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**SERVICE AND WHOLISM
IN THE TEACHING AND PRACTICE
OF PARISH NURSING**

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Introduction

Among the current changes in professional nursing is the growing practice of “parish nursing”. Parish nursing is paid or volunteer professional nursing practice focused on improving total health for the members of a church congregation. The purpose of this paper is to explain the roles of nurses in churches and demonstrate how concepts of faith, service and wholism can be integrated through such practice. The history of health care in churches is reviewed. This current paradigm for improving congregational and community health is discussed in relation to the example and instruction of Jesus as well as to sociological and health care trends. Models for the process of implementing a parish nurse program are presented. Implications for the education of nurses and pastors are considered.

Historical Perspective

The ancient Greeks and Romans did not separate healing and religion. Temples were considered places of healing (Solari-Twadell, Djupe, and McDermott, 1990). The Greek word for “savior”, *sator*, could be applied to philosophers (who saved people from life’s meaninglessness), statesmen (who saved groups of people from social or political crises) and physicians (who saved people from disease) (Allen, 1979).

In many cultures medicine has been a mixture of religious practice, magic, and physical care. The agent for physical or spiritual healing was the same person. In a primitive manner, the doctor/healer/witch doctor/medicine man/shaman assumed the role of providing wholistic care (Solari-Twadell, et al, 1990; Allen, 1979).

The magical perspective was rejected by some religious groups, especially the Hebrews. They, however, integrated spiritual, mental and physical health through the Mosaic Law which contained religious, ethical, legal and health guidelines. The Seventh-day Sabbath as a day of rest promoted total health.

Healing is prevalent in the gospels. Jesus was so focused on the health of the people that, according to the gospel record, He performed more miracles of healing than of any other category. He stressed the interrelationship between the components of a total person and instructed His disciples to do the same. Almost one-fifth of the material in the Gospels is devoted to stories of Jesus’ healing (Blohm, 1997). Luke the physician wrote of Jesus commissioning the apostles to treat both mental and physical ills: “And He called the twelve together and gave them power and authority over all demons and to cure disease, and He sent them out to preach the kingdom of God and to heal” (Luke 9:1). The disciple Matthew wrote “and Jesus went about all of the cities and villages, **teaching** in their synagogues, and **preaching** the gospel of the kingdom, and **healing** every sickness and every disease among the people. But when He saw the multitudes, He was moved with compassion on them, because they fainted, and were scattered abroad, as sheep having no shepherd. Then saith He unto His disciples, “The harvest truly is plenteous, but the labourers are few; pray ye therefore the Lord of the harvest, that He will send forth labourers into His harvest” (Matthew 9:35-38). Jesus was instructing His disciples to do as He had done, and apparently labourers

who would teach, preach and heal were in short supply. Paul, in his first letter to the Corinthians (12:9), listed healing as one of the gifts of the Spirit.

Peter, Paul and their associates set about teaching, preaching, and healing. Congregations were established and existing communities of faith accepted the Messianic message. James wrote that “pure religion and undefiled before God and the Father is this; to visit the fatherless and widows in their affliction, and to keep himself unspotted from the world” (James 1:27). It appears that the mission statement of these early congregations would have included the following elements: (a) to teach and preach, (b) to conduct worship and promote fellowship, and (c) to perform direct service such as healing the sick, feeding the hungry and providing comfort and protection to widows (Solari-Twadell, et al, 1994).

Nursing traces its beginning to the early churches. Phoebe, a deaconess, is often considered to be the first nurse. (Striepe, 1993) After becoming a follower of Jesus, this rich woman opened her home to the sick, providing care for them (Rom 16:1-2). Other deacons and deaconesses visited people in their homes. Deaconesses established the first hospitals between 300 and 400 A.D. During the medieval age, healing was associated with churches. Through this entire period monks and sisters were active in the work of healing. It was not uncommon for monasteries and convents to have rooms for the sick.

During the Crusades the disease of leprosy was brought to Europe from the Orient. Health care institutions called “lazarettos” (after Lazarus the Leper in the New Testament) were established. As institutions became the source of health care the direct ministry of health was removed from the congregation.

Another influence, not associated with religious groups, fueled the separation of religion and health. The philosopher Descartes in the mid-1600's emphasized the dualism of spirit and body. This view of humanity became pervasive and medical science developed “with the clergy and their associates supposedly pursuing the matters of the spirit while physicians and their associates in medicine supposedly pursued the matters of the body” (Solari-Twaddell, et al, 1990, p. 16). With increased scientific discoveries, science and religion not only followed separate tracks, but even became suspicious of each other.

Even so, there were those who spoke of wholistic care. Florence Nightingale, considered the founder of modern nursing, felt that the nursing role included ministering to the spiritual as well as physical and emotional needs. She also emphasized prevention and service. In Germany, beginning in 1836, Theodora Fliedner and Wilhelm Lobe founded institutions that prepared deaconesses. These women became either teaching or nursing deaconesses. Deaconesses were addressed by the title *Schwester*, meaning sister, and those who worked in a parish were known as *Gemeindeschwestern*, or parish nurses. These parish nurses, sent to cooperate with the clergy and parishioners in providing nursing service to the congregation were the forerunners of visiting nurses, family social workers, and contemporary parish nurses. It is worth noting that the strength of nineteenth century German parish nursing lay in the spiritual discipline the nurses received as part of their training (Zersen, 1994). There are accounts of parish nurses in other parts of Europe also. In Hoffnungstal, in the Ukraine, nurse deaconesses left a deep impression (Wahl, 1995).

In the 19th and 20th centuries renewed interest in the role of churches in health care has emerged. Churches of many denominations established health care institutions. Seventh-day Adventists, with sanitariums turned into medical centers and healthy life style education programs, are leaders in this movement. Seventh-day Adventist health care institutions in 73 countries have made major contributions in improving world health. This process has not been without conflict. In the early 1900's Battle Creek Sanitarium separated from the church due to disagreement between medical leaders and church leaders. However, through God's guidance the church went on to establish medical schools and hospitals. Loma Linda University Medical Center established the motto "To Make Man Whole" (Schaeffer, 1990).

These contributions are cause for rejoicing. However, with sociological and economic changes, there is need for adaptation. Churches in North America are beginning to reclaim and herald wholeness (Blohm, 1997). Evidence of this can be seen in the parish nurse program. An understanding of parish nursing's historical roots provides assurance that this is more than a contemporary transient fad.

The Development of Parish Nursing

The current trend toward emphasis on the congregation as a focused health care entity began with Dr. Granger Westberg. In the late 1960's he established family practice offices in churches. The idea grew out of his observations that the greatest health care effort and money was being expended toward care of "the really sick" rather than focusing on maintaining wellness. His other concern was that care which integrated the physical, mental and spiritual was not available to most people (Nakamura, 1997). Consequently, the goal of the church clinics was to provide wellness-oriented wholistic care by having spiritually oriented family doctors, nurses and clergy working together. One of the sponsors of this project was the W. K. Kellogg Foundation of Battle Creek, Michigan. (W. K. Kellogg was a brother to John Harvey Kellogg who founded the Battle Creek Sanitarium.) At least twelve of these clinics were started in neighborhood churches in lower, middle and upper income areas of various cities. Those who evaluated this project concluded that the quality of care delivered when these three professions worked together was "measurably more wholistic than the average doctor's office" (Solari-Twadell, et al, 1990, p. 27). It also became clear that the nurses were the "glue" that bound the three professions together.

The evaluators, being disinterested scholars coming from nonreligious backgrounds, began with a bias against the possibility of scientific medicine and religion actually collaborating in a joint approach. . . Over the years, they saw that it was working very well. As they tried to ascertain why it worked, they gradually came to the conclusion that most of the nurses employed in these clinics could speak two languages: the language of science and the language of religion. . . They helped the doctor and the minister communicate in ways that were helpful to the whole person approach to health care (Solari-Twadell, et al, 1990, pp. 27, 28).

As it became more expensive to operate the health centers in churches someone suggested: "If the nurses in these clinics have proved so valuable, why not try placing a nurse on the staff of a congregation and see what happens?" Lutheran General Hospital in Chicago, Illinois agreed to organize and implement such a program. Dr. Westberg then began to approach the churches, hoping to find several large churches which would pay a half-time salary for a nurse. Pastors and congregational groups responded positively, but none of them "had a line in their budget with funds appropriated for 'risk taking'". Lutheran General Hospital then agreed to pay 75% for the first year if the church would pay 25%. The churches could continue the program after that by increasing their financial participation by that amount each year until by the 4th year they could pay the full salary. Six churches agreed to participate, and the program began in 1985 (Solari-Twadell, et al, 1990, pp. 27-31). The experiment was successful. It is estimated that now there are over 3,000 parish nurses practicing in the United States of America (Marquette University, 1997).

Several changes in North American culture have led to the rebirth and growth of parish nursing. The health care delivery system is having problems in all areas - cost, quality, and accessibility. Many people do not have health insurance and many more are under-insured. The cost of health-care has risen exponentially. Congress, third-party payers, corporations and others are calling for preventive health maintenance strategies. Health care leaders are more interested than ever in the role of the church in health. They recognize that future improvements in health will come about only as people assume greater responsibility for their health and for the health of their communities. They also recognize that the church is a valuable and unique social institution for impacting knowledge and behavior. According to Blohm (1997), author of a parish nursing manual for churches, more than 70% of citizens of the United States of America are members of a church group. Other literature shows that more than 40% attend a worship service at least once a week (Matthews, 1997). Increasing numbers of politicians, sociologists and health care professionals are suggesting that the church is a natural center for wellness promotion. Numerous studies provide evidence that listening is beneficial to healing. "Often, better listening opportunities occur outside the mainstream health care system walls in atmospheres that are conducive to relational freedom. The Church represents one setting where opportunities for story sharing are more affordable" (Rydholm, 1997, p. 49). Researchers, in studying health care in rural settings, are finding that informal networks are an important source of support. According to 1993 statistics from the United States Department of Health and Human Services, two-thirds of all rural elders attend weekly church services (U.S. Department of Health and Human Services, 1993).

Parish nurses have the potential to help individuals, insurance agencies and governments save health care costs. Studies of the first parish nursing services show that the nurses were able to reduce hospitalization in the elderly by 20 to 25% with a similar reduction in costs (Blohm, 1994). Initial studies of parish nursing among the African-American community demonstrate effective preventive health care (Kuhn, 1997).

If churches were to become involved in health care only because of economic crisis that would be a sad commentary on the ability to practice the values upon which they are founded. Another factor which has led to the success of parish nursing is the growing acceptance of the

role of spirituality in total health. Through providing whole-person care the parish nurse models an understanding of health as being much more than physical.

The Concept of Wholism in Parish Nursing

Words have different meanings for different people and in different paradigms. Some uses of the word “wholistic”, for instance are associated with ideas which “connect the individual to the universe, its forces and energies, in such a way that the individual is ‘part of God’ or ‘becomes God’ or is offered complete transcendence of suffering and care” (Westberg, 1990, p. 5). These ideas are often presented with “New Age” philosophy along with the word “holistic”.

A Biblical model of wholism is found in the description of the development of Jesus from childhood to manhood: “And Jesus increased in wisdom and stature and in favor with God and man” (Luke 2:52). Four components are in evidence here:

mental	- wisdom
physical	- stature
spiritual	- favor with God
social	- favor with man

Parish nursing is wholistic in the context of considering the physical, mental and spiritual needs of each individual and recognizing their interrelationships. The social component is significant also, as the focus of the ministry is a group of people who already have social contact through church affiliation. However, most of the parish nursing literature describes the person as “a whole being made up of body, mind and spirit. These facets interact with each other to maintain optimum health” (Wilson, 1997, p. 13). Adventist Health Systems West developed a parish nurse logo to represent the integration of body, mind, and spirit:

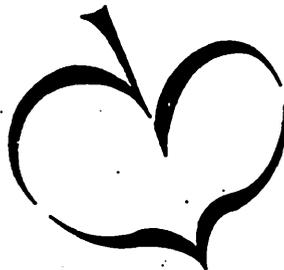


Figure 1: The heart represents the mind (feelings and thinking); the apple represents the body (physical and temporal needs) and the dove represents the Holy Spirit.

Westberg discovered that many who chose the nursing profession “were motivated by a desire to serve people in a whole-person manner”. He also found that nurses have often been disappointed by positions in which there was no time for “the kind of personal caring they felt patients needed so desperately. Complete freedom to minister wholistically to patients is the gift that parish nurse positions offer” (Westberg, 1990, p. 12). Parish nurses are Christian

nurses who function primarily in congregations of their same faith. They know that prayer as well as discussion about God are expected. Their desire is to bring "salvation to people", understanding that the basic meaning of the word "salvation" is "being made whole" (Solari-Twadell, et al, 1990, p.37).

Although other health care professionals also provide wholistic care, people naturally are willing to talk to nurses about personal matters. "In many ways nurses represent the health-care community to a patient" (Shelley, 1988, p. 57). Janice Striepe (1993, p.9) described a parish nurse experience which illustrates this kind of care:

I responded to a call at church from a health care center nurse. "Alma is critical. The family wants a pastor." My response was, "Our interim pastor lives twelve miles away, but I can come over right now." I experienced momentary panic. Then I gathered my thoughts, prayed, collected my Bible and devotional book, left a message at the pastor's house and went to the nursing home.

As I entered the room, six family members were present. After I introduced myself, I went over to Alma. As I talked to her, I assessed her: no response to verbal stimuli, pulse regular and full, breathing rapid but not labored, very warm to touch, no mottling. Death was not imminent. I knew I had time to get acquainted with the family, and I asked them to tell me about Alma.

This proved to be a heart-warming experience. I asked the family to participate in devotions and suggested to her son that he take Alma's right hand and join hands with me, completing the circle around the bed by holding Alma's left hand. After the prayer, I read a few Bible verses, a short devotion and concluded with prayer.

I felt the presence of the Holy Spirit that day and learned how comforting the familiar Bible passages are to people. This experience also illustrates the combining of the pastoral and nursing roles - my assessing, use of Scripture, prayer, and reminding the family to talk to Alma since, despite a lack of response, she could probably hear. I encouraged them to talk with her about their life memories. I remembered that dying people can be very whole; our wholeness depends on being in harmony with God, ourselves and others (Striepe, 1993, p. 9).

In a church such as the Seventh-day Adventist Church, in which health principles are an important component of the belief system, this emphasis on congregational health allows nurses as well as parishioners to more fully integrate belief with behavior, faith with learning and practice. It provides opportunity to follow the counsel of early church leader Ellen White: "Let the workers keep Christ, The Great Physician, constantly before those to whom disease of body and soul has brought discouragement. Point them to the one who can heal both physical and spiritual disease" (White, 1942, p. 144). The dedicated parish nurse understands that wholeness exists because of relationship with God, not just that the physical, mental and spiritual pieces are working together. Building relationship takes precedence over keeping the pieces together.

Parish Nursing Defined and Explained

The terms “Minister of Health” and “Parish Nurse” have been used interchangeably. Some prefer to use the term “Minister of Health” as a way to “address a difference in mind-set, to articulate an organized approach in keeping people well. . . It is a new integration of the classic nursing perspective with an intentional pastoral and theological orientation” (Blohm, 1997, p. 1-4). In this paper, the term “parish nurse” is used.

The suggested framework for parish nursing is that of health promotion, prevention and response. “Hands-on” skilled nursing care is avoided.

Health promotion focuses on healthy human development. For example, at a church potluck dinner there could be one table of foods specifically prepared with healthful ingredients. Recipes could be displayed next to the dishes on the table. Those with allergies or dietary restrictions could see what the ingredients are, and choose foods appropriate for their diet. Other members would have opportunity to make knowledgeable food choices. Parish nurses might conduct focused support groups or teach classes on self-care, hydrotherapy, exercise, or stress management. Short paragraphs with pertinent health information could appear regularly in the church bulletin and/or church newsletter. A bulletin board may be designated for health promotion information, and the parish nurse would freely distribute health education materials.

Prevention highlights the lowering of risk factors and reduction of the incidence of illness. Many of the activities described in the previous paragraph could focus on prevention. Other examples would be blood pressure screening, body fat analysis, health risk appraisals and parent-education classes.

Response is the action taken to address actual conditions which affect health and healing. This could include home visits, teaching, health referral, and organization of volunteers to provide meals (Solari-Twadell, 1997). In most congregations parish nurses monitor hospital admissions. They visit or call individuals in the hospital and then follow-up at home or in long-term care after discharge. They receive referrals from the pastoral staff when parishioners are sick and injured. They coordinate with other community resources so that comprehensive care can be provided. They provide education and support services for parents with newborns. Parish nurses may provide some nursing services to church schools.

In providing these services the nurse helps the congregation, the pastoral staff and the community. Following is a list of activities which a parish nurse is likely to do for these different groups.

1. For the congregation parish nurses:

- provide wellness education to various age groups, as needed
- coordinate health fairs and exhibits
- advise members on health care at their invitation
- inform members about community social service and health-care agencies
- train, support and supervise volunteers in caring ministry
- help maintain health records and provide health education and counseling in the church school.

2. For the pastoral staff parish nurses:
 - accept referrals to make health assessments of selected members
 - assess physical, mental, emotional and spiritual states of members as indicated
 - introduce wellness programs
 - serve as team members with the pastoral staff to provide whole person ministry.

3. For the community parish nurses:
 - provide health education classes and support groups open to the community
 - collaborate with community health care services
 - serve on boards and committees of health-care agencies on behalf of the congregation
 - initiate congregational response to provide food, shelter and health needs to community members in need (Lutheran Social Services, 1997).

Although every congregation is different, it is helpful to look at studies conducted on the type of health concerns parish nurses encounter. Structured field notes of approximately 40 parish nurses pertaining to 1800 contacts with the elderly were evaluated. Psychosocial-spiritual concerns accounted for 53% of the concerns and physical-functional concerns accounted for the other 47% (Rydholm, 1997).

Organizationally, there have been four basic models for Parish Nursing (Blohm, 1997). The major differences between models are based on the choice of coordinating organization and on payment vs. nonpayment for nursing services. The models are as follows:

1. The hospital/agency paid model. In this model there is a contract between a congregation and a health care facility. Employees are paid by the facility to consult with and assist churches or other community groups.

2. The hospital/agency volunteer model. The parish nurses are volunteers who relate to the health care institution. The institution may provide services such as continuing education and supervision. In some cases the hospital hires a Parish Nurse Coordinator to encourage the development of volunteer parish nursing in the community and to provide education and support for the volunteer parish nurses.

3. Congregation paid model. The nurse (or nurse coordinator) is employed by the congregation.

4. Congregation volunteer model. The nurse functions as a volunteer who reports directly to the pastoral staff and church board.

A recent study indicates that 58% of parish nurses are salaried (Marquette, 1997). The current parish nurse movement is young. Many different models and emphases are likely to be explored. Several models are discussed in the Winter, 1997 issue of the Journal of Christian Nursing, including a model which establishes a framework based on the accepted major

concepts of all nursing theories: person, health, nursing and environment (Miller, 1997). Models are also described in a manual by Streipe (1989), and in a book by Granger Westberg (1990).

Within the existing variety of models and program styles job descriptions are created around the specifics of a particular setting. A key thread running through these job descriptions is that the parish nurse does not duplicate other available nursing or medical services, but seeks to creatively bridge the gaps in health education and care delivery.

The Process of Establishing a Parish Nurse Program

The process for establishing and maintaining a parish nurse program is outlined in the manual by Maxine Blohm (1997) and in the book Nurses in Churches by Jan Striepe (1989). This process can be adapted to the size and structure of a congregation.

Although the process will vary depending on the congregation, there are several key components of an effective enduring parish nurse program. These components include: (a) choosing a parish nurse coordinator, (b) establishing a Health Ministries Committee, Board or Cabinet, (c) providing information to the congregation, and (d) surveying congregational needs.

Choosing a Parish Nurse Coordinator

If there is a local health care institution with a parish nurse coordinator, that person should be involved in helping the local church find its own parish nurses. Whether or not the position is volunteer or paid, there should be an interview process. Sample interview forms are included in the manual by Maxine Blohm (Blohm, 1997). In churches with many nurses it seems most efficient to choose a coordinator who interviews and supervises the other nurses. Spiritual commitment, communication skills, educational background, knowledge of and personal involvement with congregational life, nursing experience and knowledge of community resources should be taken into consideration.

Establishing a Health Ministries Committee, Board or Cabinet

The Health Ministries Committee is the inter-disciplinary team which works closely with the nurses to coordinate the health-related activities of the church. Depending on the professionals in the congregation, it is appropriate to have physicians, nurse practitioners, nutritionists, physical and/or occupational therapists, social workers, counselors and business or marketing personnel represented. In churches associated with colleges it is important to have students studying nursing, theology and other helping professions on the committee. This committee guides in the process of assessing health-related needs and establishing plans for health prevention and promotion programs.

Providing Information to the Congregation

As in any other community, the congregation will respond best to a new program if the membership has been involved and informed in the initial stages of setting up the program. All pastoral staff members and church board members should receive written information about parish nursing. Obtaining official approval by the church board, and having names of parish nurses and Health Ministries Committee members approved by the Nominating Committee or Placement Board, will give credence to the program and provide opportunity for educating more people about the philosophy and goals of the program. Once the program is established the health ministries of the church should be constantly communicated through bulletin boards, church bulletin, newsletters and announcements. Even when sharing office space with some other church entity (which is usually the case) the parish nurse name should be on the door. When doing health screening or conducting health promotion programs parish nurses wear name tags which designate their professional role.

Surveying the Needs of the Congregation

Maxine Blohm (1997) has developed several tools for surveying the health needs of a congregation. Under the supervision of the Health Ministries Committee this process can be approached in the same manner that a community needs assessment may be done for any community. Demographic factors of any group affect the health needs. Those involved in congregational health can work most efficiently if they have congregation-specific objectives.

Potential Limitations

The scope of potential problems in the practice of parish nursing is largely unknown. Extrapolating from other domains of practice, the following areas are worthy of advance problem-solving: liability, burn-out, and lack of continuity.

All health care practitioners need to be aware of the potential for litigation. Parish nurses decrease the chances of legal problems by communicating objectives clearly to parishioners, avoiding invasive nursing procedures, remaining current in the profession, establishing and maintaining professional protocols for teaching and documentation, and carrying personal malpractice insurance. Within the Seventh-day Adventist Church structure in North America most conferences now have parish nursing specifically covered in church insurance policies. In nursing textbooks parish nursing is considered to be a form of community health nursing, an area of practice usually reserved for the nurse with baccalaureate education or more. Although many current parish nurses have advanced degrees as well as additional education in psychology, teaching or theology, there are also many retired nurses who attended diploma schools of nursing. These nurses can provide spiritual depth and life experience to the role. It is essential, however, that parish nurses recognize and practice within their limitations.

“Burn-out” is also common among health care professionals. Most parish nurses in the Seventh-day Adventist Church are volunteers whose emotional exhaustion will not be

compensated by monetary remuneration as in an employment setting. All parish nurse education programs need to include emphasis on self-care and stress management. In the book Whole-Person Medicine (Allen, 1980, p. 33) there is an interesting idea about the process of providing whole-person care:

To minister to the whole person, especially to the spiritual needs, there must be what I can only call a spiritual reaction between patient and physician. It may be such a powerful reaction that we feel emotionally and spiritually drained afterward. Yet we must be willing to take on some of our patients' hurts and to have some of our own spiritual strength transferred to them. Both Mark and Luke, in describing the healing of the woman with bleeding of twelve year's duration, spoke of Jesus knowing that "virtue had gone out of him" at the moment of healing. There was a spiritual reaction between healer and healed.

The parish nurse as a team member with the pastoral staff needs to be supported by them and maintain an active personal devotional life.

In analyzing various programs of local congregations it is evident that some have higher priority than others. In Seventh-day Adventist churches, for example, it would be surprising if childrens' Sabbath Schools did not exist. However, the emphasis on other church programs varies widely depending on congregational interest. Any church establishing a parish nurse program should plan the appropriate process through the board and committee system to ensure longevity. Then, even if the active nurse(s) move away the church will be committed to finding other nurses to continue the congregational health care.

Parish Nurse Education

Parish nurse education takes several forms. Most of the educational opportunities have been in the form of continuing education for registered nurses. Several colleges and universities have sponsored short continuing education courses in parish nursing. Some have offered distance learning programs. Some, such as Messiah College in Pennsylvania, offer a certificate program in congregational health ministries. Other models of parish nurse education continue to develop, such as the one at Houston Baptist University, which offers a family nurse practitioner program with emphasis on pastoral counseling skills.

The mission of the International Parish Nurse Resource Center of Advocate Health Care is "to promote the development of quality parish nurse programs through research, education, and consultation." Since its establishment in 1986, the primary emphasis has been on education. The resource center maintains a listing and sample curricula of parish nurse education programs from across the country. A current priority is to develop a basic curriculum model for parish nurses and parish nurse coordinators (International Parish Nurse Resource Center, 1997).

Some schools are including parish nurse theory and practice in undergraduate programs (Noble, 1996). In an interview conducted at Loma Linda University on June 18, 1997, Dr. Penny Miller discussed the involvement of Loma Linda University nursing students in parish

nursing practice through the University Church. She explained that this has been positively received by the students and the community. Students have stated that the experience has helped them integrate their knowledge of the body, mind and spirit. This type of education brings solution to the following long-standing educational problem:

Even in seeking a preparation for God's service, many are turned aside by wrong methods of education. Life is too generally regarded as made up of distinct periods, the period of learning and the period of doing-of preparation and of achievement. In preparation for a life of service the youth are sent to school, to acquire knowledge by the study of books. Cut off from the responsibility of everyday life, they become absorbed in study, and often lose sight of its purpose. The ardor of early consecration dies out, and too many take up with some personal, selfish ambition. Upon their graduation, thousands find themselves out of touch with life. They have so long dealt with the abstract and theoretical that when the whole being must be roused to meet the sharp contests of real life they are unprepared. Instead of the noble work they had purposed, their energies are engrossed in a struggle for mere subsistence. . . The world is robbed of the service it might have received, and God is robbed of the souls He longed to uplift, ennoble, and honor as representatives of Himself (White, 1952, p. 265).

Using the church as a location for student clinical experiences encourages spiritual growth. "The church is organized for service, and in a life of service in Christ, connection with the church is one of the first steps. . . This is an important part of one's training: and in a church imbued with the Master's life, it will lead directly to effort for the world without" (White, 1952, pp. 268,269).

Steven Garber (1996, p.43), a current author who has analyzed the factors which contribute to the integration of belief and behavior during the university years, states that "true education is always about learning to connect knowledge with doing, belief with behavior, and yet that connection is incredibly difficult to make for students in the modern university".

A practical component has historically been important in nursing education. No patient in the health-care delivery system would want to be cared for by nurses who had never practiced the basic skills of therapeutic nursing intervention. In a belief system of wholism, students should not be expected to be able to integrate physical, mental and spiritual care without practice, for "it is not enough for students to record their teacher's words. It is not even enough for students to think about these words, weigh them, and give mental assent. Learning the truth requires that we enter into personal relationships with what the words reveal" (Parker, 1993, p.43).

Dreams for the Future

Envisioning the future of parish nursing one might see the Seventh-day Adventist Church hiring nurses as members of the congregational team internationally. In fact, every division, union and conference would have a nurse or other health-care professional on the administrative team. Perhaps there would be a change in title for the position. In congregations with predominately female pastors the parish nurse coordinator would be male; in congregations with predominately male pastors, a female. Nurses would also provide health promotion services to members of small congregations of other denominations. Other health and social service professionals would work with the parish nurse to provide wholistic care and to organize the entire congregation in service to each other and to the community. Such a congregation would have adolescents visiting senior citizens, active retired persons transporting children of working parents to appointments, and open sharing of burdens and talents.

All educational programs in nursing and theology would include theory and practice in parish nursing. Church educational institutions which offer advanced degrees in nursing would offer a masters degree in parish nursing. Ongoing research on the effects of congregational health care would take place. Pregnant women, troubled teens, drug addicts, frightened elderly widows and all others would know that there were people available who cared about them. With the gospel being presented in this manner, the Lord would come soon.

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