **research question** such as: What is the lived experience of surgery? How is suffering lived for persons who are dying? Then the **study sample** is identified from a population living the experience of the phenomenon being studied. **Protecting the rights of human subjects** is an important aspect of phenomenological research. The subjects are invited to respond in writing or orally. The purpose of the study and the involvement of the subject are explained. Confidentiality and anonymity are assured.
3. Data gathering
Since a phenomenological method aims to describe meaning of human lived experience, the questions to the subjects must lead them to reflect on and describe a situation in which the experience occurred and is presently remembered. The in-depth interview by the researcher and asking the subject to express their experiences in written form are appropriate.
4. Analysing the data
The data analysis of the phenomenological method is a rigorous, systematic approach. The researcher must strictly adhere to the data, and undistractedly, read and re-read the descriptions with the intent to uncover the meaning of the subject's lived experience.
5. Describing the findings
Reporting a phenomenological study requires the presentation of the fundamenatal structure of the experience with indicated data. A discussion is included with the description of findings.

In doing phenomenological research, several procedural interpretations are available as guidelines for analysis such as Colaizzi, Van Manem, Giorgi method. (Streubert and Carpenter, 1994). The

Colaizzi method is commonly used in phenomenological nursing research. This method has a seven-stage process of analysis occurring as follows (Holloway and Wheeler, 1996, p. 125):
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;
2. The next step involves the researcher in extracting words and sentences relating to the phenomenon under study. Colaizzi calls this process **extracting significant statements;**
3. The researcher then attempts to ***formulate meanings*** for each significant statement;
4. The researcher repeats this process for each description from the participant and arranges these formulated means into ***clusters of themes;***
(a) The researcher returns to the original descriptions to validate the themes; and
(b) At this stage, there may be contradictions among or between the groups of themes. The researcher is advised by Colaizzi to resist the temptation to ignore data or themes which do not fit;
5. Following this step, the researcher is able to integrate all the resulting ideas into an ***exhaustive description*** of the phenomenon under study;
6. The researcher then reduces the exhaustive description of the phenomenon to an essential structure. Colaizzi describes this as an ***unequivocal statement of identification of the fundamental structure*** of the phenomenon; and
7. In the final stage, the researcher returns to the participants in the research for a further interview to elicit their views on the findings and to validate them.

Phenomenological Research on Caring Phenomenon in Nursing

Caring is a basic constitutive phenomenon of human existence. "To be is to care", and the different ways of caring are the various ways of "Being-in-the-world" (Heidegger, 1962). Caring in nursing is a human phenomenon of being in the world of nursing practice, education, and administration. People in these world embodies caring experience. Phenomenological perspective is lifeworld, the true reality of perception and experience (Donaldson, 1987). Therefore phenomenology is one of the most appropriate method to study caring as it is context-bound-inextricably linked to life situations (Watson, 1985; Benner and Wrubel, 1989).

In the past two decades, a number of nurse researchers have used a phenomenological approach as a method of study caring phenomena. Selective sampling of the research studies are shown in Table 1:

Table 1: Examples of Phenomenological Research on Caring

Nursing practice
- The essence of caring interaction (Reiman, 1983)
- The essence of nurse caring during labour and delivery (Luegenbiel, 1986)
- Lived experience of caring in professional nurses (Hernandez, 1987)
- Nurses' caring as perceived by post-operative patients (Sherwood, 1988)
- The meaning of experience of feeling cared for (Warren, 1989)
- Investigation of phenomenon of caring with hospital staff nurses (Forrest, 1989)
- Nurses' experiences giving post-mortem care to patients who have donated organs (Wolf, 1991)
- Exclusion and confirmation: A phenomenology of patients' experience with caregivers (Drew, 1986)

Nursing education
- Student's perceptions of caring: nursing student faculty experience (Beck, 1991).
- The meaning of a caring experience between a nursing student and a patient (Beck, 1993).
- The lived experiences of students in nursing: voices of caring speak of the tact of teaching (Sorrell, 1997).

A phenomenological research method is considered most appropriate and valuable to investigate caring phenomena in nursing. With this approach, much has to be elicited and a bank of caring knowledge has begun to emerge from the studies done thus far. Although nurses provide care to

clients in every stage of life, in both the health and illness states, there is still a great need to better understand caring phenomena in all life situations. In this regard, (Leininger, 1991; Watson, 1988) saw that development of caring knowledge as the focus of the discipline of nursing is an ongoing process.

In the area of nursing education, caring is an important ingredient in the teaching-learning process, although the understanding of caring in this area is, to say the least, rather sketchy. In addition, caring research in the area of nursing administration is negligible, though it is emphasised as an important aspect. Therefore, in the beginning stages of knowing about caring within the nursing administration sphere, a phenomenological method is offered as the best method to explore loved experiences of caring in students and teachers. The uncovering and baring of caring lived experiences of administrators and other members of the organization will surely help to capture and provide an insight into the caring phenomenon as it is experienced and perceived by both residents and transients of just such an establishment.

Table 2: Two Example of Phenomenological Studies

Nursing Practice (Streubert & Carperter, 1995:56-57)
Phenomenon
The concept of caring as a lived experience form human and nursing perspectives
Author/Date
Green-Hemandez, C. (1990)
Domain
Practice
Method
Colaizzi
Sample
Purposive sample of 20 nurses that stated they had experience in caring.
Data Generation
Audiotaped interviews that were transcribed verbatim.

Findings
Six themes emerged as descriptive of the lived experience of natural caring and included being there, touching, social support, reciprocity, time/extra effort, and empathy. Fourteen themes emerged related to professional nurse caring and included holism, touching, technical competence, communication, listening, being there, professional experience, empathy, social support, reciprocity, involvement, time, formal and informal learning and helping.
Nursing Education (Streubert & Carpenter, 1995: 54:55)
Phenomenon
The meaning of a caring experience between a nursing student and a patient
Author/Date
Beck, C.T. (1993)
Domain
Education
Method
Van Manen
Sample
22 undergraduate students
Data Generation
Students wrote in-depth accounts

Findings
Five essential themes of a caring nursing student-patient experience emerged: authentic presence, competence, emotional support, physical and positive consequences.

Summary

Caring is embedded in human lived experiences that can be inquired from a phenomenological perspective. Understanding the essence meaning of human lived experience is the purpose of using a phenomenological research method. As well, where the focus component of nursing is caring in human health-illness lived experience, a development of knowledge in this area will ensure substantial contributions to nursing science. Phenomenological research is most valuable for uncovering caring phenomenon within the context of health-illness lived experiences. Moreover, it is considered most appropriate in the understanding of the caring phenomenon within teaching-learning processes as well as in the area of nursing administration.

The phenomenological research method is concerned with the transformation of human experiences as it is lived into validated knowledge. There are five basic elements of phenomenological research. These elements are: identifying the phenomenon; structuring the study; data gathering; analysing the data; and describing the findings. Within the research process the researcher must bracket or suspend preconceptions about the studied phenomenon. Several procedural interpretations are available for data analysis. Colaizzi is a commonly used method consisting of seven steps: reading and re-reading participants transcriptions; extracting significant statements; formulating meanings; clustering of themes; integrating exhaustive description; reducing to identify fundamental structure of the phenomenon; and validating by participants.

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Perspective

Caring Inquiry : Transformation Through Action Research

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abstract

This paper aims to introduce the idea of how action research can be used as the methodological approach for caring inquiries. The inquiry modes of action research comprise of three main characteristics according to Habermas' critical theory. These are technical action research (informed by Natural Science), practical action research (informed by Hermenneutic Science or Interpretive Science), and emancipatory action research (informed by Critical Social Science). Inquirers in action research play the roles of not only investigators but also participant and facilitators. Inquirers ask questions: What is the aim or purpose of inquiry?, What is the nature of knowledge in action research paradigm?, What criteria are appropriate for judging the quality of inquiry? What happened ? How do we feel?, What does it mean? How can we perform better? Definition characteristics, methods and limitations of action research will be presented .

The study on ***"Mindfulness and meditation training as ways of developing a healing relationship with self, patients, and other"*** *will be presented to illustrate how nurse can transform compassion, loving kindness, and a healing relationship to themselves, patients and family. The presentation will conclude by highlighting the main factors in improving quality of caring inquiry through action research*

Perspective

Therapeutic Touch: Compassionate Caring for Healing

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abstract

As we ourselves are healed, we provide an example for others. As we desire to help and heal others, we ourselves are also healed. The result is that relationships become a temple of healing in which healing is recognised as a collaborative venture that leads to the recognition of our underlying unity

(Vaughn, F and Walsh, R: 1992 p.1)

This paper will cover aspects of health, healing and wholeness, compassion, touch and the development of Therapeutic Touch (TT). A brief discussion on philosophical, cultural, scientific and nursing foundation of Therapeutic Touch will be presented. The clinical application of Therapeutic Touch will be described arising from research and case studies of practitioners.

As we approach the 21st century and beyond, a gradual shift in human consciousness is emerging in search of a paradigm beyond mind-body orientation. The predominance of scientific mechanistic world view is evident in our health care system that have become sanctuaries of quick-fix techno-cure sick care institutions. Much attention have been given to physical health needs while mind and spirit are usually considered to be separate entities. We are becoming aware that behind every physical illness is an emotional element, with simultaneous effect on mental and spiritual aspect of our being. If we believe that health and healing is a harmony of mind-body-spirit, then we are faced with a conflict of how to reconcile the old Western medical tradition of curing with the emerging world view of caring and healing.

Health - the birthright of the whole person

Briefly, health is regarded as a birthright of every human being. It was in terms of positive health that the World Health Organization defined health in its Constitution: Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (WHO, 1947). At the time, some considered this definition impractical; some view it as a possible goal for all people, while others consider complete well-being unobtainable. However, the WHO definition of health includes three characteristics basic to a positive concept of health.

- It reflects concern for the individual as a total person rather than as merely the sum of various parts.
- It places health in the context of the environment.
- It equates health with productive and creative living (Pender 1987, p.17).

The meaning of health and its social and cultural influences

Culture and social interactions also influence a person's notion of health. Each culture has ideas about health, transmitted from generation to generation. Social and cultural values, beliefs and changing health trends have a significant influence in our way of life. We have acquired in some way or another a good sense of how illness can be effectively treated by traditional allopathic medicine. Some of us truly

believe that medicine alone cures. According to Florence Nightingale,

"it is no such thing; medicine is the surgery *of functions, as surgery proper is that of limbs and organs. Neither can do anything but remove obstructions, neither can cure, nature alone cures. Surgery removes bullet out of the limb, which is the obstruction to cure, but nature heals the wound. so it is with medicine. The function of an organ becomes obstructed, medicine so far as we know, assists nature to remove the obstruction, but does nothing more. And what nursing has to do in either case, is to put the patient in the best condition for nature to act upon the person (Notes on Nursing, 1969, p.133).*

The Western world have only begun to address the state of consciousness that provides the foundation for wellness and healing. In Australia, the evidence of this is revealed in the outcome of research conducted in 1993 by Professor Alastair MacLennan of Adelaide University in South Australia. He found that Australians spend $621 million a year on alternative medicines and therapists (Evans, 1996, p. 12; Hailstone, 1996, p.3). This survey demonstrated that the community needed more than what medicine can offer. Medicine can not mend all the human hurting and suffering. The medicines meant to save lives, sometimes not only failed to heal but was also increasingly perceived as a threat to health in itself or incomplete on its own in restoration of health.

Today, advances in science reveal that we exist in and are part of an infinite ocean of energy. Mind and matter are not separate; it appears that they are different aspects of a single, unifying order. In light of this, now is the time to expand from a body/matter-based orientation to a new reality based on energy, consciousness, wholeness and healing.

Healing and wholeness

The etymology of the word heal from the Middle English word is `helen' whereas the Old English is `haelen' which is akin to a whole. The verb heal means to restore to health whereas the intransitive verb denotes to become whole and sound.(Universal Dictionary, 1988, p.711). It appears that heal and wholeness are germane to each other.

We can heal ourselves by becoming more conscious of our physical, emotional, mental, and spiritual states, and we can help one another heal. We can also interact with each other and with our environment in ways that facilitate healing. We have the capacity to influence one another energetically and the most potent of this energy is compassionate caring that stems from love of fellow human being.

Laskow (1992, p. 250) states that love stimulates healing by relating us to the natural order and harmony inherent in our cells, in our selves, and in universal consciousness. Healing through love is a process of becoming whole. Healing is making whole again what was once whole but has become separate. In this way, love and healing are similar, since love also brings together and dissolves the illusion of separation.

Just as healing bridges the gap from illness to health, from disharmony to harmony, so love bridges the space between fragmentation and wholeness, between separation, individuality and unity. (Laskow, 1992. p. 250). The power of love moves us to compassion and is evident to many areas of our lives.

Compassion - the grace that binds us together

The word compassion is derived from the Latin words '*pati'* and '*cum*' together, it means "to suffer with." Compassion asks us to go where it hurts, to enter into places of pain, to share in brokenness, fear, confusion, and anguish. Compassion challenges us to cry out with those in

misery, to mourn with those who are lonely, to weep with those in tears. Compassion requires us to be weak with the weak, vulnerable with the vulnerable, and powerless with the powerless. (Fiand,1993. p.32).

Let me share with you an exemplar from my TT practice.

Sonia is a middle aged woman, wife and a mother of two grown up sons. Her sister in-law requested me to do Therapeutic Touch (TT) on Sonia. The physical changed in Sonia surprised me. I knew her as a woman who used to be healthy and full of life. She lost a lot of weight and looked gaunt. On the first TT assessment, her energy field was in a state of disarray. She was emotionally depressed and her family were very concerned about her health. I taught TT to her husband who is a motor mechanic and her youngest son who is doing computer engineering at the university. I instructed them to do it once a day, preferably before she goes to bed. I decided to see her once a week. TT takes only 20 minutes to do but I found that most of my time was spent on listening and counselling Sonia and her family. What moved me to respond to the cry of help from Sonia and her family is compassion. I felt powerless to say "Sorry, I can not help you." Being sensitive to her healing needs gave me the courage to join her and her family in their journey towards healing. In this journey to the unknown is a comforting presence of the Divine Healer - Jesus. Her husband said to me during one of the TT treatments " I know there is hope." Her doctor told her that whatever treatment it is she was having, to continue with it.

Compassion according to Roach (1992, p.58) is being sensitive to the pain and brokenness of the other, a quality of presence which allows one to share with and make room for another. Therapeutic Touch practitioners attest to Sr. Roach view of compassion. The sense of compassion must extend to all regardless of colour, race, gender, or creed. According to Kunz (1995, p.293) the certain features common to many healers of TT from her observation is that there are several common denominators which seem essential:

"First, the healer has to have a conviction or faith that there is a power which is greater than himself, on which he can draw. Secondly, he of course must have a genuine compassion and the desire to help others. Thirdly, to be truly effective, he has to leave his own ego or sense of self-importance out of the healing process." One develops compassion only if one is willing as a first step to use one's energies to help another. If one is really indifferent to what others feel, then clearly it is not possible to develop compassion (p.299)

Fox (1990, p.iv) states that compassion is not pity, it is not sentiment but is making justice and doing works of mercy. It is passionate and caring, not anti-intellectual but seeks to know to understand the interconnections of all things. It is a flow and overflow of the fullest human energies. It is not altruism but self-love and other-love at one. It is cosmic in its scope.

Fox (1990) explains that to be compassionate is to incorporate one's own fullest energies with cosmic ones into the twin tasks of
(1) relieving the pain of fellow creatures by way of justice-making, and
(2) celebrating the existence, time and space that all creatures share as a gift from the only One who is fully compassionate.

Compassion is our kinship with the universe and the universe's Maker: it is the action we take because of that kinship.

Touch is a connecting gift of Compassion.

According to Gordon (1978) our hands are a gift and through them, we can channel the love in our hearts to relieve the suffering of those around us (p.8).

Touch that special sense that is used by nurses as they render care. Touch is an integral part of nursing, yet its meaning can be difficult to articulate. It is used in a variety of ways to comfort, soothe, feel, appreciate, understand, respect, and heal. It is use as a vehicle for communication. Nurses are able to effectively communicate through touch. In a simple touch, more love and understanding can be conveyed than could have been communicated with any amount of words. This has become extremely important as society and patients increasingly confront a world of high technology. The challenge for nurses has thus become the creation of a viable approach to balance technology with touch. Touch, as an act of understanding, can give energy, love, respect, and dignity to those who are vulnerable and whose lives are entrusted to nurses. It is an intimate act that allows nurses to rise above social taboos. Nurses touch the private parts of their patients' bodies, which enable a formation of trust and closeness that can almost be spiritual. Physical touch not only provides a mechanism for the assessment of patient status and the provision of nursing acts such as bathing but also conveys the emotional element of caring so crucial to patient well being. Touch truly unites the head, the heart, and the hands of the nurse to provide the strong foundation for modern-day nursing. (Donahue, 1989, p.28).

Touch as a mean of conveying feeling and meaning has been used since the beginning of mankind in every known human culture. It is used between parent and child and lovers and friends to convey love, kindness, and empathy (Barnett, 1972). The word touch is derived from the French word 'touche.' Touching is defined by Webster (1972) as the action of feeling something with the hand. The operative word, feeling, expresses the emotion or sensation of touch (Montague, 1971). As a means of communication, touch has come to be regarded as a valid field for research (Barnett, 1972).

Montague (1971) has long studied and written about touch and the human significance of the skin. Montague described touch as 'the mother of the senses' (p.199) and the earliest of the senses to develop in the human embryo. The growth and development of the skin and touch sense improve throughout life and depend largely upon the type of environmental stimulation received. To all of these stimuli, the skin is equipped to respond with efficiency. The largest organ system of the body, the skin comprises about 2,500 square centimetres in the newborn and approximately 18,000 square centimetres in the average adult male and constitutes about 16 - 18 % total body weight. Tactile points of the skin vary from 7 to 135 per square centimetres with the number of sensory fibre entering the spinal cord by the posterior root being well over half a million (Montague, 1971).

Until recent years, there has been very little interest in the functions and properties of the skin. However, the importance in human behaviour of the tactile functions of the skin has not gone totally unrecognised. There are expressions commonly used in everyday language in which these functions appear. Collins (1977, p.85) spoke of someone who is "a soft touch," of "rubbing" people the wrong way, of positive "strokes," and of "the human touch". Some people have to be "handled" carefully or might be described as "thin-skinned" or "thick skinned" (Montague, 1971, p.66). Some individuals get "under one's skin," while others remain only "skin deep." Some people are "touchy" or oversensitive, while an experience that is deeply felt is described as "touching" (Collins, 1977, p.86).

An infant from the beginning is dependent upon direct physical contact for comfort but does not have the mature capacity to reach out for the comfort it needs as the infant monkey does. During the 19th century, over half the infants died in their first year of life from a disease called

marasmus (Montague, 1971). The term marasmus is derived from a Greek word meaning wasting away. As late as 1920 in the United States, the death rate for infants were almost 100% (Montague, 1971). It was not until after World War II that studies of the cause of marasmus were undertaken. It was found that a child required handling, cuddling, and caressing if it were to prosper (Montague, 1971).

Extreme sensory deprivation can be survived as long as the sensory experiences of the skin are maintained. A case which emphasises the importance of tactile stimulation is that of Helen Keller. Both deaf and blind at birth, she was reached through tactile communication and eventually learned to communicate with the human world entirely through the skin. She learned, through touch, an awareness of the world other than herself (Montague, 1971).

Jourard (1971, p.206) commented that one of the events which is believed to inspire faith and hope in a hospitalised patient is the conviction that someone cares about him. He also observed that through direct contact, the patient somehow increases his sense of being a worthwhile individual. He stated that this experience inspires the patient and does something to the body which helps him throw off illness. According to him, wellness comes about from having one's individuality respected and that being heard and touched by a caring person mobilises a person's spirit, reinforces his identity, and promotes self-healing (p. 206). If the practice of 'touch' is culturally safe and appropriate, then Jourard's notion can only enhance the sense of well being of the patient if applied within the context of nursing care.

O'Brien (1978) stated that the ability to touch another person physically, mentally, emotionally, or socially is an art. This art, as it is developed and refined, will provide the ability to have a profound effect on others.

The term, the laying on of hands, in relationship to healing, can readily be found in biblical writings. Healing events in the New Testament are attributed to Jesus, among which are the laying on of hands. Jesus is forever touching the sick. In fact, he is the healer 'par excellence.' The disciples were told to lay hands on the sick so they would recover (New Testament, 1982, Mark 16:18).

In everyday living the relationship of touch to well-being was acknowledged as significant. Throughout life, touch was said to be a necessary human experience.

Healing and compassionate touch

Healing through touch is as ancient as civilisation itself. All cultures, both ancient and modern have developed ways of healing touch such as rubbing, pressing, massaging, holding and laying on of hands. These practices have evolved as natural manifestations of the desire to heal and care for one another (Dossey et al, 1988). However, differences in practices, beliefs and values exist from culture to culture. One may view touch as necessary, whereas the other may view it as taboo. Since healing touch is culture specific, it is important that nurses should have the knowledge of values, beliefs and practices of the client towards healing touch to avoid cultural conflict.

Healing touch and the emergence of Therapeutic Touch

Although healing touch therapy has been around for some decades, it is relatively new in the nursing literature. Hand holding has been described as a positive means of communication and one that seems to break down barriers. Through a mechanism of touch, a nurse can convey feelings of caring and understanding to the client. Patients most often affirm the positive and reassuring effect of the nurses touch. Nurses in comparison to other health care

professionals, touch the patient most. The nursing profession would not survive if nurses are not able to touch the patients.

Therapeutic Touch and nursing practice

In life with all the innumerable stresses one struggles with, there are moments when human beings may be tempted to resign to the inevitable, or worse, to despair. Nurses have the unique opportunity to present a powerful healing force to patients/clients in their care through the use of Therapeutic Touch. It is possible that Therapeutic Touch would enhance the quality of care, help patients/clients to achieve health or wholeness.

I came across Therapeutic Touch during my sabbatical leave in the early 1990 at Denver, Colorado. Professor Jean Watson requested me to see Dr. Janet Quinn who teaches Therapeutic Touch at the School of Nursing, University of Colorado. My meeting with Dr. Quinn changed the way I view curing, caring and healing of patient/client. After the informative and challenging dialogue with Dr. Quinn, Professor Watson encouraged me to visit the Center for Human Caring where Therapeutic Touch is used as one of the healing modalities in caring for patient with HIV. What impressed me about Therapeutic Touch during this visit to the Center was the affirmation given by patients/clients relating to their experience of the sense of wellness and the difference it made in relation to their quality of life. I became interested in this healing modality and had a very strong sense that I could use it to enrich the quality of my nursing practice as a way of complementing medical intervention. On my return to Australia in April 1990, I resumed my teaching duties at the School of Nursing, Flinders University. I shared information about Therapeutic Touch with my colleagues and students and I also started to put into practice the knowledge and skills I learned at the School of Nursing about Therapeutic Touch. At first, I treated my family members, then my colleagues and friends. With good outcome from those I have treated, it got to the point that treating colleagues, students and clerical staff in my office is no longer suitable and practical. I decided to open a clinic using one of the rooms in the Nursing Laboratories. Later, as the number of patients/clients grew, I taught some of my colleagues Therapeutic Touch and afterwards opened two clinics using the Nursing Laboratories. We had varieties of patients/clients coming to us to treat once a week. We kept our documentation faithfully. The written records became a valuable treatment history to show us the effects Therapeutic Touch had on our patients/clients condition. We treated varieties of condition ranging from hypertension, chronic pain associated with Rheumatoid Arthritis, bone injury, muscular sprain, migraine, depression, insomnia and backache to name a few. Most of my colleagues have their own private practice now. I had also a private practice treating patients/clients with HIV. Unfortunately, I had to give up this private practice due to an overseas project with the World Health Organisation and the National Cancer Institute in Bangkok, Thailand.. In this cancer hospital, I taught Therapeutic Touch. Once you have learned how to use Therapeutic Touch you will always carry with you a knowledge and skill that never goes out of fashion. You will never feel hopeless and helpless in a most seemingly hopeless clinical situation. Looking back, I believe that my experience at the Center for Human Caring opened a window for me to view human life as a complex, multidimentional system of physical, emotional, mental, and spiritual energy.

Historical development of Therapeutic Touch

Dolores Krieger, a nurse-physiologist from New York University became interested in the ancient practice of laying-on of hands

as an applied nursing practice during the 1970's. She asked Oscar Estebany, a world renowned healer to work with her on experiments to measure human haemoglobin levels. Haemoglobin was chosen as the dependent variable because it is a sensitive indicator of the body's oxygen uptake. Krieger (1973,1976) reported significant increased in the mean haemoglobin in Estebany's treatment group compared to a control group.

Krieger believes everyone has a natural healing ability which can be developed. She refined the laying-on of hands process into Therapeutic Touch working in partnership with Dora Kunz. Dora Kunz is a world renowned healer. After teaching nurses the technique, she conducted experiments using nurses to administer either causal touch such as touching an arm, or Therapeutic Touch on patients in a hospital setting (Krieger, 1975). Since then, a variety of nursing studies have emerged researching the effects of Therapeutic Touch response on human subjects. These studies vary in the method of Therapeutic Touch and in the control treatments. Generally, most of the studies on the effects of Therapeutic Touch have favourable results.

Assumptions that underlie the practice of Therapeutic Touch. Four of these scientific premises are:

• All life scientists agree that, physically, a human being is an open energy system. The assumption implies that the transfer of energy between people is natural, continuous event. Therefore, when a healer transfers energy to a healee during Therapeutic Touch, it is by a nonstressful, "effortless effort" that is guided by a conscious, mindful action. The important ingredient added by the healer is intentionality within a context of compassionate concern for recipient of Therapeutic Touch.

• Anatomically, a human being is bilaterally symmetrical. This symmetry is the rational basis for inferring that there is also a pattern in the underlaying energy field.

• Illness is an imbalance in an individual's energy field. For example, in a state of injury or disease, the field is obstructed, disordered, disturbed, depleted. The healer directs and modulates this energy field using the sense of touch. In the practice of TT, the intent is to restore order to the field, and change the energy in the direction of wholeness and health. The practitioner is simply assisting nature to reestablish order.

• Human beings have natural abilities to transform and transcend their conditions of living (Krieger, 1988, pp.12-13) As human beings, we are continually, simultaneously, and mutually exchanging energy with all things in our environment. In a state of health, energy flows freely in, through and out of the field in an organised, balanced manner. Living organisms are "self-organising' wholes. The ability to heal, to restore wholeness is an innate capacity or tendency in all living things. "Healing" is an intrinsic movement to restore order within living organisms.

Traditionally, nursing has adhered to the mechanistic, allopathic model. A move toward holism in nursing practice would balance science and technology with the human side of care. Therapeutic Touch is a holistic healing modality which may strengthen the human rhythmic pattern. It is used by nurses as a complimentary, health-oriented, inexpensive intervention which potentiates the natural or self-healing process.

Dr. Dolores Krieger and Dora Kunz introduced TT to the medical community twenty-five years ago. Since then, supportive research and experience has shown its effectiveness in the promotion of relaxation and reduction of anxiety, changing the patients' perception of pain and facilitation of the body's natural restorative processes.

Many nurses and other professionals include TT in their practices and view it as an essential tool which they use to improve the quality of patient care in both the hospital and the community. We have many reports from practitioners who find TT effective in situations where other medical and nursing measures have failed to give relief.

Philosophical foundations and theoretical framework

• *Platonic Philosophy*

Weber (1981) discussed early philosophers who provides foundation for the healing modality of TT. According to Plato, the primary power for health or illness is attributed to our unobstructed connectedness with the Platonic forms (energy fields). Health according to Plato involves the spiritual well - being of the whole person (pp. 27-28).

• *Indian Philosophy*

Sankhya, an Indian philosopher of the sixth century B.C. wrote that the mind and spiritual conscious are primary over physical matter. For him, the primary power of both health and disease is attributed to consciousness, not material body. The Yoga of Patanjali's theory was built upon Sankya theory (Weber, 1981, pp. 28-30).

• *The Yoga of Patanjali's theory*

The Yoga of Patanjali's theory of scars which claims a prominent role in health and disease. These scars are tracings left on us by our experience, akin to energy patterns etched into our organism. Patanjali's advice for defusing and deenergizing the destructive effect is through a healing approach such as visualisation (Weber, 1981, pp. 30-32) and imagery. Both techniques are employed in TT

• *Spinoza and the healing framework*

The 17th century rationalists, Spinoza felt that the mind and body are not two distinct substances but merely two ways of describing one and the same spiritual substance. A healthy consciousness is reflected in a healthy body. (Weber, 1981, p. 32-34). In the esoteric tradition of philosophy, restoration to health according to Weber, is return to pristine state of wholenesss involving all creation and, above all, union with the ultimate source (p.38).

Cultural influences

The Eastern world view is founded on the energy described as "Chi". In Indian medicine which is "Ayurveda", energy is referred to as "prahna." It is believed to be the vital force and is the centre of vital function. The Western world view is based on the reductionism of matter. It maintains that all forms of healing is influenced by cellular changes in the body. This basic cultural differences has resulted in the evolution of widely differing approaches such as meditation, aromatherapy and many more. A blending of Eastern and Western techniques has resulted in an explosion of new and widely practiced healing modalities.

According to the tenets of Eastern philosophy, an energy system flows through living things (Thayer, 1990). This life force (Prahna) interconnects all forms of matter and consciousness. A healthy person has an overbalance of energy and an ill person has deficit. Eastern philosophers believe that energy is transferred from one individual to another so that the healthy person directs excess energies to the ill person (Krieger, 1979). Although Krieger acknowledged the influence of Eastern philosophy upon her energy transfer in the healing art, it did not involve the depletion of the healer's personal energy. The TT practitioner acts as a conduit to direct universal energy.

Scientific foundation

- Energy Flow

There is another world view derived from the so called Newtonian Universe. It is called the post modern world view. It is from this world view that healing modality such as TT aligns itself. This world view emerged from a science that is developed in a less mechanistic, materialist universe. Scientists as Paul Davies and Griffins (1991) have asked in their book entitled "the Matter Myth: Toward the 21st century science".

" Is there something else going out there? They argued that there is more to the world than cogs in a gigantic machine".

We do not live in a cosmic clockwork but in a cosmic network.. The new physics recognises fields of influence such that an electron at one end of the universe can be affected by an electron at the other end or at any distance in between. Even Einstein (1923) says, "it is possible that there exist human emanations that are still unknown to us. Do you remember how electrical currents and unseen waves were laughed at? The knowledge about man is still in infancy".

When Einstein (1923) published his theory of relativity (E=mc2) he completely confused the science community at that time. I believe he simply means that energy could be turned into matter and matter back into energy, there is no difference between energy and matter. Energy is particles that do not stick together, they become matter. We all are complex fields of life energy that relate to our universe. Quantum theorists say that where energy fields cross, there is evidence of the momentary creation of particles, or matter. Eighty years have passed and still scientists and physicists can not disprove Einstein's theory. These energies that surround all living things are called fields."

In TT it is the incessant flow of the patient's energy fields that one looks for when assessing a patient's condition. All the life sciences agree that, physically, a human being is an open energy system, in dynamic interface with the environment. Energy enters the system, circulates through the system and then exits. These natural fields can also be photographed by Kirlian photography. Although these energy fields are not material, we have physical access to them. Also, human emotions are a type of energy. Most people know, either directly or indirectly

Martha Rogers' Theory of the Science of Unitary Human Being and Therapeutic Touch

Martha Rogers (1970) propose that all person are highly complex fields, coextensive with the universe, and that nursing seeks to enhance or strengthen human and environmental rhythmic field patterns toward the direction of improved health.

The Therapeutic Touch (TT) process is a creative use of Rogers' conceptual system. Therapeutic Touch is the transference of the universal life energy from one person to another for healing. It is an alternative, non-invasive method of healing that repatterns or replenishes the human's energy flow. By repatterning the energy flow, TT participates in the reordering and balancing of the human energy field manifest in the immune system. New patterns of health can then emerge. Therapeutic Touch is the use of self. Self is the instrument and , through the hands, assesses and modifies the direction and nature of energy flow.

There are three fundamental principles upon which the TT process is based. These are;
1. wholeness and unity,
2. energy, and
3. intentionality.

Macrae states that all living organisms share the same life energy and the life energy follows our intent (1987, pp.xv, 19). Macrae (1987, p.14) explains that biology posits living organisms are self-organising wholes. These living organisms grow, develop,

maintain, restore, and reproduce themselves through continual exchange of energy with the environment. This shows their ability to restore wholeness (Macrae, 1987, pp.14,16.) According to Macrae (1987, p.14) the ability to heal, or to restore wholeness, is thus an innate capacity or tendency in all living things.

The concept of wholeness in turn implies the qualities of order and integrity (Macrae, 1987, p.14). In disease, there is disorder within the individual and between the individual and the environment. The disorder is a result of the blockage of flowing energy through the individual and between the individual and the environment. The blockage, thereby, creates a disturbance in the pattern of energy flow. Therapeutic Touch helps to reorder (and integrate) the individual's pattern of energy flow and move the person towards wholeness (Macrae, 1987, pp. 15-16).

Rogers conceptual system is the science of unitary human beings. It informs the theoretical bases of TT. This conceptual system flows from a new negentropic world view of open systems (as opposed to the Old World view of Newtonian Physics). From this world view, Rogers has derived the following five postulates.

1. The human is a unified whole possessing his/her own integrity and manifesting characteristics that are more than and different from the sum of parts.
2. The human and environment are continuously exchanging matter and energy with one another.
3. The life processes evolves irreversibly and unidirectionally along the space-time continuum.
4. Pattern and organisation identify the human and reflect his/her wholeness.
5. The human characterised by the capacity for abstraction and imagery, language and thought, sensation and emotion. (Rogers, 1970, pp. 47, 54, 59, 65 and 73).

Rogers (1990, p.7) defines unitary human being as an irreducible, invisible, multi-dimentional energy field identified by pattern and manifesting characteristics that are specific to the whole and which cannot be predicted from knowledge of the parts. Rogers replaced four dimensional and multi-dimensional with there term pandimensional in 1990. Rogers defines environment as an irreducible, indivisible, pandimensional energy field identified by the pattern and integral with the human field (1990, p.7). Rogers clearly states that the human is an energy field. The energy field is the fundamental unit of the living and non-living (p.7). It is in continuous motion and manifests itself in pattern. All reality is postulated to be pandimensional. It is a way of perceiving reality (Rogers, 1990, p.7). The human can perceive the energy field through the manifestation of its pattern.

Rogers (1970, p.96) states that the life process is homeodynamics rather than homeostatic. The Principles of Homeodynamics are:

Principle of Resonancy: Continuous change from lower to higher frequency wave patterns in human and environmental fields.

Principle of Helicy: Continuous innovative, unpredictable increasing diversity of human and environmental field patterns.

Principle of Integrality: Continuous mutual human field and environmental field process (Rogers, 1990, p.8).

Several research studies has been done focusing on the Principles of Homeodynamics. These studies support that the human is pandimensional in awareness and being in which manifestations of reality are not limited to perception through five senses (Malinski, 1989). Rogers' postulates that the Principles of Homeodynamics comprise the abstract system upon which TT is practiced.

This is the conceptual framework behind TT. How the improved function and healing actually "scientifically" happens within the human organism is still not clearly understood. However, it took many

years before the germ theory was proven. Many people died painfully and needlessly because the mainstream, highly respected scientific and medical community adamantly refused to wash their hands. Eventually, research caught up with the concept. In the case of bioenergy field healing, innovative and creative research will eventually catch up to this concept as well.

Traditionally, nursing has adhered to the mechanistic, allopathic model. A move toward holism in nursing practice would balance science and technology with the human side of care. Therapeutic Touch is a holistic healing modality which may strengthen the human rhythmic pattern. It is used by nurses as a complimentary, health-oriented, inexpensive intervention which potentiates the natural or self-healing process.

The phases of Therapeutic Touch

After observing the work of Estebany, Krieger (1975) with Dora Kunz, a well known clairvoyant and observer of paranormal healing (Weber, 1984) developed the specific process of therapeutic touch. They conceived four phases of Therapeutic Touch (Krieger, 1979) are:

• In the first phase of therapeutic touch, the person in the role of healer 'centers' himself/herself. The consciousness of the person intervening with Therapeutic Touch is 'meditative'. In this centred state the healer becomes aware of self as an open system of energies and concentrates upon an inner center of stability. In the centred state the practitioner makes the intention to help the subject (Krieger, 1979). Centering oneself physically, psychologically and spiritually in a state of inner peace and wholeness.

Intention connotes a clear formulation of a goal. It suggests that the TT (Therapeutic Touch) practitioner should have a lucid concept of how to help heal as well as the mere desire to do so. The practitioner's motivation provides the psychodynamic thrust toward the direction that this healing/helping act will take and, therefore, it colours the emotional tone of the dyadic relationship between healer and healee. Finally, it is important for the practitioner to understand his/her own drives in wanting to play the role of the healer. It does not matter what these drives are; what is important is that the practitioner willingly recognises the personal foundation for his/her involvement in this highly personalised interaction (Krieger, 1979, p.5).

• The second phase is assessment of energy field for symmetry. The practitioner passes both hands over the subject from head to toe just above the level of the skin. An assessment of the recipient's energy field for areas of imbalance is accomplished by sensing areas of heat, cold, pressure, emptiness, tingling, or electric shocks (Krieger, 1979). The healer assesses the energy field of the client for any cues to variations in pattern or symmetry of energy flow.

• Phase three involves unruffling the field. The purpose of this phase is to relieve areas of accumulated tension or static congestion in the energy field. Passing the hands over this area of pressure or congestion is believed to change the ionic structure of the energy field in such a way as to free the bound energy for a short time in order for the subsequent transfer of energy of the fourth phase to take place (Krieger, 1973). The healer directs or mobilises areas in the client's energy field that he or she may perceives as being obstructed, sluggish, congested or static. This is a conscious direction by the healer of his/her excess body energies to assist the client to repattern his/her own energies (Dossey, Keegan, Guzzetta and Kilmeier, 1988).

• In phase four, the healer serves as a channel of energy for the subject. Concept of blue or coolness may be sent to areas of heat or inflammation; concepts of yellow or warmth to areas of cold or emptiness (Krieger, 1979). This phase may involve physical contact, but according to Quinn (1984), it is not a necessary component. The process is ended when the practitioner can no longer perceive cues to energy disturbances. This indicates a rebalancing of the energy flow (Krieger, 1979).

Benefits of Therapeutic Touch based from research of TT researchers and practitioners

A review of the literature revealed varieties of research conducted in the area of **relaxation response** (Krieger, Peper and Ancoli, 1979), **pain relief** (Wright, 1987; Keller and Bzdek, 1986), **promotion of wound healing** (Wirth, 1990) **anxiety reduction** (Heidt, 1981; Quinn, 1984, and most recently, it has been used in mental health nursing (Hill and Oliver, 1993)

Therapeutic benefits of TT for the client and the practitioner, as well as the impact of TT on health, are primary reported in the conceptual (non-research-based) literature.

A consistently reported effect within the client is one of **profound relaxation** (Borelli, 1981; Fanslow, 1983; Leduc, 1987; Meehan, 1990; Newshan, 1989; Thayer, 1990; Turton, 1986; Wirth and Cram, 1993). The relaxation response associated with TT, characterised by warmth and flushing in the extremities, an audible sign of relaxation or verbalisation of relaxation, a decrease in the client's voice by several decibels, and slower, deeper respirations, occurs in 90% of the clients (Heidt, 1981b). Additional client responses include **decrease or elimination of pain** (Heidt, 1981b), feeling more relaxed, calmer, and peaceful (Turton, 1986), and Decrease in anxiety (Gagne and Toye, 1994; Heidt, 1981a, 1991; Newshan, 1989; Quinn, 1984; Thayer,1990).

The practitioner also benefits from the practice of TT. Heidt (1981b) reported that the practitioner may note changes in emotion, cognition, memory, sense of time, sense of personal identity, sense of internal and external environment. The practitioner becomes more **sensitive to the environment** (Macrae, 1987; Meehan, 1990; has **improved health** (Macrae, 1987), and can **avoid professional burnout** (Jurgens et al, 1987; Meehan, 1990). Croll-Young (1985) the practitioner **develops altruistic feelings and compassion for others, is more accepting of people and their choices, and experiences a spiritual quality in life.**

The literature included numerous accounts of health benefits related to TT. TT may **accelerate wound healing** (Heidt, 1981b; Wirth, Johnson, Horvath and MacGregor, 1992), and **helps relieve nausea, dyspnea (breathing difficulties), tachycardia (increased heart rate), pallor (paleness) associated with psychosomatic illnesses and autonomic nervous system disorders** (Heidt, 1981b), TT is **effective in the treatment of acute pain** (Meehan, 1990, 1993; Newshan, 1989; Payne, 1989; Thayer, 1990), **symptoms control of AIDS** (Newshan, 1989), and the psychosocial-spiritual effects of cerebrovascular accident (Payne, 1989). **TT is helpful in assisting the transformation of the client and the family during the dying process** (Fanslow, 1983; Leduc,1987). TT is associated with **weight gain and neurological development in premature infants** (Fedoruk, 1984; Kreiger, 1979), and **enhanced bonding between parents and infants** (Thayer, 1990). TT is a useful modality for infants with meningitis, meconium aspiration, bronchopulmonary dysplasia (Leduc, 1987), and cystic fibrosis (Thayer,1990).

However, missing from the early publications on TT is definitive scientific evidence that TT has an objective quantifiable impact upon the physiology of the subject (Wirth and Cram, 1993). In

more recent research, Quinn and Strelkaukas (1993) found that TT enhances immunologic function in practitioners and recipients; Wirth and Cram (1993) found that TT significantly altered in selected muscle groups and lowers emotional arousal; and Wirth et al (1992) suggested that TT may accelerate the rate of tissue regeneration (p.59).

Research on Therapeutic Touch and children

The three studies published on Therapeutic Touch in children also focused on the effects of TT.

In 1984, Fedoruk studied the effects of TT on the stress response in premature neonates. On all the infants in the study, Fedoruk studied the effects of TT and mock TT on transcutaneous oxygen blood gas pressure and infant state. She rated infant state on the Assessment of Premature Infant Behaviour Scale and found greater change from a higher arousal state to a more relaxed state with TT.

Fedoruk (1984) studied the use of Non Contact Therapeutic Touch (NCTT) to rescue behavioural stress in 17 premature infants. Behavioural stress was measured by assessing the infant's neurological statues and state of alertness. All infants were treated twice with Non-Contact TT, twice with a mimic TT, and twice with no treatment after vital signs were taken. Analysis of covariance showed that infants showed a greater change from higher to lower relaxation states when treated with Non Contact TT than when given a mock treatment or no treatment (p=.0295). The study supports the use of TT to reduce state-anxiety, but the results cannot be generalised to adult.

In 1990, Kramer examined the effects of TT on the stress response in children 2 weeks to 2 years old. She measured stress reduction by pulse, peripheral skin temperature, and galvanic skin response 3 minutes and 6 minutes after treatment. Similarly to Heidt (1981), Kramer measured the effects of TT and causal touch and found a statistically significant difference in the stress response in the TT group as opposed to causal touch group.

In 1993, France conducted a phenomenological study on children's lived experience of perceiving the human energy field using Therapeutic Touch. Eleven children (3 to 9 years of age) participated in the study. The findings suggest that children can feel the human energy field with purpose or intent to help thus supporting TT as an innate human potential.

Use of qualitative methodology in researching the effects of Therapeutic Touch

Bulbrook (1984), in describing Therapeutic Touch, presented 15 case studies as evidence of the effectiveness of this intervention. These case studies included such areas as stress, anxiety, depression, strained muscles and tendons, diseased organs, and trauma. The case studies presented in this review involve pain relief.

Bulbrook described a patient complaining of severe back pain from a previous injury. While at a workshop, the healee had been on her feet continuously and had aggravated her condition. The healee knew nothing about therapeutic touch, but was agreeable to treatment by this method. After 10 minutes of therapeutic touch, the healee was completely free of back pain.

A case study involving a child injured in a car accident was presented. The child suffered cuts and superficial abrasions over his entire body. Following therapeutic touch, the child immediately relaxed and fell into a deep sleep. Upon reaching home several hours later, the wounds had begun to develop a scab over the wound.

The next case study was a 5- year- old who jammed his finger in a door. His fingernail was badly injured. Therapeutic touch was initiated while holding and rocking the child. He stopped crying almost immediately and in about 10 minutes looked very sleepy. He reported no more pain and the finger healed without losing the nail, there was no bruising and no infection.

Bulbrook (1984) used 'case study method' which described the procedure performed and the patients' perceptions.

Some cautions to remember when practicing Therapeutic Touch

Practitioners need to be cautious and to try to proceed with extra sensitivity and limit treatment to shorter periods are as follows:

- babies
- frail elderly
- pregnant women (particularly last trimester). You need to be an experienced midwife and have a very good knowledge and skill of Therapeutic Touch to treat these type of patients/clients because of the two complex systems you will be dealing with. One of these systems belongs to the mother and the other belongs to the baby.
- head injuries
- debilitated patients
- psychosis
- shock (Sayre-Adams, 1995)

Therapeutic Touch as a nursing intervention has become widely accepted by the nursing community. Its continued development are supported by considerable formal research and clinical studies by Krieger and many other Therapeutic Touch practitioners and researchers.

The Nurse Healers - Professional Associates ensure high standards of practice and teaching, ethical conduct, and sharing of information. It is a non-profit organisation. It has a wide international membership.

As I reflect on my practice of Therapeutic Touch, when I center, I place myself in a state of silence and pray to Jesus - the Divine Healer to grant me and the person receiving TT the grace of peace and healing. My faith encourages me to abandon myself and the healing process in His hands. It is from this faith that the essence of love which is compassion that gives me the courage to be of service to my fellow human being and to trust Him to use me as an instrument of His healing grace. Mother Teresa summed it up beautifully when she said that:

"The fruit of silence is prayer
The fruit of prayer is faith
The fruit of faith is love
The fruit of love is service
The fruit of service is peace (Rai, R and Chawla, N. 1996, p.19)."

Finally, as we begin to practice Therapeutic Touch and have a sense of it as a 'way of life' within our personal and professional life, we find that our own energy field becomes balanced and opened enabling us to have a richer and fuller healing sense of harmony and peace with others, the universe and the Divine.

In closing I would like to share this prayer with you.

Prayers for Healers'
Lord, make me an instrument of your healing grace;
where there is sickness, let me bring warmth of compassionate caring;
where there is injury; aid;
where there is sadness, comfort;
where there is despair, hope;
where there is death,' acceptance and peace.
Grant that I may not; so much seek to be justified, as to console; to be obeyed, as to understand; to be honoured, as to love...
for it is in giving ourselves that we heal,
it is in listening that we comfort,
and in dying that we are born to eternal life.

Modified from: The Prayer of St. Francis, as modified by Charles C. Wise, This prayer appears in the beginning of Elizabeth Kubler-Ross's Death: The Final Stage of Growth (New York: Simon & Schuster, 1986, p.v).

In harmony, I wish you all a wonderful, enriching and peaceful healing experience throughout this conference.

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Perspective

Biblical and Pastoral Journeys with the Sick

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Abstract

The word "pastoral" has been widely used in the Church context since the Second Vatican Council. It has been used for a variety of ministry: of the marriages, the families, the workers, the youth, the divorced and separated, the elderly, etc.

The word Pastoral derives and is connected with the image of the shepherd and his way of knowing by name and being present to the sheep guiding them to the pastures, carrying the wounded on his shoulders, searching for the lost one, forming unity.

Providing pastoral care in the health care world means transiting the attitudes and the ministry of Jesus into the daily relationship and encounters with the sick.

The meanings, contents and methodology of providing pastoral care will be addressed through the analysis of four biblical journeys and by drawing a parallel between the Scriptural accounts and some specific situations of crisis manifested through the presentation of fragments of dialogues. The objective is to a more global concept of healing and caring of the sick.

The topic I have been asked to discuss is an invitation to consider pastoral healthcare not only as something that involves the experts specialised in this field, that is, hospital chaplains or pastoral healthcare personnel, but also as an aspect that nurses and other medical staff can include in their work.

Jesus, who dedicated a third of his life to the sick, made no distinction between physical and spiritual illness in his role as physician of the body and the soul.

The care of the sick is not therefore limited to the bodily sphere, but embraces psychological and spiritual needs.

The term "pastoral," widely used in the Second Vatican Council, is deeply rooted in the teaching of Jesus who in John 10:11,16 identifies himself with the good shepherd, whose example should inspire all those who wish to follow him.

Pastoral care means following the ways of the good shepherd in one's daily work: kindness, "I am the good shepherd;"dedication, "the good shepherd lays down his life for the sheep;" mutual understanding, "I know my sheep and my sheep know me;" care for society's outcasts, "I have other sheep that are not of this sheep pen;" the search for unity, "they will listen to my voice, and there shall be one flock and one shepherd."

The good shepherd also looks after and defends his flock from danger, takes care of the wounded sheep and goes in search of the lost one.

The vast scope of pastoral healthcare extends beyond the hospital to the parish and local health centres; it is aimed at the sick, their families, medical staff and the healthy; it makes use of individual and group testimony, of the work of parish and diocesan co-ordinators, of the role of Catholic associations, and of the mass-media; it includes preventive, therapeutic and rehabilitation treatment.

In this talk, I am going to focus my attention on counselling of the sick in the hospital, in the hope that my thoughts will have meaning and be of practical use in other areas of pastoral healthcare. I shall use three Biblical journeys starting from Jerusalem, to illustrate the protagonists' outer and inner pilgrimage and to indicate paths for pastoral healthcare.

The three journeys to be considered are:

- the journey from Jerusalem to Jericho (Luke 10:30-37), that represents the impact with suffering and the experience of compassion;
- the journey from Jerusalem to Emmaus (Luke 24:13-35), that symbolises loss and the recovery of hope;
- the journey from Jerusalem to Gaza (Acts 8:26-39) that represents the search for meaning and inner healing.

1st Journey: from Jerusalem to Jericho: the path of compassion (Luke 10:30-37)

This parable, the best known in pastoral healthcare, maintains all its immediacy and power to inspire even after 2000 years.

Let us look at the pastoral relationship established by the Good Samaritan and note the 6 indications he left us that can be of practical use in pastoral healthcare:

• **First indication**: *awareness*, **"he saw him"**

"A man was going down from Jerusalem to Jericho, when he fell into the hands of robbers. They stripped him of his clothes, beat him and went away leaving him half-dead. A priest happened to be going down the same road, and when he saw the man, he passed by on the other side. So too, a Levite, when he came to the place and saw him, passed by on the other side. But a Samaritan, as he travelled, came where the man was, and when he saw him he took pity on him."

All three "see" the unfortunate man, but each observes him through different eyes and with a different heart. The priest and the Levite, conditioned by their religious role, by a vertical conception of the relationship with God, by precepts and cultural rules "pass by ," while the Samaritan, who listens to his heart, stops his journey.

All forms of responsibility start from awareness: we become responsible because of what we see and know, not because of what we are unaware of. A sick person is a unique example of suffering for everyone, an open book on the meaning of life before which each of us chooses whether to stop or pass by.

• **Second indication**: *compassion,* **"he took pity on him"**

The Samaritan, touched and moved by what he sees, unites outer awareness with an inner response. Compassion, from the Latin "cum passione" = to suffer with, is not made up of either a feeling of pity or superiority; it means being moved by the suffering of others.

Pastoral care aims at developing inner attitudes of compassion, sensitivity and motivation so that they can inspire appropriate action.

• **Third indication**: *nearness,* **"he went to him"**

It is not enough to feel your heart shudder at disturbing or touching scenes, i.e. inner sensitivity without external action is sterile and cold.

Being near the sick means breaking down geographical or cultural barriers to get close to them. This action is particularly difficult when patients are affected by illnesses such as drug addiction, mental disorders, HIV-positive, AIDS or terminal disease that sometimes cause uneasiness or rejection in healthcare workers.

• **Fourth indication:** *care,* **"he bandaged his wounds, pouring on oil and wine"**

The Samaritan does not arrive at the scene empty-handed, as he is wise and practical enough to carry some resources with him.

Nowadays bandaging wounds mean offering hospitality to those who suffer with gestures of kindness, while pouring on the oil of hope and the wine of consolation symbolises caring for the physical and moral wounds of those in pain.

• **Fifth indication:** *the act of accompanying,* **"Then he put the man on his own donkey, brought him to an inn and took care of him."**

After interrupting his journey to help the unfortunate man, the Samaritan accepts responsibility for accompanying him to an inn where he watches over him all night.

The act of accompanying means travelling the road with someone who feels lonely and disheartened or tempted to give up because he is tired and at the end of his tether. It also means living the following message: "Don't walk in front of me because I can't follow you, don't walk behind me because I can't see you, walk beside me and be my friend."

• **Sixth indication:** *co-operation,* **"The next day he took out two silver coins and gave them to the innkeeper. 'Look after him,' he said, 'and when I return, I will reimburse you for any extra expense you may have".**

The Samaritan personally pays for all expenses incurred but does not wish to do everything alone. He enlists the innkeeper's help too. This is the crux of present-day pastoral healthcare. 2000 years later, this is the aspect of the parable that has been most fully developed. The inn has been replaced by numerous health structures: hospitals, first aid and rehabilitation centres, nursing homes, etc., and the innkeeper has become the surgeon, radiologist, anaesthetist, cardiologist, nurse, technician, nursing auxiliary, each with his own specific task.

Nowadays thousands of different episodes recall the misadventure of the wounded man in the Bible and the good Samaritan's actions find echo in the gestures of those who are close to the sick and suffering. Let us listen to an encounter that illustrates, on the one hand, the feelings and anxieties of an elderly woman hospitalised after a trauma, and on the other, the comfort brought by a voluntary worker who is close to her.

• **Dialogue**

E.: Elsa (voluntary worker)
R.: Rita (patient)

This encounter takes place with a widow, aged about 75, who has been knocked down by a car while crossing the road. I have been told that after knocking her down, the driver panicked and drove off. The old lady has a broken thigh-bone, some bruises on the right of her face and arm and appears to be shocked. The meeting takes place the morning after she was admitted to hospital.

E.1: Good morning, my name's Elsa. I'm a voluntary worker on this ward. I've come to say hello. I hope they'll take good care of you here. What's your name?

R.1: Rita (pausing a moment) I didn't sleep a wink last night. The slightest movement was painful (grimacing)..... every time I called the nurses I had to wait for them to come (closing her eyes). I didn't think this would happen to me! (With a sorrowful expression) I'm fed up with this horrible life!

E.2: You seem very upset and bitter about what has happened to you.

R.2: Yeah. The longer you go on, the harder life gets. My husband died 8 years ago and I was left alone... we couldn't have children and now I only have my cats for company. I'm worried because there's no one at home to look after them. (After a short pause)..... That damned driver! I'll never forgive him! How can you knock down an old woman and leave her on the street like that? People like him ought to be locked up.

E.3: Rita, it's natural to be resentful towards someone who has caused you such pain. When the wound still hurts you can't think about forgiveness...

R.3: Forgiveness.... You must be joking! I'd like to murder people like him. I'll feel the consequences of this accident for the rest of my life, what's left of it (she moves slightly and winces in pain). Oh, my God, my God (sighing), I feel as if there were thorns sticking in my side (then, trying to relax).... My poor cats....!

E.4: I see you're very worried about your cats, isn't there anyone who can look after them while you're here?

R.4: I live in a condominium and I don't see much of the neighbours. Everyone keeps himself to himself..... we just say hello and goodbye. Some of them hinted they don't like my cats. The only person I'm on friendly terms with is another widow on the floor below. We get together for a chat now and then, when she doesn't go to see her children and grandchildren.

E.5: Well, if you think it's all right and you have her phone number, I could try to get in touch with her to tell her what's happened. Perhaps she could see to feeding your cats and perhaps bring you something you need from home....

R.5: Yes, perhaps that's a good idea.... Could you come back later so that I can talk to the doctor first and see how long I'll have to stay here? That way I can decide what to do.

E.6: Yes, okay. The doctors will be coming round soon and they'll tell you about your condition. I'll come back later so you can tell me if you want me to contact your neighbour.

R.6: All right. Thank you, you've been very kind.

E.7: Not at all. See you soon.

• **Brief analysis**

Rita, our unfortunate victim on the road to Jericho, met with violence and abandonment. The dialogue also reveals grief and bitterness for previous losses: the death of her husband, failure to have children, the impersonal atmosphere that surrounds her condominium.

Her only company are the cats that compensate a little for the lack of affection around her. Even after the accident, her thoughts turn to them in case they should be hungry or she should lose their precious company in the future. The only ray of hope comes from the relationship with the widow on the floor below, with which she shares a sense of loss.

The voluntary worker, imitating the Good Samaritan's behaviour, adopts a sensitive approach: she stops and pours the oil of compassion and empathy on the patient's wounds, thereby communicating her closeness.

She does not judge, but rather tunes in to the other woman's feelings, especially those of resentment against someone who, through lack of caution, has complicated her present and future existence. She doesn't blame her for being unable to forgive. She gives her the chance to vent her bitterness and anger knowing that forgiveness, a combination of God's grace and human willingness, needs time to mature.

In the face of Rita's bitterness, the voluntary worker is a human and humanising presence. A presence that forms a link, as the Good Samaritan does with the innkeeper, with other community resources, in this case the neighbour, whom can alleviate Rita's anxiety by taking care of her cats and being part of the chain of solidarity.

On the whole, Rita reacts in a positive way to the voluntary worker's visit marked by simplicity and the willingness to listen.

2nd Journey: from Jerusalem to Emmaus: the path of dismay (Luke 24:13-35)

A second journey the pastoral healthcare worker often finds himself making recalls the meeting between Jesus and his disciples on the road to Emmaus.

It is an encounter that illustrates, on the one hand, the temporary and precarious nature of certainties in life, revealed by the disciples' dismay at the death of Jesus, and, on the other, the importance of discovering that we are not alone in our suffering. There is someone who walks beside us, if we are not too blind or deaf to notice his presence.

Let us take a look at the Bible story and consider its implications for pastoral care:

• **Jesus' initiative**

"As they talked and discussed these things with each other, Jesus himself came up and walked along with them."

Jesus' initiative turns the story of Emmaus into an historical event. If he had chosen not to make the journey with these strangers, nothing would have happened. It was his nearness that enabled them to be cured.

The pastoral healthcare worker also offers his presence to the sick, even when it is not invited, knowing that there are those who do not appreciate it or feel the need for it, others who desire it, and still others who find faith, hope or reconcilement in this fortuitous encounter.

There can be no possibility of a relationship without first offering one's presence and allowing the patient the freedom to choose what kind of attitude to adopt before such presence.

• **Getting to the heart of the question**

"He asked them, 'What are you discussing together as you walk along? ' "

Jesus must have noticed the travellers' troubled and dismayed expressions, for he asked a question to penetrate their thoughts. Questioning is a way of starting a conversation, of stimulating thought, of getting someone to open up and communicate.

Pastoral healthcare workers often begin their visits by asking: "How are you feeling?;" "How are you reacting to treatment?;" "Did you manage to rest a bit during the night ?."

Sometimes, there's the danger of asking too many questions and turning the conversation into a sort of interrogation or of simply appearing to be curious, instead of establishing real contact with the other person.

However, when questions are appropriate and aimed at better understanding the patient's inner world, they offer an opportunity for deeper insight and enable the other to tell his story.

• **Giving words to pain**

"They stood still, their faces downcast. One of them, named Cleopas, asked him, 'Are you only a visitor to Jerusalem and do you not know the things that have happened in these days..?' "

The predominant feeling at this stage of the story is one of sadness. Cleopas explains to the stranger that they are sad because Jesus has met a tragic death on the cross and their expectations have vanished: "We had hoped he was the one who was going to redeem Israel".

Another feeling accompanies the tragic outcome - perplexity at the testimony of "some women who report not finding his body in the tomb and having seen a vision of angels who said he was alive."

This is the longest part of the story. It contains the disciples' grief, the dramatic narration of events, disappointment at unfulfilled expectations and dismay at developments that were difficult to interpret. The unknown pilgrim listens to their outburst without interrupting their tale, thus allowing them to express their grief.

Jesus' behaviour is an example for all that approach the sick. It invites healthcare workers to overcome the temptation to judge what the other one is saying or feeling, to avoid the risk of giving advice, minimising pain or making it seem commonplace, of making patients who complain feel guilty by suggesting there are others who are suffering more than they are, of interrupting every time the other stops for breath or of changing the subject to superficial matters.

The story of each person, full of expectation and disappointment, illusion and disillusionment, has the right to be heard. By listening we are like the ocean that receded to allow the continents to emerge. The listener gives way to the other thereby enabling his story, limits and potentialities to emerge.

• **Honest confrontation**

"He said to them: 'How foolish you are, and how slow of heart to believe all that the prophets have spoken! Did not the Christ have to suffer these things and then enter his glory?' "

After listening carefully, there is an honest confrontation between Jesus and the disciples going to Emmaus because they give only a partial version of the truth. They await the glorious coming of the Messiah but forget that he had to suffer.

Confrontation is aimed at opening minds and hearts to the truth, at widening horizons to welcome God's plan for saving mankind by giving himself in supreme sacrifice.

Without denying that the final goal is glory and resurrection, Jesus reminds us that there is an obligatory transitional phase marked by the cross. The disciples' behaviour is similar to that of many patients who elude themselves that they can live a relatively quiet life without the unpleasant surprise of coming to grips with pain.

The impact with suffering, an unfavourable diagnosis or an imminent death generates incredulity, consternation and a sense of betrayal: "Why me?", "Why doesn't God take it out on drug peddlers and prostitutes, instead of my family?;" "Why does God make innocent people suffer instead of punishing the wicked?"

The pastoral healthcare worker constantly comes up against a barrage of 'whys' that put God up for trial. The complaints of many sick people about being victims of unfair situations stem from the fact that their expectations have been betrayed or denied. Others are upset because God is silent, he does not reply or intervene and his silence arouses dismay and consternation.

God sends us to represent him at the bedside of these wounded and lamenting creatures. He does not ask us to defend him, because he's big enough to defend himself, he does not want us to get involved in complicated theological discussions on suffering, because this would not ease the pain; what he does ask us to do is to be near those who suffer like Mary at the foot of the cross. Mary, in her silence, represented the presence of love.

In every human tragedy, it is not so much a question of the creature interrogating God, as pain

forcing the sufferer to interrogate himself. The painful moments of life reveal one's vision of the world, one's uncertainties and naiveties. In the painful confrontation with life's truths, the pastoral healthcare worker is not there to give answers he does not have, but rather to ease the patient's inner struggle.

The why and wherefore of so many tragedies remains an imponderable mystery. There are no neat, clear maps to help us to understand the meaning of human misfortune. Some of this is due to irresponsible behaviour, some to human imperfection, but much occurs without there being a logical thread that helps to understand or justify it.

Pastoral healthcare workers accompany the sick along their difficult path so that the impact with illness leads to a deeper understanding of reality, renewed faith and a more mature vision of life. He is aware that suffering needs time to turn into growth and hope. Confusion and a sense of dismay are an inevitable phase of the journey towards inner peace.

• Catechesis

"And beginning with Moses and all the Prophets, he explained to them what was said in all the Scriptures concerning himself."

Jesus passes from confrontation to guidance by leading his disciples to revisit the Holy Scriptures so as to have a better understanding of the identity and mission of the Jesus they had put so much faith in.

Their mysterious companion's expert knowledge of the Holy Scriptures helps the travellers to see events in a different light.

Understanding is an essential element in the inward elaboration of incarnate and paschal faith. Catechises is a valuable instrument that pastoral healthcare workers can use to promote the human and spiritual growth of their fellowman.

Sometimes catechises consists in helping a sick person who has had no real religious education to know God and the mysteries of the Christian faith; at other times it means teaching the sick to discover the significance of prayer and the Holy Scriptures; on other occasions it is preparing them to receive the sacraments; in some cases it involves searching together for the meaning of pain or resorting to the virtues of faith and hope. Illness, in itself, offers fertile ground for reflection. An Italian journalist wrote that in a world where we all have hundreds of things to do the only way to reflect and meditate is to get sick. Sick people, confined to their bed, are forced to turn to their inner self. This opportunity for introspection may result in conclusions and intuitions of the following type: "It's the first time I've understood what fear really means". "I don't feel as sure of myself as I did before"; "I've only just realised how many people really love me"; "After years and years I've felt the need to pray and ask God to help me"; "From now on I'm going to change my way of life, I can't behave as I did before, if I want to go on living"; "These days spent in hospital have changed my life, I'm not the same person that came in here ten days ago."

Hospitalisation helps a lot of people to become more human. It questions life styles, helps to distinguish what is ephemeral from what is truly important, creates solidarity between patients, demands greater personal responsibility for illness and health, teaches humility and at the same time, wisdom.

The pastoral healthcare worker witnesses this introspective journey and, through the counselling relationship, helps his patients to see things from a different angle, strengthens their intuitions and encourages them to go ahead with their new resolutions.

• Communion

"As they approached the village to which they were going, Jesus acted as if he were going further. But they urged him strongly, 'Stay with us, for it is nearly evening; the day is almost over'. So he went in to stay with them."

By listening to their story and being able to penetrate their hearts and minds with his teaching, this stranger has encouraged the disciples to trust and like him.

Jesus was no longer a stranger, he was a friend. He reached their heart, broke down their defence and transformed them with his healing presence.

Initially it was Jesus who started the relationship, now it is the disciples on the road to Emmaus who want to deepen it. Their intimacy gradually grows,

passing from a casual encounter to true communion.

Sick patients also often feel the need to have someone near them, especially at night time or when darkness descends on their life, for example when they are awaiting an operation or experiencing moments of loneliness or the pangs of death.

Being with someone often means staying in silence rather than speaking words, offering a sign of affection or a prayer that brings peace. The more difficult the path, the more deeply patients feel the need for communion.

A person in the throes of Good Friday needs someone willing to share his hours of pain rather than someone who will announce the resurrection. Anyone able to accompany him on Good Friday is the symbol of resurrection.

• Revelation

"When he was at table with them, he took bread, gave thanks, broke it and began to give it to them. Then their eyes were opened and they recognised him, and he disappeared from their sight. They asked each other: 'Were not our hearts burning within us while he talked with us on the road and opened the Scripture to us?' "

Jesus brings about a complete transformation in the disciples by breaking the bread. Symbolic language is stronger than verbal language.

The Eucharistic gesture of breaking the bread and giving thanks reminds them of another supper and reveals the guest's true identity. Now all the pieces fit together: grief for the death of Jesus becomes jubilation at his resurrection, sadness turns to joy. The physical presence of the resurrected Christ is no longer needed because the disciples' eyes have been opened and their hearts converted.

At every encounter the pastoral healthcare worker enters the holy sphere of revelation. The sick reveal themselves through the symbols that surround them: the objects on their bedside cabinet reflect their values and feelings. A newspaper or a book tells of their cultural interests, a bunch of flowers or a photograph speaks of their family affections, a prayer book or a rosary indicate their religious sentiments. The sick also reveal themselves in their words: the messages they transmit, the feelings they show, the hopes they harbour all tell us how they are experiencing this crisis. Pastoral healthcare workers can use these "indicators" to reach their patients' hearts and understand their make-up.

• Bearing witness

"They got up and returned at once to Jerusalem. There they found the Eleven and those with them assembled together ... Then the two told what had happened on the way, and how Jesus was recognised by them when he broke the bread."

Peter tells us that we must always give the reason for the hope that we have (1 Peter 3,15). The disciples from Emmaus give their reason for hope by bearing witness to their encounter with the resurrected Christ.

The two travellers afflicted and then healed, become bearers of hope and announce the resurrection. The sick who find physical, psychological or spiritual healing are also called to bear witness to their renewed hope as their suffering make them credible evangelisers. They, who have seen God's light, can turn their wounds into compassion and use their wisdom to serve the healthy.

Every day we witness the same miracle when pain is turned to love. Instead of closing in on themselves, patients who have had a heart attack, drug addicts, cancer sufferers, people undergoing dialysis, widowers and so on, offer others help through mutual support groups and by undertaking initiatives designed to convey hope.

Pastoral healthcare workers witness this miraculous transformation and try, where possible, to assist the sick in conveying their message to the healthy for the betterment of society.

3rd journey: from Jerusalem to Gaza: the search for truth (Acts 8:26-39).

The Acts of the Apostles describes a third journey that pastoral healthcare workers find themselves making.

On this road we meet the two key figures in the story: Philip who might symbolise any one of us,

and the Ethiopian who represents everyone in search of God and the truth.

Philip embodies the missionary force within the Church that is not confined to Jerusalem but is propelled by the Holy Spirit to spread the gospel throughout the world.

The Ethiopian recalls the multicultural, multiethnic world we live and work in, where numerous religions live side by side.

Let us examine this passage and pinpoint useful insight for the pastoral care of the sick.

• Setting out

"Now an angel of the Lord said to Philip, 'Go south to the road - the desert road - that goes down from Jerusalem to Gaza'. So he started out."

One of the most evocative images used by the Second Vatican Council to define the Church is that of "people on the move"; every day each of us goes down a different road, most probably guided by an angel of the Lord.

The road the angel tells Philip to take is a desert road: perhaps 'desert' means that few travellers journey along it, or that the sun blazes down on it or that it is fraught with danger.

For us that desert road could mean a hospital, a symbol of human suffering.

In the same hospital room we can find a teacher and a person of no fixed address, a young man and an elderly one, a believer and an atheist, a woman who has suffered a miscarriage and one who wants an abortion, a person who lives in the past and one who plans for the future; a person who conveys hope and one who spreads despair; a person who is totally dependent on others and one who is too shy to ask for anything; a person who is surrounded by affection and one immersed in solitude.

A hospital is a complex kaleidoscope of humanity as well as an ambiguous symbol of man's strength and weakness. All those who work there are faced with the challenge of transforming this citadel of suffering into a citadel of love and compassion.

• The search for hidden treasure

"And on his way he met an Ethiopian eunuch, an important official in charge of all the treasury of Caudace, queen of the Ethiopians. This man had gone to Jerusalem to worship, and on his way home was sitting in his chariot reading the book of Isaiah the prophet."

Here we meet the second character in the story, the Ethiopian, who had been to Jerusalem to worship and on his homeward journey was trying to understand a passage of the prophet Isaiah.

Let us try to relate this information to a modern context. The fact that it refers to an Ethiopian suggests that we should be tolerant and hospitable towards people of different cultures and customs, and not show prejudice.

Peter said to the first Christian community, "I now realise how true it is that God does not show favouritism but accepts men from every nation who fear him and do what is right" (Acts 10:34-35).

The Acts present the Ethiopian as an eunuch, an important court official, in charge of the treasury.

These details underline the fact that when a person is admitted to hospital, he brings with him his past, his uniqueness, his personal, professional and family roles.

In caring there is a risk of focusing attention on the problem and forgetting about the person: a mother becomes number 27; an employee an unusual cancer case; a young undergraduate a case of paranoia.

The eunuch represents those particular and individual characteristics present in all of us. In those times, becoming a eunuch meant being able to serve the king more freely. Today this condition may remind us of the different sexual tendencies present in our society.

No one is so poor that he has no dignity to defend. We do not have to be "important court officials" to merit care and attention. Whatever one's own impressions and judgements might be, everyone has some kind of hidden treasure, however big or small.

Each of us harbours not only a sick, fragile and insecure self, but also a physician with resources and values.
In some of us these qualities are of a more physical nature, giving us the ability to act and react, helping us to face up bravely to arduous treatment or to look after ourselves and our body. In others, the treasures to be counted on are of a more mental nature and find expression in a positive outlook, in the trust placed in medical staff, in the variety of cultural interests that help to pass the time, and in the desire to gain new knowledge.

Others rely on psychological resources such as character, a positive self-image, the ability to exert a creative control over their states of mind, openness with others and a balanced vision of reality. Finally there are those who possess spiritual resources such as a sound relationship with God, a positive integration of their past, an ethical code based on evangelical principles and the experience of community life.

Listening to the sick enables pastoral healthcare workers to discover and bring to light the variety of resources that can help to heal and restore hope.

• Spreading the word

"The Spirit told Philip, 'Go to that chariot and stay near it.' Then Philip ran up to the chariot and heard the man reading Isaiah the prophet. 'Do you understand what you are reading?' Philip asked. 'How can I,' he said, 'Unless someone explains it to me?' So he invited Philip to come up and sit with him. The eunuch was reading this passage of Scripture:

He was led like a sheep to the slaughter and as a lamb before the shearer is silent, so he did not open his mouth……

The eunuch asked Philip, 'Tell me, please, who is the prophet talking about, himself or someone else?' Then Philip began with that very passage of Scripture and told him the good news about Jesus."

This is the central part of the story: the Ethiopian, busy reading and meditating, is like the sick man who lives his hospital experience as a kind of retreat, a chance to reflect and look inside himself.

Philip, endowed with the Holy Spirit, is the pastoral element. He approaches the Ethiopian, sees what he is doing and engages him in a conversation that helps him understand the meaning that had previously escaped him.

Taking Philip as our example, we can trace four lines of conduct that sum up pastoral care of the sick:

1. Being a companion on the journey

Above the entrance to one of the oldest hospitals in Rome, is written the following message:

"Come to be cured,
If not cured, cared for,
If not cared for, comforted"

Curing, caring for, comforting are three key verbs in the vocabulary of compassion.

Pastoral healthcare workers are particularly concerned with consoling. Their task is not so much to resolve problems as to become friends along the way. Their supportive presence cannot eliminate suffering but it helps to soothe the pain and ease the sense of loneliness.

2. Cultivating the art of non-verbal Communication

Philip sees that the Ethiopian is busy reading and goes up to him. Communication is based largely on observation. To communicate effectively we must be aware that our face is composed of two eyes, two ears and just one mouth, so we should follow this anatomical pattern and devote double our time to observing and listening and only half our time to speaking.

Unfortunately, when communicating with the sick, we often invert this anatomical pattern and behave as if we had only one eye, half an ear and two mouths because we are too intent on speaking and giving advice instead of observing and listening carefully.

By asking Philip to sit near him, the Ethiopian invites us to find time to establish a trusting relationship with people. Nowadays time is one of the most precious, yet elusive, commodities.

Timetables and practical commitments undoubtedly impose limits and restrictions. There is no time to linger because there are too many

sick people to visit or too many things to be done. However, the important thing in a relationship is quality not quantity. Sometimes ten minutes can be too long, whereas a minute well spent can leave precious memories. Today more than ever before, finding time means giving health.

In his book "Life is wonderful in any case", Buttafava asks himself what value can guarantee a lasting love between a man and a woman: "Beauty perhaps?" This is important at the beginning but, with the passing of time, it loses its prominence unless it is sustained by more important factors. "Perhaps, it's wealth?". This counts a lot today because it can satisfy material needs, but it is no guarantee of a lasting relationship. "Perhaps, it's a person's character or nice personality?" Personality is definitely a dynamic element that keeps the relationship alive, but this alone cannot assure a lasting love. The value that truly consolidates the bond between a man and a woman is devoting time to one's partner, because love is like a flower, if it is not tended, it fades and dies.

3. Providing lights for those who search

When the Ethiopian says "Tell me, please, who is the prophet talking about?" Philip explains this Bible passage and teaches him about Jesus.

In the same way, the pastoral healthcare worker can become a spiritual guide for those in search of answers. By doing this, he interprets the role of a catechesist as Jesus did on the road to Emmaus. Knowledge and meditation on the Holy Scriptures will help the pastoral healthcare worker to better meet the requirements of modern man, as will reading books and attending refresher courses, since these make him a more attentive, incarnate and wiser minister.

The continual challenge is to perceive Christ in the sick and to be Christ for the patient. Pastoral healthcare commences by recognising the Saviour in the sick man's features: "I was sick and you looked after me" (Matthew 25, 36) and is accomplished by following his example: "I have set you an example that you should do as I have done for you" (John 13, 15).

- **The sacramental aspect**

"As they travelled along the road, they came to some water and the eunuch said, 'Look, here is water. Why shouldn't I be baptised?' And he gave orders to stop the chariot. Then both Philip and the eunuch went down into the water and Philip baptised him. When they came up out of the water, the Spirit of the Lord suddenly took Philip away, and the eunuch did not see him again, but went on his way rejoicing."

The meeting between the Ethiopian and Philip culminates in the celebration of a sacrament: the Ethiopian's baptism.

The previous phases of their pastoral relationship prepared the way for conversion through baptism, a sacrament by which Christians are born again to a new life in Christ.

The Ethiopian's joy as he continues his journey, is a manifest sign of the grace he has received. He no longer needs Philip because the grace of God will guide him in future.

This episode highlights the meaning of the sacraments in the ministry of the sick. Some sacraments are particularly suited to times of illness: Holy Communion, Reconciliation, and the Anointing of the sick.

Holy Communion binds more closely to Christ who said: "Come to me, all you who are weary and burdened, and I will give you rest" (Matthew 11, 28).

Reconciliation, which opens the heart to forgiveness and divine mercy, brings the gift of peace.

Anointing is the sacrament of healing understood in a global sense, not simply confined to the body.

Pastoral care must give due consideration to the importance of the sacraments since it is through these that Christ's salvation takes place in the believers.

In the past, pastoral healthcare workers risked over emphasising the sacramental aspect to the detriment of a truly supportive relationship and a constructive process of evangelisation among the sick. On the contrary, today the danger is that of giving too much importance to the human aspect and not enough attention to proclaiming the Word and celebrating the sacraments as moments of intense union with Christ and the Church.

Conclusion

I have tried to outline the contents of three Biblical journeys in order to provide insights for pastoral care of the sick. We are all pilgrims travelling through life and the routes taken by the unfortunate man on the road to Jericho, the disciples travelling to Emmaus or the Ethiopian could become our own road.

Introspective analysis of their experiences may help us to live our future in a better way. The journeys from Jerusalem to Jericho, Emmaus and Gaza still preserve their validity in modern times. Characters and geographical places may change, but doubts, feelings, needs and hopes remain the same for pilgrims of today and yester year.

The three routes outlined sum up important truths about life that can be condensed into three key principles:

1. There is no growth without suffering

Suffering is an unpleasant but essential part of life. Our growth depends more on the constructive elaboration of pain rather than on the accumulation of happiness.

For example, the Good Samaritan was able to turn his wound of being considered inferior by the Jews, into compassion towards one of their kind in difficulty. Pain can become fertile and enrich people or it may cause them to close in on themselves and become alienated. Reactions depend on how each person lives this experience.

2. There is no suffering without hope

Hope enables us to face adversity and discover new horizons even when some doors close. The story of Emmaus tells of the hope Jesus puts in the heart of his dejected disciples. They then begin to announce his resurrection

3. There can be no hope unless we open up

Hope needs space in which to grow. Opening up means communicating, revealing ourselves, being open to the mystery of God and life, exposing our wounds to the healing light of day, not wrapping ourselves up in our own suffering. The Ethiopian opened up to Philip and asked for help in understanding the truth he was avidly seeking.

In conclusion, an analysis of the three Biblical stories shows us how careful contemplation and integration of the past can provide light and wisdom to guide our journey into the future.

Perspective

"Caring in Nursing" In Educational and Clinical Setting, and Family and Community Setting. The South African Perspective

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Introduction

Caring is a characteristic, basic and inborn, in all creatures (animals and human beings) on earth as created by God. Caring in nursing as associated with human beings, is part of a process that was commenced at grass-root level by individual families from time immemorial. Caring in nursing is not only thought of in the context of the two settings, but also the Divine savior, God, who blessed the participants with life and procreation. The initial stage in which caring in nursing occurs should be contemplated from the very beginning of communication of the least of human beings, the "child". What was practiced on the child in the form of "nurturing and upbringing" is indicated later in the child's play and games, which is an informal caring and nursing.

Caring in Nursing in Educational and Clinical Setting

The Genesis of Educational and Clinical Setting:

In educational setting, caring in nursing is commenced in schools where children of South Africa are nurtured and guided according to their interests and demands for resources of the country through career guidance centres, during their years of final grades. The nursing institutions also do make an attempt to visit schools or invite the students to their open days to market their institutions, thereby influencing the mindset of students towards a career in nursing.

It is at this stage that caring in nursing appears to surface in the minds of the society. The fact that caring in nursing is associated with educational and clinical setting is a reality that its inception was nurtured in the family; and the community setting is indicated in home based care, family participation and community health workers.

For the Church to minister meaningfully, it must read the "signs of the time" correctly. Significant social developments and events provide the material with which to understand what God is saying to His people. From the ashes of the late seventies the country witnessed interesting developments. One of them was the re-emergence of powerful forces which sought to unite all communities in South Africa. It was not easy due to the vast diversity in communities (The Bishop Speaks, 1995 p. I).

Political Origin of Caring:

Caring in nursing in South Africa is politically influenced. There is a paradigm shift from curative to preventive, promotive and rehabilitative care in the form of the primary health care (PHC) approach. This approach was introduced by WHO at the international conference on PHC held at Alma Ata in 1978. It is practised by developed as well as developing countries world wide. The new South African government pledged itself to the country to promote the Alma Ata declaration of PHC

approach. The national health plan was supported in its formulation by WHO, UNICEF and the African National Congress (ANC) health committee. From this document emerged the white paper on transformation of the national health system.

The white paper on transformation of the health system in S.A. was published by the Ministry of Health. The object of the white paper is to present to the people of S.A. a set of policy objectives and principles upon which the unified National Health System of the country will be based. In addition to the objectives, the document presents various implementation strategies designed to meet the basic needs of all the people of S.A. with the limited resources available. (Govt. gazette '97/4'). The white paper applies the principles of PHC and these principles cover caring in nursing in all settings in totality.

The Spiritual Influence of Caring in South Africa:

The spirituality of catholic nursing in S.A. is "see Christ in every person". With this spirituality in mind, our catholicity guides and unites us, giving rise to communities that illustrate God's unifying power. The slogan becomes a moral guidance in any setting where interaction with the well and sick experienced. The mindset of nurses in adoring Jesus Christ becomes the emotional, spiritual tool for delivering verbal and practical care to whoever the recipients are in all settings.

It should be noted that the catholic nurses guild does not operate in isolation, except when it comes to religious deliberations, where they participate in exclusivity of other non-Catholic groups. From the highest echelons of the political government structures, the catholic nurses guild has representation. The Minister of Health is a catholic doctor. Other members country wide are involved in different structures of nursing care. Although participating with and under the authority of the non-Catholics they still uphold their faith.

The Formal Architect of Educational and Clinical Setting of Caring in Nursing:

The government gazette through the white paper for transformation of health services in S.A. provides a policy guide for both the educational and clinical settings of health care. Academic health service complexes are essential national resources. They play an important role in educating and training health care workers, caring for the ill, creating new knowledge, developing and assessing new technologies and protocols, evaluating new drugs and drug usage; and assisting in the monitoring and improvement of the quality of health care.

In nursing education, the goal is to train nurses to be professionals who are competent and can treat patients in totality. The nurses therefore need knowledge and skills to interact with patients, to identify the signs and symptoms and data about the patient and his environment. These cues help the nurse to generate tentative hypotheses and arrive at an appropriate course of action.

A key component of nursing practise is the nurse's ability to process information and make decisions. One of the goals of educational programmer for nurses is to enhance students' cognitive abilities and clinical decision making abilities. Cognitive skills development is a significant goal of clinical practice and must be of major concern to the teacher in the clinical setting. It is separate from, but interrelated to affective psychomotor domains of learning. Cognitive skills essential for nursing practice encompass concept learning, problem solving, critical thinking and clinical judgement. There are different levels of training for different categories of nurses, viz.:

- Bridging course in nursing - which aims to close down the former enrolled nurse category of two years training,
- The comprehensive four years training at nursing colleges, and
- Degree courses in B.A. in nursing for four years at universities.

These programmes lead to registration for the nurses who are different, but are all expected to have broad knowledge base and to master intervention skills which will enable nurses to deliver high quality care in practice.

The primary health care approach is also applied in educational as well as clinical setting. The principle of equity is here applied as equal distribution of education, students and tutors as resources in all nursing colleges in the public sector. In the private sector, individual colleges' choices is exercised. This scenario is non applicable in Catholic hospitals colleges as they have been unfortunately taken over by the government. Training is also conducted by the N.G.O.s in the field of AIDS counselling; youth counselling and guidance; marriage and family counselling; and community enrichment programmes.

Care in nursing in education and clinical setting enjoys the support of the government financially in management capacity building of PHC managers. The objective of this effort is that the govt. aims to build a vehicle with which to drive its vision of moving towards the PHC approach and a goal of health for all by the year 2005. It is assisted by the international donors to entrench the PHC approach in S.A..

Caring in Nursing in Family and Community Setting:

In a country as large as S.A. there are a number of geographical regions and boundaries. These regions determine the ethnic groupings and cultural affiliations of the people in these regions. The apartheid govt. was very instrumental in creating discriminating boundaries for the black communities, while the white communities enjoyed free movement and settlement of their choice, e.g. the Zulus were confined to what is known today as KwaZulu-Natal. These discriminatory boundaries gave rise to rigid vertical cultural ethnicities, uncontrollably diverse. Hence, today although we are South Africans our cultures are completely different. Different cultures also known as tribes have their own languages, set of norms and behaviours that subscribe to their own standards for health practice and general behaviour.

Caring in nursing for family and community takes in to cognisance that particular communities' cultural norms and values in order to make a measurable impact in the health of the original family setting, i.e. father, mother and children has become destabilised over the years for various reasons, e.g. western influence. The S.A. legacy of the past with the result that a single parent family which was unacceptable in the past has become a normal and accepted behaviour in the society. Strong religious groups are fighting a never ending battle among its membership on this issue. In most South African families, the mothers for the health behaviour.

Unfortunately, illiteracy is still very high in the black nation but, the health centres and other community workers educate the mothers during the periods of confinement. This influence arises from the family members, community workers, women's groups and the community clinic. It is during these periods that the nurses and the community health workers make an often long lasting impression upon the mother and the health of her family. Endorsement of this ideology is the slogan "You teach a woman you empower the nation!" It is a supple effect staring from women outward to family, community, district, province and the whole nation at large.

Disparity in Health Provision:

As mentioned in the previous passages health provision has never been evenly distributed, e.g. in the urban areas even though there is still the same disparity that due to various reasons such the vastness of rural areas, thus making them in accessible since facilities are lacking. Incentives to attract health workers are also lacking. In spite of the lack of funds to support the provision of health in the rural area, the church for many years made a big contribution by establishing clinics and hospitals in the rural areas. Unfortunately, because of vastness of the areas, some communities have never been reached.

Non-Governmental Organisations:

NGOs have for many decades pioneered the health services offering health, preventive and community programmes. They have been very active in the governments' transition period. They are in the fore front of concern and empowerment of the community to manage the AIDS pandemics.

Catholic Nurses Guild:

Membership is very limited, but this organisation has also made measurable contribution to in the caring in nursing. They are actively involved in the church throughout the country in observing and organising "the day of the sick", financial contributions and participating of the church, ownership of managing preparations of one Sunday per month, etc. As mentioned before they are directly involved in caring in nursing in different employment fields.

Conclusion:

Health care in S.A. is currently undergoing transformation. It is difficult to identify exactly which stage the country is at now but, progress is quite measurable. Change is very difficult and causes enmity among the participants yet the element of caring can not be rubbed off by the transition. The rainbow nation is rich in diversity, culturally, racially, educationally, economically and in health status. The government has identified health as right. With the support and guidance of the Alma Ata declaration of Primary Health Care approach and the financial help from the international donor funding towards health care projects, South Africans plan to propagate the improvement of health of all its nation in all settings.

Perspective

Nursing and the Changes in the Structure of Japanese Society

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Abstract
After fifty years of steady economic and technological advancement, Japan has now arrived at a time for reflection on past achievements and re-evaluation for future needs of society. The most pressing problem is dealing with demographic changes in which the population over 65 million is rapidly increasing, while the birth rate is declining. This means that in the future, fewer and fewer young people will have to support more and more older people. It is projected that by the year 2020, one in every four persons in Japan will be over 65.

Thus the most serious problem facing Japan today is providing for a secure social life for future generations. Since Japanese have in modern times depended on the hospital for their medical needs from cradle to grave, so to speak, the official medical system is now at the limits of its capacity to respond to current needs. Because of the high expense and difficulty of securing qualified health care professionals, reforms in the basic structures of medicine and nursing are at a critical stage.

Some efforts have been made to establish facilities to care for the needs of the infirm aged in non-hospital institutions, through visiting nurses programs, and in expanded home care programs. However, much remains to be done. At the same time, dramatic advances in medical technology have resulted in an alarming dehumanization and depersonalization of medical care and nursing in institutions.

The basic problem is caring for the basic human needs of the individual patient. The current trend toward over-dependence on technological and impersonal medical treatment must be challenged. It is precisely here where the Christian ideal of the intrinsic value of each individual person can and must be witnessed to in a society that is materially and technologically advanced, yet spiritually and morally weak.

Nursing and the Changes in the Structure of Japanese Society

Social Change

As the dawn of the twenty-first century approaches, Japan is undergoing a time of great social change. In the past half-century, Japanese society as a whole has been striving toward material and economic wealth. But in many different areas, people have come up against obstacles, limits have been reached, and contradictions have become apparent. People are now beginning to reflect on the past and to search for a new way. This is apparent not only in the structural reforms of politics and economics. In the areas of medical care and nursing, a reform movement is also underway, as those responsible for institutions, administration and education attempt to meet the needs of a new, changing society.

Demographic Change

There have also been noticeable changes in the population structure of Japan. The population is rapidly becoming older, and fewer children are being born. Because of changing attitudes toward marriage and the family and because of women's advances in society, the birth rate has declined from 3.65 in 1950 to 1.50 in

1994. On the other hand, due to the improvement in the standard of living, and advances in health and medical treatment, the average life span has increased from 50.06 years for men and 53.96 years for women in 1947, to 76.57 years for men and 82.98 years for women in 1994. As a result, the percentage of people over the age of 65, which was 14.5 per cent in 1995, is projected to be the highest in the world at 17.0 per cent in the year 2000. This is expected to climb to 25.5 percent in 2020, when one in every four persons will be over 65.

The Problem of Social Security

The most serious problem facing Japan today is providing for a secure social life at a time when the financial burden has become heavier due to the expansion of the nuclear family, the weakening of the traditional family, the decline in the number of younger workers, and the increase in the number of retired persons. In other words, the traditional mutual dependence of family members has weakened and the dependence on society has grown, and this makes it difficult for society to provide the necessary financial resources and personnel for a secure life. There has been much focus recently on the problem of securing adequate funds for medical insurance and old-age pensions. A comprehensive plan must be established to prevent the financial burden from growing so large that it cannot be sustained by the younger generation in the future.

The Problem of Medical Facilities

There is already a high proportion of older persons in medical facilities in Japan. This has made the management of these facilities difficult. Expenses for high quality medical care and the financing of medical facilities have become pressing problems and public demand for more human medical care and nursing is growing stronger. Reforms must be made in the basic structures of medicine and nursing.

One example is the establishment nation-wide of health facilities for the aged. These facilities are intended to help in the rehabilitation of the infirm aged who have completed hospital treatment but are not well enough yet to be cared for at home. Similarly, various facilities to help the aged are being built, but there is still a long way to go before they are adequate in number.

Visiting Nurses' Stations

Under these conditions the need has arisen for medical treatment, nursing, and care outside of the hospital. As indicated by the widespread notion of cradle-to-grave medical care in the hospital, people in Japan have become accustomed to depend entirely on the hospital system for medical care. But this system has put an excessive burden on medicine and nursing. Efforts are now being made to develop new forms of medical treatment and nursing to support the patient and family. Reforms are also being made in the medical system to more adequately meet the needs of present-day society. For example, birthing at home, treatment at home, and terminal care at home are becoming more and more widespread. Efforts have been made especially in the area of home treatment. National and local authorities as well as the private sector are cooperating to establish a nation-wide network of visiting nurses' stations. The Japan Nursing Association has also responded to this pressing need and is cooperating in these efforts.

A Medical and Social System Worthy of Human Beings

In this time of change, I believe we must re-think the meaning of human life and happiness, to expand the horizons of our thinking on health and healing, and to reconsider in a comprehensive way the importance of human personality. In other

words, because of an over-dependence on medical technology, the modern hospital system has reached its limits and we must now deal with an attitude in medicine and nursing that has forgotten the human element. We must combine our knowledge and efforts to strengthen and humanize the practice of medicine and nursing to make it more worthy of human life and the dignity of the human personality, and make it more human in its approach to the beginning of human life, its growth and its end. But this requires not only efforts on the individual level, but demands reforms in the entire system of medicine and nursing and in society in general. I believe that true love and healing, that is, and practice of medicine and nursing, that true cares for the human person, is possible only when the efforts of the hospital staff to resist the dehumanizing attitude of medicine and nursing are supported by similar efforts in present-day society and especially in the family.

Medicine and Nursing and the Worth of the Individual

The establishment of a system of medical care and nursing that truly values each individual is not a problem only for our own citizens. With the advance of international exchanges, the medical care of foreigners has also become a serious problems. When people studying, working, and living abroad become ill, they face the problem of getting medical treatment ad finding the money to pay for it. The problem is compounded by not being able to communicate because of a difference in language and culture, and not being eligible for medical insurance because of foreign citizenship.

Countries that admit foreign nationals must also help protect their health and guarantee their access to medical treatment in the same way as their own citizens. Similarly, medical professionals and nurses should internationalize the system through agreements with other countries, so that people entitled to medical care and nursing in their home countries should be able to receive the same care in a foreign country.

The Japan Catholic Nursing Association.

At our national conference last year, we the members of the Japan Catholic Nursing Association considered the theme, "Nursing that supports the family." Actually, this was a continuation of the theme of the last Asian Regional Conference of CICIAMS that was held in Japan. In the light of the Gospel, we studied the problems of pastoral care of terminal patients and their families, and the problems of patients who are separated from their families. These pressing social issues have received much attention in Japan recently, and Christian medical and nursing leaders and educators have been performing a pioneering role.

The Japan Nursing Association

Last year, the Japan Nursing Association, which has about 440,000 members nationwide, invited Empress Michiko to attend its fiftieth anniversary ceremony. The empress has always had a special interest in social welfare, and was educated in a Catholic school. The words of the empress at the anniversary ceremony were a great encouragement to us in the medical and nursing professions as we strive to keep the human element in our work. I would like to cite a part of Empress Michiko's address now as a kind of meditation on the role and attitude we in the medical care and nursing professions need in modern society.

The development of medical technology has made rapid strides in the past fifty years. The life span has become longer, people are becoming more interested in health issues, and the demand for more and better nursing care is growing.

How do people experience and respond to birth, illness, and death the inevitable changes in mind and body that confront us

in the course of a lifetime? The task of nursing requires, in addition to a profound insight into the human experience, a considerate manner that does not leave the patient feeling uneasy or isolated. Countless people, pained and wounded in mind and body or grown weak with old age, have been helped and supported by nurses who, together with the excellent diagnostic and medical technology of doctors, have helped patients draw out their hidden reserves of strength in order to accept the circumstances of their situation, to overcome them, and to live out their lives in the face of suffering.

I think the history of nursing has been the history of nurses fostering a love for life, approaching suffering people with consideration, and quietly developing their professional skills and sensitivity. The nursing profession also includes the difficult but important task of supporting patients and helping them find meaning in the experiences of life after medical treatment has exhausted its efficacy. I know that those of you in the nursing profession are constantly aware of your calling, but it is my fervent hope that proper regard will always be shown for the important role that nurses play in society. (Newsletter of the Japan Nursing Association, No. 356)

And it is my hope that we doctors and nurses, hand in hand, and filled with the fullness of life, can continue to offer care filled with the warm love of God to our neighbors, and resist the depersonalization brought about by technological advancement, computerization, and an information-based approach to medical care.

Perspective

Sharing Our World : Health and Healing through Caring: An Australian Experience

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Abstract

Much of Australia is considered to be rural or remote. Definitions of rural and remote differ from country to country but in Australia an accepted definition is an area that is predominantly agricultural or forest, has dispersed patterns of settlement and low population densities.

In an Australian context, rural can also include regional centres, small towns, mining or logging towns and farming areas. Remote areas have a lower population density than rural areas and are distanced further from population centres and access to goods and services. As health is created and lived by people within the settings of their everyday life, the rote of the rural/remote once nurse is one that has gained much prominence in Australia over the last few years, as these nurses are often the only health care workers with whom these people have easy contact.

In Australia the role of these nurses has finally been recognized and, at present, a framework to legitimise the role of these advanced practice nurses is being developed. Many of the communities these nurses work in are small and are ideal for developing a community based approach to health care. The rural/remote nurse works with the people as they foster their own health. These nurses do their best to function as primary health care practitioners and encourage people to attain long term positive health results. The curative workload of these nurses is great, but many are aiming for a change from a sickness service to health care.

Aboriginal communities abound in remote areas of Australia. Historical influences, poverty and negative attitudes are all complicated by the lack of facilities and conflict between the traditional and western medical systems.

Language difficulties and value clashes are also common. Health workers must be sensitive to the importance of providing a culturally safe environment in order to facilitate the physical, ethical and legal safety of these people.

Introduction

Nurses form the largest part of the rural/remote health workforce. A little over 25% of registered nurses working in Australia work in these areas. These nurses require a great generalisation of skills and wide clinical experience.

Rural and remote area nursing bodies are urging the federal government to undertake strategies to attract and retain more country nurses. Incentives such as paid professional development leave, legislative changes to remove restrictions on nursing practice and professional recognition as specialists, are needed to encourage them to stay in the country and help improve the health of their communities.

Nurses in country areas are multi-skilled and work in varied environments that present challenging situations and the necessity for playing varying roles. Rural/remote nurses are some of the most resourceful people within the health system.

Rationalisation of the health care system

The recent rationalisation of the health care system in Australia has resulted in the closure of many small hospitals and the introduction of new models of service delivery. With these changes have come opportunities and challenges for nurses to renegotiate traditional roles. The move to community based care has seen many health care services become nurse-led with increased recognition of nurses as autonomous providers of care. Their practice ranges across preventative and promotive community health and includes non-emergency consultations, health screening, immunisation, emergency stabilisation and transfer and domiciliary post-natal and palliative care. Although nurses do not have prescribing rights under this scheme, protocols are being negotiated to allow standing orders for giving necessary medication in the absence of a doctor.

Extended role of the rural/remote area nurse

Pilot programs have been set up in several towns in most states of Australia. These programs have been carried out to determine the effectiveness of nurses practicing in an extended and autonomous role. It is clearly evident from these trials that nurses are more than capable of providing safe and effective primary and secondary health care to select population groups as long as they are given the necessary educational and professional preparation.

Support for rural and remote area nurses

Rural and remote nurses provide a confidential counselling and debriefing service but often need access to similar services themselves. The challenges and difficulties experienced in day to day living and working are often magnified in rural/remote area communities. Management of stressors in an active way ensures the overall effectiveness of health teams. Earlier this year, a 24-hour emergency phone service and regional counselling and support networks were set up to support health workers. The delivery of health care is continually being improved in rural/remote areas of Australia by initiatives such as the development of standard treatment protocols in rural/remote regions.

Rural/Remote nurses in action

At an aboriginal community south-east of Cairns in North Queensland, it was discovered that many of the community were suffering from diabetes. These people were not diagnosed until the complications of diabetes had set in. The nurse and several aboriginal health workers designed and effective program with the aim that each patient would be able to take control of his/her disease. The team realised that there was a need for a diabetic intervention strategy. The diabetics in this community had become dependent on the doctor. They were told what to eat and when to take medications but had not been educated about the disease. The diabetic program included group discussions, education sessions, exercise groups, follow up home visits, regular meetings and screening of the adults in the community.

The great strength of the diabetic community movement came from the empowerment of all involved through dialogue. The necessary personal skills were developed to monitor and control the disease. As those with diabetes mastered the necessary skills that enabled them to assess and record their blood sugar levels, this facet of their health was no longer a mystery they understood it – it became theirs.

As they became comfortable with controlling this aspect of their lives they looked with confidence at other areas where it may be possible to regain control. The health workers were equipped with western

medical knowledge about diabetes, but passing on this information was not as important to them as setting up true dialogue about the issues of concern to the people with diabetes.

Discussions about housing, transport, budgeting, social security and many other issues not directly related to their illness became an important part of the community diabetic group. These discussions were not just exchanging of views but reflection by people about their relationship with everything that affects them in their world. These people were able to find ways of dealing with the world, and more able to take control of things which had previously overwhelmed them with the support of others in their group. As these people learnt to put into action the decisions they made about their sickness, they began to gain control of other life decisions.

Dialogue is not easy but the most productive dialogue occurs when people realise their own lack of knowledge and feel a need to gain knowledge in a group with others. When health care revolves around a sickness service model there is little room for dialogue as people speak to others only to give information or ideas. Messages are conveyed but seldom does communication take place with the sickness service model and the health care provider remains in control. Primary health care promotes dialogue and places more importance on how you do it.

Nurses in rural/remote areas can be agents for change and promote health education through dialogue and by developing the art of critical thinking in their communities. This type of health education is essential if we wish to achieve justice, equity and health for all.

Community development in health is time consuming and requires patience to implement but it is a cost- effective way of achieving long term positive health results and moving from the provision of a sickness service to health care. Many people choose to access nurse practitioners in the community. These people may not otherwise choose to access the health care system at all. Long term cost savings will result from early detection of illness in these people and by exposing them to preventative health programs.

Rural/remote nurses working in isolated areas face cultural differences which need to be recognized within the health care system. Cultural safety needs to be addressed to allow all people a choice of health care facilities. Language, customs, attitudes, beliefs and preferred ways of doing things all need to be taken into consideration. Cultural safety, like health, is the well-being of the whole person. It encompasses the whole person, the whole family, the whole community.

Many aboriginal women desire to bear their children in their community because of the importance of family ties to specific groups and particular land. Hospital birth is often regarded with great fear and trepidation. Nurses may face the dilemma, when working with these women, of providing cultural safety which may conflict with differing professional values and priorities. Cultural safety in health is dependent on the philosophies, aims, objectives and practice of primary health care and community empowerment which focus on the whole person and the whole community. Cultural safety is achieved when health care services are designed to fit the people, the people have not been obliged to fit the service.

Conclusion

Rural/remote area nurses can promote healing in various ways, but ultimately healing lies in the response of the individual. The educative and self-responsibility aspects of health promotion are advocated by these nurses. Nursing is a flexible practice and it is not culture specific. When the care given is adapted to the culture and beliefs of the community it is far more effective. Nursing interventions aimed at healing and combined with the caring presence of the nurse effectively support people through illness and augment their self-healing ability. Nurses are taking more responsibility for improving the well-being of the communities in which they work by prescribing nursing interventions and supporting people in their own healing and health maintenance processes.

Every person is touched directly or indirectly by illness or trauma at some time in their life and will require the need of health care. We have little choice but to be interested in preventative medicine, healing, curing and the problems facing health care. I hope I have been able to give you an insight into the role of the Australian rural and remote area nurses as they contribute to the health and healing of those who seek their care.

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Perspective

Sharing Our World : Health and Healing through Caring

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The author

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One afternoon I was in the back seat of a taxi hurrying to the airport in Taipei hoping not to be late for my flight back to Taitung. This meant traveling from the North to the South. I was preoccupied with my purpose and what I had to do. All of a sudden the driver asked me…Do you belong to the true Church? I wasn't sure of the meaning of his question and answered I am a Catholic Sister. He then said yes you belong to the Church for all people, north, south, east and west. He then made the sign of the cross. It was a moment of deep insight for me, never had I thought of the North, South, East and West in this sign before. He shared that he was Buddhist. I had plenty to integrate on the rest of my trip.

This leads to the few reflections I would like to share with you. May we focus on *Vision, Mystery* and ways to express this in *caring* with the result of *healing* as we move forward together.

Vision

As nurses we have seen the vision. Not only have we shared the labor pains of the woman giving birth but we have been at the birth of the child, helping, trying to make it easier if possible. We have struggled with many of the hopes and fears present on this journey and followed the course to guide the breast feeding, and encouraged the physical therapy for a return to fitness after the birth process. We have had the chance to be the support of welcome to the infant and shared the joy with the parents. Some of have had personal experience and others have had vicarious experience. We do this in a sense of awe and wonder.

At the bedside of the sick we have stood offering support, comfort and prayers for the time of dying. There is another peak time to share. The family shares their grief with us as with few other persons except their families. We try to meet the feelings in the way the patient/family wishes. It takes on a ministry of dynamic effort and teamwork.

We have seen the world through the microscope, another universe, too small to view without instrumentation. I will always remember the first time I saw a Tuberculin Bacillus already colored with gentian violet. How can this little rod like looking thing cause such havoc on in the lungs, intestines, nervous system? I wondered, I was amazed. Now it is common to view micro viruses which grow and cause massive illnesses. The ways for healing through caring remain a continuous creative challenge.

Mystery

Several times as I mentioned birth, death and scientific views, the amazement, awe and wonder were touched. After we see, we are called to draw meaning from the power beyond words. Our world has many answers, many theories, computers, libraries full of information specialists and sub-specialists. It is time to reflect on the unknown, the hard to understand with reason alone. Is there something of Eucharist in the birth, death and science? Do we try to delve into cave of hearts for a source of inspiration to be the caring nurse? We try, but is it easy when the economics seem to be taking the place of our Mission.

In Taiwan, the National Health System has become inclusive including a very comprehensive global care system for the entire population. It is preventive, curative, in-patient, out-patient and is conducted in the public, for profit, religious health care centers, clinics, and hospitals. The thrust toward the child and the elderly demonstrate the filial respect and traditions deeply in the culture. It is easy to accept the concept and fairness of the system. It is brilliant in theory. I view this as a consumer and as a provider.

Nurses, especially Christian nurses have been pioneering Home-Health Care and Hospice care. It is expected that the gentle, focus of the religious health facility will prove of worth care and help. Physician assisted suicide has become a focal political issue recently. The use of resources is being balanced by many economic factors. The realities of managed care, pre-paid systems and economic pressures affect us as we meet the current situations. Nurses can bring the Catholic viewpoint the vision of goodness into many settings offering substance and challenge.

Our World

I wonder, if we as nurses have recently in the thoughtful and insightful reflections following the deaths of Princess Diana and Mother Theresa been given examples of caring, exposing needs and reaching out to the poor, needy, sick and destitute. Do we through them find exposure to solicitude and uniquely caring models. Recently I heard a homily and the priest asked if it didn't seem that the world had been turned upside down? The poor need the rich to provide the works education, opportunity, and help to better their condition and the rich need the poor so that they can share, contribute and bring meaning into their lives. Is it too simple to say the rich cause the poverty? Do the poor by their lives cause the wealth to be in controlling hands? As we try to make the world more caring we need the support of such gatherings to help each other move toward the next century being caring nurses, bringing healing as we journey with patients in their homes, hospitals and clinics in the events that bring us together.

Onward

It is my sincere prayer that our world will have caring nurses full of *hindsight* to learn the classical music of nursing, *foresight* to enter into new ways of serving and *insight* to enter into the mystical aspects of their service with *vision*, in awe before the *mystery*.

I personally am thrilled for this return to Thailand, a place where I was sharing with the International Committee of the Red Cross during the Cambodian refugee influx and famine of 1980. I remember well the smiling welcome of your country with every border squeezed to welcome those in need. The memory of generosity and sacrifice always struck me as being centered in a national soul of goodness. Small efforts and huge projects merge in our times for the health and healing or our world. Thank you for sharing with us. I am grateful and thanking Taiwan for giving me a chance to be connected in this part of the world.

Perspective

Caring: A Path to Health and Healing

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Abstract

Our charism is directly related to health and healing. The Church entrusts to us a share in her mission of reconciliation... to persons wounded by sin and its consequences. We are committed to their development and the promotion of justice and peace in a world disturbed by sin and conflict.

The recent passing of two extraordinary women both of whom, in life, differed vastly in stature and status, awakened us to the world of the poor. Both gave a forceful experience of genuine caring and compassion for the poor, the down-trodden, the marginalized and shunned the sick and the afflicted.

The simple language of love was also the language of Sr. Mary Euphrasia, our Founders. "I have no talents, I have no special gifts, I only loved but I love with all the strength of my soul." The culture of individualism surrounds us: we see the extreme loneliness in people, so lonely that they cannot even acknowledge their loneliness in themselves, much less to others. Their search for companionship drives them to drugs, alcohol, sex, rock music, etc.

We are called more than ever to affect a change, through an experience of deep Biblical Faith which cannot but urge us to reach out in love to those most in need.

Jesus healed "every human being," those emotionally or physically sick, giving them hope, and wholeness (health and healing). "Be not afraid." "Be compassionate." "Who is my neighbor?" These are reflections directed in the path of health and healing.

Our charism is directly related to health and healing. We have 4 Welfare Centres in Thailand: Bangkok, Nongkhai, Pattaya and Chiengrai. We work directly for those who are marginalized and in need, as our little brochure will show you.

As a member of the **Good Shepherd Congregation**, my life, like the lives of six thousand other members, is directed by the words of our Constitutions, which clearly state, **"Jesus, the Good Shepherd, has called us to live in union with him and continue his redemptive mission in the Church."** The Father, who is rich in mercy, sent his Son to bring Good News to the poor, to set free the oppressed, to heal the contrite of heart, to seek and to save what was lost. Through the Church Jesus continues to encompass, with love, all afflicted with human weakness. He looks for the lost one, brings back the strayed, tends the injured and makes the weak strong. He reveals the Father's mercy through a love, which overcomes all sin and infidelity.

The Church entrusts to us a share in her mission of reconciliation. This demands an awareness that we ourselves are always in need of conversion. In our unceasing return to the Father, we discover the depth of our sinfulness and in openness to His initiative of love we find mercy. United with all people in their struggle with sin and in their need for reconciliation, we witness among them to the power of this mercy.

The continued experience of mercy in all aspects of our lives, sends us to be a presence of Jesus, the Good Shepherd. We are envoys for Him; God is appealing through us and the appeal that we make in His name is **be reconciled to God.**

Our relationship with those we meet should be for them a means of encounter with the Good Shepherd. We seek to approach them as He does. Each person is present to Him in human uniqueness, and He calls each one friend. Our love should awaken in them a sense of their worth and dignity as children of God. At the same time, we are aware that we receive mercy from them and that we cannot separate our salvation from theirs.

We announce the message of reconciliation through a ministry of charity and evangelization, directed towards persons wounded by sin and its consequences. Our specific orientation is to girls and women whose condition in life cries out for the healing and salvation which Jesus alone can bring. We are deeply committed to their integral development. Our commitment to reconciliation demands that we promote **justice** and **peace** in a world disturbed by sin and conflict. In our ministry, we collaborate to help bring about chance in whatever condemns others to live a marginalized life. This witness is justice must posses those characteristics of merciful love, which are of the essence of the gospel and the social teaching of the Church.

We are reminded forcibly in our daily lives of the need for this caring. Only very recently the **World of the Poor** witnessed the passing of two extraordinary women, both of whom in life differed vastly in stature and status. They were Mother Teresa of Calcutta and Diana, Princess of Wales. Every bookstand in the world was covered with storied caring and compassion for the poor, the down-trodden, the marginalized and the shunned, the sick and the afflicted. We can believe that both these great women were raised by God to shake a world that feels and knows it is in need of change.

Our Founderss, **St. Mary Euphrasia**, speaks to us in similar language where she says, **"I have no talents, I have no special gifts, I only loved, but I love with all the strength of my soul."** It would seem from what we see and hear that rarely in the history of our world was there a greater need for healing and inner peace. We live in a culture of individualism and therefore we see an extraordinary loneliness among people, so lonely that many cannot even acknowledge their loneliness to themselves, much less to other. Sad, lifeless faces, especially youth, are hidden behind masks of make-up, pretense, even composure.

It is their search for companionship that drives them to drugs, alcohol, sex, rock music, etc. We are called more than ever to reach out in caring those most in need, beginning with those who are nearest to us. It is only in true Biblical faith that we can hope to affect a change. Every time Jesus met with spiritual or physical suffering, he treated it as an enemy. Jesus saw each person in need of healing as a whole person. He healed emotional sickness - anxiety, fear, and depression, "Be not afraid." and He healed all physically ill who came to Him. He left us the remedy, "Be compassionate as your heavenly Father is compassionate." "Who is my neighbor?" is one of the most critical questions asked of Jesus in the Gospel. The Jews defined "neighbor" as only fellow-Jews, but Jesus redefines this narrow concept and leads us to recognize every human being as neighbor and not to let prejudice, culture or anything stand in the way. We need to learn to work as a team rather than as competitors to bring God's healing power. We have plenty of information and how-to's at our disposal, nor do we need to envy great compassionate and caring figures like St. Mary Euphrasia or Mother Teresa, for we, like them, have only to allow ourselves to be inspired and driven by compassionate love of Jesus for others, no matter how different and removed, as beloved 'Brothers and Sisters.'

The Poor are always with us and it is Jesus who is:

Body hungry in the unfed,
Mind hungry in the untaught,
Heart hungry in the unloved,
Soul hungry in the ungraced.

Perspective

Sharing Our World : Strategic Path to Health and Healing

Ms. Theresa Cheong

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Abstract

Concept of health from the Catholic Nurse, point of views:

What is good health from the spiritual standpoint is highlighted.

That total health is a combination of several lifestyle practices and trusting in the divine power in changing unhealthy life style and unhealthy practices.

What are the Catholic nurses' role in assisting the suffering patients towards health/healing in a hospital setting?

Use of the art of listening and non-verbal communication to understand patients' sufferings.

Enlighten patients on the theology of suffering so as to help him cope with his illness.

Healing through Prayer.
Guidelines on effective praying with patients are shared.

Emotional Healing: Four phases of Emotional Healing
1. *Reaction Phase*
2. *Regeneration Phase*
3. *Adaptation Phase*
4. *Recovery Phase*

Power of Prayer of Emotional Healing
Community support - CNG

Introduction

On behalf of the Singapore delegates I'd like to thank you for hosting the 7th Asian Regional Conference of CICIAMS and it is my pleasure to be called upon to share on

"Sharing Our World: Strategic Path to Health and Healing." I would be focusing on 4 main areas and they are:

- My concept of HEALTH from the point of view of a Catholic nurse.
- What are our roles as Catholic nurses in assisting the *'suffering'* patients towards recovery to Health/Healing?
- Physical Healing through Prayer.
- Emotional Healing through Prayer.

Strategy to Health

We enjoy health when we are moving towards what God is preparing for us to enjoy and when we are collaborating with God in that preparation. The search for health encompasses more than the prevention of sickness and diseases. There are many people who are looking for the "Fountain of Youth" and will give all they have for even a few years of life. Many today do not really understand what good health comprise of. Good health is a person's ability to work, learn, think, rest and recreate to his fullest capacity. This is what in my mind Total Health means - being able to function physically, mentally and **spiritually** to its fullest potential.

Good health is the result of a combination of several lifestyle practices including proper nutrition, regular exercise and successful stress coping strategies. However one should seek to bring one's body, mind and spirit to an optimum performance resulting in complete restoration such as what Adam was before sin. We should avoid all unhealthy practices, and follow the guidelines that God has given us, trusting in God that He will energize the restoration process, and let "the God of Peace make you entirely pure and devoted to God and may your spirit, soul and body be kept strong and blameless until the day when our Lord

Jesus Christ come back again" (2 Thessalonians 5 : 23).

Trusting in divine power and changing unhealthy practices and pattern of life may not be easy but in Isaiah 4:9,19 the Lord promised that "I have chosen you and will not cast you off: fear not, for I am with you….." The bible rates Health right at the top of the list of importance. Men's mind, spiritual nature, and body are all interrelated. What affects one, will affect other parts of the body. God has given us the wisdom of good health rules and He has promised us, "And you shall serve the Lord your God and I will take sickness away from the midst of thee" (Exodus 23: 25).

Our trust in God and our willingness to go to Him for help is necessary for full and complete health. This is a choice that no one can make for us. God made man with the ability to make choices and whether we want to do things His Way or not depends on our choice. If we make that choice to want to follow His health principles, He has promised that He will give us all the strength and power to do it.

What Are Our Roles ?

In a hospital setting, the understanding of how a person is responding to his environment and illness is important. On the spiritual side it is useful for the catholic nurse to develop the art of listening as well as the capacity to observe non-verbal behavior. Patients may open up very easily when approached with the friendly casual greeting, "How are you doing." To be effective we need to have an awareness of ourselves as persons. Values, attitudes and beliefs about life are very important. For communication to be open, a non-judgemental accepting atmosphere need to be developed in order for the patient to feel that someone is genuinely interested and concerned about him as a person. We need to be conscious of our non-verbal behavior as it can speak louder than words. Active listening is a very important part of communication since it requires being actively involved with the person in his situation. Trying to hear the patient from his frame of reference is difficult since it requires knowledge and discipline of oneself. This ability to transcend into the world of the other, to experience his feelings with him, gives us a deeper understanding of how the patient is experiencing, his illness and suffering.

Our role as Catholic nurses is to help him to understand his feelings so that he can cope more realistically with his situation. In our attempt to deal with the patient's spirituality we have to believe that some patients have a very difficult time to come to terms with his illness because of their concept of God viewing his illness as suffering and as a punishment from God.

With such a patient we should try to convey a balance concept of God by sharing something of our own image of God. In sharing these passages which are most meaningful to us, we might mention the acceptance Christ offered Peter after his denial, the tender love which Christ displayed to Judas even after he predicted his betrayal, or the merciful words of Christ hanging on the cross, "Forgive them, for they know not what they do."

It cannot be expected that the sick person will change his concept of God immediately but hopefully this sharing will cause him to reconcile some aspects of mercy and love into it.

When we offer alternative views about suffering, we open other possibilities for the patient. We do not force any particular view on the sick person, but we need to mention other alternatives toward suffering so that he has the freedom of choosing between possibilities. It is beneficial if we could share our attitude with the patient as one option for him to choose. In order to be effective we need first to clarify our own theology of 'suffering', we need to reconcile ourselves with it.

I like to share these comforting words from Paul's letter to the Romans 11:33 "On the depth of the riches of the wisdom and of the knowledge of God, how incomprehensible are just judgements and how unsearchable His ways." This passage made me realize that I will never be able to find a complete satisfactory answer. That *suffering* is a mystery is further illustrated by the account of the man born blind who was brought to our Lord with the question "Who has sinned, this man or his parents that he should be blind?" Our Lord never answered this question but added this comforting thoughts about *suffering* - it is not punishment from sin, "Neither has this man sinned, nor his parents....." (John 9:2,3).

I am reminded of the fact that since Christ suffered then suffering has to be part of my life too. Then again it must be noted that our personal attitude should never be forced upon a patient but only to stir up his thinking so that he can find his own meaning.

Healing through prayer

Prayer has been acknowledged as a source of comfort, healing and miraculous cures since antiquity. For healing to take place it is important to commune with God through prayer. Through prayer the sick person is able to express his yearning and desires. These are some guidelines if we need to pray with the patients:

1. It is important to have a few seconds of quiet time before the prayer to allow ourselves time to collect our thoughts and for the patients to put other things out of his mind. This brief period of quiet in the beginning, in addition to a work pause during the prayer, also gives the Holy Spirit time to work through us and in the sick person.
2. The prayer should be brief. The patient's room is rarely a good place for a long oratorical prayer because the patient is often weak and a long prayer will tire him. We need to keep our prayer brief out of consideration for the other patients in the room who may be keeping quiet out of respect for God and religion during the prayer.
3. It is good to insert the person's name in the prayer so as to be personal that he is an individual we our concerned with. And finally to remember to reassure him of God's special care and ask God to give him the strength of Christ as he suffered on the cross.

I would like to share this prayer that we as nurse healers can identify with - it's the St. Francis Prayer.

Lord make me an instrument
Of your peace.
Where there is hatred,
Let me sow love.
Where there is injury, pardon.
Where there is doubt, faith.
Where there is despair, hope.
Where there is darkness, light,
And where there is sadness, joy.
O Divine Master, grant that
I may not so much seek
To be consoled, as to console;
To be understood,
As to understand;
To be loved, as to love;
For it is in giving that we
Receive -
It is in pardoning that we are
Pardoned;
And it is in dying that we are
Born to eternal life.

Emotional Healing

As earlier stated that health is not just the absence of disease but a positive state of 'right relatedness' to God and of dependence on him. Spiritual healing can come about only through the harmonious evolution of a fourfold relationship.

- One's physical environment
- To other people
- To Oneself
- To God

Just like the process of healing of wound healing also takes 4 phases.

The Reaction Phase

In emotional wounding there may be arguments and tears. Similar to physical wounding there is an initial shock and intense pain that claims ones attention and totally shatters one's equilibrium.

The Regeneration Phase

This is an emotional level where grieving occurs. Gradually the hurt is diminished and the pain recede into the recesses of subconscious.

The Adaptation Phase

Occurs when one can return to the routine of daily life without the pains of constant distraction. Both physical and emotional wounds may ache on occasion for years to come but not to the point of the initial disequilibrium.

The Recovery Phase

Real recovery comes in the 4th phase of Empowerment. Through the work done in the recovery process one may actually become stronger and wiser. Most individuals who have made great contributions to our world have evolved from the fighting back and recovery of the tragedy of their own personal wounding.

The healing of damaged emotions and old destructive memories (inner healing) involves Christian counseling and prayer which focuses on the Holy Spirit to bring about healing. Damaged emotions may be related to extreme feelings about personal unworthiness, sensitiveness and fear of failure. Destructive memories frequently stem from repressed unresolved anger about emotional hurts in the past.

The healing of memories does not erase the memories, indeed it commonly serves to bring them into consciousness, but their meaning is changed and their sting withdrawn. The memories become accepted and integrated into the person's total life. The basis of the healing is forgiveness - forgiving the person responsible for the hurts even to "seventy times seven" (Matthew 18:22). While both damaged emotions and destructive memories may be helped by psychotherapy, the process of healing can again be hastened by prayer. Prayer is perhaps one of the few forms of pure intention. When one engages in prayer, one usually communicates directly with God. There is deception since the request, thanksgiving or intent is moving away from the contracted ego shelled self into a greater dimension and greater purpose. The Holy Spirit may bring a buried experiences into consciousness, or help a known problem to be faced, borne or resolved. Finally, as Catholic nurses we can help achieve progressive inner healing through friendship and active listening as well as within a supportive worshipping community as the Catholic Nurses Guild.

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Perspective

Sharing Our World: Strategic Path to Health and Healing

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abstract

This paper intends to give an overall picture on hospice and pastoral care in Hong Kong. It will be of interest to readers how much has been offered to a minority group of quietly dying patients in a rich cosmopolitan city such as Hong Kong. The answers to six basic questions with respect to the local hospice and pastoral service reveal the major aspects in the establishment and development of the service. At the same time, there are also problems that hinder the development of holistic and comprehensive care to be delivered. It will be high time the health care professionals redirect their attention to the basic theme for patient care. The paper will emphasize the quality of a true healer in the field and the indispensable role of Catholic nurses.

Introduction

Vast changes occurred in nursing profession since early 1990's in Hong Kong following the cry for professionalism in nursing worldwide since the 80's. The advancement in medical technology, affluence in the country, promotion of human rights and Patients' Charter (Hospital Authority:HA, 1995) create a pressing need for high quality nursing care in terms of empowering patients with knowledge, choices, and right to participate and decide in the caring process.

At the same period, Hospital Authority that headed all 48 Government and subvented hospitals and institutions in Hong Kong (1997) has encouraged and reinforced the health carers through constant staff training, campaign, exhibition and managerial revolution to be client-based and work in multi-disciplinary team approach.

In Hong Kong, Hospital Authority has taken over 48 Government and Subvented hospitals and institutions since 90's. The orientation and management of HA is very different from previous bureaucracy. It emphasizes quality, efficiency, effectiveness, and economy (HA, 1995, 1996, 1997). All these rapid changes directly affect the staff working in the front line. Nurses especially Catholic nurses inevitably need to react promptly through the processes of unlearning and relearning so that they can work smoothly with the new system without losing sight to the basic caring philosophy related to the Christian faith. They need to remember that caring to the least brother is serving Christ our Lord to withstand against any mal-practice under the new business-oriented health care trend. It is true that during this critical time, many nurses are reminded of the Code of Professional Conduct: respect for life, dignity and the rights of man (Nursing Board of Hong Kong, 1986). Chow (1993) further added that the major tasks of health care professionals lied not only in healing, but in providing to every client love, faith and emotional support until the time of his death.

Hospice Care that valued client-focused quality care in team approach and the belief that every dying client has the right to a dignified death. The service for terminally ill that previously being a neglected field became a trend to consider last ten years. In fact most of the carers in Hospice and pastoral service do have some kind of religious belief. Probably they find

the work meaningful and fruitful in order to balance out the frequent confrontation with pain and death issues. Up to 1997, there are 12 hospitals or institutions offering 220 beds for the terminally ill with the majority with carcinogenic disease origin.

The objectives of this paper are three-fold:

1. To share the facts about the hospice and pastoral service in Hong Kong.
2. To identify the roles of a CNG member in hospice and pastoral service.
3. To ease the caring process.

The Situation in Hong Kong

At present (1998) there are 13 hospitals or institutions, mainly are subvented organizations offering hospice and pastoral service for the terminally ill clients who have cancers in final stages. All units claims to work in multi-disciplinary and holistic approach and aim at symptom relief and peaceful death for patients. Most organizations also follow up the grieving relatives and develop bereavement service of various forms and activity.

Now, the six basic questions will be answered here to give a little more information. The question is: WHO does WHAT to WHOM in the hospice and pastoral service, WHY and HOW.

WHO

As holistic is referred to physio-psycho-socio and spiritual aspects, pastoral service that may circumscribe spiritual care in addition to religious support, will be discussed together.

In Hong Kong, nursing staff take up a major role in Hospice work and Pastoral service. These hospice units are always conducted by some religious groups that develop and dominate in that particular unit. In general, workers in hospice may be divided into two types. First, the health care givers that volunteer to work in hospice and pastoral service mostly have a religion, e.g. Catholics, Protestants, Buddhists, or Taoists. They are a group of committed conscientiousness competent confident and religious workers who value life and always find meaning in life and work. They are willing to update professional knowledge and skill in order to do a better job. On the other hand, there are another group of assigned workers. They are readily transforming their behavior under the pressure of HA that leads dramatic organizational change especially in terms of organizational structure, culture, and policy. But subtly their attitude and knowledge and skill have remain unchanged and outdated. Training up this group of staff pose a major task to deal with.

does WHAT

There is no intention to describe what many of the experts around are doing as in many other countries with hospice settings. However, it aims to stimulate thoughts from health care professionals on other concepts aspects on hospice. It is relevant to include hospice as not only a kind of service but also as a caring concept and a growth process for both care givers and receivers.

Normally, once the word "hospice" is mentioned, it will be referred to as some kind of hospital service, hospice is seldom viewed as a concept that can aid Nursing profession to prosper. Few people will argue that in hospice setting, health care workers are more conscientious about life and death, meaning of life, wholistism, client-centredness, team work, and family support. The thought is whether these nursing concepts specialized in hospice should be unique at hospice setting alone or should be universal for all patient groups.

Hospice can be a growth process. In Peck's book "The road less traveled". He brought forth that the further one can travel, the more births, deaths, and experiences, the more joy and pain one will grow. Catholic nurses are privileged to

provide such care that requires spiritual growth stemmed from genuine love and ultimate goal of life. Life can only be blossomed by persistent exercise of real love, none the less, courage and wisdom cannot be certified by Academic degrees (Peck, 1983). From that implies health givers can no longer be a bystander in the helping process but walking together with clients (both patients and their relatives) to go through different stages and intensity of pains, as well as the precious moments during the final stage in life.

to WHOM

This tends to be a simple question to answer. Here will include colleagues as one of the care recipients. Catholic nurses, being the salt and light for others, inevitably act as the change agents whose care is not confined to patients and relatives, but also the colleagues in the units through positive thinking, attitude and behavior. It is hoped that the message of holistic care and respect for individuality is not just lip service but visualized through a team of 5's staff. At the moment team building is one of the objective for many hospice units.

WHY

This may seem to be a silly question to ask. There is not many nursing staff in Hong Kong willing to join the service since they do not know how much they can be rewarded. They think they have to work in a mechanistic, dehumanized and lonely environment. The fear aggravates with the staff's own limitations and incapability to control life, extend life, explain meaning of life and to face their own mortality (Kubler-Ross, 1969). For those who choose to work in the area however, find it the most precious experience. It would be rewarding to see how clients' noxious symptoms can be relieved, how clients can cope with fear and separation, how creative the clients and family can cope and make life happier and precious to them.

HOW

What are the best thing to do in hospice setting have been taught by many medical staff, social workers, pastoral workers, and psychologists. In nurses' eyes, practicability is the most thing to consider. The question is: does it work? Reflect from working experience the elements of "ASK" are essential in order to gain clients' positive feedback.

This part mentions the three elements that are crucial in daily clinical practice. They are: 'ASK' attitude skill knowledge. These 3 elements work in triad.

ASK stand for ATTITUDE, KNOWLEDGE & SKILLS. They work in hand without any one to be missing. What actually has to be done with ASK will be summarized in the following table that illustrates some important aspects during the care delivery process.

	ATTITUDE	KNOWLEDGE	SKILLS
BE	empathy, not sympathy	fulfill the basics - Maslow's hierarchy of needs, physical care go first, explain and treat symptoms	Communication skill-non-verbal, eye contact, touch, sit by them, LISTEN, & LISTEN
WITH	respect clients' age, career, courage to tolerate and survive	Acknowledge clients' family dynamics, loss of control over the multiple roles	Assessment skill 1. Initial : level of knowledge & acceptance 2. Subsequent 3. Last 24 hours
THEM	persistency & consistency	Anticipate their needs	Breaking bad news
	attention to details	teach them what to do, eg do what they dare not do like TOUCH	Caring for the last 24 hours
	small & frequent contacts		Deliver a message of helping till the last minute

The Silent Healer

Kubler - Ross (1975) speculates that meaning of life is unique. There is specific meaning for an individual's life at a given moment. Peck (1983) and Kubler-Ross (1983) believe that death brings the true meaning to life. Catholic nurses act as mediator to deliver this message through their genuine love and intimate care. The best model for Catholic nurses will be mother Teresa. Her story and acts explicit the true quality of a catholic nurses or other nursing professionals. Be a silent healer. Draw the power from GOD.

She said,
"The fruit of love is service."
"No matter what others think of you, that you work for yourself, you still have to continue your work."
"To serve and to give until we feel the pain."

Looking for the Future

The physical care in Hong Kong is more or less updated with European Countries. Effort for symptom control become a norm for medical staff. However, there is still a lot improvement can be made in terms of psycho-socio-spritual aspects. Actually much courses and experts have been working on these subjects. For Hong Kong, if hospice and pastoral service are to be improved, the most vital elements are a group of committed staff constantly working together to seek constant improvement. In other words they care how to care. This group of carers must be the silent healers themselves. Catholic nurses can be a very resourceful group for this job. They should not or should not only aim at external changes, but the internal growth for themselves and the clients they care. At present there is still a large room for improvement such as thinking alternatively over hospice as simply a service but also as the major nursing concept & a growth process; to resist professional dominance verse client-centredness; to empower self, clients, other colleagues. There are many other questions to ask and face: nursing the dying children and their families is un handled topic. Further, the service has not yet been widely accepted in caring the clients with HIV. The barrier of social stigma and misconception over the transmission of disease is common not only for layman but also health care professionals. Therefore there is plenty room important at the moment though there exists a group of confident, compassionate competent, conscientious committed HC workers who lied a good foundation for hospice

Conclusion

In Hong Kong, Hospice is often seen as another kind of hospital service serving a minority group of clients with terminal illness. The comfort of patient with cancer is a primary domain of nursing. And nursing should strive to maintain the advocacy role of individual and appropriate care. However, it is found that the quality of care delivered to these clients (both patients and relatives) depends on to a large extent the type of health care staff. In order to promote good hospice care, there must a group of dedicated staff making relief of cancer pain a reality. They have to provide leadership and active role in clinical practice. This is a challenge that will occupy all committed staff. Besides, continuous effort in the field is also needed as there are many unhandled questions to face such as hospice for HIV patients and children.

First, is changes needed in Clinical setting. 5' c staff working together more closely to see constant improvement. In other words they care how to care. And Catholic nurses can be a very resourceful group for this job. They should not or should not only aim at external changes. But the internal growth for themselves & the clients they care. Nursing leaders need to help front line workers to think alternatively over hospice as not merely a service but also as the major nursing concept & a growth process to resist

professional dominance verse client-centredness; to empower self, client & other colleagues

Types of Hospice & Pastoral Service Offered by Local Hospitals

	Bedstead	Home Care Service	Day Hospital	Pastoral Service
Buddhist Hospital	13	V		
Bradbury Hospice	26	V	V	V
Caritas Medical Center	22	V		V
Haven of Hope Hospital	24	V		V
Nam Long Hospital	68	V	V	V
Our Lady of Maryknoll Hospital	8	V		V
Ruttonjee Hospital	10	V		V
Pok OI Hospital	10	V		
Shatin Hospital	8	V		
Tuen Mun Hospital	14		V	
Christian Union Hospital	9	V		V
Wong Tai Sin Hospital	10			
	222	10	3	7

Second, Maximum Involvement in the development of hospice service and concepts. Fostering of service needs support, permission, appraisal from above as well as monitoring and evaluating the service and self improvement. More important the maximum level should provide resource in terms of intermission, material, manpower.

Thirdly, in education, it's a crucial time for nursing curriculum to include caring in hospice settings to prepare nursing education on new hospice perspectives that they are likely to face in the job.

The last but not least, I would like to share with a familiar reading from the Gospel of Luke ' Jesus had been staying with Martha and Mary on his way to Jerusalem for crucifixion. Mary was a sensitive and considerate person and acknowledges the need of Jesus so she chose to stay with him quietly and listen to him'. We, nurses always play the role of Martha as an industrious competent worker, and worried and troubled about many things. Maybe we can sometimes stop for a while to listen to our clients or even our own heart.

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Perspective

Sharing Our World: A Strategic Path to Health and Healing.

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abstract

Health plays a vital role in today's society. People can find joy and happiness through health. Both health and healing have various meanings and viewpoints. The simple meaning involves only the physical aspect of health, while the more complicated meaning involves the supernatural aspect of health. This can also be referred to as holistic, social, and spiritual aspects. Healing involves more of the holistic approach. Holistic healing is a focal point of comprehensive nursing today and it will be in the future. This leads to the Holistic Health Care Movement, who's central theme is the inseparability of mind-body-spirit in health, illness, and healing.

It is the nurses' goal to treat disease and to relieve pain. This is accomplished by using a comprehensive outlook on health. This outlook follows the passages contained in the Bible.

No universally accepted definition has been established for the team health. Some may define it as person's ability to function in society while others may describe it as a disease free state and condition.

Many concepts and technique exist to help an individual heal which range from concentrating on the physical aspects all the way to the spiritual aspects.

Wholeness is the integration of harmony and balance of mind-body-spirit in interaction with the totality of one's environment. The term holism wh·ch comes from the Greek word "holo '. meaning whole (person), emphasizes life-style, well-being, and wellness. If health is viewed as holism, then we may conceptualize healing as a process which facilitates health.

The spiritual nature is virtually ignored in our health care system. Spirit refers to that which gives meaning and direction to life as a sense of inner happiness. Spirituality has been found to be used most frequently as the practices, beliefs, and attitude that an individual might have towards a higher power Spiritual growth is experienced by actualization of inherent human potentials and personal connection to a greater reality. Nursing must include this spiritual aspect of health. In Korea, this course is offered at a few universities.

I. Introduction

Health is an essential part of everyday human life. Health can be a source of immense happiness. There is a broad spectrum of viewpoints and definitions regarding health. The concept of healing also has various meanings and definitions. These definitions vary by dictionary, WHO, and also scholars. The simple meaning involves only the physical aspect of health.

Another more complicated method involves the supernatural aspect of health. This supernatural aspect of health can also be referred to as holistic health. But in holistic health all aspects of health are used which includes the physical, mental social, and spiritual aspects. The definition of healing involves more of the holistic health all aspects of health are used which includes the physical, mental, social, and spiritual aspects. The definition of healing involves more of the holistic approach. Holistic healing is used in comprehensive nursing to day and will be continually used in the future of comprehensive nursing. This leads us to what is called the Holistic Health Care Movement. The Holistic Health Care Movement has a central theme

which is the inseparability of mind-body-spirit in health, illness, and healing. A holistic approach emphasizes self-responsibility and self-determination of health care goals for goal attainment.

In nursing, our goal is to treat disease and to help relieve pain. We do this by using a comprehensive outlook on health which involves all aspects of health. It is the focus of nursing to heal and provide comfort. But in reality, we usually only use the physical, mental, and social aspects of health. We tend not to emphasize the spiritual dimension of human nature. In the Bible, the meaning of health not only involves the physical, mental, and social aspects of health it also emphasizes the supernatural aspect of health. So nursing follows the passages contained in the Holy Bible.

Therefore, I'd like to investigate both health and healing in-depth to find a cohesiveness between the two. I will find a strategic path to health and healing through spiritual care. Also, I will explain spiritual care in Korea.

II. Definition of Health and Healing

Although the term health is used as part of everyday living, no universally accepted definition has been established.

A typical dictionary may define health in terms of a person's ability to function in society. Some other definitions also describe health as a disease free state and condition.

WHO states that health is "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity."
Thus according to WHO, to be healthy, a person must be physically, mentally, and socially in a state of well -being.

In Korea, one research about the concept of Health and Illness, and Health Behavior (1996, Park) has defined health as follows: Health is having the absence of disease in body and mind, health is having physical and mental comfort, and health is having harmony between body and mind.

Many concepts and techniques exist to help an individual heal. These techniques focus on different aspects of the individual's nature ranging from concentrating on the physical aspects through to the mental aspects to the spiritual aspects of life which include nutritional methods, exercise, massage, acupresser, imagery, meditation, laying on of, prayer, healing of the memories, etc. (Hogben, 1985).

Wholeness can mean integration of harmony and balance of mind-body-spirit in interaction with the totality of one's environment. Holism comes from the Greek "holos", meaning whole (person). In 1962, the meaning was used by Jan C. Smith Ph.D. to theorize the relation of parts to a whole.

During the decade of the 1970's, the term holism is being used for health care of the whole mind-body-spirit personality, with emphasis on life-style, well-being, and wellness (Yahn, 1979).

Another basic holistic health goal is complete wellness rather than mere absence of symptoms. The integration between mind-body-spirit is not adequately measured through conventional tests. Complete wellness includes vitality, joy, physical fitness, no health-impairing habits, meaningful and productive work, a profound love relationship, and minimal tension and stress. This modern method is used in selected cases so that no possible therapeutic method are overlooked or ignored.

A healing art may thus be conceptualized, over-simplistically, as a skillful practice which facilitates the integration of harmony and balance of mind-body-spirit in the recipient. Given this set of definitions one cannot practice a healing art without attending to the spiritual nature and needs of the recipients (Quinn, 1985).

If we think of health as wholism, which is consistent with the origins of the word, then we may conceptualize healing as a process which facilitates health.

But usually the focus of our health care system is curing of the disease rather than the healing of whole person. The spiritual nature and needs of people are virtually ignored in our health care system, while mind and body are usually considered to be separate entities. This phenomenon occurs because there is a lack of content in school curriculum and a lack of effort to see the holistic view.

III. A Strategic Path to Health and Healing Through Spiritual Care

Spirit refers to that which gives meaning and direction to life as a sense of inner happiness. Spirituality has been found to be used most frequently as the practices, beliefs, and attitude that an individual might have towards a higher power or supernatural force in the universe (Larson&Larson, 1992). Spiritual growth is experienced by actualization of inherent human potentials and personal connection to a greater reality, which may be God, history, or merely nature.

Conceptualization of health and well -being are related to points of view about human beings. These points of view should be made explicitly for the purpose of understanding human health and well being.

The human is a complex being composed of physical, psychological and spiritual components and thus, if human beings are to receive comprehensive nursing care, nursing must include spiritual care.

Nursing theorists describe a person as complex and integrated beings who are more than the sum of their biological, psychological, and spiritual dimensions (Johnson, 1959, Rogers, 1971, Roy, 1976). Each dimension is a reflection of the whole person (Rogers, 1971) and can be defined as a set of universal human needs. When needs are met, the result is health: When needs are not met, the result is sickness or at best absence of illness (Maslow, 1968).

Based on Parse's experiment (1981), she explained the human simultaneity paradigm as a unified pattern of the interaction process regarding Human-Universe-Health. Also, based upon Watson's findings (1985), she explained the totality paradigm which details health as a harmony of mind, body, and soul. Nursing emphasizes the holistic meaning through these experiences. Through years of work in intensive care units, Fish and Shelly found out the holistic views. These were gathered in clinical settings. By gathering this information. Fish and Shelly (1979) developed a theory on spiritual nursing based upon the information obtained in a clinical environment.

Humans, as physical beings, need oxygen, food, elimination, rest, and activity. We are always trying to satisfy these human needs. In the same token, we are spiritual beings. Thus, the ultimate concern is to satisfy these spiritual needs. Spiritually, we try to find an object that we absolutely dependant upon. This need is satisfied by an upper being. This desire toward spiritual nursing is received through God. Physically, socially, mentally, and spiritually, the human being has a relationship with God. Human beliefs can be described in this following verse: (For by him were all things created, that are in heaven, and that are in earth visible and invisible, whether they be thrones, or dominious, or principalities, or power: all invisible, whether they be thrones, or dominious, or principalities, or power: all things were created by him, and for him. Col., 1:16).

Nurses provide holistic healing. A nurses' client is an individual, family and community, whether in sickness or health. Nurses use their rich experience to pray and read Scripture to give spiritual care to satisfy their clients' spiritual needs. If necessary, nurses refer to priests to satisfy their spiritual needs.

Now, I would like to investigate spiritual nursing care in Korea. In Korea, a few universities offer specialized courses in

spiritual (parish) nursing. But research involving spiritual nursing is scarce. Research that involves spiritual nursing follows.

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Perspective

The Paulinian Approach to Nursing Education: A Response to the Call for Compassionate Nursing

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Abstract

The formation of care givers, particularly of Catholic Nurses has always been in the forefront of the apostolic work apostolic work of the Sister of St.Paul of Chartres. In the Philippines, this evangelizing activity formally begun in 1946, after the liberation to the county, when the Sisters established St.Paul School of Nursing in Iloilo in order to meet the need for trained professional nurses who could minister to the patients of St.Paul Hospital, the only Catholic hospital in the region. From its inception, the focus of the school was to prepare nurses who would care not only to the physical and medical needs of the patients but for the spiritual and moral aspect of the patients illness as well. Hence, the program of studies of Nursing even as it seriously pursued academic excellence and professional competence among its student, has always been anchored in the Christian tenets of knowing, serving and loving God in the person of the sick; of seeing Christ in the patients/clients and being Christ to them. In a nutshell, the Paulinian Nursing Education hopes and strives to form catholic professional nurses who ,following the Blessed Mother as their model ,and inspired St.Paul their Patron, thinks with the mind of Christ, serves with hands of Christ, and loves with the heart of Christ. Admittedly, this is a very ambitious goal, but with God's help and the commitment of the formatters, St.Paul College forges on strong in their resolve-"Caritas Christi Urget Nos."

Within the last 50 years, St. Paul School of Nursing has graduated thousands of professional nurses imbued with the zeal of St.Paul, who are now scattered in many countries and spreading the good news of Christ through their caring ministry. They work as educators, as practitioners, clinicians, community health workers, and volunteer workers. From a nursing school offering a graduate nursing certificate program, St.Paul is now a College offering not only a Nursing Baccalaureate Degree, but other courses as well. There are now four Paulinian College of Nursing in the Philippines, two of which has been chosen/recognized by the Philippines Commission of Higher Education as Centers of Excellence for Nursing Education.

The proposed paper for the conference presentation shall delve mainly on:

1.TheVision-Mission, the Objective ,Thrust, Institutional Culture of the Paulinian Nursing College and how these are actualized in the various activities of the program;

2.the conceptual framework of the formation and development of the Professional Paulinian Nurse Vocation;

3.the theoretical and practical component of the professional training ;

4.the process that goes into the system.

5.Some impact of the Paulinia Nursing education on the Nursing profession in the country and abroad;

6.initiatives, future direction, meeting the challenge of the third millennium for a more caring and compassionate nursing. Statistics and transparencies shall be utilized to make the presentation objective, objective, clearer and more scientific.

Madame Chairman, distinguished Guests, Officers of the CICIAMS , Rev. Fathers and Sisters, Ladies and Gentlemen, Friends, Good afternoon.

For this past two days, we have been listening to and have been enriched by experts who have detailed to us their comprehensive views on the philosophy, theory, and theology of caring as it relates to Nursing. This afternoon, I am afforded the

privilege of sharing with your our own experience of its praxis - in the Philippine setting. I am happy and honored to have come to this forum, for what I have heard this far, has affirmed what we in the Philippines have been doing during this 50 years of our school's existence.

Let me begin my sharing by introducing our school to you. St. Paul College of Iloilo is a catholic tertiary educational institution. It is one of the schools and colleges operated or own by the Sisters of St. Paul of Chartres in the Philippines. It is located in Iloilo city, one of the oldest and beautiful cities of the country. The college is relatively small in terms of its population, having an enrollment of 1100 students- by design, because of its strike entrance policy. It is co-educational, with the male students making up today, 20% of its population. It offers Baccalaureate degree programes in Management, Computer Information, Mass Communication, Physical Therapy, Home Management, and Nursing. Nursing, by the way, is the college's flagship program.

The formation of care givers, particularly of nurses, always been in the forefront of the apostolic work of the Sisters of St. Paul of Chartres. In our country, the Philippines, this activity formally begun in 1946, when St. Paul School of Nursing was established by the Sisters. Primarily, the purpose for opening the school was to meet the need for trained nurses who could minister to the patients of St.Paul Hospital, the only Catholic Hospital in the region. In a way, the move was also a response of the Church to the challenge laid by the burgeoning Protestant Mission School of Nursing in the province, and of preparing the laity to carry on the caring ministry of the church. From its inception therefore, the school has aimed at forming nurses who could care, not only - for the physical and medical needs of the patients, but for the spiritual and moral aspects of the patients' illness as well. To attain this goal, a program of study that would promote the enhancement and development of the Gospel caring values, as much as academic excellence and professional competence, had been utilized by the school as its tool. This program of study is based on a theoretical framework which is known by all those involved in the program and by the students, as the *STREAM OF THE PROFESSIONAL PAULINIAN NURSE VOCATION*. This theoretical framework, conceptualized and graphically illustrated two years ago underlines the basic approach and core values of the Paulinian Nursing Education since its foundation 50 years ago - that while the needs of the times, the advent of innovative educational strategies, and technological progress have always been considered by us, in our curricular enrichments and program adaptations, essentially, the foundational values and framework of the Paulinian Nursing education has remained constant.

The Stream of the Professional Paulinian Nurse Vocation

The Paulinian Nurse is rooted in Christ - Christ Prophet (teacher), Christ King (servant-leader), Christ Priest (lover). Inspired by and following the footsteps of Jesus, the Paulinian nurses are to become, in their turn, teacher-learners, servant-leaders, and loving care-givers, - care-givers therefore, who are knowledgeable, competent, compassionate. These qualities, values to be acquired, are ingrained and developed in the educand's mind, hand and heart via the three-fold aspects or components of the teaching-learning process - the Cognitive aspect/component, the Psycho-motor aspect/component, and the Affective aspect/component.[2] In the context of the Paulinian Nursing Program of study, these are seen (expressed) in terms of Knowledge (Teacher-Learner), Skills (Servant-Leader), and Attitude (Lover).

Teacher-Learner (Knowledge) - The cognitive component is aimed at the development of the mind or the intellect of the Paulinian Nurse, engendered through their General Education and the Professional Nursing Subjects, and nurtured in the institutional culture that values, serious pursuit for knowledge that is good, beautiful and true. The general education subjects, consisting of courses in social, natural, practical sciences, philosophy, language, arts and humanities, broaden the horizon of the students. The professional subjects

equip them with the knowledge of nursing concepts, principles, theories and practice. The students are exposed to various philosophies, intellectual persuasions, and secular subjects and orientations, but the Christian message and perspectives are brought out to them. In other words, they are taught to uncover the Gospel values that are at the ground of all cultures and of science, and to enrich with the Gospel truth and values their secular learnings.[3] In the words of the Holy Father, "to unify culture and faity"[4] This ingression of scientific knowledge and faith is even more explicit in the treatment of the professional nursing subjects. Here, the wholistic approach is demonstrated with the symbol of the Eucharist, with each of Nursing Year Level subject requirement, representing a segment of the Host.

Servant - Leader (Skills) - The second component of the program refers to the skills or psychomotor development portion of the STREAM. This aspect is focused on the application of the knowledge gained in theory, of acquiring the competency expected for the Level and the living out of the Christian notion of leadership as service. Of utmost importance in this portion is enabling the student to work in, with and for the community; living out the work ethics they are taught in the classroom, and witnessing in their day to day activities their Christian commitment to serve like Christ. This is carried out in the Related Learning Experience activities, in the clinical area and the community setting, and in their involvement in the parish activities through the Campus Christian Ministry Program. To inculcate the value, they are immersed in an institutional culture, which promotes "the building of and service to the community and the Paulinian family." The current global shift of the health care services from the institution to the community, in a very real sense dovetails with the Paulinian approach to community service. In fact, in the 1980's, the College of Nursing has been chosen by the Department of Nursing Education to be the pilot school for the new curriculum, which required intensive student community immersion. Today, once again, the Paulinian College of Nursing are spearheading the new Health Resource Development Program - Community Organizing Participatory Action Research (HRDP-COPAR) approach to Primary Health Care.

Attitude/Affective Component - The third component directly pertains to the heart. It therefore, most directly touches the core of the Paulinian Education. Without minimizing the importance of the knowledge and skills components, the students are made aware of the primacy of this dimension in their education. Christian value formation and transformation is impressed on them as that which makes their training different; that which sets them apart form other nurses. When the STREAM is explained to them for the first time, the students are thrilled to learn that they are to become LOVERS - compassionate, humane, gentle, warm, tender- lovers like Christ.

Among the three components of learning, this dimension in the Paulinian educative process, is the one most in need of stressing today. This is because, the students that come to us at this point in time are "children of the media" whose values, more often than not are shaped by this "very powerful teacher". It is unnecessary to detail how the values of the "world" are directly in opposition to the Gospel value of loving service and of caring. To help bring about Christian Curative transformation, great stress is placed on the Christian formation program. This consists of an integrated course in Religious education and Gracious Living, the regular celebration of the Liturgy and the Sacraments, provision for spiritual retreats and time for prayers, guidance and counseling and in patiently allowing the students to express themselves and to become, in an existential experience of life in an environment of respect that is borne out of love for; God, persons, creation, and country, In truly loving them.

The Paulinian approach to Nursing education is holistic, its focus - Christic! It is called the STREAM because like the gentle body of water we call stream, the Paulinian Nurse's is rooted, soured, and flows from Christ. It is active, life-giving and

dynamic… flowing from Jesus, given to the Church, shared by the Congregation of the sisters of St. Paul of Chartres, commissioned to St. Paul College of Iloilo, and made actual in the BSN Program. It is PROFESSIONAL, because it is organized integrated, and systematic, with its own set of objectives, goals, standards, policies, practices, and activities - the performance of which entitles the person to receive a commensurate remuneration. Its process is clearly understood and appreciated by all concerned and have been passed on from generation to generation, not only in the classrooms, but also through the witness and example of its graduates. The term PAULINIAN is the benchmark of the training. This identifies the nurse as a member of a particular group or family, formed according to a specific approach, upholding a particular tradition and believing in the same ideal in life. The term NURSE defines and particularizes the discipline of the educational program. The students are trained to become nurses, not midwives, not doctors, not physical therapist, not any other health professionals, but Nurses. And finally, theirs is not only a profession, an occupation that shall be their source of income, but most of all a VOCATION, RESPONSE TO A CALL, the call to follow Christ - Prophet, King, and Priest, - the Health Care Giver par Excellence. This is clear to every Paulinian and is deeply engrained in their hearts, especially the older graduates, who have had the fortune to be taught by the nuns themselves.

What is this STREAM? The approach? This theoretical framework of the Paulinian Nursing education? Clearly, the Paulinian approach to Nursing education is undertaken within the context of the Sisters of St. Paul of Chartres's Mission Affair. The fact that ours is a Christian country, and that 95% of our students are Catholics is the one great factor, that enables us and facilitates the anchoring of our Program of study in the Christian tenets of knowing, serving and loving God in the sick; of seeing Christ in the clients and of being Christ to them.[5] In a nutshell, the Paulinian Nursing Education hopes and strives to form catholic professional competent nurses who, with the Blessed Mother as their model, and inspired by St. Paul their patron, think with the mind of Christ, serves with the hand of Christ, and loves with the heart of Christ. Admittedly, this is a very ambitious goal, but always reminded by the proverbial Gospel "seed" and the various kinds of "soil" and trusting in God, the Paulinians forge on with their motto - "Caritas Christi Urget Nos."

"You will know the tree by its fruit."[6] The effectiveness of an educational approach is generally measured by the performance of its graduates.[7] On the academic plane, an assuring confirmation of the efficacy of the Paulinian Approach is the tract record of its graduates' performance in the National Nurses Licensure Examination. Since 1948, the school has always been among the Ten Outstanding Schools/ Colleges of Nursing in the country recognized by the Philippine Regulation Commission, Board of Nursing. Today, it is one of the eight Centers of Excellence for Nursing Education recognized by the Philippine Commission on Higher Education and deputized by the same Commission to implement its Expanded Tertiary Education Accreditation Program. Within the last 50 years, St.Paul College has graduated thousands of professional nurses who are now scattered in many countries. Quite a number have made their marks in their places of work, recognized not only for their competence but also for their Christian professionalism. Some have been recipients of prestigious awards such as the Legion de Honor of France and the Posthumous Award of Recognition for Dedication to Duty. Mostly they work as missionaries, educators, administrators, practitioners, clinicians, community health workers, volunteers, nurse entrepreneurs or simply parenting their children, quietly spreading the Good News of Christ through their caring ministry.

Yet, another affirmation of this approach is the support from grateful parents the school receives parents who believe in the quality of education that the school offers, and therefore continually trust the formation of their children to the College. But perhaps, the most satisfying assurances are the testimonies of the graduates themselves whose lives are marked by the mark of

Christ-their coat of arm, "Caritas Christi Urget Nos! Once a Paulinian, always a Paulinian!"

The Future:

Today as we face the coming of the third millennium, what are the challenges, the obstacles the College is facing? First of all, is the loss of appreciation of the youth for the service professions, which do not bring in the cash coupled with the high cost of Nursing education. This is very evident in the Philippines. As previously pointed out, the youth of today are very much influenced by the culture of the mass media, which extols materialism and consumerism as a way of life. Success is equated to having more, what is big, being beautiful. Also, due to the closure of the American employment market, on the one hand, and the economic difficulty prevailing in the country on the other, there has occurred, a marked decrease of enrollment in the course. This has serious repercussions. Many schools had to retrench, others had to close. Nursing employment opportunities has been affected, faculty had to be deloaded or their employment terminated.

Another challenge that has to be met, in our country as least, is the political passivity of our Nurses. Because historically, Filipino nurses were trained and made to believe that they are handmaidens of the physicians, many Filipino nurses has remained the passive silent majority. Uninformed and unconcerned of many social and/or political issues, legislation prejudicial to their welfare are passed and become laws without their knowing it. An example of this is the provision in the Philippine nursing law which regulates the eligibility of entrance to the Nursing school to the upper 40% high school graduates. While the intent of the law is good, its application is prejudicial, both to the prospective students and the Colleges of Nursing. Nursing education must therefore provide opportunities to develop Christian assertiveness among their students - to be able to stand for a just cause with serenity and courage.

A third and most exciting challenge, is the globalization of the third millennium.

Nursing must make the quantum leap or perish as a profession. Considering the pace at which social changes are taking place today, nursing can not afford to stand still and live by the glory of its past. It must adjust, adapt, and change, be in step with the progress in science and technology. It should, as some modern psychologist put it, be like the dolphin, able to gracefully ride the crest of the waves of change. However, in this quest for progress and amidst the whirling rapidity of societal and cultural change, nursing must never forget its essence of caring and loving service. Maintaining this balance is the challenge that all nursing educators share today.

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Research

The Experiences of Nurses in Caring for Patient with AIDS in Thailand:A Phenomenological Study

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abstract

This study was designed to investigate the experiences of nurses in providing care for AIDS patients in Thailand using a phenomenological approach. Data were collected during a seven-month period in a university hospital and a communicable disease hospital. Data collection involved audio-taped interviews with twenty-eight full time nurses working from the two settings. The inquiry focused on five areas; (a) how nurses construct a view of nursing AIDS patients; (b) how nurses think, act and reflect on their clinical practice; (c) how nurses feel about caring for AIDS patients; (d) the factors that facilitate or inhibit the providing care for AIDS patients; and (e) the impact such experiences have on nurses.

Data were analyzed through the process of hermeneutic interpretation, using both manual analysis and NUDIST computer software. As a result, ten themes were identified and used to describe the meaning of the lived experience of nursing AIDS patients; that is: being aware of AIDS patients; being safe when nursing AIDS patients; accepting AIDS patients; being obliged to nurse AIDS patients; doing the right thing for AIDS patients as good things will return in consequence; nursing unco-operative AIDS patients; nursing co-operative AIDS patients; providing technical care; providing compassionate care; and self-fulfillment from caring out nursing actions.

Four significant factors indicated by the nurses as inhibiting factors include: inadequate and poor quality protective equipment; lack of cheerfulness and support by nursing administration; lack of collaboration and recognition of nurses by the health team; and work stress in relation to unco-operative AIDS patients. The participating nurses identified four facilitating factors: professional obligations and compassionate attitudes towards AIDS patients; having knowledge and gaining more experience in nursing AIDS patients; nursing co-operative AIDS patients; and good interpersonal relationships within the nursing team.

The experience of nursing AIDS patients can be both satisfying and stressful for nurses as found in the Theme: The impact of nursing AIDS patients. Four issues were identified: the impact on nurses; on their attitudes towards nursing practice; and on their attitudes towards the nursing profession. The implications of these findings for the development of knowledge in the areas of AIDS care for nursing practice, education, management and research are discussed.

Background of the Study

Since the first case of acquired immunodeficiency syndrome (AIDS) was recognized in the United States and subsequently named in 1981, AIDS has evolved from a discretely limited disease to become a major public health problem (Larson, 1988).

HIV infection is spreading at an alarming rate in Thailand. In August 1984, the first AIDS case in Thailand was found in a Thai male homosexual who returned from abroad. From 1991-1995, the number of AIDS cases reported to the division of epidemiology had increased dramatically. The epidemiology of HIV infection was classified as an epidemic Pattern III country, and could be summarized as it

first rapidly transmitted in IUDU and then appeared to spread to other high risk groups, from heterosexual men and more recently transmitted to the low risk in general population. Among heterosexual men, the risk factor contributing to HIV transmission was unprotected sex with female prostitutes (Weniger et al, 1991).

It is acknowledged that AIDS is a chronic disease and the care of patients with AIDS (PWA) will be long term. Whilst nurses assist PWA to maintain meaning, values and their life goals, they can also experience burn-out as a result of the emotional stress related to caring of these patients. Stress experienced by AIDS caregivers may be affected by the fact that: AIDS is a chronic terminal disease; AIDS sufferers are often from the younger age groups; and PWA are often not accepted by the society as they are seen as mostly intravenous drug abusers, homosexuals and prostitutes (Nashman, Hoare & Heddesheimer, 1990).

Morever, one of the significant stressors associated with caring for PWA is the infectious nature of the disease and anxiety may be experienced in response to the perceived threat of catching the disease. Despite the scientific evidence of the low risk associated with occupational exposure to this infection, many nursing staff demonstrate highly fearful behavior (Meisenhelder & La Charite 1989).

Earlier studies largely based on surveys reported that there were significant stressors for nurses who cared for people suffering from AIDS. Earlier findings suggested the need for research to examine the lived experiences of nurses who care for PWA in the real world of nursing practice. Such information will provide ways to support and encourage nursing staff who are willing to provide care for AIDS sufferers. The need to have staff development programs to help the nursing profession understand the experience of providing care for these patients will, in the long term, improve nursing care and prevent the depletion of nursing staff.

The Research Questions

The research questions center around one pivotal theme - ***What are the experiences of nurses in providing care for patients with AIDS of HIV infection in Thailand?***

In effect, this study intends to investigate:

1. how nurses construct a view of caring for AIDS patients;
2. how nurses think, act and reflect on their clinical practice;
3. what are the factors are that inhibit and facilitate nurses in providing care for AIDS patients; and
4. the impact the experiences have on nurses.

Conceptual Framework

Because nursing practice is heavily influenced by experience, I have chosen to use the 'everyday nursing experience' as a 'window' to grasp the meaning of the lived experience of nursing care for AIDS patients. Phenomenology offers great potential for this topic because phenomenology can answer questions such as, 'What is it like to have a certain experience?' (Field & Morse, 1990). Phenomenology is a descriptive approach which aims to identify the essence of the human experience as it is lived. It is based on meditative thought and aims to promote an understanding of human beings wherever they may be (Omery, 1983).

Data Collection Methods

In line with the phenomenological perspective, data for the study were collected using the in-depth interviewing method. Data were collected during a seven month period in a university hospital and a communicable disease hospital. Audio-taped interviews were conducted with twenty-eight full time nurses working in the two settings.

All participants were asked to participate in five specific semi-structured inquiries. The main aim of the interviews was to capture the participant's feelings and thoughts from the participant's narration.

The first inquiry focused on the participant's view of the meaning of 'nursing care' and 'nursing care for patients with AIDS.'

- *What is the meaning of 'nursing care' for you? and*
- *What is the meaning of 'nursing care for patients with AIDS' for you ?*

The second inquiry aimed to explore nurses' experiences in providing care for AIDS patients. The actual question usually started with the following statements:
Tell me about the AIDS patients with whom you were impressed and what happened when you gave nursing care to them.

Usually, the interview would continue with open-ended questions, and then go on to explore the whole experience by asking the nurse to think of a specific instance, situation, person, or event by referring to these questions:
Can you explain more or give me an example? or
How did you feel in that situation? or
What did you feel like? or
In what way?

The third inquiry aimed at investigating the inhibiting and facilitating factors in providing care for patients suffering from AIDS. The question was:
What are the factors that inhibit and facilitate you in giving care for AIDS patients?
The fourth inquiry aimed to explore the impact of the experience of providing care for PWA on nurses.
How and what impact did the experience have on your nursing practice?

The interview was taped until the participant had nothing further to narrate about the experience. After conducting the twenty-eight interviews, I transcribed the audio-tapes into written text. A copy of each transcribed interview was given back to each participant as a means of checking that the transcripts were clear and understandable and faithful to what the participant had conveyed. After participants gave approval, each transcribed interview was ready for data analysis and hermeneutic interpretation.

Method of Data Analysis and Hermeneutic Interpretation

The process of data analysis and hermeneutic interpretation was executed in two phases. The purpose of the first phase was to identify and reflect on the preliminary themes and the structure of the experiences of nurses in providing care for PWA. The tasks in the first phase involved manual exploration of the preliminary themes and structure of the studied experience and returning to validate preliminary insights with the participants. The second phase of data analysis and hermeneutic interpretation was conducted after I had withdrawn from the fieldwork. The analyzing task in this phase consisted of manual data analysis and NUD'IST (Non-numerical Unstructured Data Indexing Searching and Theorizing) computer analysis.

The themes which emerged form manual analysis served as the input data for NUD'IST computer software analysis. Using NUD'IST computer software, the essential themes were indexed, categorized, restored and shaped until finally the essential structure of the studied phenomenon was developed. Throughout the process of data analysis, ten major themes were identified and used to describe the structure of lived experience of the nurses concerned.

Findings & Conclusion

The experience of nursing PWA is illuminated and examined for its meaning in this study. Ten major themes are identified and used to describe the meaning of the experience of nursing PWA as it is lived. These ten themes are: being aware of PWA; being safe when nursing PWA; accepting PWA; being obliged to nurse PWA; doing the right thing for PWA as good things will return in consequence; nursing unco-operative PWA; nursing co-operative PWA; providing technical care; providing compassionate care; and self-fulfillment from carrying out nursing actions.

Nurse participants' perceptions, feelings, knowledge and attitudes towards AIDS, PWA and their care are described in their experience of 'being aware of PWA.' The nurse's awareness of taking full precautions and of preparing themselves so as to maintain their safety are demonstrated in the nurses' experience of 'being safe when nursing PWA.' The nurses' experience of 'accepting PWA' demonstrates nurses' acknowledgment and realization of the AIDS situation as a major health problem in Thailand and the importance of their nursing role in helping AIDS patients. The nurses' experience of 'being obliged to nurse PWA' illustrates the nurses' commitment and obligation to provide care for patients who need care, regardless of their social status and their health problems. Another aspect of their experience of nursing PWA as described by Thai nurses is reflected in the theme 'doing the right thing for PWA as good things will return in consequence' which demonstrates the profound influence of religious beliefs (in particular Buddhism) on the beliefs and values of Thai nurses and illustrates how the Buddhist philosophy is adapted to everyday nursing practice. The theme 'nursing unco-operative PWA' and the theme 'nursing co-operative PWA' provide an understanding of how the nurses received PWA who are unco-operative as an inhibiting aspect of care whereas co-operative behavior was perceived as a facilitating factor. The nurses' experience of 'providing technical care' and 'providing compassionate care' illustrates how the nurses considered the care they provided as dependent functions which involved tasks assigned by physicians and focused on physical care, and as independent functions which involved tasks to be willingly performed by nurses and focused on psychosocial care. Finally, the nurses experienced 'personal and moral satisfaction' when their practice fostered the well-being of patients.

The experience of nursing PWA can be both satisfying and stressful for nurses. The satisfying aspects of nursing AIDS patients is illustrated when the nurses described their feelings of self-fulfillment when carrying out nursing actions. The nurses felt a sense of personal and professional achievement when they were able to foster the well-being of AIDS patients and they were appreciated by the patients. On the other hand caring for PWA can be a stressful experience for nurses if they are unable to cope with the repeated stresses associated with caring for these patients. Based on the findings of this study, the possibilities for nursing practice, education, management administration and research are suggested.

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Research

Caring Behavior of Clinical Instructor and Professional Attitude of Nursing Students under the Jurisdiction of the Ministry of Public Health

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Beside being the major user of professional nurses, the Ministry of Public Health has become a major producer of professional nurses in Thailand. Each year, nurse educators experience a number of drop out students due to bad attitude toward nursing profession. They also experienced that the student nurses who still maintained their studentships gradually developed negative attitude toward the nursing profession. Several literatures suggested that clinical instructors were a factor influencing their nursing students (Leddy & Pepper, 1985: Reilly & Oermann, 1992). During clinical teaching, interactions between the clinical instructor and nursing students occurr. Roach (1987) believed that the interaction between the clinical instructor and the student nurse was a natural process requiring caring behavior: the behavior which included compassion, competence, conscience, confidence, and commitment. By being a role model of caring behavior and exhibiting caring behavior towards the student, the clinical instructor could transfer all essentials for nursing practice competency to the student. Through a direct experience of being cared for, the student could gain insight to provide holistic nursing care for their clients. Successful nursing care of the student might have an impact on her/his attitude toward nursing profession.

Objectives

1. To examine level of caring behavior demonstrated by the clinical instructor as perceived by the nursing student.
2. To examine level of professional attitude of the nursing student.
3. To investigate relationship between caring behavior demonstrated by the clinical instructor and professional attitude of the nursing student.

Methodology

This study is a descriptive design. The population of this study was second, third, and fourth year nursing students enroled in 5 Baromrajchonnani Nursing Colleges in the Northern region, that is, Payow, Ttaradit, Lampang, Buddhachinanraj and Sawanpracharuk Baromrajchonnani Nursing Colleges. Two hundred and eighty five subjects were stratified randomly selected. A three part questionnaire developed by the investigator was used to collect data. The questionnaire consisted of a demographic data record, Caring Behavior Questionnaire and Professional Attitude Questionnaire. The Caring Behavior Questionnaire (CBQ), consists of 52 items and each of them allowed 5 scales of responses, was developed by using Roach's five components of caring behavior as a conceptual framework. The Professional Attitude Questionnaire (PAQ) was based on Triandis theory (Triandis, 1971). It consisted 36 items which each of them allowed 5 scales of responses. Both questionnaires were validated through panel judges and tested for their internal consistency. Cronbach's alpha coefficient of the CBQ was 0.95, and that of the PAQ was 0.85.

The package of questionnaires was distributed to the subjects by mail and directly by the investigator. There were 283 completed questionnaires (99.30 percent) returned. All collected data was analyzed by using SPSS/PC program. Percentage, mean, standard deviation, one way analysis of variance, Scheffe's test, and Pearson's Product Moment Correlation were statistics used in the data analysis.

Results and Discussion

1. Level of caring behavior demonstrated by the clinical instructor as perceived by the nursing student.

Level of caring behavior demonstrated by the clinical instructor as perceived by the nursing student was at moderate level (mean=3.66, SD=0.46). By having a close examination on the five components of the caring behavior: compassion, competence, conscience, confidence, and commitment; it was found that each of them was also at moderate level. The compassion component yielded the lowest score (X=3.14, SD=0.60) while the score of conscience component was the highest (X=3.95, SD=0.53).

Caring behavior dealt with feeling and emotion. Although caring behavior was an intention of an individual, sometime it was difficult to be detected by the counterpart. During clinical practice, a clinical instructor was responsible for 18-35 students at a time and it was required for a student to spend 3-4 weeks or less practicing in a unit. This situation allowed the clinical instructor to have minimal contact with the student and resulted in the student's perception of moderate level of caring behavior. This finding is congruent with a study reported by Sarawalee Reungwiscs (BF.2537) which demonstrated a moderate level of interaction between nurse educators and nursing students of Baromrjchonani Nursing Colleges, Ministry of Public Health.

2. A comparison of levels of caring behavior demonstrated by the clinical instructor perceived by the nursing students of different classes.

By using analysis of variance, it was found that there was a significant difference between levels of caring behavior demonstrated by the clinical instructor perceived by the nursing students of different classes ($F=17.15$, $p<001$). Through a Scheffe's test, it was found that the second year students perceived the caring behavior demonstrated by the clinical instructor in the higher level than those of third and fourth year students accordingly ($p>.05$).

This finding reflected the fact that during the second year, the students were closely supervised by the clinical instructor because they were new to the actual nursing environment. The clinical instructor was more likely to stay away to allow the students opportunity to make their own decision during clinical practice when the student was in the third year and stay further away when the student was in the fourth year. This manner was assumed to be essential in order to develop sense of autonomy of the student. The clinical instructor would intervene the student's performance whenever there were mistakes or risks. Hence, the clinical instructor was perceived by the more senior students as demonstrating less caring behavior.

3. Professional attitude of the nursing student.

The subjects expressed good professional attitude (X=3.91, SD=0.32). However, it was found that the affective component of the professional attitude was scored as moderate level (X=3.52, SD=0.36=0.36). The other two components, cognitive and behavioral, were scored as good level (X=4.46, SD=0.35; X=3.74,SD=0.50 accordingly).

In Thailand, professional nurses have always been needed. To call attention from the high school student to attend nursing training program has been

desirable. Since educational guidance was operated in the secondary school, it has been an excellent chance for the nurse educators to provide information regarding nursing education to those high schoolers. It was assumed that the student was prepared to gain their perception of actual situation about nursing and nursing practice. As described by Triandis (1971) an individual tended to express positive attitude toward something whenever he or she developed his or her recognition and understanding of such thing which were congruent or similar with the reality. This explanation may be implied to this finding.

4. A comparison of professional attitude of the nursing students of different classes.

By using analysis of variance, it was found that there was a significant different professional attitudes expressed by the nursing students of different classes ($F=6.55, p>0.1$). Through Scheffe's test, it was found that the second year students expressed better professional attitude than those of the fourth and third year students accordingly ($p>0.5$).

Practicing clinical nursing of the students of Baccalaureate program mostly began in the second year of schooling but with minimal amount and under close supervision of the clinical instructor. The heaviest clinical practice fell in the third year. This year, the students were required to provide bedside care, learned new tasks, and challenged to exercise be autonomous whenever possible. The fourth year students were required to practice in special areas such as psychiatric nursing and community nursing. Clinical workload for this year was lesser. Although the clinical instructor did not supervise them closely during the practice, the students were ready to be autonomous for their practice because of their competence in nursing skills which they earned during their third year in nursing program. Fear of making mistakes accompanying with hardship of all clinical requirements might lead the third year students expressing their lowest level of professional attitude.

5. Relationship between caring behavior demonstrated by the clinical instructor and professional attitude of the nursing student.

There was a significant positive relationship between caring behavior demonstrated by the clinical instructor and professional attitude of the nursing student ($r=0.40, p>.001$).This finding demonstrated that caring behavior exhibited by the clinical instructor was a positive reinforcement for the nursing student to develop self confidence (Gallagher, 1992) which according to Hanson & Smith (1996), motivated the student to face hardship in learning. Through their understanding of the reality regarding nursing profession, the positive attitude toward the profession could be expressed. Moreover, caring behavior demonstrated by the clinical instructor could stimulate the student's acceptance of caring behavior and adoption of the behavior during their clinical practice (Pardo, 1990 cited in Sarawalec, BF. 2537). Successful clinical experience itself might lead to the positive attitude toward the nursing profession.

Summary and Suggestion

Professional attitude of the nursing student has been an important issue raised by many nurse educators. This study showed that caring behavior demonstrated by the clinical instructor was perceived as moderate level and was perceived differently by the students of different years of education. Professional attitude was good and varied depending on the year of education, and there was a relationship between caring behavior demonstrated by the clinical instructor and professional attitude of the nursing student. The findings suggested the need to develop the clinical instructors' awareness of their caring behavior during clinical supervision. Reassessment of the clinical instructor's caring behavior and related factors for the future improvement of caring behavior of

the clinical instructors is also suggested. These investigators are concerned of the limitation of this study that only particular nursing students were selected, therefore, repetition of this study with the larger group and different setting is required. Moreover, other factors related to professional attitude of the nursing student should not be overlooked.

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Research

Model Development for Participatory Caring Relationship Between Nurses and Patients to Enhance Self-Care Abilities in Kanghangmaew,Community Hospital, Thailand

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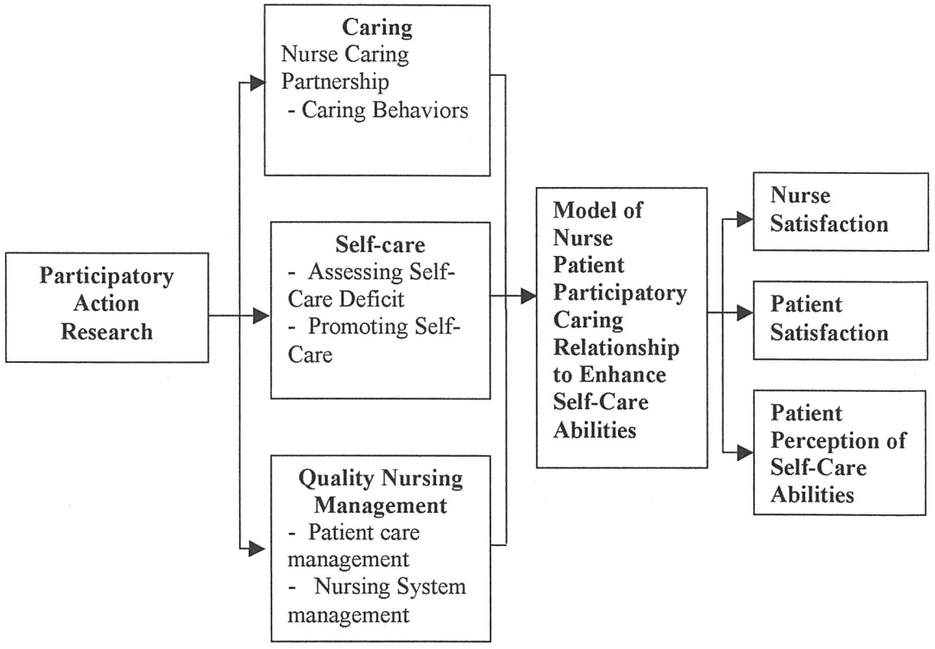
Introduction

Self-care is a main policy in providing health service in Thailand. Kanghangmaew hospital is a newly established community hospital situated in a remote area, Eastern of Thailand. Nurses and clients involving in providing and receiving care in this hospital perceive that nursing care service is not clearly self-care goal directed. Therefore, development of a nursing care model to promote client participation in self-care is necessary.

Purpose

The purpose of this study was to develop a model for participatory caring relationship between nurses and patients to enhance self-care of patients admitted in Kanghangmaew Hospital, Chantaburi Province, Thailand.

Conceptual Framework



Setting and Participants

- Kanghangmaew Hospital, Chantaburi Province, Thailand
- 16 Nurses (8 Professional Nurses and 8 Technical Nurses)
- 20 Admitted Adult Patients

Conduct of the study

Participatory Action Research was used to conduct the study. The study was conducted from November 1995 - September 1996

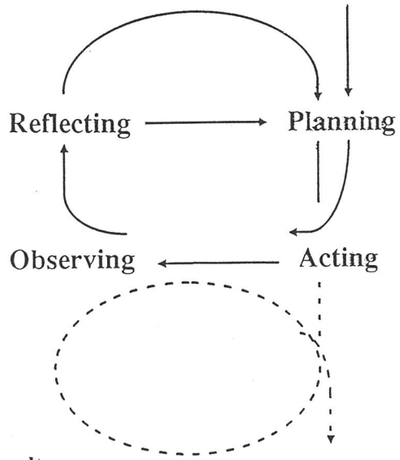
Phase I Preparation
- Researcher

Phase II Development of the model
- Evaluating problems and needs
- Developing initial model
- Implementing of the model

Phase III Evaluation of the model

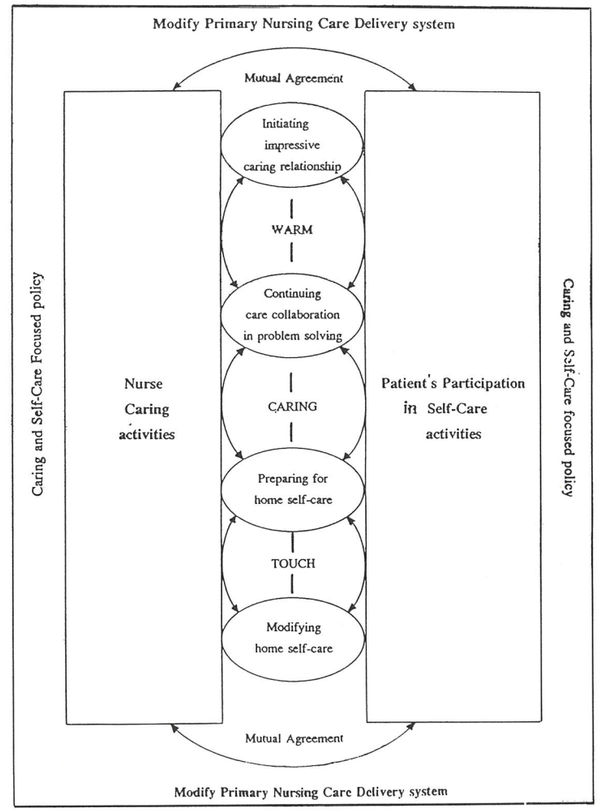
Conduct of the study (Continued)

The research was conducted based on action research cycle



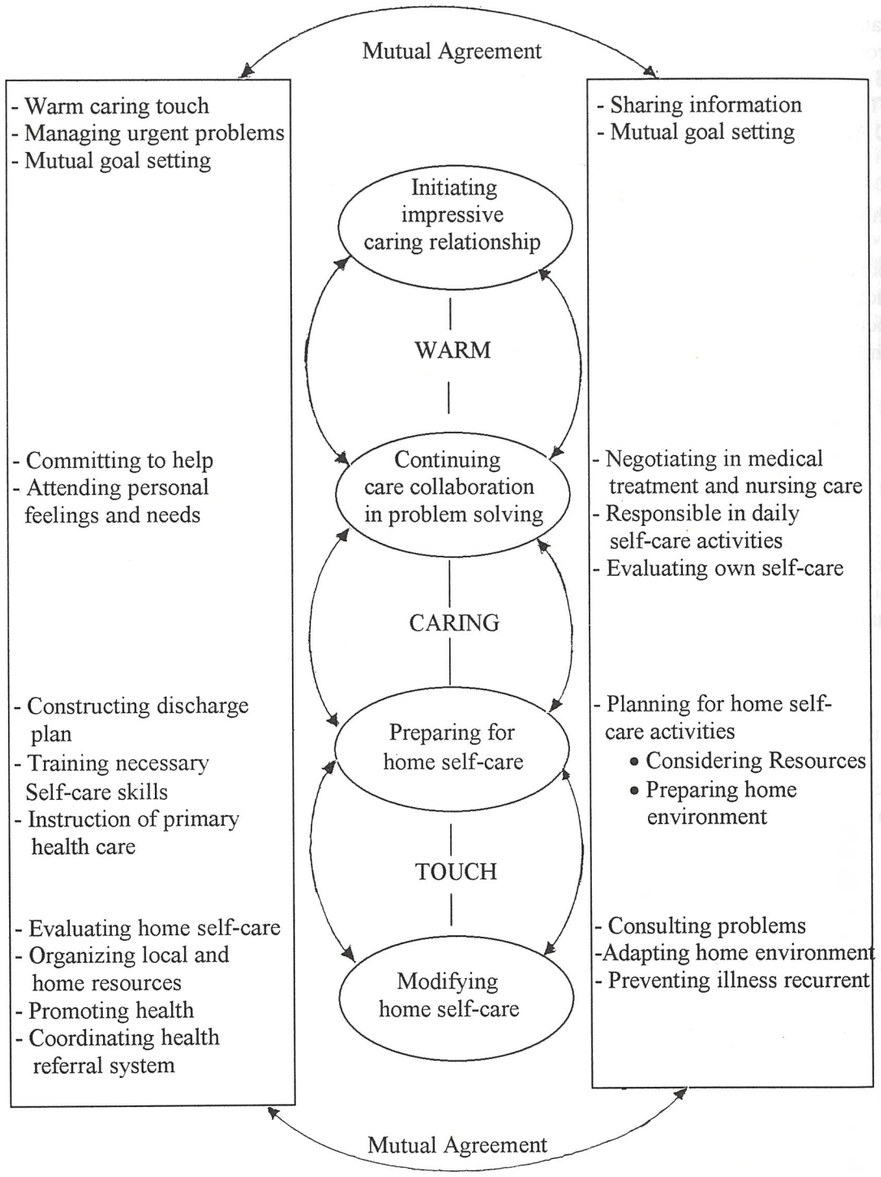
Result

A nursing care model of one to one nurse-patient continuing caring relationship was developed to enhance patients' participation in self-care. It was composed of four phases:
1. Initiating impressive care relationship
2. Continuing care collaboration in solving problems
3. Preparation for home self-care
4. Modifying home self-care



A Model of Nurse Patient Participatory Caring Relationship to Enhance Patient's Self-care in Kanghangmaew Community Hospital

Modify Primary Nursing Care Delivery system



Modify Primary Nursing Care Delivery system

A Model of Nurse Patient Participatory Caring Relationship to Enhance Patient's Self-care in Kanghangmaew Community Hospital

Strategies Used to Improve Nurse Caring Attitude and Behaviors:

- Reflecting on quality of care
- Mutual agreement in improving the nursing care practice
- Providing information and knowledge
- Role modeling
- Empowering nurses in care management
- Supporting among colleagues

These phases go along with nurse caring touch and mutual agreement of both nurses and patients, within the context of caring and self-care focused policy, and modified primary nursing delivery system. Both the nurses and the patients have high level of satisfaction in participation of the model. In addition the patients perceive their self-care abilities.

The Patients' Participation in Care

- Sharing information
- Being mutually goal setting with nurses
- Negotiating in medical treatment and nursing care
- Being responsible in daily self-care activities
- Evaluating own self-care management
- Planning for home self-care activities
- Consulting problems
- Adapting home environment
- Preventing illness recurrent

Patients Perception of Self-Care Abilities

- Selecting appropriate food intake
- Performing appropriate activities
- Maintaining normal elimination
- Development skills in decision making for self-care
- Interacting with people for seeking care
- Managing self in prevention of associated complication

Conclusion and Recommendation

Nursing care model of the nurse-patient participatory caring relationship is developed. It consists of four phases of nursing care; initiating impressive care; continuing care collaboration in solving problems; preparing for home self-care; and modifying home self-care.

This model is used as a framework for nursing practice in Kanghangmaew hospital for the goal of patient participation in enchanting self-care abilities. However, it has a potential to be used in other community hospital.

Research

Mindfulness and Meditation Training as Ways of Developing a Healing Relationship with self, Patients, and Others

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This study was a part of the action research project on "A Study of the Process and Outcome of Collaboration between Nursing Service and Nursing Education in Thailand." Its aim was to operationalize and assess the implementation and the outcomes of collaboration between nursing services and nursing education in order to improve the quality of nursing service and education. A 40-bed medical ward was selected to implement the project. Although the main research focus was not on developing healing relationships, it was a major concern identified by participants. A busy atmosphere and lack of relationship with patients and among participants were factors that inhibit nurses from providing effective nursing care. The purpose of this paper is to present the process of how nurses can develop healing relationships with themselves, patients, and others.

Action Research was employed as a methodological framework by going through its spirals of planning, acting, observing and reflecting. Two workshops on "Developing interpersonal relationships" and "How to gain merit from work" were conducted to prepare the approach and plan for implementation. A 3- day retreat for 25 nurses and clinical teachers was also conducted to teach mindfulness and meditation. Teaching mindfulness and meditation included understanding a basic sense of humanity, refinement, and meditation instruction. The meditation instruction comprised of mindfulness cultivation, walking meditation, sitting meditation, active meditation, and Dhamma talking. The retreat was designed to teach nurses to live in a calm, respectful relationship with their own body. By learning to embody the trust of compassion, loving kindness, and a healing relationship to the self, the nurses then tried to extend this to their family and nursing practice. The data were collected through the methods of participant observation and interviews. Researchers recorded events on audio-tapes and wrote field notes. The data then were analyzed through qualitative methods and critical reflection. The results revealed that nurses and teachers were more open, calm, active, and respectful and the atmosphere of collaborative work open, calm, active, and respectful and the atmosphere of collaborative work were more stimulating, encouraging and enjoyable. The result then, in turn, improved the quality of nursing practice. Self development through mindfulness and meditation training is clearly a key factor in any successful professional development in nursing.

Research

To Study of Nurses' Self Awareness and Caring Behavior for Terminally ill Patients

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Abstract

Death is common, inevitable, and occurs only once in our human life. Therefore, death has a greater importance for terminally ill patients. They have an indeterminate interval of time for living and dying, which creates grief and suffering in the dying phase. Nurses are important resource in helping those patients to have a good quality of life and harmony in their physical, mental, and spiritual condition. Nurses help to decrease suffering and grief for the patients, which allow them to die with greater peace of mind.

For nurses to be effective in this role, they must have a real desire to help and posses a caring behavior. Caring behavior, in this instance, is defined by the ten carative factors of Watson's Transpersonal Caring Theory. Nurses must develop themselves to fit into the role. Therefore, the researcher was interested to study caring behavior of nurses with terminal patients, and nurses' self awareness, which is defined as a consciousness and sensitivity to themselves during the caring process, and which involves their thinking, feeling, and behavior.

In order to obtain and measure data, registered nurses who had had prior experiences with nursing terminal patients were selected for this study. The target group was 149 registered nurses from all Catholic Hospitals in Thailand: St. Louis Hospital and Carmillian Hospital in Bangkok, St. Mary Hospital in Northeast of Thailand, and San Carmillo Hospital in East part of Thailand. The two instruments developed by the researcher consisted of the self awareness and the caring behavior questionnaires in which their internal consistency coefficient were 0.80 and 0.95, respectively. Statistics used in this study were percentage, mean, standard deviation, Pearson's Product Moment Correlation and One- Way Analysis of Variance.

The overall results of this research in this target group showed a tendency to have a high score in nurse self awareness and caring behavior, and nursing self awareness correlated positively with caring behavior at the moderate level with a significance of $P < .001$ ($r = .31$). When the target group was studied in detail, the scores of nurses caring behavior with the terminally ill patients were separated by 10 carative factors. The seventh factor, which was the promotion of interpersonal teaching learning, and the tenth factor, which was the allowance for existential phenomenological spiritual forces, showed a tendency to have low scores with more than half of the target group, wheras the remaining factors showed a tendency to high scores. Moreover, the result of this study showed that nurses who have high score in self awareness, will have high score in caring behavior with terminally ill patients. The researcher suggests that nurses should develop their self awareness, and adjust their caring behavior to complement terminally ill patients under their care.

Research

Effects of Affective Touch on The Level of Pain Among Primipara after A Normal Spontaneous Delivery

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Touch is an important caring behavior of a nurse to ease the pain among women who undergo the process of labor and delivery especially when an episiotomy is done for a primipara. According to the gate control theory, in affective touch, the large peripheral nerve fibers at the injury site to transmit pain impulses appears to decrease. The act of touching and being touched involve the stimulation of receptors in the skin that transmit messages to the brain that are interpreted by the person. By enhancing the activity of the autonomic nervous system, touch can cause the release of norepinephrine from the sympathetic nervous system and/or acetylcholine from the parasympathetic nervous system (Tovar and Cassmeyer, 1989).

The importance of touch and being touched begins in humans during infancy. Frank cited by Barnett, revealed that on infants and children nothing was more important to early physical and mental growth than touch. Field, founder of the Touch Research Institute at the University of Miami found that infants up to six months who were massaged for 15 minutes a day for two weeks took only 9 minutes to fall asleep compared to 22 minutes when not massaged.

The present research which was initiated with enthusiasm and interest sought to assess the perceptions of pain and touch and the effect of affective touch on the level of pain among primipara after a spontaneous normal delivery.

Specifically, the study sought to determine:

1. The perception of pain and touch among primipara after a normal spontaneous delivery;
2. The effects of affective touch on the level of pain by determining the pre-test and post-test mean scores of the experimental and control groups in terms of blood pressure readings, respiratory rate, heart rate, pain rating scale and level of activities;
3. Whether there is a significant difference between the pre-test and post-test mean scores of the experimental and control groups.

Definition of Terms:

Affective touch - is the physical contact with the use of hands administered in slow firm manner at the lower back, arms and hands of the patients as she experiences pain.

Pain - is an unpleasant sensation caused by the stimulation of certain nerves as a result of injury.

Vital signs - includes blood pressure, heart rate and respiratory rate.

Level of pain - through the use of visual analog scale the degree of pain is rated by indicating the number: 0 for least pain and 10 as the worst pain.

Level of activities - this is indicated by numbers:
1= lying in bed - unable to sit by oneself
2=sitting with assistance
3=sitting without assistance
4=walking with assistance
5=walking without assistance

The study involved thirty fully awake primipara with episiotomy after a spontaneous normal delivery in a government hospital. Fifteen randomly assigned subjects in the experimental group received affective touch from the researcher herself while the other fifteen randomly assigned subjects in the control group did not receive any intervention.

A quasi-experimental research design was utilized. The researcher used a non-standardized interview guide, the pain flow chart and the visual analog scale to gather the needed data. The pain flow chart was adopted form McCaffery and Beebe. This instrument has three parts namely: the vital signs record, the pain rating scale and the level of activity. The visual analog scale is a two-faced hard paper showing variations in the intensity of red on one side and the corresponding numerical values representing the degree of pain on the other side. The higher number represents intense pain and zero represents least pain.

In the experimental group, vital signs, pain rating and the level of activities of each mother were recorded. Then affective touch was applied; after which the vital signs, pain rating and level of activities were recorded. In the control group, vital signs, pain rating and the level of activities of each mother were recorded. No affective touch was applied but the vital signs, pain rating and level of activities were recorded after ten (10) minutes.

Data gathered were statistically treated utilizing frequency, percentage and mean. The t-test for independent samples was employed to determine whether a significant difference exists between the experimental group and control groups. The t-test for matched samples was employed to determine whether a significant change in the pain parameters occurred in the experimental group after the intervention as well as in the control group.

Results of the study revealed that the subjects described their pain experiences as shooting, throbbing, stabbing, tender, gnawing, fearful, tiring and exhausting. They perceived affective touch as an experience that eases pain, gives comfort, brings happiness and gladness, gives security and a feeling of being loved. Patients felt more comfortable to verbalize pain to the doctor and husband who are being looked up as guide and support. Surprisingly, only 23.33% recognized touch as a comfort measure, contrary to Stuart and Sundeen's claim that Orientals tend to touch more and are more open to touch. The study revealed that there is a significant difference in the pre- and post readings in the pain parameters among subjects in the experimental group. The findings further suggest that changes occurred in the blood pressure readings, heart rate, respiratory rate, pain rating scale and level of activities after employing touch to the experimental subjects. On the other hand, there is no significant difference in the pre- and post readings in the pain parameters among subjects in the control group. The study further revealed that there is a significant difference in the post readings in the pain indicators between the experimental and control group as shown in table 1 and figures A, B, C, D and E. The blood pressure readings, heart rate, respiratory rate, pain rating scale of the experimental group were lower than the post readings of the control subjects. The level of activities of the experimental subjects were higher than that of the control subjects. Therefore, affective touch was effective in reducing episiotomy pain experienced by primipara who have undergone spontaneous normal delivery.

Results of the study revealed that pain can be relieved by a non-pharmacological intervention called affective touch. Relief of pain can be indicated by pain parameters such as diastolic and systolic blood pressure reading, heart rate, respiratory rate and level of activities.

From these findings, the researcher strongly recommends the integration of touch as a mode of managing pain among patients. Greater emphasis should be given on the non-pharmacological intervention called "touch" in the nursing undergraduate curriculum through the inclusion of touch as a separate concept in

the different levels. Nursing students should be afforded opportunities in employing touch in the clinical area. In-service programs and seminars on affective touch should be conducted among doctors, nurses and members of the health teams. Further study on the use of affective touch among post-operative cases can be explored.

Table 1

Pain Parameters of the Experimental Group Before And After Affective Touch

N	Systolic BP		Diastolic BP		Heart Rate		Resp. Rate		Pain Rating		Level of Activities	
	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST
1	115	110	70	70	74	75	79	18	6	5	1	5
2	130	120	100	100	116	106	28	24	5	4	1	5
3	120	120	80	80	108	98	26	26	8	7	1	3
4	120	12	90	80	96	93	24	24	8	7	2	3
5	115	0108	80	75	91	89	26	24	5	4	1	2
6	120	117	80	80	80	82	21	21	5	5	1	5
7	100	95	70	70	75	70	23.3	22	6	4	3	5
8	103	100	70	70	91	91	22	20	9	8	1	3
9	97	92	70	67	94	89	26	22	9	7	1	3
10	100	100	70	70	80	80	26	24	7	7	3	5
11	110	100	70	70	98	96	26	28	2	1	3	5
12	120	100	91	80	70	76	30	26	8	6	1	3
13	97	92	70	65	88	87	25	23	4	3	1	3
14	110	110	80	80	88	84	28	26	1	0	1	3
15	125	110	60	60	74	73	28	25	5	3	1	5

Table 2

Pain Parameters of the Controlled Group Before And After Ten (10) Minutes

N	Systolic BP		Diastolic BP		Heart Rate		Resp. Rate		Pain Rating		Level of Activities	
	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST
1	110	110	73	80	93	97	30	31	6	6	4	3
2	120	120	90	90	68	70	22	21	6	6	3	1
3	110	110	80	80	78	76	22	23	9	9	3	3
4	100	100	80	80	441	110	26	26	5	5	1	3
5	105	110	65	65	94	94	28	31	7	7	3	3
6	110	110	77	70	91	99	29	23	8	9	1	1
7	110	110	70	70	97	99	27	27	8	8	1	4
8	113	115	80	80	91	94	41	42	9	9	1	2
9	103	103	70	70	85	88	25	26	8	8	1	3
10	100	100	70	70	100	100	25	28	3	3	1	3
11	120	120	85	85	79	74	28	25	9	9	3	3
12	120	120	90	90	95	100	24	24	5	7	1	3
13	100	100	60	60	82	82	24	25	1	1	1	2
14	110	110	80	80	87	80	25	26	7	7	3	1
15	127	127	90	90	90	93	24	27	3	2	1	5

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Research

A Survey Study of Nursing Diagnosis Use in Clinical Practice

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The purpose of this study was to identify the degree to which nursing diagnoses accepted by NANDA are used to identify problems in application of nursing diagnoses in clinical practice. With the expanding potential for computerization of nursing diagnosis, the survey also included data on the present status of hospital computerization and willingness to use computerized nursing diagnoses.

The data collection was done from July 1 to August 3, 1996 using structured questionnaires. The questionnaires were mailed to 1,126 head nurses working in 44 hospitals with on occupacy of over 500 beds located in Korea, of these, 883 were returned from 40 hospitals. Among the 883 questionnaires, 867 were used for the analysis.

The results of the analysis are as follows

1. *Among 109 nursing diagnoses, pain, constipation, diarrhea, hyperthermia, high risk for infection, sleep pattern disturbance, and anxiety, chronic pain, altered urinary elimination, and altered nutrition: less than body requirements were the ten most frequency used diagnoses.*
2. *The primary problem in the use of nursing diagnoses was lack of time and personnel. Others were lack of knowledge and motivation, absence of protocols and absence of appropriate methods to apply nursing diagnoses.*
3. *Among the 40 hospitals, 27 hospitals used a computerized system and expressed willingness to utilize the computerized system of nursing diagnoses that is planned for the future.*

A Survey Study of Nursing Diagnosis Use in Clinical Practice

Since the concept of nursing diagnosis has been used for the first time in 1950, the awareness of its effectiveness has been increased and variety of activities for nursing diagnosis enhancement such as NANDA (North America Nursing Diagnosis Association) for preparation and classification of nursing diagnosis and several international conferences. According to the NANDA conference report in 1990, when we define the nursing diagnosis it is "clinical determination for responses of individual, family or community about the course of life as actual or potential health problem (Kim M. J. et. al., 1993)." The definition of nursing diagnosis, that is defined diversely by different scholars, can be summarized to be applied effectively in the nursing and educational fields as a series of course that states health conditions through nursing practice and solves the corresponding problems as well as assures its solution (Carlson, 1982; Gordon, 1976; Meridearn, 1987; Purushotham, 1981; Shoemaker, 1984; Titler, 1987). However, unlike the above definition, the application of nursing diagnosis in Korea seems low. So we should consider the possibility of application of nursing diagnosis, reliability of it when it is applied in clinic treatment, and validity and sensibility of it for stabilization and enhancement of it.

Therefore, this study will check the application of nursing diagnosis in actual clinical field and problems of usage. Also

this study will identify the current status of computerization for the purpose of computerization of it as an ultimate aim in today's trends that emphasize the automation of work.

Methods

Design

This study is a descriptive cross-sectional survey design. The subjects of this study are 1,126 head nurses who work in university general hospitals or equivalent hospitals with 500 beds or more nationwide. We select these subjects with consideration of their clinical experiences and status as leader and educator.

Instrumentation

In order to survey the status related to computerization of hospital and practicing frequency of nursing diagnosis, there are 4 kinds of research tools. Tools for general characteristics of head nurses, 109 nursing diagnosis action tools for certified by NANDA, current status of computerization, problems in application of nursing diagnosis, 109 of nursing diagnosis frequency is recorded by 3 point scale with 'used frequently' , 'used often', and 'never used.'

Procedure

The survey tools (total of 1,126 packages) were mailed to each subject hospitals (total of 44 hospitals) at July 1, 1996. 883 packages are returned from 40 hospitals until August 3 same year (78.4% of return ratio), and 867 packages, excluding 16 incomplete survey packages, were used for this study.

Data Analysis

Collected data are processed using SAS. Usage frequencies and orders of each diagnosis, hospital related matters, characteristics of survey subject and computerization-related matter, and problems in clinical application of nursing diagnosis were analyzed with actual counts and percentages. Problem recognition level in using nursing diagnosis by characteristics of subjects were analyzed by t-test and ANOVA.

Results

1. General characteristics of subjects

The department that the largest number of head nurses, the subjects of this study, work for are internal medicine department (222, 25.6%) and medium age distribution is 35 to 39 years old, (322, 37.1%). Mean age was 38.5 years old. They were mostly female (861, 99.3%). The largest frequency of education level is college graduate with 327 (37.8%) and the period of clinical work experience is 16-20 years with 340 (39.2%).

<Table1>General characteristics (n=867)

General Characteristics		No. (%)
Work site	I.M. (Internal Medicine)	222 (25.6)
	G.S. (General Surgery)	195 (22.4)
	OBGY (Obstetric & Gynecology)	131 (15.1)
	I.C.U. (Intensive Care Unit)	65 (7.5)
	O.P.D. (Out Patient Department) & E.R. (Emergency Room)	45 (5.1)
	O.R. (Operating Room)	40 (4.6)
	Complex Ward	116 (13.4)
	Etc.	53 (6.1)
Age (yrs.)	~ 34	189 (21.8)
	35~ 39	322 (37.1)
	40~ 44	287 (33.1)
	45~	69 (8.0)
Gender	Female	861 (21.8)
	Male	6 (0.7)
Education	Diploma	327 (37.8)
	B.S.N	297 (34.4)
	M.S.	220 (25.5)
	Etc.	20 (2.3)
Working years (yrs.)	~ 10	115 (13.3)
	11~ 15	307 (35.4)
	16~ 20	340 (39.2)
	21 ~	105 (12.1)

2. Current status of Computerization and Related Characteristics

For the computerized areas in hospitals, they answered that administration and accounting operation (26 hospitals, 96.3%), out patient department (OPD) prescription transferring system (19 hospitals, 70.4%), ward prescription transferring system (16 hospitals, 59.3%), equipment request management system (15

hospitals, 55.6%) are computerized. For inquiries regarding necessity of hospital automation, 730 (85.2%) nurses answered "generally needed" , that shows high demand for computerization. For the area that are needed to be computerized, the largest number answered for 'treatment material prescription input system' of nursing operation area (847 nurses, 97.7%), and next were 'prescription input' (846 nurses, 97.6%), 'various equipment request management system' (841 nurses, 97.0%), 'laboratory result report' (840 nurses, 96.9%), 'discharge billing' (820 nurses, 94.6%), and 'Doctor's visiting reservation management' (817 nurses, 94.2%).

<Table2>Current computerization status

computerization status		No. (%)
Hospital Computerization (n=40)	Yes	27 (67.5)
	No	13 (32.5)
Computerized area in Hospital (n=27)	All Ward	18 (66.7)
	OPD & Dr's room	5 (18.5)
	Etc.	4 (14.8)
Computerized area (n=27)	**Yes No. (%)**	**No No. (%)**
Ward OCS system	16 (59.3)	11 (40.7)
OPD OCS system	19 (70.4)	8 (29.6)
Ward nursing record (Progress note)	3 (11.1)	24 (88.9)
Personal management	14 (51.9)	13 (48.1)
E - Mail	7 (25.9)	20 (74.1)
Scheduling program	5 (18.5)	22 (81.5)
Equipment request management system	15 (55.6)	12 (44.4)
General accounts	25 (96.3)	1 (3.7)

<Table3> Characteristics related computerization (n=867)

Characteristics related computerization		No. (%)
Necessity of Hospital Automation	Don't need	1 (0.1)
	Partly needed	126 (14.7)
	Generally needed	730 (85.2)
Area that are needed to be computerized		
1) Nursing area Treatment material prescription input system		847 (97.7)
Nursing Process Note		504 (58.1)
Nursing Care Plan recording system		617 (71.2)
Assessment Flow Sheet		578 (66.7)
Medication sheet		705 (81.3)
RN Worksheet		634 (73.1)
Head Nurse Daily Worksheet		597 (68.9)
Various equipment request management system		841 (97.0)
2) Doctor's prescription		
Prescription input (Lab, medicine & injection, etc.)		846 (97.6)
Lab. Result report (including X-ray etc.)		840 (96.9)
Lab. Result flowsheet		754 (87.0)
3) General Management System		
Personal management		597 (68.9)
Stock means management		769 (88.7)
Scheduling program		745 (85.9)
4) Insurance system		
Discharge account		820 (94.6)
Insurance audit program		716 (82.7)
Ward management		773 (89.2)
Doctor's visiting reservation management		817 (94.2)
Reservation order management		752 (86.7)
5) PACS		565 (65.2)
6) E - mail		568 (65.5)

3. Frequency of Nursing Diagnosis

1) Frequency of Nursing Diagnosis in Comprehensive Area

The most frequently practiced diagnosis overall from 109 nursing diagnosis was 'pain' as other study results. The top 10 nursing diagnosis are 'pain', 'constipation', 'diarrhea', 'hyperthermia', 'risk for infection', 'sleep pattern disturbance', 'anxiety', 'chronic pain', 'altered urinary elimination', and 'altered nutrition: less than body requirements' When we compare this with orders shown in Gordon and Hiltumen's (1995) study with 135 nursing diagnosis (108 of NANDA and 27 diagnosis suggested by Critical Care Nursing Journals), the pain has the most frequency and risk for infection, sleep pattern disturbance and anxiety were same with top 10 frequencies of this study.

2) Frequency of Nursing Diagnosis that were least practiced

Nursing diagnosis such as 'Altered nutrition: more than body requirements', 'Altered nutrition: risk for more than body requirements', 'Risk for disuse syndrome', 'effective breastfeeding', 'interrupted breastfeeding', 'ineffective infant feeding pattern', ' relocation stress syndrome', 'rape - trauma syndrome', 'rape - trauma syndrome: compound reaction', 'rape - trauma syndrome: silence reaction' were not practiced by over 70% of subjects.This result shows that there were no nursing diagnosis from 109 suggested by NANDA that were not practiced, but practice frequency of nursing diagnosis varied by departments. Especially for the diagnosis such as rape-trauma syndrome, even if it is

not common in Korean culture, it is not true that is not practiced at all as we see from the data. Therefore, validity study for each diagnosis should be done so that each can be practiced properly according to the conditions of individual patients.

4. Order of Nursing Diagnosis by Areas

The 109 nursing diagnosis based on 9 characteristic response pattern about human health distributed from 1 diagnosis in communication area to 42 diagnosis in exchange area. Average point order for each diagnosis area is shown as knowing, communicating, exchange, moving, perceiving, feeling, choosing, valuing, and relating.

<Table 4> Classification of nursing diagnosis by human response pattern

(n=867)

Response Pattern	No.of Nsg.Dx.	Frequency	Means	Standard Deviation
1. Exchange	42	718	1.96	0.37
2. Communicating	1	845	2.02	0.73
3. Relating	11	814	1.54	0.51
4. Valuing	1	837	1.59	0.67
5. Choosing	11	808	1.60	0.50
6. Moving	20	809	1.78	0.40
7.Perceiving	9	818	1.76	0.56
8. Knowing	2	833	2.03	0.59
9. Feeling	12	813	1.74	0.36

5. Problems in clinical application of Nursing Diagnosis

According to study that has arranged the problems when nursing diagnosis is applied in clinic by their precedence, the biggest problem was 'lack of time and manpower (83 nurses, 59.6%)'. This shows the same result as other study that pointed out 'lack of time and manpower' as the biggest problem.

6. Problems in clinical application of Nursing Diagnosis by general characteristics of subjects

When we see problems in clinical application of nursing diagnosis by general characteristics of subjects, there were significant differences of 'lack of administrative support from nursing administration department (P<0.01)' in 'education of nursing diagnosis', and 'lack of administrative support from nursing administration department (P<0.01)' and 'lack of adequateness of method (P=0.01)' from 'nursing record', 'lack of time and manpower (P<0.05)' from "age", 'lack of administrative support from nursing administration department (P=0.05)' from 'work length', and of lack of adequateness of method and mean (P<0.05)' from "education". Among the problems in clinical application of nursing diagnosis, it shows that 'lack of administrative support from nursing administration department' had significant difference from subjects' education of nursing diagnosis, nursing recording, work length. It shows the importance of administrative support. Especially as a study that shows that support from working facility greatly contributes the practice of nursing diagnosis by nurses. Johnson (1989) reported that nursing diagnosis practicing has increased to 93% after she tried to change working form and audit the result. Also, Thomas and Newsome (1993) reported that supports from institutes have important effect on nurses practicing nursing diagnosis.

<Table5> Problems of clinical application of nursing diagnosis by general characteristics of subjects (T or F)

Problems of Clinical Application of Nursing Diagnosis	Education of Nsg. Dx.	Nsg. Record	Age	Work length	Education
Lack of Administrative Support	3.48**	4.70**	0.96	2.62*	1.31
Lack of time and manpower	-0.85	0.41	3.43*	0.76	2.06
Lack of Knowledge and motivation	-1.62	-1.82	1.54	1.22	1.20
Lack of Adequateness of method	-1.55	-2.48**	1.93	2.41	3.02*
Absence of Protocol	0.53	-1.83	0.67	1.29	0.73

*p < 0.05 **p < 0.01

Perspective

Vision and Mission of Caring: The Role of Catholic Nurses and Health Workers

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abstract

Is it possible to speak of a Christian vision of nursing? Indeed, there is hardly any religion or civilization which does not claim to be attentive to those who suffer. Can Christianity have a specific influence on the behavior of Catholic health workers? Are they not like all the others, believers or non believers, at the service of their patients? Can they do more than their non-Christian colleagues, especially in societies which have a notion of existence different from that of Christianity? These questions represent a challenge for everyone of us. This communication will try to respond to this challenge.

The central idea of the communication are the following: In view of the pessimism and the discouragement that health workers may feel before the overwhelming nursing problem they are confronted with, those who profess the Christian faith can and should be the architects of a new world, the one who Paul VI has called "a civilization of love".

In all times and civilizations, there were men and women practicing a sort of "human religion" and devoting their lives to meet the most urgent needs of their contemporaries: therefore, isn't the Christians' pretension of giving birth to a new man a kind of fable in order to calm their fear of the realities of existence? In short, is it right to speak of a Christian vision of nursing in a pluralized society, or in a society which does not derive from the Christian faith the reasons for leaving?

The answer is YES, on both these grounds:
**The Christian vision of existence is, by nature, entirely different from a political program or philosophy which could be opposed to another one;*

**Catholic health workers do not impose their vision of existence on their fellow workers, they only claim the right to live in accordance with their beliefs and consequently the freedom to organize.*

Ladies and gentlemen,
I should like to raise a preliminary objection: Is it possible to speak of a Christian vision of nursing? Indeed, there is hardly any religion or civilization which does not claim to be attentive to those who suffer. Can Christianity have a specific influence on the behavior of Catholic health workers? Are they not like all the others, believers or unbelievers, at the service of their patients? Can they do more than their non-Christian colleagues, especially in societies which have a notion of existence different from that of Christianity? These questions represent a challenge for everyone of us. I will try to respond to this challenge as briefly as possible here.

The central idea of my presentation will be this: In view of the pessimism and discouragement that health workers may feel before the overwhelming nursing problems they are confronted with, those who profess the Christian faith can and should be the architects of a new world, the one Paul VI has called "a civilization of love". *(Paul VI, Speech at the midnight mass for the closing of the Holy Year, December 1975.)*

First of all, let us clarify the **challenge** we are to take up: Is there a place for a religious – and therefore a Christian – vision of nursing in our present world?

I wish to start my reflection with an episode from the Gospel. "A man was going down from Jerusalem to Jericho" (LK 10:30).

Most of us know the parable introduced by this sentence. In fact, the Good Samaritan has always been regarded as a model for health workers, especially the Catholic ones. Now, doesn't this parable make of health care a mere question of solidarity and human kindness?

A man was going down from Jerusalem to Jericho, and he fell among robbers who stripped him and beat him, leaving him half dead. You know what comes next : A priest and a Levite were going down the same road and, despite the message of brotherhood they were supposed to embody, both of them ignored the injured man and passed by on the other side. Then a Samaritan came to the place. In the eyes of Jewish society Samaritans were like parias, unclean people nobody would talk to (cf. Jn 4.27); but that Samaritan took care of the man he saw lying on the ground, bound up his wounds, brought him to an inn and provided generously for his needs.

We can replace the actors of this evangelical scene by our contemporaries. It is easy to assume that many Christians go past a suffering fellow-being and ignore him, not knowing what to do, telling themselves they are too busy with other things, or yielding to an impulse of selfishness, whereas a non-Christian who happens to go the same way does take care of him. In that case, how can we speak of a Christian vision of caring for others, a Christian vision of nursing? Could assistance given to those who are in distress be prompted merely by a law of solidarity and kindness as an attribute of human nature, as something imposed on our conscience whatever our vision of life may be, either Christian or non-Christian? Moreover, aren't Christians the victims of an illusion when, while claiming that men and women can build a new civilization, many of them disregard their natural duty of solidarity with the poorest, whereas non-Christians treat the destitute as brothers without adducing any religious motives?

This situation is not peculiar to our century. In all times and civilizations there were men and women practicing a sort of "human religion" and devoting their lives to meet the most urgent needs of their contemporaries. In a world where everything happens again and again but nothing seems to change, isn't the Christians' pretension of giving birth to a new man, of creating "a new heaven and a new earth", *(Rev 21:1)* a kind of fable which they try to believe so as to calm their fear of the realities of existence? Can we truly speak of a Christian vision of life? Could the priest and the Levite who went the other way have done more than the Good Samaritan for the man lying at the side of the road? And yet the Samaritan's motives were but humanitarian, on his own admission.

I was thinking about that story when suddenly a TV broadcast come back to me. Cardinal Veuillot, Archbishop of Paris, was giving a live interview and shortly before the end, the reporter asked him point-blank: (*In Revue de la vie diocesaine de Paris, 1968/7).*

"What would you answer if you were told that the atheists attitude to death is more courageous than the believers, for the first ones dare to look death in the face instead of evading this unpleasant fact by hanging on to a hypothetical afterlife?"

"I will answer this:

"The question is not to know which attitude is the most courageous, but to know which behavior is the truest. Has a Christian the right to believe Jesus Christ when he tells him that he has conquered death? The tragedy of man's death is therefore linked to his believing in the death and resurrection of Christ.

"... ...My own belief in eternal life is not intended to give me hope at the moment of death, but I hope because I believe in Christ... ... With all my human experience, I envision God as the One who lives, and

He lives close to us, even if many of us do not know Him."

This dialogue shows the specific feature of Christian behavior in society. The interviewer raises an objection: Instead of looking death in the face, you evade its sad reality by "hanging on" to a hypothetical afterlife. Cardinal Veuillot refuses the terms of the problem as it is posed. He has not to choose between two opinions based on rational arguments; on the contrary, he believes the word of Christ who tells him that death has been conquered because of his very faith in Christ. Health workers, like many other Catholics working in different fields, go through a similar experience when they must choose between what they hold to be the truest, according to their faith, and what appears to be the most reasonable, in the view of those who surround them.

A new difficulty arises here: The claim of Catholic health workers that they act in line with their conscience seems to introduce an element of division into modern society at a time when it is trying to promote cooperation among people belonging to different cultures and religions. Isn't such a claim to a distinctive identity out of place in our present world? Let us look, for instance, at the way humanitarian aid is given out. This aid for refugees and displaced persons throughout the world is greatly facilitated by the presence, in the camps, of many nongovernmental organizations which are ready to combine their initiatives with those of the UN High Commissioner for Refugees. As a result, Catholic health workers find themselves placed on an equal footing with others whose motives are merely altruistic. We can then wonder why the fact of being a Christian should change in one way or another the nature of the help given to people deprived of all working opportunities and unable to lead a normal life. Under the circumstances, it seems improper to cite personal beliefs, for the divisions this would cause within humanitarian teams would run counter to the refugees' interest. Therefore, social peace in modern pluralist societies is not possible unless the basic principles coming from religion are replaced by a consensus philosophy; otherwise conflicts are unavoidable in groups of people with different ideologies and beliefs. **In short, is it right to speak of a Christian vision of nursing in a pluralist society, or in a society which does not derive from the Christian faith its reasons for living?**

My answer is YES, on both these grounds:

1. The Christian vision of existence is, by nature, entirely different from a political program or philosophy which could be opposed to another one.
2. Catholic health workers do not impose their vision of existence on their fellow workers who think differently; they only claim the right to live in accordance with their own beliefs, on which they rely for proposing a more human organization of health services.

I. At the Root of the Christian Vision of Existence

To begin with, let us clarify the meaning of this expression: a Christian vision-or conception - of existence. The specific nature of the Christian vision of existence:

A possible misunderstanding has to be cleared up in the first place. The Christian vision of existence is not a matter of opinion, but a matter of faith. It differs from other explanations of life by the very fact that, instead of being a product of the human mind, it is based on the acceptance of a revelation coming from God, a loving God who is the way, the truth, and the life. An example will make this easier to understand.

If I ask you to comment on the evolution of today's world and the role Asia is likely to play in the 21st century, you will give me different answers. Some may say that such and such a State will be among the great Powers, while this or that country will lose its present influence; others may lay stress on the factors on which the evolution of Asia will depend, etc. If you start a discussion about this question, each will try to convince the others of the truth

of his vision by resorting to rational arguments of a juridical, sociological or economic nature. Now this is not the case with what we have called the Christian vision of existence, because this vision rests above all on the biblical revelation relating to the destiny of human beings and creation.

Accordingly, the Christian conception of nursing does not result from a "philosophical theory of...man", *(Pacem in Terris, 159)* nor is it a doctrine worked out among so many others in order to solve professional or social problems. Its root is much deeper: it views caring activities with respect not to ideas (which are always questionable), but to a primal fact (which is unquestionable).

At the root of the Christian vision of existence:

What does "primal fact" mean in this context? An example will help us to understand it: A mother is everything for a newborn baby or a very young child still dependent on her. Indeed she is the most reliable safeguard for her child's life. This will give rise, throughout the adult existence of that child, to an indestructible feeling of affection and confidence as solid as a wall that withstands all imaginable attacks. Here we are faced with an original or "primal" fact in the name of which one fights any contradictory feelings that may appear later on.

The Christian vision of existence is also based on a primal fact. Reasoning comes only as secondary to this first experience. Let us illustrate our point with an example from the Gospel, among several others. In Jn 6:60 ff., a famous passage about the loyalty of the twelve Apostles, Jesus Christ had just told his listeners, in the Capernaum synagogue, that they needed to eat his bread and drink his blood in order to be raised up at the last day. Many of his followers found Jesus words too hard and left him. To a certain extent, the Apostles shared the feelings of doubt that caused this desertion. So Jesus asked them: "Do you also wish to go away?" And Peter gave him this admirable answer: "Lord, to whom shall we go? You have the words of eternal life; and we have believed, and have come to know, that you are the Holy One of God." Here are two opposite attitudes: on the one hand, the attitude of those Jews who trusted their own reason and therefore rejected Christ's words which contradicted it; on the other hand, that of Peter who put his personal relationship with the Saviour first, acknowledging him as the Holy One of God and accepting his teachings even if he did not grasp their true meaning.

The same goes for our lives. Through different experiences, we become aware of our bonds with Christ and of the fact that our vision of existence will lose its unity and strength if we fail to consider him as the cornerstone of our decisions. To those who have been brought up in a Christian environment their faith seems to be an integral part of themselves; they would say with the psalmist: "If I had gone away from Thee, I would have been untrue to the generation of Thy children!." Others, who have followed different paths to find Christ, feel attached to him because he has opened up new prospects to them by giving a new sense to their lives. All of them know that abandoning their faith would mean a rift in their inner selves, or, as Peter said: "Lord, to whom shall we go? You have the words of eternal life."

The Christian vision of existence, and consequently the Christian vision of nursing, leads the believer to a different logic from that of the world he or she lives in; in other words, they judge things and situations differently from the nonbeliever. In their view, personal life continues after death. The first Christians, who represented a persecuted minority in a wholly materialistic Roman empire, were well aware of this difference. One of them, Lactantius, who lived in the 4th century A.D., came to understand perfectly that logical, ideal element of Christian life to which every believer ought to adjust his behavior. In one of his books, Christian Institutions, he brings up the case of two shipwrecked sailors fighting for a single plank to save their lives, and that of two

soldiers trying to get away from the enemy with only one horse at their disposal; in both cases the weaker man had the plank or the horse in his possession. Now according to human logic, says Lactantius, the stronger man will get hold of the only available lifeline. Christian logic, however, demands that the believer give way to the other, Why? The driving force of the Christian attitude lies in the answer to the following question: Can I do anything else for my distressed brothers and sisters? When St. Maximilian Kolbe volunteered to take the place of a condemned man during the Second World War, he conformed to this logic; he discovered that submitting to it was for him a way of living out his personal relationship with Christ which lies at the heart of every Christian commitment. People who spend their whole lives in the service of the poorest do not do it out of mere compassion so as to free themselves from their desires, but they do it because they meet Jesus in the poorest and those who are overlooked by society.

II. The Christian Vision of Existence and the Health Professions

Our thoughts have led us to give an affirmative answer to this question: Is there a Christian vision of nursing? We say YES, because such a vision has its source in faithfulness to Christ as master of truth. Now we ask ourselves a second question: How can we put our faith into practice, whether we live in a pluralist world or in a social environment where Christians are a minority?

Let us get one thing clear: a Christian is not supposed to campaign for his vision of the world and of nursing as if this vision were an ideology, nor to promote it like an industrial product; he is only expected to live in accordance with his recognition of Christ as master of life. Therefore, in all circumstances he must be able to discern what will ensure the development of life and what will slow it down.

In this connection, there is a very characteristic document coming from the Pontifical Council for Pastoral Assistance to Health Care Workers, the president of which was Cardinal Angelini since its foundation (1985) until last year. Several months ago (1995), the Council issued a most instructive booklet entitled Charter for Health Care Workers, *(Pontifical Council for Pastoral Assistance to Health Care Workers, Charter for Health Care Workers, Libreria Editrice Vaticana, 1995, p. 126 (there are editions in French, Spanish, etc.). Quotations from JOHN PAUL II: Address to the Mercy Maternity Hospital, Melbourne, Nov. 28th 1986)* where it showed the concrete, practical nature of the Pope's teachings on this matter. As an introduction, there is this statement : "The activity of those engaged in health care is a very valuable service to life. Then we read:

"It expresses a profoundly human and Christian commitment, undertaken and carried out not only as a technical activity, but also as one of dedication to and love for one's neighbor. It is a form of 'Christian witness'."

Or, in other words, also from John Paul II:

"Their profession calls for them to be guardians and servants of human life."

The attachment to Christ ("You have the words of eternal life", said St. Peter) can find expression in the nursing activities themselves. For a Christian, his patients are not merely suffering people who inspire pity, but suffering members of Christ's body: "As you did it to one of the least of these my brethren, you did it to me" (Mt.25.40). This identification of Christ with our suffering fellow-beings is at the root of the uninterrupted flow of men and women who devote their whole lives to serving the poor and the distressed. Thus nursing, for a Christian, is not limited to a series of professional services; it means to accept "full responsibility" for the sick persons whom one loves and tries to understand as the Good Samaritan did; and he carries out his task "by getting involved in the concrete situations of each patient" (*John Paul II, Address to the Italian Congress of Catholic Doctors, in Osservatore Romano, Oct. 18th 1988).*

Here you may argue that care for others, dedication, sympathy for a patient and his problems, etc. are ordinary human virtues that can be and actually are found among non-Christians. I quite agree. In every human being there is a spontaneous urge, a sort of instinct, to help another person who is in trouble. This is a law of nature, even if one does not know where it comes from. Nonetheless, faith put into practice reveals its real foundation, as I am going to demonstrate, not by reasoning, but through a personal recollection dating back to 1963.

That year most of you were not yet born, or you were too young to become aware of the international impact of Pope John XXIII's encyclical *Pacem in Terris*. The world was then split into two hostile blocs which had been on the brink of confrontation several times; that was the Cold War period. Now the Pope's encyclical included a paragraph urging both sides to put an end to that ideological conflict which could easily degenerate into a third world war. Never mind the political theories of the past, said John XXIII; what really matters is that you attend to the concrete historical movements aiming to ensure the good of all peoples. The Pope also supported the policy of peaceful coexistence to which many Westerners were opposed.

Around that time, I happened to meet the director of an international organization who had always defended the idea of coexistence between the two blocs, despite the criticism he was the butt of for this reason. While talking to me, that man, who was not a Christian, mentioned John XXIII's initiative. He took a sheet of paper and drew two superimposed circles in the middle of which he wrote the letters P, meaning the Pope, and K, the initial of Khrushchev, who was the Soviet premier in those years. He told me, "I understand that they can cooperate for the time being;" then, drawing a long horizontal line signifying the future, he added : "But the Pope will be the loser of this coexistence game. " I replied : "No, I am sure he will be the winner." This was no bragging on my part; I said it because I am convinced that Christ "has the words of eternal life" and that these words will keep on nurturing the faith of future generations as they have done until now. I did not give my interlocutor any reasons for this conviction, but he understood or rather felt that my behavior was rooted in a world I valued above all and to which he had no access.

Thus, Christians who strive to live up to their faith day after day offer nonbelievers an opportunity to discover a way of life introducing them into a world they know nothing of. The same is true of nursing, where Catholic health workers disclose their special respect for the whole human being in their relationships with patients and their families. The feeling of love for others that they develop within themselves, following Christ's footsteps, makes them uneasy about social structures which too often fervor the rich to the detriment of the poor.

III. The Christian practice of nursing

Fidelity to Christ compels us to act in keeping with specific principles and to give coherence to our lives. This is the point we are now going to clarify with regard to nursing. Let us look at it from three different angles: nursing 1) as a professional activity; 2) as a social responsibility; 3) as a Christian way of life.

1. Nursing as a professional activity

The former members of the CICIAMS made it a point of honor to raise the technical standards of the profession. They wanted male and female nurses coming from Catholic schools or belonging to their associations to be the best, both as health professionals and human beings; that is why they played an important part in the professionalization of nursing. Their efforts were crowned with success: nowadays the technical standards among health workers are quite satisfactory in

most countries and they are improving in less developed ones where health care still remains at a low level. Nevertheless, we ought to ask ourselves whether today high technical standards are enough to guarantee good performances in nursing. Many health care workers think they are not. Technical skills are necessary, of course, but not sufficient; a growing number of health workers wish to have a say in the main orientations of health policies. While there is a lot of talk about health care for everybody, poor people in many countries have little or no access to it. That is why health workers want to be consulted when it comes, for instance, to choosing between the purchase of very expensive materials or medical supplies and the generalization of health services in order to make them accessible to all, or when discussing profit-oriented measures that would entail limitations on free health care for the poor. Therefore, besides technical abilities, health care workers need something else today, something we could call "social abilities"

This term, "social abilities" should be correctly understood. We could give it a narrow sense related to trade-union movements or some kind of political action, but here we take it a much broader sense which allows us to specify the mission of the CICIAMS in modern society.

2. Nursing as a social responsibility

Health care workers are used to establishing personal, human relationships with their patients, as the Good Samaritan did with the robbers' victim; but these days we act differently from 2000 years ago, or even from 50 years ago. The Good Samaritan of the Gospel set the wounded man on his own mount, found a place for him to recover and decided how he should be looked after. In our times, however, a "Good Samaritan" would turn to public services for carrying the man to hospital and he would leave him in doctors' and nurses' care. All health workers are subject to the laws and regulations of their country regarding health care and so each of them, at his or her own level, shares responsibility for the consequences of those regulations. In this case, it is impossible for health workers not to wonder whether such rules afford everyone equal opportunities for medical care or not, and whether their implementation is respectful of the patients' dignity, especially when "depriving the dying person of consciousness" *(Charter, op.cit., 124).* No responsible person, let alone a Christian, can snap his fingers at the social consequences of his actions. He or she is like a scientist who cannot help worrying about the use others will make of his discoveries. Just as the scientist must wonder whether the results of his research will be used in favor or to the disadvantage of human beings, *(PIUS XII, Address to Army Doctors, Oct. 19th 1953; Address to the World Medicine Congress, Sept. 30th 1954; JOHN PAUL II, Discourse to the Pontifical Academy of Sciences, Sept. 24th 1982: "It is the duty of scientists to help prevent the perversion of their achievements and to stress that the future of mankind depends upon the acceptance by all nations of moral principles transcending all other considerations.")* health care workers cannot help wondering, especially in democratic societies, whether the health system they are part of takes into account the general good and, above all, the "material progress and spiritual development" of people living on the fringe of society.

Every action has a social significance; or, as Paul VI wrote in his encyclical Popularum Progression, "every action is a warrant for a doctrine". *(PAUL VI, Popularum Progression, 39.)* This is the reason why a Christian cannot live today without showing concern about justice. The struggle for justice and for the liberation of the world appears to be a true dimension of the preaching of the Gospel (*cf. Synod of Bishops, 1971*). If my love for Christ makes me "want to free my brothers and sisters from every oppressive situation" (ibid.), then I cannot help wondering about the structural situations of injustice I find in my professional

environment; I cannot agree to cooperate directly in actions or policies that are contrary to my vision of existence.

A vast field of action is opening up before the member organization of the CICIAMS. As they are neither connected with trade unions nor representative from a professional point of view, they should appear to be the social conscience of their milieu, a "meeting place" for the analysis of the different aspects of a given situation. These organizations as such do not get involved in any struggle to solve the existing problems so as not to be likened to political movements; their purpose is to become a moral reference point for those who take action.

What we have just said can be summarized as follows: Whenever a society excludes any individuals or groups from the advantages of health care, or whenever it implements an idea of health care that does not take human dignity into consideration, Christian doctors and hospital workers must bring about a counter-culture aiming at free health care for all and restoring dignity to the patients. Of course, this posed delicate problems in regard to the organization of health services and the behavior of hospital staffs.

**The organization of health services.* Health care workers are not free to do as they like; the sphere of their activities is circumscribed by the law, professional regulations, the patients, public opinion and even religion, for it requires them to evaluate concrete situations according to its conception of existence. No wonder, then, that certain health care practices have always raised moral questions some of which go back to ancient times, as in the case of pregnancies, administration of sedatives to the dying, interruption of treatment for patients with incurable diseases, etc.

Today these issues seem to be more relevant than ever. Technical progress has made possible a variety of operations on the human body about the morality of which one cannot help wonder. What should we think, for instance, of those scientific discoveries that enable us to alter the genetic structure of a human being? What of the tests performed to find out the sex of an unborn child, or the experiments on embryos for the removal of such and such anomaly? New horizons are opening up for medical science and new tasks are taking shape for health care workers. How will Christians react to those scientific advances? The encyclical Evangelism Vitae gives a general directive which may help us find the right path in unclear circumstances: all that fervors life is licit; what undermines or endangers life directly must be condemned.

**The behavior of hospital staffs*. Here we are confronted with another difficulty. What is life? The answer to this question depends on the conception of existence shared by the members of a given society. This explains the differences of opinion among health care workers when it comes to assessing the morality of this or that medical treatment. Furthermore, civil and moral laws can be in conflict in some cases. It is not unusual for health care workers in all countries to be asked to comply with laws or professional regulations that go against their conscience. The encyclical Evangelism Vitae also deals with this question: *Evangelism Vitae,74.*

Christians, like all people of good will, are called upon under grave obligation of conscience, not to cooperate formally in practices which, even if permitted by civil legislation, are contrary to God's law. Indeed, from the moral viewpoint, it is never licit to cooperate in them....The cooperation can never be justified by invoking respect for the freedom of others or by appealing that civil law permits it or requires it.

In view of this situation, the Church asks civil authorities to recognize everyone's right to conscientious objection, as stated in the Council's Declaration *Dignitatis Humanae*: "Nobody should be forced to act against his convictions. *(Dignitatis Humanae,2.)* One of the most original contributions of Christianity to the

civilizations it came across in the course of its history consists in having spread the idea that no one ought to be compelled to act against one's conscience, nor is anyone allowed to do it on one's own initiative. That was the reason why the first Christians bore witness to their faith even by sacrificing their lives. Today also many Christians prefer to suffer great hardships rather than do something that they deem to be intrinsically evil. From Paul XII to John Paul II, all popes have reminded Christian health workers of their duty to resort to conscientious objection in certain circumstances *(PIUS XII, Discourse to the International Congress of Criminal Law, Oct. 3rd 1953; Address to army doctors, Oct. 19th 1953; Address to the World Medicine Congress, Sept. 30th 1954. JOHN PAUL II, Message for the World Day of Peace, Jan. 1st 1991; Address to the Pontifical Academy of Sciences, Nov. 12th 1983; Discourse to Catholic Health Workers and Pharmacists, Nov. 3rd 1990; Discourse to the International Lawyers' Union, March 23rd 1991; Encyclical Evangelism Vitae, 1995).*

There is nothing surprising about that, when so many pacifist groups are appealing to conscience in their struggle against any recourse to force between nations, or when the International Labor Organization recommends the right to conscientious objections to be included in the various national legislations: (*International Labor Conference, Recommendation 1977: 157, art.18).*

Nursing personnel should be able to claim exemption for performing specific duties, without being penalized, where performance would conflict with their religious, moral or ethical convictions and where they inform their supervisor in good time of their objection so as to allow the necessary alternative arrangements to be made to ensure that essential nursing care of patients is not affected.

As shown in the extract we have just read, respect for the rights of conscience is becoming more and more obvious in contemporary society, a trend we are delighted with. Now what can we do to speed it up?

3. Nursing as a Christian way of life

Health workers, who are well aware of the gap existing sometimes between civil law at large and certain hospital practices or implementation rules, may ask themselves: What can I do all alone, at my own level of responsibility, in a world that fails to agree with my vision of nursing? How can I help to solve these problems?

The answer to this question is to be found in a discourse delivered by John Paul II in front of Spryer Cathedral ten years ago (1987): What you are unable to do by yourself becomes possible if you join forces with others to create a current of opinion: *(JOHN PAUL II, Discourse delivered in front of Speyer Cathedral, 1987).*

[In view of] the crucial challenges of our times, what can I do by myself? Can I really help? To this question I answer YES. You can initiate a new movement all alone, for every good resolution, every task taken voluntarily upon oneself, owes its eventual success to a single person. Even though sometimes it is necessary to join forces with others to achieve great results, the "yes" uttered by each partner in a spirit of generosity and faithfully maintained in his own sphere of activity is essential for effectively initiating and promoting those profound improvements within the Church as well as society.

The role of Catholic professional associations

The main sentence in that extract of the Pope's discourse seems to be this one: "Sometimes it is necessary to join forces with others to achieve great results." Hence the importance of Christian professional associations for giving their members access to decision-making structures within a particular society.

A second statement in the discourse is also worth mentioning: the existence and

vitality of such associations depend on individual choices; each person must decide to do something and then join forces with others who share the same concerns so as to work out the social problems posed by the exercise of their profession.

I can see two reasons why Catholic professional associations should play an essential role both in the Church and in society:

**Associations drag people away from their isolation, fears or discouragement* when it comes to tackling the ethical problems they are faced with in their profession. To take a decision, one has to know that one is not left alone and that the difficulties one encounters are shared by others.

**Nobody can trust his or her own judgment to make an important decision.* They must be enlightened as to how Christian communities envisage the problem in question, especially the community of Catholic professionals they belong to. Catholic health workers' associations appear thus to be ideal places for reflecting and discerning, places where everyone learns how to behave as a Christian in any situation whatever. These groups can help their members live up to their professional responsibilities by making use of the famous analytical grid of the J.O.C. (Jeunesse Ouvriere Chretienne), the Young Christian Workers: Seeing, Judging, Acting.

- **Seeing**. Christian associations are, as we said, places for analyzing concrete situations and seeing whether they are instrumental or not in facilitating structural injustice. That analysis helps to find out the point of view of the Church and to search for new ways of fighting injustice or strengthening structures that would make easier the establishment of a just world.

- **Judging.** The analysis of facts allows Christians to compare their views on how to develop a positive attitude towards society and particularly towards the changes that are taking place in their professional environment.

- **Acting**. In a world divided over the sense of life and suffering, where urbanization enables people to enjoy a certain degree of autonomy because they feel less sociologically bound by the religion they were brought up in, **Catholic professionals should set themselves up, in their working milieu, as an example of a new solidarity open to all and based on their faith vision of life.** The groups they make up can bear testimony not only to the friendship and brotherly feeling that prevail among believers, but also to the faith which transform their daily lives.

This Christian vision of nursing combines doctrine with action. Doctrine, because it is constantly trying to establish what a human health care organization should be. Action, because it leads believers to strive to make health care accessible to all. Of course, it is not easy to carry out such a programme, which relies on faith, put into practice by the members of the associations. Only by reflecting in depth on Christ's love for every human being will you be able to preserve the vitality of your associations.

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CICIAMS

10 November 1997 — 7th ASIAN REGIONAL CONFERENCE NEWSLETTER — 1st ISSUE

THAILAND CICIAMS WELCOMES DELEGATES

to the 7th ASIAN REGIONAL CONFERENCE

Australia Bangladesh Belgium Canada
England FIJI Hong Kong India Indonesia
Italy Japan Kenya Korea
Malaysia Netherlands Pakistan Philippines
Scotland Singapore South Africa Taiwan
Thailand Vietnam

EUCHARISTIC CELEBRATION

His Eminence Michael Cardinal Michai Kitbunchu, Archbishop of Bangkok was the main celebrant during the Eucharistic Celebration which marked the opening of **CICIAMS 7th Regional Conference**. The Mass was held at the Trinity Hall of St.Joseph's Convent School, Bangkok. Thirty-five priests mostly CNG Spiritual Directors of various countries concelebrated with the Cardinal. The combination of local Thai musical instruments and organ accompanied the choir from Saengtham College (major Seminary); SPC Novices and St.Louis Nursing College. More than 300 participants from 23 countries were present to offer praise and thanks to the Lord.

To the CICIAMS 7th Regional Conference Organizing Committee :

"Thank you very much for the excellent preparation you had made for the coming conference. You have been working very hard and I really appreciate your efforts...You have sacrificed a lot of your prime time instead of spending quality time with your family and loved ones at home.

I really enjoy working with you, even though I did not put in any hard work as you did ... Words cannot express my sincere thanks and gratitude for your total dedication - a total commitment to the end."

Mr.Richard Lai - CICIAMS 1st Vice President

- OPENING CEREMONY -

Welcome to the Family and Jubilee Song were magnificently sung with choreography by the Senior Nursing students of St.Louis Hospital Nursing College. Speeches followed. Excerpts are printed in this Newsletter. The joyful entrance of the SJC Band followed by the entrance of country flags was a very picturesque sight and with great jubilation the participants clapped their hands attuned to the melody of marches played by the SJC Band. The final and most important act of the opening ceremony was the declaration by His Eminence Michael Cardinal Michai followed by the striking of the Gong - 3 times: for Thailand, the Church and CICIAMS. The amazing and exotic presentation of traditional Thai dances was the main attraction during the Reception Ceremony.

"It is my pleasure on behalf of the Catholic Nurses' Guild of Thailand to welcome you to the 7th Asian Regional Conference of CICIAMS. Our Catholic Traditions have always emphasized a loving and attentive presence to all who come to our hospitals and clinics. We carry out our work in the spirit of Jesus, remembering His Words, 'Whatsoever you do to the least of my brethren you do unto me.'"

Ms.Theresa Angoon Vacharatith President, CNG Thailand

"The Asian Region is very active and contribute greatly to the work of CICIAMS and I congratulate you for this. You are a role model for the rest of CICIAMS. The efforts you make in expanding your membership are very dear to my heart."

On behalf of all members of CICIAMS, I bring greetings and prayers for a successful conference. May your ministry in Health Care bring you ever close to Christ and may Our Lady, Health of the Sick guide you in your deliberations...

Ms.Eileen M. Lamb, CICIAMS President

"We hope that the sharing and lively discussions during these four days will challenge each one of us to re-evaluate our thoughts and attitudes in helping the sick, the disabled and the elderly beyond competent and diligent service towards human warmth and compassion....Our unique and individual caring roles in clinical nursing and health care profession, our inspired faith and guidance of the teaching of the Catholic will strengthen us.

Janet P.G. Chan, CICIAMS Vice President / Asian Region President

ACKNOWLEDGEMENT

Our most sincere thanks and appreciation to **His Eminence Michael Cardinal Michai Kitbunchu; Mother Francoise Jiranando,** Provincial, St, Paul de Chartes, Thailand; **Sr.Rose de l'Enfant Jesus Lake** and all those generous and caring hands for the very magnificent and impressive Welcome Ceremony and Reception. **GOD BLESS YOU A HUNDREDFOLD!!!**

Final statement of The 7th CICIAMS Conference on CARING A PATH TO HEALTH AND HEALING

VISION: At the threshold of the Third Millennium, we the ASIAN Catholic Nurses, Midwives and Medical Assistants commit ourselves to evangelize the world through the Ministry of CARING : A Path to HEALTH AND HEALING.

MISSION: To participate CHRIST'S loving caring and saving mission of bringing compassion and relief to the suffering sick, the elderly, the handicapped and the marginalised in this dehumanized world.

COMMITMENT: We will move forward in Christ- like manner on the path to health and healing, with Our LADY, the role model of every Christian health worker, offering LOVE and CARING SERVICE to every person in need regardless of religion, race, color and language.

CARING

"AN ESSENTIAL HUMAN ATTRIBUTE"

(Roach, 1985 : 170)