

## **<sub>1</sub> Spirituality in Nursing: Standing on Holy Ground**

*God called to Moses out of the bush: "Moses, Moses!" And he said, "Here I am."  
"Come no closer," God said. "Remove the sandals from your feet, for the place on  
which you are standing is holy ground."*

EXODUS 3:4-5

perhaps no scriptural theme so well models the spiritual posture of . nursing practice as the Old Testament depiction of Moses and the burning bush. In the biblical narrative, God reminded Moses that, when he stood before his Lord, the ground beneath his feet was holy. When the nurse clinician, nurse educator, nurse administrator, or nurse researcher stands before a patient, a student, a staff member, or a study participant, God is also present, and the ground on which the nurse is standing is holy. For it is here, in the act of serving a brother or sister in need, that the nurse truly encounters God. God is present in the nurse's practice of caring just as surely as He was present in the blessed meeting with Moses so many centuries ago. In an editorial in the *Journal of Christian Nursing*, Judy Shelly reminded us that "the holy ground we as nurses are called to enter may be ... difficult ... we face pain, suffering, fear, communication barriers, cultural and ethnic prejudice, injustice, impossible working conditions and constant obstacles" (2003, p. 3). However, Shelly adds, although we may at times "feel inadequate and defeated ... God is with us. He offers us his peace" (p. 3). This, I believe, is the gift and the grace of our nursing vocation of "standing on holy ground." This is the blessing; the precious knowledge that, however great or small our nursing task may be, God is with us and will give us His peace.

This introductory chapter addresses the nurse's spiritual posture, "standing on holy ground," while also offering a historical perspective on the spiritual ministry of nursing. The overall relationship between

spirituality **and** nursing practice is explored; the concepts of spirituality-as distinguished from religiosity or religious practice-and nursing are defined with a view to understanding their meaning for the contemporary nurse. Nursing practice is examined in relation to the nurse's spiritual stance in caring for patients, the nurse's participation in the provision of holistic care, and the nurse's role as healer. Finally, a practice model, labeled a "Nursing Theology of Caring," is described.

The empirical data on the spiritual concerns and needs of the ill in the present chapter, as well as those in the following chapters, are derived from nursing research with persons suffering from a multiplicity of illness conditions in a variety of settings. The author conducted both formal and informal interviewing and observation with these patients, their family members, and their nurse caregivers. The interview and observational data are supplemented by materials excerpted from journals maintained during the conduct of the research and also during a hospital chaplaincy experience.

# THE SPIRITUAL MINISTRY OF NURSING: A HISTORICAL PERSPECTIVE

In a small but classic volume, *The Nurse: Handmaid of the Divine Physician*, written in the early 1940s, Franciscan Sister Mary Berenice Beck articulated what a great number of nurses of her era, especially those of the Judeo-Christian tradition, understood as the spirituality of their practice. Historically, nursing was viewed in large part as a vocation of service, incorporating a clearly accepted element of ministry to those for whom the nurse cared. A nurse's mission was considered to be driven by altruism and empathy for the sick, especially the sick poor. The practicing nurse of the early and middle 20th century did not expect much in terms of worldly rewards for her efforts. She envisioned her caregiving as commissioned and supported by God; to Him alone were the thanks and the glory to be given. This vision of nursing as a spiritual ministry is reflected in Sr. Mary Berenice's nurse's prayer:

I am Thine Own, great Healer, help Thou me to serve Thy sick in humble charity; I ask not thanks nor praise, but only light to care for them in every way aright. My charges, sick and well, they all are Thine. (1945, p. xvii)

Other nursing authors of the time also supported the concept of nursing as a calling, with a decidedly spiritual element undergirding its practice. As nurse historian Minnie Goodnow (1916) asserted, "Nursing is not merely an occupation, temporary and superficial in scope; it is a great vocation" (p. 17). She added, "It [nursing] is so well known to be difficult that it is sel

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dom undertaken by a woman who has not, in the depths of her consciousness, an earnest purpose to serve humanity" (p. 17). And, in the introduction to a basic fundamentals of nursing textbook, *The Art, Science and Spirit of Nursing* (1954), author Alice Price observed, "Nursing is possessed of a spiritual quality. in that its primary aim is to serve humanity. not only by giving curative care to the bodies of the sick and injured, but by serving the needs of the mind and spirit as well" (p. 3). For the Christian nurse, the frequently quoted scriptural text supporting practice was that of Matthew 25:35-40, "For I was ... sick and you took care of me.... I tell you, just as you did it to one of the least of these ... you did for me."

A condition that kept the original spiritual ministry of nursing alive in this country was the fact that many early to mid-20th century nurses received their education in nursing schools affiliated with one of the predominant religious denominations. Prior to the development of contemporary undergraduate and graduate programs in nursing, the three-year diploma schools that were the norm were generally not associated with academic institutions. Rather they were sponsored by individual hospitals, many of which were religiously affiliated. These schools tended to be small and insular in character, taking on the spiritual elan of the hospital with which they were connected. This was evident in the rituals of passage such as "capping" and graduation that were often conducted in places of worship with the blessing of a cleric included as part of the ceremony.

In the latter half of the 20th century, however, although some U.S. nursing schools did retain a strong spiritual milieu as a characteristic feature, many of the newer university- and college-affiliated programs began to focus on the professional character of nursing. Nursing publications and conferences described the characteristics of a profession, and much debate centered around how nursing incorporated specified professional criteria, particularly the criterion of autonomy of practice. These discussions were appropriate, as advanced health care technology and burgeoning knowledge generated by the behavioral sciences resulted in the practicing nurse requiring and receiving ever more sophisticated education related to patient care. For a time, at least, the proverbial pendulum appeared to swing toward the *science*, rather than the *art*, of nursing. This represented a concerted effort to bring nursing practice up to standard alongside medical practice and that of other caregiving professions.

During the 1970s and 1980s, however, despite the fact that curricula in undergraduate and newly emerging master's and doctoral programs in nursing were becoming increasingly more complex in terms of the biological and behavioral sciences, many were beginning to acknowledge the need for

holistic health care. With the advent of the concept of holism, came a reawakening of the importance of the ill person's spiritual nature and a heightened concern for spiritual needs. In identifying a model for holistic nursing, nurse clinician and researcher Cathie Guzzetta (1988) described holistic concepts as incorporating "a sensitive balance between art and science, analytic and intuitive skills, and the ability and knowledge to choose from a wide variety of treatment modalities to promote balance and interconnectedness of body, mind and spirit" (p. 117). Thus, in the holistic nursing model, patients' spiritual nature and needs are brought into equal focus with their cognitive and physiological needs.

Recently, an abundance of literature, both professional and lay, has begun to address the spiritual component of the human person. Books and articles abound relating to such topics as prayer, spiritual counseling, "near death" experiences, interactions with angels, and volunteer activities undertaken for spiritual motives. Many individuals in our society are seeking to find transcendent meaning in their lives. It is not surprising, then, that nurses, now more solidly entrenched in their professional identities, should follow suit. As theorist Barbara Barnum (1994) pointed out, whereas nursing's focus during the past two decades has been on the "biopsychosocial" model of care, more recently nurse scholars have demonstrated a renewed interest in the spiritual dimension of caregiving (p. 114). Barnum's assertion is reflected in an increase in the nursing literature in conceptual and research-based articles related to the association between spirituality and health/illness. One example is the work of Jean Watson (1995) who observed, "At its most basic level nursing is a human-caring, relational profession. It exists by virtue of an ethical-moral ideal, and commitment to provide care for others" (p. 67). Watson's comment reflects a contemporary understanding of the spiritual ministry of nursing practice.

## **SPIRITUALITY AND NURSING PRACTICE**

In order to provide some basis for beginning a discussion of spirituality and contemporary nursing practice, there must be a common understanding of the concepts of spirituality and nursing. Spirituality, as a personal concept, is generally understood in terms of an individual's attitudes and beliefs related to

transcendence (God) or the nonmaterial forces of life and of nature. Religious practice or religiosity, however, relates to a person's beliefs and behaviors associated with a specific religious tradition or denomination. Nurses need to have a clear understanding of this distinction or they may neglect spiritual needs in focusing only on a patient's religious practice (Emblen. 1992, p. 41).

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### **Spirituality**

Spirituality, as related to holistic nursing, is described by Dossey (1989) as "a broad concept that encompasses values, meaning, and purpose; one turns inward to the human traits of honesty, love, caring, wisdom, imagination, and compassion; existence of a quality of a higher authority, guiding spirit or transcendence that is mystical; a flowing, dynamic balance that allows and creates healing of body-mind-spirit; and may or may not involve organized religion" (p. 24). Pamela Reed (1992) presented a paradigm with which to explore spirituality in nursing by defining spirituality as "an

expression of

the developmental capacity for self-transcendence" (p. 350). Nurse anthropologist Madeleine Leininger (1997, p. 104) identified spirituality as a relationship with a supreme being that directs one's beliefs and practices.

Spirituality viewed as a human need has been described as "that dimension of a person that is concerned with ultimate ends and values.... Spirituality is that which inspires in one the desire to transcend the realm of the material" (O'Brien, 1982, p. 88). For many individuals, especially those adhering to the Western religious traditions of Judaism, Christianity, and Islam, the concept of transcendence incorporates belief in God. This is reflected explicitly in the conceptualization of spirituality articulated by nurse Ruth Stoll (1989) who asserted, "Through my spirituality I give and receive love; I respond to and appreciate God, other people, a sunset, a symphony

and spring" (p. 6). Prayers as a meaning in life have been identified as indications of spirituality (Meraviglia, 1999); spirituality may thrive, however, outside the sphere of organized religion (Kendrick and Robinson, 2000).

Three characteristics of spirituality posited by Margaret Burkhardt (1989) include "unfolding mystery," related to one's attempt to understand the meaning and purpose of life; "harmonious interconnectedness," or an individual's relationship to other persons and/or to God; and "inner strength," which relates to one's personal spiritual resources and "sense of the sacred" (p. 72). Spirituality is proposed as a "cornerstone" of holistic nursing by Nagai, Cobson and Burkhardt (1989) who suggested that questions appropriate to exploring a patient's spirituality might include how the individual understands God and what things give meaning and joy to life (p. 23). Each nurse needs to understand his or her own spirituality, keeping in mind that this personal belief system may differ significantly from that of a patient and family. . The nursing literature offers no one clear definition of spirituality. As pointed out by Verna Benner Carson in the *Journal of Christian Nursing* (1993), "Conceptions of spirituality represent a variety of worldviews and the opinions of people from divergent walks of life" (p. 25). Common to most definitions of spirituality, as reflected in the nursing literature, are the elements

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Writing in the early 1950s, Alice Price, RN (1954), offered a definition of nursing that incorporated not only the concept of the patient's spiritual nature, but the altruistic vocation of the nurse as well. She described nursing as neither pure science nor true art, but as a combination of both. "Nursing, as a profession, will embrace more than an art and a science; it will be a blending of three factors: of art and science, and the spirit of unselfish devotion to a cause primarily concerned with helping those who are physically, mentally or spiritually ill" (p. 2). Price ultimately defined nursing as "a service to the individual which helps him to regain, or to keep, a normal state of body and mind; when it cannot accomplish this, it helps him gain relief from physical pain, mental anxiety or spiritual discomfort" (p. 3). Although Nurse Price was writing some 25 to 30 years prior to the widespread acceptance of the term *holistic nursing*, her vision of the professional nurse's role clearly included attention to the needs of a patient's spirit, as well as to the needs of the body and the mind.

In their book *Introduction to Nursing*, written 40 years after publication of Price's 1954 text, coauthors Lindberg, Hunter, and Kruszewski (1994) argued that, presently, because of the continual growth and development of the profession, no single definition of nursing can be accepted (p. 7). The authors presented excerpts of nursing definitions articulated by a cadre of theorists from Florence Nightingale in 1859 to Martha Rogers in 1970 but, ultimately, suggested that each practicing nurse develop a definition of his or her own. Lindberg and colleagues did, however, express the hope that, whatever one's definition, it will contain an emphasis on caring or nurturing as a motivating factor for choosing nursing (p. 7).

Following the suggestions of Price in 1954 and Lindberg, Hunter, and Kruszewski in 1994, a current working definition of nursing follows:

Nursing is a sacred ministry of health care or health promotion provided to persons both sick and well, who require caregiving, support, or education to assist them in achieving, regaining, or maintaining a state of wholeness, including wellness of body, mind, and spirit. The nurse also serves those in need of comfort and care to strengthen them in coping with the trajectory of a chronic or terminal illness, or with experiencing the dying process.



The spiritual dimensions of the definition relate to two concepts: first, the sacred ministry of caring on the part of the nurse; and second, the ultimate goal of the patient's achievement of a state of wholeness, including the wellness of body, mind, and spirit. These concepts are next explored in terms of the nurse's spiritual posture, the patient's spiritual wholeness, and the nurse-patient spiritual interaction.

### **THE NURSE'S SPIRITUAL POSTURE: STANDING ON HOLY GROUND**

Sister Macrina Wiederkehr (1991) advised, "If you should ever hear God speaking to you from a burning bush, and it happens more often than most of us realize, take off your shoes for the ground on which you stand is holy"

(p. 2). How appropriate, it seems, to envision practicing nurses, who must come together with their patients in caring and compassion, as standing on holy ground. God frequently speaks to us from a "burning bush," in the fretful whimper of a feverish child, in the anxious questions of a preoperative surgical patient, and in the frail moans of a fragile elder. If we "take off our shoes," we will be able to realize that the place where we stand is holy ground; we will respond to our patients as we would wish to respond to God in the burning bush.

But what does it really mean to "take off one's shoes"? Sister Macrina asserted that it means stripping away "whatever prevents us from experiencing the holy" (1991, p. 3). She added that God speaks to us in many "burning bushes of today" and that "the message is still one of holy ground"; it is a message that is often missed "because of [our] unnecessary shoes" (p. 3). In the contemporary conduct of nursing practice, nursing education, nursing administration, and nursing research, some of us may admit to having a number of unnecessary pairs of shoes littering our professional closets. First, there are running shoes, which many of us wear as we rush pell-mell from task to task in order to manage the day. As we fly about, feet barely touching the ground, it is easy to forget, in the busyness, that where we are standing is a holy place. Another often-relied-on pair of shoes are sturdy walking brogues, which provide protection against

unwanted intrusions. Unfortunately, their insulated soles, which keep us safe and secure, may also prevent our feet from feeling the holy ground on which we walk. And then there are old, favorite loafers, well worn and cozy. When we are wearing these shoes, we can so rest in their comfort that we need not be troubled by any disturbing bumps in the holy ground. We nurses probably have, I am sure, many more unnecessary pairs of shoes that prevent our feet from experiencing holy ground. But recollections of times past when, literally or

figuratively, we have been able to take off our shoes, even if only briefly, well validate the Old Testament message. A personal experience recorded in the author's journal describes the powerful spiritual impact of physically removing a pair of shoes during the course of a worship service.

I had been invited to attend an early morning church service at "Gift of Peace," a home for persons with terminal illness operated by Mother Teresa's Missionaries of Charity. On arrival, I settled quietly into a back corner of the small chapel. There were no pews; the sisters sit or kneel on the floor. As I began to observe the sister Missionaries of Charity entering the chapel, I noticed, with some astonishment, that none were wearing shoes; they were all barefoot. I knew that the sisters wore sandals when they cared for patients but these had apparently been put aside as they came to kneel before their Lord. Not wanting to violate the spiritual elan of the service, I proceeded, as inconspicuously as possible, to slip out of my own sandals. Somehow, becoming shoeless in church, a condition I had not experienced before, provided a powerful symbol for me. I felt that I was truly in the presence of God, of the Holy Mystery, before whose overwhelming compassion and care it seemed only right that I should present myself barefoot, in awe and reverence. Near the end of the service, as I went forward and stood before the altar in bare feet to receive the sacrament of the Eucharist, I sensed in the deepest recesses of my soul that I was indeed "standing on holy ground." That memory will, I pray, serve as a poignant reminder that whenever I stand before a suffering patient, I am, there also, just as surely in the presence of God, and I must take care to remove whatever unnecessary "shoes" I happen to be wearing at the time. I need to allow the "bare feet" of my spirit to touch the "holy ground" of my caregiving, so that I shall never fail to hear God's voice in the "burning bush" of a patient's pain.

## **HOLISTIC NURSING: THE BODY, MIND, AND SPIRIT CONNECTION**

At times one hears an individual described as being truly healthy. The assumption underlying such a remark may relate not so much to the physical health or well-being of the person as to the fact that he or she is perceived as solidly grounded spiritually. One can be possessed of a healthy attitude toward life, even if suffering from a terminal illness. In order to achieve such a spiritual grounding in the face of physical or psychological deficit, the in

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dividual must be closely attuned to the body, mind, and spirit connection; one must understand and accept the value of the spiritual dimension in the overall paradigm of holistic health.

As our society advanced scientifically during the past half-century, it became increasingly more difficult for some in the health care community to give credence to the importance of the spiritual nature of the human person, especially in relation to health/illness issues. More recently, however, caregivers are recognizing that sensitivity to a patient's spiritual needs is critical if they are to provide truly "holistic" health care. Nurse and minister Ann Robinson (1995) believes that nurses must "embrace the spirituality of the human community" in order to support their patients' holistic health behaviors (p. 3).

Authors Dossey and Keegan (1989) defined the concept of holism, which undergirds holistic health and holistic nursing care, including the body, mind, and spirit connection, as "the view that an integrated whole has a reality independent of and greater than the sum of its parts" (p. 4). They described holism as consisting of a philosophy of positive, interactionally based attitudes and behaviors that can exist not only in one who is well but *also* in one who is seriously or terminally ill (p. 5). Nurses practicing care supportive of such holism need to envision the spiritual needs of a patient as deserving of attention equal to that provided in response to physical and psychosocial concerns.

Overall, holistic nursing is supported by and alternately supports the intimate connection of body, mind, and spirit. Nursing of the whole person requires attention to the individuality and uniqueness of each

dimension, as well as to the interrelatedness of the three. In *The Wholeness Handbook*, Emeth and Greenhut (1991) described the body, mind, and spirit elements: The body is the physical substance of a person that can be perceived in empirical reality; the mind is that dimension of an individual that conceptualizes; and the spirit is the life principle that is shared with all humanity and with God. "It is the dimension of personhood that drives us to create, love, question, contemplate and transcend" (pp. 27-28).

For the nurse seeking to provide holistic health care, then, the spiritual dimension and needs of the person must be carefully assessed and considered in all therapeutic planning. Spiritual care cannot be separated from physical, social, and psychological care (Lo and Brown, 1999; O'Connor, 2001). Often it is uniquely the nurse, standing either literally or figuratively at the bedside, who has the opportunity and the entree to interact with patients on that spiritual level where they strive to create, love, question, contemplate, and transcend. Here, truly, the nurse is standing on holy ground.

## THE NURSE AS HEALER

The nurse, standing as he or she does on the holy ground of caring for the sick, is well situated to be the instrument of God's healing. In the sacred interaction between nurse and patient, the spiritual healing dimension of holistic health care is exemplified and refined. The nurse stands as God's surrogate and as a vehicle for His words and His touch of compassionate care.

Healing has been described variously as facilitating openness to the

"communication of the Holy Spirit, whose message is always wholeness" (Johnson, 1992, p. 21); "the process or act of curing or restoring to health or wholeness, the body, the mind and the spirit" (Haggard, 1983, p. 235); and "to make whole" (Burke, 1993, p. 37). The concept of the nurse as healer incorporates the characteristics of all three definitions; that is, the nurse healer must listen to the voice of God; desire to restore health either of body or of

spirit; and attempt to assist the patient in achieving wholeness and integrity of body, mind, and spirit. For the nurse of the Judeo-Christian tradition, spiritually oriented scriptural models of healing abound in both the Old and the New Testaments.

Yahweh's healing power is reflected in Old Testament Scripture in such narratives as Elijah's healing of the widow's son (1 Kings 17:17-23) and Elisha's cleansing of Naaman's leprosy (2 Kings 5:1-14). In the New Testament account of the ministry of Jesus, 41 healings are identified (Kelsey, 1988, p. 43). Jesus healed by word and by touch, sometimes even using physical materials such as mud and saliva. Always, Jesus' healings were accompanied by love and compassion for the ill persons or their families, as in the case of Jairus' young daughter, who her parents thought to be dead. Jesus comforted Jairus with the words, "The child is not dead but sleeping" (Mark 5:39). And then, "He took her by the

hand and said to her, 'Talitha cum,' which means 'Little girl, get up!' And immediately the girl got up and began to walk

about" (Mark 5:41). In her doctoral dissertation entitled "Biblical Roots of Healing in Nursing,"

Maria Homberg (1980) posited that an established biblical tradition reflecting the healing power of such concepts as respect for human dignity and positive interpersonal relationships has parallels in contemporary nursing (p. 2). Homberg suggested that the biblical history of healing can be

used by nurse educators to support the importance of these concepts. Dossey (1988) identified the characteristics of a nurse healer as having an awareness that "being present" to the patient is as essential as technical

skills, respecting and loving all clients regardless of background or personal characteristics, listening actively, being nonjudgmental, and viewing time with clients as times of sharing and serving (p. 42). These characteristics reflect the spiritual nature of healing described in the Old and the New

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Testament Scriptures. Finally, nurse educator Brenda Lohri-Posey says that to become a "compassionate healer" a nurse must "recognize the ability to be a healer" and understand that "healing occasions are unique for each patient" and that "the healing occasion" may change a nurse's "beliefs about pain and suffering" (2005, p. 37).

### The Nurse As Wounded Healer

When a nurse is described as a healer, one tends to focus on his or her ability to relieve suffering. The label "healer" evokes the concept of a strong and gifted individual whose ministry is directed by care and compassion; this is an appropriate image. What may be forgotten in such a description is the fact

that sometimes the gift of healing has emerged from, and indeed has been honed by, the healer's own experiences of suffering and pain. In chapter 5, which explores the nurse's healing role as an "anonymous minister," a gerontological nurse practitioner, Sharon, describes using her own pain in counseling patients: "I may not talk about my pain ... [but) I understand where they're coming from if they're hurting." Sharon, who imagined this experience as being "united in suffering" with those she cared for, reflected Henri Nouwen's (1979) classic conceptualization of the wounded healer. Nouwen described the wounded healer as one who must look after personal wounds while at the same time having the ability to heal others. The wounded healer concept is derived from a Talmudic identification of the awaited Messiah:

He is sitting among the poor covered with wounds. The others unbind all their wounds at the same time and bind them up again, But he unbinds one at a time and binds it up again, saying to himself: "Perhaps I shall be needed; if so, I must always be ready so as not to delay for a moment."

TRACTATES ANHEDREN (as cited in Nouwen, 1979, p. 82)

The nurse, as any person who undertakes ministry, brings into the interaction personal and unique wounds. Rather than hindering the therapeutic process, the caregiver's wounds, when not unbound all at once, can become a source of strength, understanding, and empathy when addressing the suffering of others. The nurse as a wounded healer caring for a wounded patient can relate his or her own painful experiences to those of the ill person, thus providing a common ground of experience on which to base the initiation of spiritual care.



## **ANURSING THEOLOGY OF CARING**

In the previous pages the nurse is described as having the opportunity to heal and to facilitate wholeness, and in the process, to be in the posture of standing on holy ground. But what is it that initiates and supports such nursing practice? What theological or spiritual understanding and beliefs guide the nursing activities of contemporary practitioners? Perhaps these questions can best be answered in the exploration of a nursing theology of caring. The theology of caring encompasses the concepts of being, listening, and touching and was derived from the author's clinical practice with a variety of acutely and chronically ill patients. The nursing theology of caring is supported by the Christian parable of the Good Samaritan:

Aman was going down from Jerusalem to Jerico, and fell into the hands of robbers who stripped him, beat him and went away leaving him half dead .... But a Samaritan, while traveling ... saw him and was moved to pity. He went to him and bandaged his wounds, having poured oil and wine on them. Then he put him on his own animal, brought him to an Inn, and took care of him.

(Luke 10:30, 33-34)

The Gospel relates Jesus' parable of the Good Samaritan, told in response to a question posed by a scholar of the law who asked, "Teacher, " he said, "what must I do to inherit eternal life?" (Luke 10:25). Jesus said to him, "What is written in the Law?" In response to Jesus' question, the scholar replied, "You shall love the Lord your God with all your heart ... and your neighbor as yourself" (Luke 10:27). To justify himself, however, the scholar added, "And who is my neighbor?" (Luke 10:29). Jesus related the parable of the Good Samaritan in reply. At the conclusion of the parable, Jesus asked the scholar, of all those who had seen the beaten man, which one was truly a neighbor. The scholar replied, "The one who showed him mercy." Jesus said to him, "Go and do likewise" (Luke 10:36-37).

In a commentary on the parable of the Good Samaritan, Kodell (1989) noted that Jesus' story was intended to challenge a prevailing but discriminating attitude in the society of the time-the fact that a

Samaritan, a member of an ethnic group despised by some, could behave so lovingly. The parable, Kodell pointed out, exemplified the love commandment: while the lawyer suggests that not all persons are his neighbors, Jesus' reply indicates that one must consider everyone a neighbor regardless of nationality or religious heritage and affiliation (p. 62). This Gospel narrative provides nurses with a model of unequivocal concern and nondiscrimination in providing

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care to those in need; it reflects the conceptual framework to support a nursing theology of caring. Prior to discussing a theology of caring, on which nursing practice may be based, the key concepts of theology and caring will be explored briefly.

### Theology

The term *theology* comes originally from the Greek words *theos* meaning "God," and *logos* or "science." The contemporary meaning of theology is "an intellectual discipline, i.e., an ordered body of knowledge about God" (Hill, 1990, p. 1011). The study of theology is often described according to Anselm of Canterbury's conceptualization as "faith seeking understanding." In this context, faith is viewed as "a stance of the whole person towards God, characterized by radical trust, hope, love and commitment" (Fehr, 1990, p. 1027). Each nurse's personal understanding of theology will be informed by myriad factors: religious or denominational heritage, formal and informal religious education, religious and spiritual experience, and current faith practices.

### Caring

James Nelson (1976), in his exploration *Rediscovering the Person in Medical Care*, reported that "Underneath ... important assumptions about the unity of the person and the individual's and

community's participation in the healing process lies a fundamental truth: the importance of caring" (p. 62). Nelson added that in health care facilities (clinics, hospitals, nursing homes) staff have a primary interest in "curing" certain disease and illness conditions. Ministers and nurses must, however, remember the importance of their vocational call to care (p. 62). Nelson defined caring as "an active attitude which genuinely conveys to the other person that he or she does really matter.... It is grounded in the sense of uniqueness and worth which, by the grace of God, the other has" (p.63).

One of the earliest nursing theorists of caring is Madeleine Leininger, who defined the concept as referring to "direct (or indirect) nurturant and skillful activities, processes and decisions related to assisting people in such a manner that reflects behavior attributes which are empathetic, supportive, compassionate, protective, succorant, educational and otherwise dependent upon the needs, problems, values and goals of the individual or group being assisted" (1978, p. 489). In her later writings, Leininger described caring as the central focus or dimension of nursing practice (Leininger, 1980, 1988, 1991). Nurse authors Eriksson (1992); Montgomery (1992); and Benner,

Tanner, and Chesla (1996) also identified caring as a central concept of nursing, as did Simone Roach (1992), who postulated five attributes of the concept: "compassion, competence, confidence, conscience, and commitment"

(p. 1). In their practice, nurses have always embraced the concept of caring as integral to the essence of the profession (Picard, 1995; Pinch, 1996). And ultimately, through the manifestation of caring nursing practice, nurses engender the kind of trust and confidence in their patients that leads to the promotion of good health (Bishop & Scudder, 1996, p. 41).

The following section, "Dimensions of Caring," encompasses the characteristics of caring as identified in the theological and health care literature and the goal of a healing outcome as understood in the clinical practice of nursing. Patient examples are drawn from the author's journal chronicling a chaplaincy experience at a research medical center.

## **DIMENSIONS OF CARING**

For the nurse practicing spiritual caring, three key activities may serve as vehicles for the carrying out of the theological mandate to serve the sick: being with patients in their experiences of pain, suffering, or other problems or needs; listening to patients verbally express anxieties or emotions, such as fear, anger, loneliness, depression, or sorrow, which may be hindering the achievement of wellness; and touching patients either physically, emotion-

or spiritually to assure them of their connectedness with others in the family of God.

In and of themselves the acts of being with, listening to, or touching a patient may not constitute spiritual care. These behaviors, however, grounded in a nurse's spiritual philosophy of life such as that articulated in the parable of the Good Samaritan, take on the element of ministry; they constitute the nurse's theology of caring.

## **Being**

*Being with a sick person without judgement creates space for meaning to emerge and for the holy to be revealed.*

E. EMETH and J. GREENHUT (1991, p. 65)

A description from the author's journal of an experience with a young cancer patient reflects the importance of being with a patient in need.

This morning a young man, Michael, who was facing mutilating surgery in hope of slowing the progress of advanced rhabdomyosarcoma,

#### Dimensions of Caring

asked to talk to me; he said, "I need you to help me understand why this is happening. I need you to help me deal with it." I sought consultation both in prayer and from my own spiritual mentor before the meeting. I entered Michael's room, however, with much trepidation; how could I possibly help him "understand why" God seemed to be allowing his illness. As it turned out, Michael was the one who helped me. As soon as I sat down, he said, "There are some things I've been thinking about that I need to tell you," and the conversation continued with Michael sharing much about his own faith and his attempt to understand God's will in his life. As I prepared to leave, Michael got up, hugged me, and said, "Our talk has helped a lot"; we prayed together for the coming surgery. Simply being with Michael as he struggled with the diagnosis of cancer in light of his own spirituality constituted the caring. I did not have, nor did I need, any right words; I only needed to be a caring presence in Michael's life.

Emeth and Greenhut (1991), in their discussion of understanding illness, described the importance of being with patients and families, especially when, as with Michael, they need to ask questions for which there are no answers. "We cannot answer the question, 'Where is God in this experience?' for anyone

else; rather, we must be willing to be with others in their experience as they live with the questions and wait for their personal answers to emerge. This 'being with' is at the heart of health care" (p. 65).

## Listening

*Many people are looking for an ear that will listen . ... He who no longer listens to his brother will soon no longer be listening to God either. ... One who cannot listen long and patiently will presently be talking beside the point and never really speaking to others, albeit he be not conscious of it.*

DIETRICH BONHOEFFER (1959, p. 11)

The concept of listening is an integral part of being with a person, as was learned from interaction with Michael. However, as his illness progressed, there were also times when being with Michael in silence was a significant dimension of caring. In some situations, however, active listening, with responsive and sensitive feedback to the person speaking, is important in providing spiritual care. Ministering to Philip, a young man diagnosed with anaplastic astrocytoma, revealed the importance of such listening. Philip, because of his neurological condition, had difficulty explaining his

thoughts, especially in regard to spiritual matters, yet he very much wanted to talk. Philip described himself as a born-again Christian, a fact of which he was very proud.

On my first visit Philip showed me a well-worn Bible in which he had written comments on favorite Scripture passages. As our meetings continued, I began to realize that if I opened the Bible and focused on a particular passage, Philip's speech was helped by looking at the words. I tried to listen carefully, to follow and comprehend Philip's thoughts on the Scripture and its meaning in his life. Our sharing was validated one day when Philip reached out and took my hand and said, "I'm glad you're here; I really like our talking about God together."

In a discussion of spirituality and the nursing process, Vema Carson (1989) recognized the importance of such listening. "The ability to listen is both an art and a learned skill. It requires that the nurse completely attend to the client with open ears, eyes and mind" (p. 165). And, in a poignant case study entitled *A Lesson Learned by Listening*, palliative care nurse Katie Jantzi affirmed the importance of listening to a dying patient, reminding us that patients are our "best teachers" (2005, p. 41).

## **Touching**

*And there was a leper who came to Him, and knelt before Him saying: "Lord, if you choose you can make me clean." He stretched out His hand and touched him saying: "I choose. Be made clean." Immediately his leprosy was cleansed.*

MATTHEW 8:2-3

The Christian Gospel message teaches us compellingly that touch was important to Jesus; it was frequently used in healing and caring interactions with His followers. Loving, empathetic, compassionate touch is perhaps the most vital dimension of a nursing theology of caring. At times the

touch may be physical: the laying on of hands, taking of one's hand, holding, or gently stroking a forehead. At other times a nurse's touch may be verbal: a kind and caring greeting or a word of comfort and support. Physical touch has been described in the nursing literature as encompassing five dimensions of caring: physical comfort, emotional comfort, mind-body comfort, social interaction, and spiritual sharing (Chang, 2001).

### Dimensions of Caring

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Perhaps one of the most rewarding experiences with the use of caring touch occurred during an interaction with Erin, a 9-year-old newly diagnosed with acute lymphocytic leukemia.

Erin was about to begin chemotherapy and was terrified at the thought of having Ns started; the staff asked if I would try to help calm her during the initiation of treatment. One of the pediatric oncology nurses pulled up a stool for me next to Erin so that I could hold and comfort her during the needle insertion. After the procedure was finished and I was preparing to leave, Erin trudged across the room dragging her N pole, wrapped her arms around me, and said, "Thank you for helping me to get through that!"

It is not surprising that Carson (1989) identified touch, associated with being with a patient, as critical to the provision of spiritual caring. She suggested that the nurse's "presence and ability to touch another both physically and spiritually" is perhaps his or her most important gift (p. 164). And, in describing the power of "compassionate touch," Minister Victor Parachin asserts, "Whenever we reach out with love and compassion to touch another life, our contact makes the burden a little lighter and the pain more bearable.... By reaching out and touching someone through deed or word, we provide the extra push that person needs to carry on, rather than give up" (2003, p. 9). "The human touch," Parachin concludes, "can make the difference between life and death" (p. 9).



Ultimately the activities of being, listening, and touching, as exemplified in Jesus' parable of the Good Samaritan and in a nursing theology of caring, will be employed in a variety of ways as needed in the clinical setting. This is what constitutes the creativity of nursing practice; this is what constitutes the art of the profession of nursing.

Nursing, as a profession, has developed significantly during the past half-century. The vocation or spiritual calling to care for the sick, somewhat diminished during nursing's heightened concern with professionalism, is experiencing a reawakening among contemporary nurses. This may be related to the interest in spiritual and religious issues manifested in the larger society. Nursing, as an occupation, encompasses a unique commitment to provide both care and compassion for those one serves. The subject of spirituality in nursing practice includes concern not only with the personal spiritual and religious needs of the patient and nurse, but with the spiritual dimension of the nurse-patient interaction as well.

## 2 A Spiritual History of Nursing

*Nursing is an art, and if it is to be made an art, it requires as exclusive a devotion, as hard a preparation, as any painter's or sculptor's work. For what is having to do with dead canvas or cold marble compared with having to do with the living body, the temple of God's spirit.*

FLORENCE NIGHTINGALE, 1867 (cited in Baly, 1991, p. 68)

recently there has been a resurgence of nursing publications di

rected toward the spiritual concerns of those who are ill. To better understand practicing nurses' contemporary interest in spirituality and the spiritual vocation of nursing, it is important to walk briefly in the world of our ancient and medieval past, as well as to examine the post-Reformation period, to explore the powerful and compelling spiritual history of nursing up to the modern era.

It is said that we stand on the shoulders of those who have gone before us; in the stories of the pre-Christian and early Christian caregivers are found many strong shoulders on which to stand. They are exemplary models whose ministries of love and care for the sick speak eloquently to us as nurses today. The spirit and spirituality of these pioneer nurses provide a foundation and a vision that informs, strengthens, and supports contemporary caregiving as nursing moves into the 21st century.

In this chapter, selected caregivers to the sick, whose activities prefigure the role and posture of the modern nurse, are described. The spiritual attitudes and behaviors of these individuals and communities are presented chronologically, beginning with the pre-Christian era, and continuing through the early and later Christian period, up to the present day. The common thread unifying the persons and communities discussed is their concern with the spiritual as well as the physical and psychosocial needs of those who are ill or infirm; these caregivers viewed nursing the sick as a religious vocation supported by the individual's personal spiritual belief system. This chapter is based on the extant nursing and theological literature that documents the historical role of the nurse in providing spiritual care.

## NURSING IN THE PRE-CHRISTIAN ERA

*Whatsoever they receive for their wages . . . they do not keep as their own, but bring into the common treasury for the use of all, nor do they neglect the sick who are unable to contribute their share.*

PHILO, writing of the "Essenes" (cited in Robinson, 1946, p. 6)

Prior to discussing the Christian influence on care of the sick, health care in the pre-Christian era should be examined briefly.. Medicine and nursing in ancient civilizations provided the foundations on which many of the health care practices of Christian nurses rested. These ancient cultures also influenced the concept of Christian charity in relation to caring for those who are ill (Bullough & Bullough, 1987). Archeological study of the pre-Christian cultures has revealed two related yet distinct types of nurses. One group consisted of skilled women who "nursed for hire"; more commonly identified, however, were "nurses" whose positions were those of slaves in wealthy households (Dolan, Fitzpatrick, & Herrmann, 1983, p. 81). These nurses practiced their art according to the established medical models of their respective societies.

Nursing might be explored in a number of early cultures. In Babylonia, the "Code of Hammurabi" suggested that nursing care was provided for patients between physician visits (Walsh, 1929, p. x). Early Buddhist discoveries in China of the curative value of many plants led to nursing therapeutics employing herbology (Sellew & Nuesse, 1946, p. 6). Hindu medical practice in India included a role for the male nurse (Grippando, 1986, p. 3). In Ireland, ancient druidic priests and priestesses advised on care and healing in illness (Dolan, Fitzpatrick, & Herrmann, 1983, p. 40). The four key societies, however, whose spiritual and cultural contributions are most frequently cited as supporting the art and the science of modern medicine and nursing are those of Egypt, Greece, Rome, and Israel.

### Egypt

Egyptian medicine contained a strong element of religious magic in its origins; however, the practice of embalming taught the Egyptians human anatomy, from which they were able to derive surgical procedures (Deloughery, 1977, p. 7). Egyptian history boasts the first physician, Imhotep, as well as the first medical textbook, *Ebers Papyrus* (Frank, 1959, p. 9).

### Nursing in the Pre-Christian Era

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The Egyptians were concerned about public health problems such as famine and malnutrition. While offering prayers and sacrifices to religious deities, they also took preventive measures such as storing grain against future need. Researchers have determined that a school for the education of Egyptian physicians existed as early as 1100 B.C., and as a result a number of practical therapeutic remedies for care of the sick were developed. Nurse historians Dietz and Lehozky (1967) concluded, thus, that "undoubtedly some form of instinctive nursing care must have existed at this time" (p. 10).

### Greece

History documents the fact that "nursing in the Greco-Roman era was largely the responsibility of members of the patient's own family or that of slaves employed to provide specific skills. The spiritual rationale for providing nursing care was duty to and love for a relative" (Swaffield, 1988, pp. 28-30). The consummate ancient Greek physician, of course, was Hippocrates (460-370 B.C.), who instructed caregivers to "use their eyes and ears, and to reason from facts rather than from gratuitous assumptions" (Deloughery, 1977, p. 8). Hippocrates cautioned those who tended the sick to be solicitous to their patients' spiritual well-being and "to do no harm" (Frank, 1959, p. 17).

Although Hippocrates did not identify nursing as a profession, many of his prescribed therapies fall within the realm of nursing practice. Some examples include the teachings that "fluid diet only should

be given in fevers"; "cold sponging [should be used] for high temperatures"; and "hot gargles [should be taken] for acute tonsillitis" (Dietz & Lehozky, 1967, p. 16).

Researchers have explored the characteristics and role of the "nurse" in Greek life by studying the literature, art, and culture of Grecian society. From a study of the early Greek world, Gorman (1917) determined that the nurse "thOUGH usually a slave, was sometimes manumitted; that a preference was frequently shown at Athens for the foreign-bred nurse; and, that, on occasion, free women resorted to nursing as a means of gaining a livelihood" (p. 15). The nurse's role was considered a noble one among the Greeks of the era, and, Gorman pointed out, "instances of love and devotedness of nurses are not wanting in the [Greek literature]" (p. 30).

It is also noted that Greek religious mythology introduced the concept of women's involvement in the healing arts, in the tale of Aesculapius, the god of healing: "One of his five children, Hygeia, became the Goddess of Health and another, Panacea (from whom comes our word for 'cure all'), the Restorer of Health" (Deloughery, 1977, p. 9).

## Rome

Rome did not offer great advances in medical and nursing practice prior to Christianity but depended greatly on the knowledge of the Greek physicians. Prior to the advent of Greek medicine, care of the sick in Roman households was guided primarily by the use of natural or folk remedies. For example, in the writings of the early Roman scholar, Cato the Elder, is found "advice for the treatment and care of gout, colic, indigestion, constipation, and pain in the side" (Bullough & Bullough, 1969, p. 24). Religion was influential in nursing the sick; Roman gods were offered libations in petition for favors related to health and illness needs. Following the conquest of Corinth many Roman youth began to study in Athens and personally achieved the skills of Greek healing (Pavey, 1952, p. 78). Together with this professional education, however, appreciation and respect for the favor of the gods continued as an important adjunct to therapeutic procedures. Prayer to a god, or to several gods, was considered a critical adjuvant therapy in nursing a sick Roman.

## Israel

The Hebrew people of Israel identified in their Mosaic Law much concern for the provision of nursing care for the ill and infirm. There were religious proscriptions concerning general health and hygiene: "Rules of diet and cleanliness, and hours of work and rest" (Sellew & Nuesse, 1946, p. 35). Sellew and Nuesse observed that "Since these rules were enforced by the group and not left to the will of the individual, they were, in effect, rules of public health" (p. 34). Robinson (1946) asserted that the people of Israel actually "laid the foundations of public health nursing on enduring principles, [as they] naturally regarded visiting the sick (*'bikkur holim'*) as a religious duty incumbent upon all" (p. 4). The Israelites articulated specific rules regarding the nursing of those with contagious diseases, and were particularly noted for their care of children and of the elderly. Another religious tradition of the Hebrew people related to nursing of the sick encompassed the concepts of "hospitality" and "charity" for anyone in need. This resulted in a system of "houses for strangers," supported by each citizen tithing a tenth of his or her possessions toward charitable work (Pavey, 1952, p. 29).

Finally, the Old Testament Scriptures contain references to the "nurse"; one who "appears at times as a combination servant, companion and helpmate" (Bullough & Bullough, 1969, p. 14). An example from Genesis 24,

verse 59, describes Rebekah's going forth to meet Isaac, her future husband, accompanied by her nurse, Deborah: "... they allowed Rebekah and her nurse

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to leave, along with Abraham's servant and his men." Grippando (1986) asserted that "Deborah was the first nurse to be recorded in history" (p.3).

## CHRISTIANITY AND CARE OF THE SICK Early Christian Nurses

*Then Jesus went about all the cities and villages, teaching in their synagogues, and proclaiming the good news of the Kingdom, and curing every disease and sickness.*

MATTHEW 9:35

In the early Christian Church, nursing of the sick or injured was accorded a place of honor and respect, associated as it was with one of the primary messages of Jesus: to love one's neighbor. Scripture describes many instances of Christ's healing the sick; His teaching regarding the need for each individual's care for brothers and sisters is reflected especially in the parable of the Good Samaritan (Luke 10:30-36).

Nurse historian Josephine Dolan (1973) pointed out that the way in which Jesus interacted with the sick provides our example. "Instead of saying the word and healing the sick, Christ gave individual attention to the needs of all by touching, anointing, and taking the hand" (p. 47). She concluded, "The least gesture of human kindness" was important to Jesus, and even "a cup of cold water given in His name did not pass unrewarded" (p. 47). Thus, Christ, in His own ministry of healing and teaching, prepared the way for his early followers to serve, with care and tenderness, the needs of their ill brothers and sisters. Central among the early Christians involved in nursing the sick were those persons identified as having a diaconal role in the young church.

## Deacons and Deaconesses

*I give you a new commandment, that you love one another . . . by this everyone will know that you are my disciples.*

JOHN 13:34-35

Among the first "titled" followers of Jesus for whom care of the sick and infirm was an identified task were the deacons and deaconesses, the term *deacon* being derived from the Greek verb *diakonen* meaning "to serve." These men and women were obliged, by their positions, to visit and nurse the sick (Frank, 1959).



And whoever gives even a cup of cold water to one of these little ones in the name of a disciple, truly, I tell you, none of these will lose their reward.

(Matthew 10:42)

Following the exhortation of Jesus to give "a cup of cold water" in His name, these early disciples of Christianity opened their homes, as well as their hearts, to those in need of physical and emotional care. "The Deacons and Deaconesses were especially zealous in seeking out cases of need, and not only nursed the sick by a system of visiting, but brought them into their own homes to be cared for" (Nutting & Dock, 1935, Vol.1, p.118). These settings, precursors to the modern hospital, were called diakonias, associating, again, the diaconate with the work of nursing. The diakonias were, in the very early days of the Church, called "Christrooms," suggesting a direct association with Jesus' teaching, "I was a stranger and you took me in" (Dolan, 1973, p. 56). A wellknown deacon, Lawrence, was asked to bring the treasures of the Church before a Roman prefect, prior to his trial for being a Christian. He brought to the prefect a group of the "halt, the blind, and the very ill who were unable to care for themselves, and presented them ... as the treasures of the Church" (Walsh, 1929, p. 2). For his trouble, Lawrence was roasted on a gridiron in martyrdom.

An early Christian woman, Phoebe, described as a friend of St. Paul, is identified as a deaconess in the New Testament. "I commend to you our sister Phoebe, a deacon of the Church ... for she has been a benefactor of many" (Romans 16:1-2). Phoebe, who lived around 55 A.D., was known as a woman of great dignity and social status; she is said to have spent many hours nursing the poor in their homes (Grippando, 1986, p. 4).

These deacons and deaconesses and their later counterparts, the Roman matrons, were the earliest forerunners of professional nursing in the Christian Church.

## ***Roman Matrons***

A number of Roman matrons who had converted to Christianity served the early Church around the third and fourth centuries. These women were able to use their power and wealth to support the charitable work of nursing the sick. The matrons founded hospitals and convents, living ascetic lives dedicated to the care of the ill and infirm. Three of the most famous Roman matrons were Saints Helena, Paula, and Marcella.

St. Helena, or Flavia Helena, was empress of Rome and mother of Constantine the Great. After embracing Christianity, she devoted her life to

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care of the sick poor. She is identified as having started the first "gerokomion" or home for the aged infirm in the Roman Empire (Dolan, 1973).

St. Paula, a learned woman of her time, founded the first hospice for pilgrims in Bethlehem (Frank, 1959). Paula also built hospices for the sick along the roads to the city; she both managed the institutions and personally nursed the tired and the sick for almost 20 years. St. Jerome wrote of her, "She was oft by them that were sick, and she laid their pillows aright; and ... she rubbed their feet and boiled water to wash them. And it seemed to her that the less she did to the sick in service, so much the less service she did to God"

(Jameson, 1855, as cited in Nutting & Dock, 1935, Vol. I, p. 141).

St. Marcella, who has been described as the leader of the Roman matrons (Pavey, 1952, p. 102), was known as a scholar and a deeply spiritual woman. She founded a community of religious women whose primary concern was care of the sick poor. Marcella instructed her followers in the care of the sick, while also devoting herself personally to charitable works and

prayer. Although individual deacons, deaconesses, and Roman matrons cared for many of the sick, especially the sick poor, during the early Christian era, it was with the advent and rise of monasticism that the work of nursing began to become institutionalized.

### **Early Monastic Nurses**

*The care of the sick is to be placed above and before every other duty, as if indeed Christ were being directly served by waiting on them.*

Rule of ST. BENEDICT. 529 A.D.

The monasticism of the fourth, fifth, and sixth centuries was born out of a desire of many Christian men and women to lead lives of sanctity, withdrawing from the world to be guided by the vows of poverty, chastity, and obedience. At first the monks' daily work consisted primarily of prayer and manual labor. This began to change with the advent of such communities as that of St. Benedict of Nursia, whose rule was written in 529 A.D. Although early monasteries, such as those of Benedict, were centers of learning, eventually "nursing of the sick became a chief function and duty of community life" (Donahue, 1985, p. 127). In this era, twin communities of men and women also developed. Three of the most famous abbesses who ruled these groups were St. Radegunde at Poitiers (559 A.D.); St. Hilda of Whitby (664 A.D.); and St. Brigid (487 A.D.), who was the first woman to rule an abbey in Ireland (Donahue, 1985, pp. 129-130).

St. Radegunde, daughter of a Thuringin king, initially took poor patients into her own palace to nurse them. She later founded Holy Cross Monastery, with a community of more than 200 nuns (Goodnow, 1916). Radegunde also established a hospice where she herself cared for the patients; she is reputed to have cared lovingly and tenderly especially for those afflicted with leprosy. Radegunde's work is said to have encouraged many other women to make a life commitment to caring for the sick.

St. Hilda, a cultured and scholarly woman, directed her monastic community in the care of the sick; she nursed the sick poor, including lepers, herself. Hilda also supported a group of associate members of the monastery, called oblates, who assisted in the nursing of those who came under her care (Seymer, 1949).

St. Brigid, who became one of the most famous abbesses in Ireland, was the daughter of an Ulster chieftain and also a disciple of St. Patrick. Brigid founded the great monastery of Kildare, where the ill were received with charity and compassion. Dolan (1973) related that "In Fifth Century Ireland, when leprosy was an incurable scourge ... they [lepers] came in droves to Kildare to be bathed and treated by Brigid" (p. 60). Brigid became known as the "Patroness of Healing."

Although the monastic communities initiated a more formalized nursing care program for the physically ill and infirm, a greatly neglected and significantly stigmatized population in need of support were those suffering from mental illness or other cognitive impairments.

## **Mental Illness in the Middle Ages**

### ***OymphnD ofBelgium***

*The people ofGheel have learned from childhood to live with the patients; their reception and care have been passed on from generation to generation.*

"Foster Family Care in Gheel," 1991. p. 15

Dymphna, the seventh century Irish saint, identified to this day as the patroness of the mentally ill, devoted her life to care of the sick poor in the manner of the early monastic nurses ("Foster Family

Care," 1991; Matheussen, Morren, & Seyers, 1975). According to legend, Dymphna traveled to Gheel, Belgium, to assist the Irish missionaries. Once there, she focused her compassion and care especially on persons with impaired mental health. Dymphna was martyred at a young age, but after her death the Belgian women of Gheel believed that she could still intercede for the needs

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of the ill. Thus, a church and small clinic were erected in Dymphna's honor in the town. Many pilgrims traveled there hoping for a cure and, as the clinic could not house all of these visitors, local Gheel families began offering hospitality to mentally challenged pilgrims (Dolan, Fitzpatrick, & Herrmann, 1983, pp. 59-60). The practice has continued for centuries, and today the Flemish community of Gheel, with its own psychiatric hospital under the supervision of the Belgian government, is considered a model for home health care of the mentally ill ("Foster Family Care," 1991).

At this point in Christian nursing history, the concept of free-standing institutions or hospitals to care for both the mentally and physically ill was beginning to emerge. These early facilities were staffed primarily by men and women inspired by religious motives to care for their less fortunate brothers and sisters.

### Medieval Hospital Nursing

*Augustinian nuns began their attendance at the Hotel Dieu; for twelve hundred years immured within these walls; alive yet not of this world; aloof from the human race. with the breath of God upon their faces. To and fro they walked the wards. back and forth throughout the days and years*

*and centuries.*

ROBINSON (1946, p. 50)

Two of the most famous medieval Christian hospitals built outside monastic walls were the Hotel-Dieu of Lyon (542 A.D.) and the Hotel-Dieu of Paris (650 A.D.). The title *Hotel-Dieu*, or "House of God," was often chosen as the name for a French hospital of the era (Grippando, 1986, p. 10). In the beginning, these "hospitals" served as almshouses and orphanages, as well as facilities for care of the sick. Goodnow (1916) reported that the early nurses in these facilities were "religious women who devoted their lives to charity"

(p.29). The Hotel-Dieu of Lyon eventually added to its cadre of women nurses a group of men called "brothers" who also assisted with the care of the sick. The hospital was designed to care for pilgrims, orphans, the poor, and the sick. It was one of the first hospitals to separate those with contagious illnesses from those with more ordinary ills (Nutting & Dock, Vol. 1, 1935). The Hotel-Dieu of Paris began as a hostel providing care for a small number of the sick poor. After a brief period, the group of women who had ultimately been constituted as a religious community known as the Augustinian Sisters took over the hospital (Dietz & Lehozky, 1967, p. 25). The

Sisters lived under a very strict rule; following profession of religious vows their entire world became the hospital where they both lived and worked with no thought of ever returning home even to visit. The Sisters gave excellent care to the patients; for each the work was her life. AS Nutting and Dock (1935) observed, "Their home is the 'Hotel-Dieu: From the day of their profession they live and die there" (Vol. 1, p. 296).

Although these early hospitals served the civilian populations until about the 10th century, it was recognized with the undertaking of the Crusades that casualties generated by the wars would overwhelm existing nursing facilities. It was anticipated that following the conflicts large numbers of wounded crusaders would return home weakened and battle scarred, many in need of extensive nursing care. Thus an entirely new cadre of nurses was created whose mission was centered on the care of wounded crusaders; these nursing communities were called the military nursing orders.

## **Military Nursing Orders**

*To the Knights Hospitallers of St. John of Jerusalem: With regard to the hospital which thou hast founded in the city of Jerusalem . . . that House of God . . . shall be placed under the protection of the Apostolic See.*

Bull of POPE PASCAL II 15 February 1113

Out of the 11th-, 12th-, and 13th-century Crusades to the Holy Land came the military nursing orders. orders of men who were committed by their religious ministry to the care of those wounded in battle. The three major groups were the Knights Hospitallers of St. John of Jerusalem, the Teutonic Knights, and the Knights of St. Lazarus. The three general classes of members in the orders were knights, priests, and serving brothers (Kalisch & Kalisch, 1995). The knights participated in the Crusades and helped to care for the injured, the priests served the religious needs in camps and hospitals, and the serving brothers were responsible for general care of the sick (Pavey, 1952, pp. 163-164). All members of the orders, however, professed religious commitment of their lives as exemplified in the Rule of the Order of St. John of Jerusalem, as written by its first grand master, Raymond du Puy:

Firstly. I ordain that all the brethren engaging in the service of the sick shall keep with God's help the three promises that they have made to God, ... poverty. chastity. obedience ... and to live without any

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property of their own, because God will require of them at the last judgement the fulfillment of these three promises. (Austin, 1957. p. 73)

The largest of the orders, the Knights Hospitallers of St. John of Jerusalem, is thought to have been created around 1050 A.D. to staff the two Jerusalem hospitals organized to care for those wounded in the Crusades: one for men, dedicated to St. John; the other for women, dedicated to St. Mary Magdalene (Seymer, 1949). Historians assert that the order was originated under the guidance of Peter Gerard, a deeply religious man. An associated order for women was also created to nurse the sick, under Agnes of Rome (Jensen, Spaulding, & Cady, 1959). The knights of St. John were characterized by a specific dress: a black robe with white linen cross.

A second community, the German order of Knights Hospitallers or Teutonic Knights, was founded in 1191 A.D. at the time of the Third Crusade. These knights, who followed the rule of the Knights of St. John, taking the usual vows of poverty, chastity, and obedience, also took a vow of care of the sick (Donahue, 1985, p. 155). The Teutonic Knights were in charge of many German hospitals and later became a separate organization under the Rule of St. Augustine (Jensen, Spaulding, & Cady, 1959).

The Knights of St. Lazarus were organized primarily to care for the lepers in Jerusalem; they also admitted lepers to their order. There were two categories of knights: warriors and hospitallers. The latter group had a special commitment to care for those with leprosy. The community's first grand master was himself a leper (Seymer, 1949). It might be suggested here that the military nursing orders of the 11th, 12th, and 13th centuries which were founded specifically to care for the Crusaders, the soldiers of the day, fallen or injured in battle—were indeed the forebears of contemporary military nurses in this country and throughout the world. Members of the early military nursing orders, as military nurses today, took an oath of obedience and promised a willingness to risk their lives in order to care for those wounded in war (see O'Brien, 2003, "Navy Nurse: A Call to Lay Down My Life").

During the period of the Crusades and afterward, while the military nursing orders cared for those wounded in war, medieval monastics continued to provide nursing care for civilians. Some of these monastic nurses were highly respected and honored for their care and compassion, as well as for their healing powers. One of the most respected



healers of medieval monasticism, who currently has a following among some contemporary nurses, is Hildegard of Bingen.

## *A Spiritual History of Nursing*

### **Medieval Monastic Nursing**

#### ***Hildegard of Bingen***

*I raise my hands to God, that I might be held aloft by God, just like a feather which has no weight from its own strength and lets itself be carried by the wind.*

Letter from HILDEGARD to Guibert of Gembloux (cited in Fox, 1987, p. 348)

Sometimes described as the "Sybil of the Rhine" (Livingstone, 1990, p. 241), Hildegard of Bingen (1098-1179), German abbess, visionary, musician, writer, and nurse, was one of the most outstanding of the medieval monastic women. At the age of 8, she was given over to the care of the anchoress Jutta who lived in a hermitage within the walls of the great Benedictine Monastery at Disibodenberg. While yet in her teens, Hildegard took the Benedictine veil and some 20 years later was herself named abbess of the small group of women who had joined her at the monastery. Hildegard ultimately broke away from the abbey at Disibodenberg and founded two new monasteries for women: Rupertsberg and its daughter house at Ebingen.

Hildegard was told by God to relate what she "saw and heard" in her many visions; her first book of visions was entitled *Scivias* or "Know the Ways [of the Lord]" (Lachman, 1993). Hildegard's writings were numerous and included works on medicine and nursing, as well as theology; she had learned a great deal about illness and healing during an internship of nursing in the Disibodenberg infirmary. Two other medical books written around 1159 were entitled *Physica* and *Liber Composite Medicinæ*. The former described anatomy and physiology; the latter explained the symptoms and cure of illness and disease.

In her books, Hildegard described diseases of "various organs of the body, pallor and redness of the face, bad breath, and indigestion" (Sellew & Nuesse, 1946, p. 125). She was continually sought out by those with various ailments and frequently provided cures; she was even thought to

perform miracles (Jensen, Spaulding, & Cady, 1959, p. 77). For Hildegard, diseases and cures were all associated with "the four qualities of heat, dryness, moistness and cold ... fire, air, water and earth, and, the humors and personality types to which these elements give rise" (Bowie & Davies, 1992, p. 48). For example, she wrote in her "Third Vision: On Human Nature", "I noticed how the humors in the human organism are distributed or altered by various qualities of the wind and air...." (Fox, 1987, p. 56).

For centuries, Hildegard of Bingen's work, in its original Latin, lay forgotten. Then in the early 1960s, her Benedictine Sisters began to translate

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#### Christianity and Care of the Sick

the writings into German. During the last decade, especially, Hildegard's extensive contributions to medicine, nursing, and theology have been recognized in this country as well. Barbara Lachman (1993), who has spent 20 years studying the life and writings of Hildegard, identified the mystic's early awareness of the body-mind connection. "Hildegard reminds us ... that the body can be afflicted with sickness and torments only the spirit can heal" (p. 10). This concept is most timely in light of our present-day emphasis on holistic health care, uniting rather than isolating the needs and problems of

body, mind, and spirit. Among other outstanding monastic nurses of the Middle Ages, and their tertiaries, who contributed notably to the healing arts were Francis and Clare of Assisi, Elizabeth of Hungary, and Catherine of Siena.

#### ***Francis and Clare of Assisi***

*Great was his [Francis'] compassion for the sick, and great his care for their needs. He entered into the feelings of all the sick, and gave them words of sympathy when he could not give words of help.*

*Life of St. Francis*

BROTHER THOMAS OF CELANO, 1228 A.D. (cited in Austin, 1957, p. 86)

While distinguished as the primary founder of mendicant monasticism, Francis of Assisi (1184-1224) is also considered by many nursing caregivers as a patron of those who tend the sick. Francis is best known for his care and compassion for those suffering from leprosy, the most fearful and stigmatizing illness of his time. Francis not only requested that his Friars Minor visit and care for lepers, but also spent much time personally caring for those with the disease. Virtually every biography of Francis recounts his conversion experience' describing how one day, as a young man, Francis Bernardone was moved to dismount from his horse and embrace a leper approaching him in the road (Dennis, Nangle, Moe-Lobeda, & Taylor, 1993; Green, 1987). Following this epiphany, Francis began to visit "leper houses." "There the lepers were always waiting for him ... knowing that he brought love" (Maynard, 1948, p. 43). Sabatier (1894) recounted the story of one particularly difficult victim of leprosy who was always dissatisfied with his care and blaspheming God. When the Brothers described this behavior to Francis, their leader went to the leper and said, "I will care for you myself"; "St. Francis made haste to heat some water with many sweet smelling herbs; next he took off the leper's clothes and began to bathe him" (p. 142).

In the *Life of St. Francis*, written by Brother Thomas of Celano in 1228, Francis' great compassion for the sick is noted. "He entered into the feelings of all the sick, and gave them words of sympathy when he could not give words of hope" (cited in Austin, 1957, p. 86). In 1262, St. Bonaventure, then the eighth superior general of the Friars Minor, graphically described Francis' commitment to the sick. "Thence that lover of uttermost humility betook himself unto the lepers, and abode among them, with all diligence serving them all for the love of God. He would bathe their feet, and bind up their sores ... yea, in his marvelous devotion, he would even kiss their ulcerated wounds, he that was soon to be a Gospel physician" (*Legenda Maior S. Francisci*, St. Bonaventure, as cited in Austin, 1957, p. 86).

Clare of Assisi (1194-1253), daughter of a wealthy Italian family who gave up all to follow Jesus in the way of her beloved Francis, is also considered a model for those who commit their lives to the care of the sick. St. Clare's "Rule" for her original group of "Poor Ladies" mentions only care of the ill within the community. "I am obliged to serve and provide for their Sisters who are ill just as they would wish to be served themselves" (*Rule of St. Clare*, 1252, cited in Armstrong & Brady, 1982, p. 220). The literature, however, recounts numerous instances of Clare and her Sisters caring for the sick poor of the area, especially lepers. Robinson (1946) reported that "Francis sent the diseased and deformed to Clare and her nuns, who nursed them in little huts of mud and branches, grouped around the convent" (p. 41). The veracity of this account is reinforced by Nutting and Dock (1935, Vol. 1) who also described "little mud huts" where the "Poor Clarisses" "received and nursed the sick which Francis sent to them, so that finally San Damiano became a sort of hospital, and nursing one of the chief interests of the community" (p. 215). Clare is said to have cared personally for many of the sick sent by Francis.

## ***Elizabeth of Hungary***

*It was not alone by presents or with money that the young [Elizabeth! testified her love for the poor of Christ, it was still more by personal devotion, by those tender and patient cares, which are assuredly, in the sight of God and of the sufferers, the most holy and most precious alms.*

*Life of St. Elizabeth of Hungary*

COUNT DE MONTALEMBERT (cited in Austin, 1957, p. 91)

### Christianity and Care of the Sick 3S

One of the most distinguished Franciscan tertiaries, noted for her compassion for the sick, especially for lepers, was Elizabeth of Hungary (1207-1231). Elizabeth was a princess of Thuringia who, after her husband's death in the Crusades, entered the Third Order of St. Francis and committed her life to the care of the sick poor. She is especially remembered as a "builder of hospitals" (Robinson, 1946, p. 42), having established no less than five institutions during her short life.

While she lived in a castle, it is reported that Elizabeth daily walked to the local village" ... distributing alms to the poor, feeding the hungry, nursing the sick ... [and placing] her compassionate hands on the bodies of the lepers" (Robinson, 1946, p. 42). A number of folk tales relate Elizabeth's ministry to the sick poor. One story (described by both Robinson, 1946, and Nutting and Dock, 1935, Vol. 1) asserts that on a cold winter day early in her ministry, when Elizabeth was walking toward the village with a large bundle of food under her cloak, she was accosted by her husband, angry that she was spending so much time and money on her work with the ill. When he ordered Elizabeth to open her cloak, she was found to be carrying an armload of magnificently blossoming red and white roses, thus validating the saintly nature of her mission. Nutting and Dock (1935, Vol. 1) reported that after her husband's death Elizabeth's entire life was dedicated to nursing. "Twice a day she went to the hospitals to care for the most wretched patients, bathing them, dressing their wounds and taking them nourishment" (p. 221). Elizabeth's life's work is perhaps best summarized in the comments of Theodoric of Thuringen, written in 1725:

She busied herself with works of charity and mercy; and, those whom poverty, sickness or infirmity had oppressed more than others ... she placed in her hospital and most humbly ministered to their wants with her own hands. She arranged their baths, put them to bed, and covered them, saying to her servants: "How well it is for us that thus we have and cover our Lord."

(Austin, 1957, p. 90)

Elizabeth of Hungary died at the young age of 24 and was buried in the chapel of one of her hospitals, which she had dedicated to St. Francis.

**Catherine of Siena**

*Then in her sacred saving hands She took the sorrows of the lands, With maiden palms she lifted up The sick times blood-embittered cup, And in her virgin garment furl'd The faint limbs of a wounded world, Clothed with calm love and clear desire She went forth in her soul's attire, A missive fire.*

ALGERNONS~NBURNE  
(1911, p. 162)

Historian of nursing James Walsh (1929) poignantly described Catherine of Siena's commitment to the sick poor:

According to ... legend, her devotion to the ailing poor was so pleasing to the Master, who had gone about healing the ailing, that she had a number of visits from celestial personages. Above all the Christ Child was so much interested in this young woman, Who, when scarcely more than a child, had insisted on devoting herself to His ailing poor, that He put a ring on her finger as an indication of the fact that she was to be His heavenly spouse.

(Walsh, 1929, pp. 121-122)

Catherine of Siena (1347-1380), known to contemporary health care providers as the "Patroness of Nursing," entered the Tertiaries of St. Dominic while still in her teens. Catherine, like Elizabeth, also died young, at the age of 34, yet during her life she became renowned as a teacher, nurse, and mystic (Sellew & Nuesse, 1946, pp. 129-130). Catherine worked extensively with the ill, especially lepers, and when Siena was overwhelmed with the Black Plague epidemic in 1372, she is said to have "walked night and day in the wards, only resting for a few hours now and then in an adjacent house" (Nutting & Dock, 1935, Vol. I, p. 230).

An anecdote is told about an indigent woman of Siena suffering from leprosy who was so diseased that no caregiver, even in the hospital, had the courage to assist her. "When Catherine heard of this ... she hastened to the hospital, visited the leper, kissed her, and offered not only to supply all her necessities, but also to become her servant during the remainder of her life"



(Raymond of Capua, 1853, pp. 93-94). In summarizing St. Catherine's extraordinary commitment to the sick, Blessed Raymond of Capua (1853) wrote, "Catherine was wonderfully compassionate to the wants of the poor, but her heart was even more sensitive to the sufferings of the sick (cited in Austin, 1957, p. 94).

## **POST-REFORMATION NURSING: THE CATHOLIC AND PROTESTANT NURSING ORDERS**

Nurse historian Patricia Donahue (1985) reported that in the 16th century alone "more than 100 female [religious] orders were founded specifically to do nursing" (p. 216). The growth of nursing communities continued, though more slowly, during the 17th, 18th, and 19th centuries, with a few new groups being founded in the early to mid-20th century. Some orders have survived and attained a notable history and tradition in the care of the ill and infirm; others were short-lived with little historical information available about them. For the present exploration, a select group of two Catholic and two Protestant communities with significant historical involvement with nursing and health care activities, and which still continue this ministry today, are discussed. These groups are the Daughters of Charity of St. Vincent de Paul and the related American communities of Sisters of Charity, who also adhere to the spirit and spirituality of Vincent de Paul; the Sisters of Mercy; the Kaiserswerth Deaconesses; and the Nightingale nursing community. Although not formally constituted as a religious order, Florence Nightingale and her nursing community, who served in the Crimean War, undertook their work out of spiritual motivation. Florence Nightingale was a staunch Christian who viewed the work of nursing the sick as a vocation. This conviction sustained her work in the hospital in Scutari and informed her leadership of the group of nurses who accompanied her to the battlefield hospital.

Briefly described also are five smaller women's religious communities that continue to maintain a significant commitment to nursing as a contemporary ministry. These include the Sisters of Bon Secours, the Servants for Relief of Incurable Cancer, the Medical Mission Sisters, the Missionaries of Charity, and the Sisters of Life.

### **Daughters of Charity of St. Vincent de Paul**

One of the largest and best known of the early religious communities of women are the Daughters of Charity founded in Paris, France, in 1633 by St. Vincent de Paul, in conjunction with St. Louise de Marillac. Some years after

ordination to the priesthood, Vincent became concerned about the lack of care for the poor and needy, especially the sick poor, in 17th-century France. His personal spirituality was centered on seeing Christ in the person of the poor; he was much attracted to the Lukan Gospel of Jesus, especially such passages as Luke 4:18. "The Spirit of the Lord ... has sent me to bring glad tidings to the poor, to proclaim liberty to captives, recovery of sight to the blind...." (Maloney, 1992, p. 14). In 1617, Vincent began gathering together a band of laity to visit and care for the sick and the poor, naming them the Confraternity of Charity. As some of the women, later named the Ladies of Charity, encountered the overwhelming needs of the sick, both in hospitals where they observed the exhaustion of the overworked Augustinian nuns and in the homes of the poor, they recognized a great need for more nursing Sisters. One of the women, Louise de Marillac, a wealthy widow, was directed by Vincent to become the first leader of the small community. "She would give the Dames de Charite instructions. She accompanied them on their rounds helping them, advising them, assisting them in their duties and making suggestions about other ways of giving care to patients" (Dolan, 1973, p. 100). The Daughters of Charity were formally established as a religious community dedicated to serving the "poorest of the poor" in 1633. The first Sisters "nursed the sick poor in their homes" as well as caring for patients in the famous Hotel-Dieu in Paris (Daughters of Charity National Health Services, 1994, p. 1). Many of the early Daughters were young Frenchwomen raised in rural areas. "They wore the French peasant costume, a heavy coarse dress of blue woolen cloth with a full skirt and tight fitting waist, a blue apron of washable material, and a large white linen headdress ... [T]hey were not nuns but 'pious women of the world' prepared to nurse on the battlefields in time of war or to be sent to care for the sick in any disaster" (Sellew & Nuesse, 1946, pp. 198-199).

Dock and Stewart (1920) noted that St. Vincent de Paul would not let the Daughters pronounce permanent vows; they took vows for one year only, as they do today. The vows can, however, be renewed indefinitely on an annual basis. Vincent's advice to his Sisters "if they were to be useful as nurses, was uncompromising in the extreme: 'My daughters,' he said, 'You are not religious in the technical sense, and if there should be found some marplot among you to say, it is better to be a nun, Ah! then, my daughters, your company will be ready for extreme unction. Fear this, my daughters, and while you live permit no such change; never consent to it. Nuns must needs have a cloister, but the Daughters of Charity must needs go everywhere" (p. 102). Vincent directed also that the Daughters were to have nei

ther convent nor cell; his emphasis in this regard has been preserved in a well-known quote from the community's rule:

Your convent will be the house of the sick; your cell, a hired room;  
your chapel, the parish church; your cloister, the streets of the city,  
or the wards of the hospital.

(Daughters of Charity, 1993)

Stepsis and Liptak (1989) observed that, given the Church's history, in the era of mandating cloistered community life for all women religious "the successful efforts of Saint Vincent de Paul and Saint Louise de Marillac to create and maintain a noncloistered congregation of women in France, during the seventeenth century and beyond ...were monumental" (p. 18). They added, "Vincent's attempt at bridging the gap between cloistered and active religious community became the American model" (p. 19). A historical overview of Vincent's vision for health care identifies the "essential attributes" as including such characteristics as "spiritually rooted," "holistic," "integrated," "flexible," and "creative" (Sullivan, 1997, p. 49).

Today the Daughters of Charity comprise one of the largest international Catholic religious communities of women in existence, with approximately 28,000 Daughters worldwide. Some 1,400 Daughters are involved in a variety of ministries in the United States, with health care, education, and social ministry being the major categories of service. In the United States, the Daughters of Charity National Health Services (DCNHS) is one of the most extensive health care systems in the world, with Sisters serving primarily in the arenas of administration, nursing, and pastoral care. In addition to ministering in hospitals and nursing homes, the Daughters serve the sick poor in settings such as "free clinics in poor neighborhoods in the cities, in rural areas, with migrant workers in the deep south, and in drug treatment centers" (Daughters of Charity, 1995, p. 1).

A related but separate group of U.S. communities of followers of Vincent de Paul are the Sisters of Charity. Communities of Sisters of Charity are located in a multiplicity of geographical locations in the United States; the sisters carry out various ministries, nursing being a central ministry of a number of the groups.

## **Sisters of Charity**

The American Sisters of Charity, also followers of the vision of Vincent de Paul, were founded in 1809 by Elizabeth Bayley Seton (1774-1821), whose father

had been a prominent physician. Mother Elizabeth's husband died as a young man, the widow determined to commit her life to the service of others by teaching children and caring for the sick. Elizabeth, then an Episcopalian, served the poor first with the Protestant Sisters of Charity. After converting to Catholicism, she opened a small school near Emmitsburg, Maryland, gradually expanding the services as other committed women came to join her.

Mother Elizabeth Seton and her young community adopted the rule of Vincent de Paul for the French Daughters of Charity, with some modifications for the American milieu of the era; their habit, a black dress, was modeled after Mother Seton's widow's costume (Dolan, Fitzpatrick, & Herrmann, 1983, p. 138). Mother Seton was interested in her American Sisters of Charity being formally united with the international community of Daughters of Charity, founded by St. Vincent in France. After Mother Seton's death in 1821, the Emmitsburg community of Sisters of Charity sought unification with the French Daughters. In 1850, the Emmitsburg Sisters became formally affiliated with the Daughters of Charity in France; they "passed under the authority of the Superior General of that Order, assuming the garb of the French sisterhood; the headpiece was the celebrated white linen coronet as given by Saint Vincent de Paul" (Stephens & Liptak, 1989, p. 292).

Prior to the unification of the Emmitsburg Sisters with the Daughters of Charity in Paris, however, some of the women who had come to join Mother Seton but wanted to maintain their American rule of life and dress branched out from the motherhouse to establish other communities of Sisters of Charity. One of the largest of the new groups with direct Emmitsburg roots were the New York Sisters of Charity and the Sisters of Charity of Cincinnati. These Sisters were responsible for the founding and administration of many hospitals, as well as the carrying out of other nursing and social ministries. Nurse historian Minnie Goodnow (1916) pointed out that while indeed nursing was only one branch of the American Sisters of Charity's ministry, it was an important one:

In 1832, during a great cholera epidemic, they [Sisters of Charity] nursed under the city authorities in New York, Philadelphia and Baltimore. They have always had many hospitals and asylums of their own. (p. 144)

Currently many different groups belonging to the Elizabeth Seton Federation, the offspring of Mother Elizabeth Seton's original Emmitsburg community, are involved in U.S. health care activities (see Stepsis & Iltis, 1989).

## post-Reformation Nursing: The Catholic and Protestant Nursing Orders **41**

### **Sisters of Mercy**

Another nursing community with a long history and tradition in the administration of U.S. hospitals and schools of nursing is the Sisters of Mercy. The Sisters of Mercy was founded in 1831 in Dublin, Ireland, by Mother Catherine McAuley (Grippando, 1986, p. 17). Catherine, wealthy from an inheritance she received at age 40, had a great concern for the poor, especially the sick poor, living in the slums of Dublin. With her fortune, she erected a building with classrooms, dormitories, a clinic, and a chapel, labeling it the "House of Mercy." Her original plan was to create a "corps" of Catholic social service workers. She began initially to work with a group of laywomen who would visit the sick in their homes, but ultimately, at the suggestion of the Bishop of Dublin, she began to organize the women into a religious community. Catherine faced opposition from family and friends. Nevertheless she persisted, and "in January 1832 seven women who had worked with Catherine McAuley were clothed in the habit of the Institute" (Walsh, 1929, p. 189).

Walsh (1929) reported that, although the Sisters began by visiting the sick in their homes, "after a time [Mother Catherine] obtained permission to visit the wards of several Dublin hospitals with her nuns to bring consolation to the patients. This was an innovation ... very greatly appreciated by the poor sufferers. Patients became ever so much more tractable. Above all, the morale of the sick improved, and with it their resistive vitality" (p. 189). The Sisters of Mercy were sent to the Crimea by the English

government and labored with Florence Nightingale (Frank, 1959, p. 94). The difficulty of the conditions at the hospital in Scutari was described by Goodnow (1916), who also lauded the work of the Sisters of Mercy in the setting. Citing a war office report, Goodnow wrote:

The superiority of an ordered system is beautifully illustrated in the Sisters of Mercy. One mind appears to move all, and their intelligence, delicacy and conscientiousness invest them with a halo of extreme confidence. The medical officer can safely consign his most critical cases to their hands. (p. 89)

Sisters of Mercy came to the United States from Ireland around 1854 and began establishing schools and hospitals. By 1928, there were 140 convents in America, and by 1965, the Mercy congregations in the United States had merged into one "federation," which ultimately evolved into the present Institute of the Sisters of Mercy of the Americas. This institute includes Mercy communities in North, South, and Central America, as well as Guam

the Caribbean, and the Philippines (Sisters of Mercy of the Americas, "Sisters of Mercy Founded," 1995, pp. 4-5).

Presently the Sisters of Mercy of the Americas "sponsor or co-sponsor approximately 140 hospitals or health-related facilities throughout the United States," as well as hospitals and health clinics in Belize. Guam. Guyana, Peru, and the Philippines (Sisters of Mercy of the Americas, "Mercy Health Care," 1995, p. 1).

## **Kaiserswerth Deaconesses**

The Kaiserswerth Deaconesses, an important Protestant community of women with a primary ministry of nursing the sick, was founded by a young Lutheran minister, Theodor Fliedner, around 1836 in Kaiserswerth, Germany (Kalisch & Kalisch, 1995), Pastor Fliedner, who was concerned about the overall social and health care needs of his poor parishioners, enlisted his wife, Frederika Munster, to gather a group of women who would visit and nurse the sick poor in their homes. The Fliedners attempted to attract a group of young women of good character; in this era, prior to Florence Nightingale, nurses were generally considered to be prostitutes, alcoholics, and generally unseemly women.

Frank (1959) described the education of the Kaiserswerth Deaconesses. "Their course of training lasted three years, their uniform was simple, and they were taught domestic duties associated with caring for the sick" (p.95). Nutting and Dock (1935, Vol. 2) quoted Pastor Fliedner's own description of the essentials of the Deaconess vocation. "In organization the work is a free religious association, not dependent on state or church authorities. It takes its stand on the mother nature of the church founded by Christ" (p. 33). The four key branches of the Deaconesses' work were described as "Nursing; relief of the poor; care of children; and work among unfortunate women" (Nutting & Dock, 1935, Vol. 2, pp. 33-34).

In commenting on the Deaconesses' religious commitment, Woolsey (1950) observed, "The Deaconess Vows are taken for five years ... however, women are expected to declare that they intend to adopt the office of Deaconess for life. Those trained as nurses are more apt ... to regard [the] vows and retain their connection with the order ... and the settled resolution, no doubt, is one of the elements that contributes to make them good nurses" (pp.30-31).

The Kaiserswerth Deaconesses began their work in the United States in 1849 when four deaconesses were sent to Pennsylvania. "They were to assume responsibility for the Pittsburgh Infirmary [Passavant Hospital]. This was the first Protestant Church hospital in the United States" (Dolan, 1973,



p. 123). The Pittsburgh infirmary was founded by Lutheran minister William Passavant, a founder of the Lutheran deaconess movement in this country. The American Lutheran Deaconess Foundation continued to grow in the years following Passavant's initiation, spreading to such places as Philadelphia, New York, and Baltimore (Olson, 1992, see "Lutheran Deaconesses in America," pp. 243-339).

The role of the contemporary Lutheran deaconess is to "serve God's people through spiritual care and works of mercy" ("Just What Is a Deaconess?", 1994). Central to diaconal ministry are the concepts of "agape love and love of neighbor" as well as a sense of "mercifulness and community" (Zetterlund, 1997, p. 11). Deaconess roles are encompassed in such professions as nursing, social work, parish ministry, chaplaincy, counseling, and missionary work. A deaconess may serve within a Lutheran Church congregation. she maybe employed by a caregiving institution such as a hospital or nursing home, or she may accept a domestic or foreign missionary assignment.

Three Lutheran deaconess communities that provide diaconal education in the United States are the Evangelical Lutheran Deaconess Association community motherhouse at Gladwyne, Pennsylvania; the Center for Diaconal Ministry of the Lutheran Deaconess Association at Valpariso University, Valpariso, Indiana; and the Deaconess Program at Concordia University, River Forest, Illinois. Deaconess education programs may vary but generally include the study of theology and ministry as well as liberal arts and courses to prepare the future deaconess for a professional role. A yearlong deacon internship is usually included in the program of study. Following diaconal education, a woman may be consecrated in the role of deaconess within the Lutheran Church.

## **Nightingale Nurses: Mission to the Crimea**

### **The Nightingale Pledge**

*I solemnly pledge myself before God and in the presence of this assembly: To pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug.*

*I will do all in my power to elevate the standard of my profession. and will hold in confidence all personal matters committed to my keeping. and all family affairs coming to my knowledge in the practice of my profession. With loyalty will I endeavor to aid the physician in his work, and devote myself to the welfare of those committed to my care.*

(cited in Kalisch & Kalisch, 1995, p. 117)

Although, as noted earlier, Florence Nightingale's community (1820-1910) is not considered a religious "order," it was, however, the first Christian community of nurses sent by the English government in 1854 to care for the wounded soldiers during the Crimean War. Nightingale trained under Pastor Fliedner at his Deaconess School in Kaiserswerth, as well as under the Daughters of Charity of St. Vincent de Paul in France. In exploring the historical roots of spirituality in nursing, Patricia Maher observed that prior to the 19th century "there was little beside spiritual care with which to heal. Within an overtly religious society, spiritual care was seen as a formidable and credible endeavor and people were suspicious of medical care for good reason" (2006, p. 419). Florence Nightingale, Maher asserts, "was one of the first to bring spirituality and science together to improve the care of the sick" (p. 419).

Nurse historian Deloughery (1977) offered a glimpse of Nightingale's personal spirituality in reporting that in 1847, "after a busy 'social summer: ... she went into retreat for ten days in the convent of the Trinita dei Monti, where she absorbed much of the spirit of the Church and where her religious belief greatly matured" (p. 52). Deloughery added that Nightingale, a member of the Church of England, "remained deeply religious throughout her life" (p. 52). Central to Florence Nightingale's spirituality was her belief in the greatness of God, as the "Spirit of Truth" (Widerquist, 1992, p. 49). Nightingale felt spiritually called to model the greatness and generosity of God in service to the sick; her first experience of this vocational call occurred immediately before her 17th birthday (Selanders, 1993, p. 8). At the age of 24, Florence wrote to her friend and mentor, Dr. Samuel Howe, to ask "if there would be anything unsuitable or unbecoming to a young Englishwoman, if she should devote herself to works of charity in hospitals and elsewhere as the Catholic Sisters do?" Howe replied, "Go forward if you have a 'vocation' for that way of life ... and God be with you" (Dolan, 1973, p. 167). Florence Nightingale sought to instill her sense of "spiritual vocation" into the team of "Nightingale Nurses" who accompanied her on the Crimean Mission. An excerpt from a work of one of the world's greatest poets is illustrative of the spiritual heritage Nightingale left to the nurses who would follow in her footsteps.

Santa Flomena

*Thus thought I as by night I read O/the great army O/the dead, The trenches cold and damp,  
The starved andfrozen camp. The woundedfrom the battle plain, In dreary hospitals o/pain,*

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*The cheerless corridors, The cold and stony floors. Lo, in that house  
of misery, A lady with a lamp I see pass through the glimmering gloom  
andflit from room to room. And slow. as in a dream of bliss, the speechless  
sufferer turns to kiss her shadow as it falls,  
upon the darkening walls.*

HENRY WADSWORTH LONGFELLOW (1857, p. 23)

The latter stanza of Longfellow's poem was based on factual reports from wounded soldiers in the Scutari hospital. The young Englishmen described in letters the peace they felt in simply seeing the "Lady with the Lamp"; her shadow falling across one's cot, it was said, brought comfort and relief.\* Contemporary nursing literature reflects a renewed interest in the spirituality of Florence Nightingale, one recent example being the 1995 article by Janet Macrae entitled "Nightingale's Spiritual Philosophy and Its Significance for Modern Nursing." In the piece, Macrae reported, "For Nightingale, spirituality is intrinsic to human nature and is our deepest and most potent resource for healing" (p. 8). Macrae also noted Florence Nightingale's attraction to mysticism, particularly the writings of Francis of Assisi and John of the Cross. She cited an excerpt from the preface to Nightingale's own unpublished book on mysticism. "Where shall I find God; In myself. That is the true mystical doctrine. But then I myself must be in a state for Him to come and dwell in me. This is the whole aim of the mystical life" (as cited in Macrae, 1995, p. 10). Ultimately, Macrae argued, Nightingale's spiritual philosophy, which views "spirituality as intrinsic to

human nature and compatible with science," may provide important direction for the current and future development of nursing theory and practice (p. 8). Florence Nightingale's spiritual legacy is also advanced for current practitioners of nursing by Ann Bradshaw (1996) who asserted that holistic

\*Longfellow's poem, although entitled "Santa Filomena," has long been considered to have been written for Florence Nightingale; thus her identification throughout history as "the lady with the lamp." Benet (1948) offered an explanation: "Longfellow called Florence Nightingale, 'Saint Filomena,' not only because 'Filomena' resembles the Latin word for 'nightingale: but also because the Saint, in Sabatelli's picture, is represented as hovering over a group of the sick and maimed, healed by her intervention" (p.970

nursing must include attention to the spiritual needs and concerns of both patient and family as envisioned by Nightingale (p. 42).

Five smaller nursing communities of Catholic religious women founded 4, 75, 105, 140, and 171 years, respectively, after Florence Nightingale's birth are the Sisters of Bon Secours (1824), the Servants for Relief of Incurable Cancer (1895), the Medical Mission Sisters (1925), the Missionaries of Charity (1960), and the Sisters of Life (1991). These communities included care of the sick as a primary ministry of the early Sisters and continue to serve the sick poor in contemporary society, both in the United States and abroad.

### **Sisters of Bon Secours**

The Congregation of Bon Secours was founded in 1824 in Paris. The Sisters' mission was to visit and care for the sick poor in their homes. The French words *bon secours* mean "good or compassionate help"; the contemporary community asserts, "Our purpose was [historically] and is to bring compassionate care to the sick and the dying" (Sisters of Bon Secours USA, 1997). Walsh (1929) reported that the community's ministry began with a group of 12 young French women living together to carry out the work of nursing the sick. The leader of the small community, Sister Marie Joseph (Josephine Potel), and her Sisters responded to the needs of 19th-century France, where health care generally was still unavailable for many people. The Sisters went out to the homes of those in need and "if the condition required extended care, the Sisters remained in the homes of the ill, often for long periods of time, always risking criticism from a public uncomfortable with such unconventional practices by religious women at that time" (O'Sullivan, 1995, p. 4). The early ministry of the Bon Secours Sisters was described by historian Walsh (1929) as follows:

The Sisters of Bon Secours devote themselves only to the care of the sick in their own homes. They have no fixed charge, the poor give nothing, the rich offer what they will. ...They make

excellent nurses, and their patients learn to love them very dearly and are very much encouraged and consoled by their presence. (p. 266)

Some 57 years after their founding in Paris, the Sisters of Bon Secours arrived in Baltimore, Maryland, where they also visited and nursed the sick poor in their homes. In the early days after their arrival, there were many requests for trained nurses to minister to the sick in their homes. "For those living in poverty, the 'sickroom' was their hospital, and their home, the place where they had to recover and learn again to live healthfully" (Stepsis &

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Liptak, 1989, p. 112). Stepsis and Uptak also reported that "the sisters were identified by the black bags they carried, filled with all sorts of food, medicines and tonics for the comfort of the sick" (p. 112).

The present work of the Bon Secours Sisters is identified as encompassing both a "healing and a spiritual ministry." The mission is carried out through "personal and corporate works, and especially through the facilities [the Sisters] operate: hospitals, hospices, long term care and rehabilitation facilities, community medical and wellness centers," among others

(O'Sullivan, 1995, p.1). Some time elapsed following the founding of the Sisters of Bon Secours, an international community, before the creation of any American communities of women dedicated to nursing the sick. One of the earliest U.S. groups was the community of nursing sisters founded by the daughter of Nathaniel Hawthorne, whose mission was care of the terminally ill.

**Servants for Relief of Incurable Cancer**

Around the year 1895, the American Roman Catholic Nursing community, the Servants for Relief of Incurable Cancer, was founded in New York by Rose Hawthorne Lathrop (1851-1926). According to the accounts of her life, Rose Hawthorne had both a good friend and an employee who were afflicted by cancer, resulting in painful and prolonged deaths. Following these experiences, Rose determined to study nursing and to commit her life to caring for the victims of cancer who, in her era, were stigmatized outcasts. After a brief period of training, she and another friend, Alice Huber, opened a free house for those with incurable cancer in New York City (Joseph, 1965). Robinson (1946) reported that "without distinction of race, or creed, or color or sex, there was only one passport to St. Rose's Free Home: poverty with Cancer" (p. 279). Gradually others came to join the two founders of St. Rose's Home, and Rose Hawthorne Lathrop became Mother Alphonsa, superior of a new community to care for those with incurable cancer. As Robinson (1946) observed, "Mother and the Sisters loved [the patients]; they were outcasts of society because of their terrible affliction, but they were

honored guests in the home" (p.280). An important point about the work of the community, which also reflects the character of Mother Alphonsa, was made by historian Walsh (1929). "Until her death Mother Alphonsa made it a rule to assume her share of the duty of taking personal care of the patients" (p. 272); she also directed her Sisters to always take a "personal share" in the work of caring for the sick. In a recent newsletter, the community of the Servants for Relief of Incurable Cancer (also referenced to as Hawthorne Dominicans) asserted



again that "the congregation has one apostolate: to nurse incurable cancer patients, providing them with a free home" where they can end their days (Dominican Sisters, 1994, p. 1). The Dominican Sisters of Hawthorne currently administer seven free homes in six U.S. states.

Since the community's founding by Rose Hawthorne Lathrop, the Sisters have cared for more than 135,000 men, women, and children suffering from cancer. The community's current mission statement asserts, "Middle-class or poor, black or white, Christian or Jew, each finds a home with us where they can spend their precious final days in dignity. We see in each the image of Christ. We minister to each with the same tender care we give our beloved Savior" (Dominican Sisters, 1994, p. 1).

Nursing communities such as the Hawthorne Dominicans were founded with the purpose of caring for the sick poor in this country. As the U.S. economy stabilized to some degree, other American women interested in nursing as a vocation began to look to the needs of those living in less developed countries. Thus, the U.S. missionary nursing communities were born. One of these groups, whose primary identified ministry focuses on medical and nursing care, is the Medical Mission Sisters.

## **Medical Mission Sisters**

Anna Maria Dengel (1892-1980) began her work with the sick poor in India after completing medical studies in England and Ireland. During her work in Rawalpindi, she realized that she could not accomplish much alone. "What was needed was a religious community of women, dedicated to serving those without access to health care" (Medical Mission Sisters "Celebrating the Gift," 1994, p. 1). Anna came to the United States to seek "recruits," and on September 30, 1925, she officially founded the community of Medical Mission Sisters in Pennsylvania (Medical Mission Sisters "Celebrating the Gift," 1994).

In a pamphlet entitled "Medical Mission Sisters: Committed to Health and Healing" (1994), it is reported, "Medical Mission Sisters have a specific call: to be present to life in the spirit of Jesus the

healer" (p. 1). The call is lived out with "the poor, the sick, the neglected, the unjustly treated, and the oppressed" (p. 1).

In a Medical Mission Sisters newsletter, "Sisters in Mission" (1991), the healing ministry of the Sisters is poignantly summarized:

It is a mission grounded in faith and lived out in love that says so simply, yet so profoundly, that each individual has a right to health and wholeness, that each individual should be cherished and held

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dear. It is a mission of being an active presence of "Christ the healer" which all Medical Mission Sisters are privileged to live out. (p. 3)

Medical Mission Sisters currently serve as physicians, nurses, health educators, hospital chaplains, hospice volunteers, and in other health care related activities. While a community such as the Medical Mission Sisters has many members engaged in professional medical and nursing care, Sisters in other communities provide nursing to the sick poor on a multiplicity of health care levels. One such group is the international community of the Missionaries of Charity.

### **Missionaries of Charity**

One of the more contemporary Roman Catholic communities of religious women who engage in nursing the sick poor today are the Missionaries of Charity, distinguished by their habit, a blue and white Indian sari reflecting

the country of their founding. Mother Teresa of Calcutta, foundress of the Missionaries of Charity, heard a call to work with the poorest of the poor while missioned in India. The

community, officially recognized in 1960, has now spread across the world. Although the majority of the Missionaries of Charity are not formally trained nurses, they are identified as a nursing community by nurse historian Josephine Dolan, who observed, "They [Missionaries of Charity] tend to the poor in the streets, in their homes, in the hospices which they have opened to care for children, the destitute, the dying and lepers" (1973, p. 315). The Missionaries of Charity commit themselves as a community to caring for the poorest of the poor. To that end, a fourth vow is added to the usual three promises of poverty, chastity, and obedience. As Mother Teresa acknowledged, "We have a fourth vow where we profess to offer wholehearted and free service to the poorest of the poor" (Mother Teresa, 1984, p. 74). The Missionaries of Charity began with young women from Calcutta, many of whom had no training in nursing; they were taught, however, to care for the sick with love and compassion. A quotation of Mother Teresa's, which has become well known, reflects her attitude toward the work: "We can do no great things; only small things with great love!" (Mother Teresa, 1983, p. 45). She explained, "The Sisters are doing small things: helping the children, visiting the lonely, the sick, the unwanted.... When someone told me that the Sisters had not started any big work, that they were quietly doing small things, I said that even if they helped one person, that was enough. Jesus would have died for one person" (p. 45).

Mother Teresa's commitment to care for Christ in the person of the sick poor is reflected in an excerpt from her daily community prayer:

Jesus my suffering Lord, grant that today and everyday I  
may see  
you in the person of your sick ones, and that in caring for  
them I  
may serve you .... (1982, p. 7).

## **Sisters of Life**

Finally, a recently established Catholic religious community, the Sisters of Life, have the mission of providing services importantly related to nursing in a variety of areas. The Sisters of Life founded in 1991 by John Cardinal O'Connor, Archbishop of New York, is a contemplative-active community whose ministries include the care of vulnerable pregnant women, the frail elderly, and those who are terminally ill (Catholic News Publishing Co., 1998, p. B-91).

The Sisters' apostolate is focused on protecting and advancing the sacredness of human life, "beginning with the infant in the womb and extending to all those vulnerable to the threat of euthanasia" (Sisters of Life, 1991a, p. 1). The spiritual philosophy of the Sisters of Life is that articulated by John Cardinal O'Connor at the time of the community's founding. "Over the course of hundreds of years, Almighty God has inevitably raised up religious communities to meet the special needs of the day. I am convinced that the crucial need of our day is to restore to all society a sense of the sacredness of human life. Basic to the worst evils of *our* day is surely the widespread contempt for human life. My reading of the 'signs of the times' impels me to believe that the Holy Spirit, 'brooding over the bent world,' wants to inspire a

religious community whose charism would be uniquely the protection and enhancement of a sense of the sacredness of human life itself' (1991, p. 1).

As well as the three promises of poverty, chastity, and obedience, the Sisters of Life make an additional vow to support the sacredness of human life. Some of the Sisters' activities include prayer, retreat work, spiritual counseling, and material assistance for those in need. A group of special concern is women facing unexpected pregnancies. The Sisters operate a residence for vulnerable pregnant women, Sacred Heart of Jesus Convent and Home for Mothers. In their apostolate of promoting the sanctity of life, the Sisters also direct the Dr. Joseph R. Stanton Human Life Issues Library and Resource Center.

Ultimately, it is stated in the community's constitutions that the heart of a Sister of Life's vocation is "the call to love as Christ loves" (Sisters of Life,