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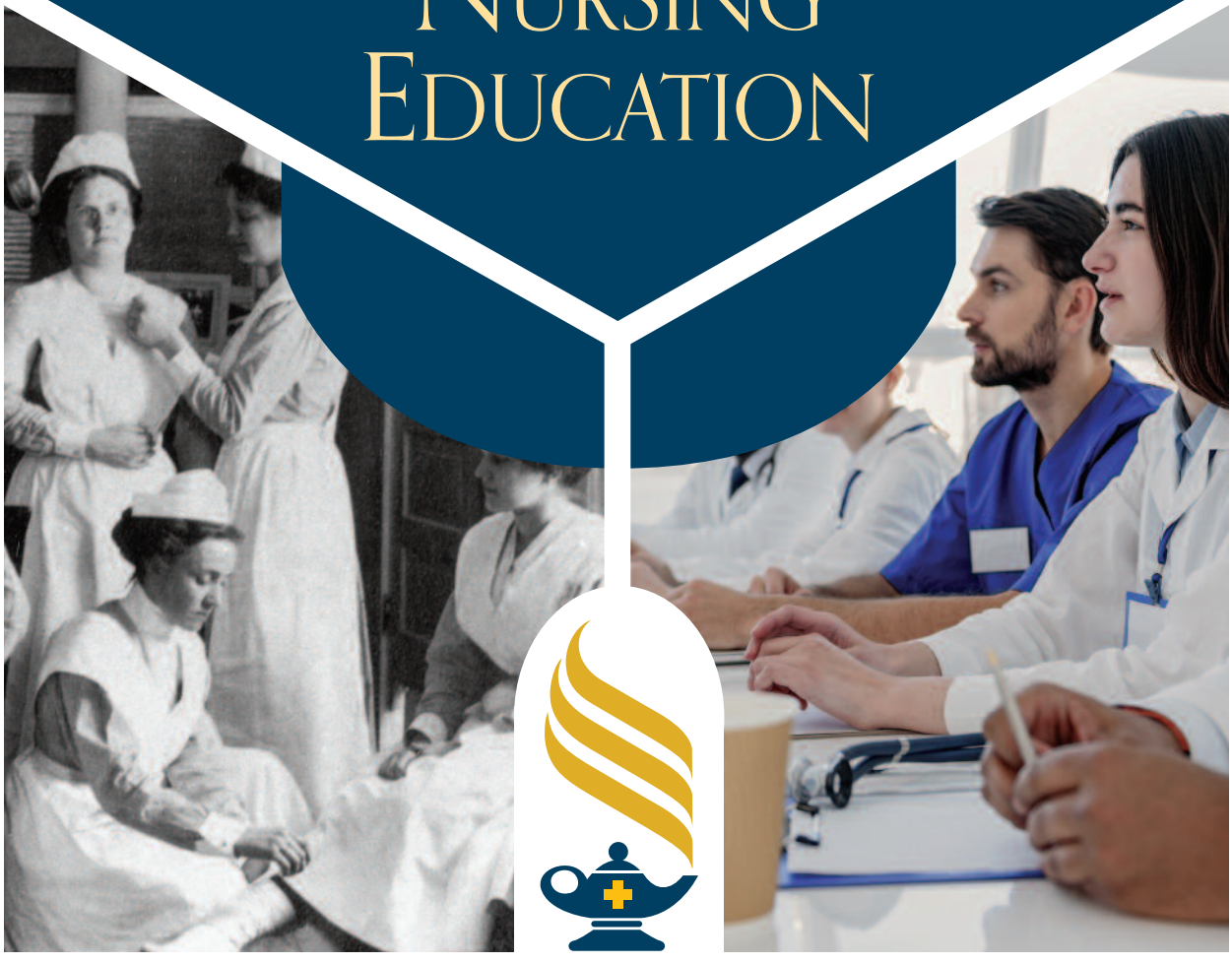

SPECIAL ISSUE

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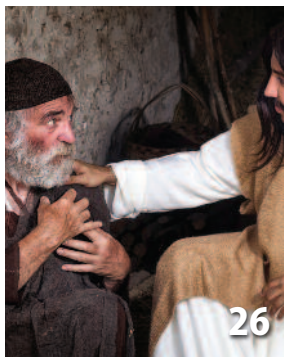

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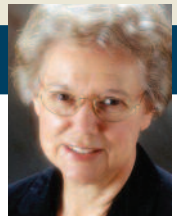
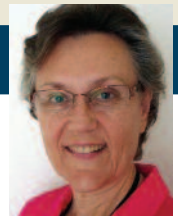




Patricia S. Jones **Edelweiss Ramal**

The Past and Future of Adventist Nursing

It's a remarkable story– one of courage, dedication, innovation, passion, and mission.

Our Legacy

At the beginning of the 20th century, Adventist nursing was not only an important player in the development of modern nursing, it was also a pioneer and global leader. For example, when Dr. Kate Lindsay started the Battle Creek Sanitarium School of Nursing in 1883, she followed the model of nursing care and education she observed while doing a medical specialty at Bellevue Hospital in New York City a few years earlier.[1] Bellevue Hospital School of Nursing was one of the first nursing schools in the United States based on the Nightingale model. Florence Nightingale and Ellen G. White were contemporaries, and both were passionate about health, healing, and care of the sick. Although there is no evidence that either was aware of the other, the combined influence of their principles gave Adventist nursing an outstanding start.

Kate Lindsay

As the health ministry of the Seventh-day Adventist Church reached out around the globe, so did Adventist nursing and nursing education. It often started with the development of clinics by doctors and nurses, followed by a small hospital and a school of nursing to train nurses to staff the facility. This is evident in the record of where and when Adventist schools of nursing were established outside of the U.S., for example in Australia (1898), South Africa (1900), Argentina (1908), China (1921), and India (1925). From the beginning, graduates excelled in providing whole-person care and were in wide demand. According to Chapman, nursing graduates of Battle Creek College were recognized as exceptional and "eagerly sought after in all parts of the civilized world."[2] The same was true of the graduates of the Shanghai Sanitarium and Hospital School of Nursing and many other Adventist nursing programs all over the world.

As early as 1921, a young nurse educator, Kathryn Jensen Nelson, was appointed to the Medical Department of the General Conference to oversee Adventist nursing globally. Jensen promptly developed a system of college credits for nursing curricula, which at that time were still hospital-based. By the time of the Goldmark Report (1923),[3] and later the Brown/Bridgeman Report (1953),[4] both of which recommended that nursing education be conducted in institutions of higher education, Adventist nursing was already moving in that direction. Washington Missionary College in Takoma Park, Maryland, started a Bachelor of Science degree in nursing in 1924 and first graduated students with baccalaureate degrees in 1928. Jensen's visionary leadership provided a foundation for the merging of nursing education into the existing network of Adventist colleges, and a relatively smooth transition into higher education.

Throughout the 20th century, Adventist nursing continued to pioneer the development of innovative and progressive nursing education. For example, in the 1970s, the University of Eastern Africa, Baraton, in Kenya, developed the first generic university-based curriculum for a baccalaureate degree in nursing in sub-Saharan Africa (not including South Africa). It earned a strong academic reputation and is still widely recognized as a superior program in the preparation of professional nurses. Graduates from Adventist programs in Asia and Africa, and all over the world, frequently earn the highest scores on the national examinations in their respective countries.

Our Future

In 2010, health care and the education of health professionals entered a new era. In the U.S., it began with the Institute of Medicine report (2011)[5] and the Carnegie Commission (2010).[6] Globally, it started with the Global Commission on Education of Health Professionals for the 21st Century.[7] All three reports called for changes in the education of health professionals that will challenge Adventist educators in the years to come. The global report called for a "fresh vision" to transform education in the health professions (including nursing) in all countries, rich and poor. The situation was described as a "slow burning crisis" requiring that the education of health professionals in the 21st century be transformative, team-based, and interdependent.

Given our record as pioneers in the 20th century, how will Adventist nursing respond to this new challenge? Will we continue to be leaders in this new era? Will we continue to be passionate, innovative, and futuristic in our approach to educating nursing profes-

Continued on page 54

A Distinctive Framework for Adventist Nursing

In the late 19th and early 20th centuries, Seventh-day Adventist sanitariums and hospitals established schools of nursing that rapidly earned high regard in their communities as a result of the excellent instruction and training their students received. Patients in those facilities received high-quality care from the students and graduates, and the cycle reinforced itself.

In the 21st century, nursing is a popular career choice for young adults, both male and female, in many parts of the world. With a global shortage of nurses and the denomination's long history of highly rated schools of nursing, Adventist colleges and universities around the world have been eager to establish academic programs in nursing to meet the educational interests of the church's young people, as well as the healthcare needs of citizens in their country. Accordingly, the possibility of a gap between the mission of Adventist nursing education and market-driven motives to attract students and boost enrollment is real.[1] It is possible for a college or university to offer a nursing program that attracts a large number of students, yet fails to reflect the values and legacy of Adventist education.

This article describes a research project that sought to identify the distinctive values of Adventist nursing from the perspective of Adventist nurses and nurse educators around the world. Its goal was to create a framework that will help new and existing programs to reflect the outstanding legacy of Adventist nursing education. Based on data from 33 countries and 213 respondents, the researchers concluded that Adventist nursing shares three overlapping constructs—caring, connecting, and empowering—that can support and facilitate its global mission.

Conceptual Frameworks

In 1973, the National League for Nursing (NLN) initiated workshops to address how conceptual frameworks influence curriculum development in nursing. A review of 50 accredited baccalaureate nursing programs in 1972 and 1973 revealed that most of the schools were using the concepts of *man*, *society*, *health*, and *nursing* as the primary focus of their curricula. Since that time, these concepts have been referred to as the core, or metaparadigm, concepts, and are used to depict the phenomena of primary concern for nursing science in both education and practice. To broaden the concept of *man*, the term was later changed to *person* or *human being*, and the concept of *society* was broadened to *environment* to include both social and natural contexts. Reflection on these now-classic documents[2] provided a background for developing a project to create a conceptual framework for Adventist nursing in the 21st century.

The Research Project

The principal investigators designed a qualitative study to determine what Adventist nurses and nurse educators perceived as distinctive about Adventist nursing in their context and culture. Investigators collected data in 10 of the 13 divisions of the world church, representing 33 countries. Nurses from eight countries were Spanish-speaking, from three countries French-speaking, and the rest were English-speaking. Focus groups of 10 to 15 people encouraged open discussions, which were documented by designated recorders. Analysis and categorization of the data were done according to the principles of qualitative analysis,[3] and using the electronic software NVivo 10.

BY PATRICIA S. JONES, BARBARA R. JAMES, JOYCE OWINO, MARIE ABEMYIL, ANGELA PAREDES DE BELTRÁN, and EDELWEISS RAMAL

The principal investigators then analyzed the data and categorized them according to their relevance to the four essential metaparadigm concepts described above. Continued analysis led to the identification of key concepts and constructs that describe distinctive elements of Adventist nursing, according to the perceptions of the informants. The findings from this analysis provided the foundation for creating a model and conceptual framework that are presented in this article as "An Integrative Global Framework for Adventist Nursing." The consistency of these concepts across diverse national backgrounds indicates that they are the product of a shared professional culture unique to Seventh-day Adventist nursing education.

Methodology

During 2013 and 2014, 27 focus groups composed of professional nurses and nurse educators were conducted at three international conferences—in Indonesia, Argentina, and Rwanda. Countries represented in the conference in Argentina included Argentina, Bolivia, Brazil, Chile, Colombia, Mexico, Paraguay, Peru, Puerto Rico, and the United States. Participants in the 11 focus groups conducted in Bali, Indonesia, came from Australia, Botswana, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, Peru, the Philippines, Thailand, and the U.S.A. At the conference in Rwanda, six focus groups were conducted with participants representing Botswana, Cameroon, Congo, Democratic Republic of the Congo, Kenya, Liberia, Nigeria, and Rwanda.

Prior to the discussions, group facilitators received instructions on how to conduct a focus group and document, summarize, and report their findings to the conference participants. The questions that guided the group discussions are shown in Table 1. Recorders documented in writing what the groups had generated verbally in their discussions and then summarized the salient points discussed in response to the questions. Additional data were gathered via questionnaires at the Adventist International Nursing Education Consortium (AINEC) meeting at Union College in Lincoln, Nebraska, in May 2014, and from Adventist nurse educators in Australia and Papua New Guinea in August of that same year. The same questions were used to facilitate focus group discussions at all the conferences.

Data collected in Spanish and French were translated into English by bilingual investigators and/or research assistants and entered into the NVivo software program, as were the data collected via written questionnaires. Once all the data were entered, the two principal investigators started to independently analyze and code the information. Data analysis[4] began with "open coding," which involved reading the data line by line and identifying the ideas or nodes therein. Coauthors independently followed the same procedure.

"Axial coding" followed the "open coding." Axial coding is a process by which the ideas or nodes already identified are organized and grouped into categories. First, the nodes were organized into the categories identified by the NLN as the metaparadigm concepts of nursing.[5] After this step, other nodes and concepts consistently reported in the data as descriptive of Adventist nursing education and practice were identified. After working independently on the open and axial coding, the two principal investigators worked together to do "selective coding," which identified the categories with the greatest amount of qualitative data support. These categories were organized according to their relevance to the core metaparadigm concepts of person/human, health, environment, and nursing (practice and education), and were used in developing the global integrative framework for Adventist nursing. Table 2 (page 7)

Table 1. Focus Group Discussion Questions

1.	What is the essence of nursing?
2.	What is unique about Adventist nursing?
3.	What values and beliefs led you to answer question No. 2 as you did?
4.	How does our Adventist heritage affect nursing care?
5.	What are the similarities in nursing care across cultural settings?
6.	What are the differences in nursing care across cultural settings?
7.	Which of the beliefs that you have identified as distinctly Adventist do you see evidenced in the practice of nursing in Seventh-day Adventist institutions?
8.	What strategies, approaches, and tools would facilitate integration and implementation of these values and beliefs into the curriculum?
9.	What strategies would promote application of these values and beliefs into the practice of nursing?
10.	What strategies would facilitate commitment to shared responsibility for translating the values and beliefs from the classroom to the clinical setting?

shows selected quotes related to each of the core concepts.

The Distinctiveness of Adventist Nursing

The various levels of analysis revealed distinctive concepts describing the metaparadigm concepts of nursing from an Adventist perspective. These are reflected in the stated mission, the descriptions/definitions of the essential concepts, and in the nature of nursing education and practice.

The Mission, Values, and Beliefs of Adventist Nursing

The mission of Adventist nursing was identified in the data as a response to questions about the uniqueness of Adventist nursing (see Table 1) with comments like "reflecting Christ's healing ministry to the whole person" and "restoration of the image of God in human beings." These statements are in keeping with Ellen G. White's description of Christ's mission as bringing complete restoration, health, and peace to human beings.[6]

Reflection on these comments led researchers to a statement of the mission of Adventist nursing as follows: *To promote healing, well-being, and restoration of the connection between humans and their Creator.* In this statement, the distinctive aspect is *restoring the connection between humans and their Creator.* The data were rich in statements about the values inherent in Adventist nursing. Some were not surprising, such as the altruistic values of love, empathy, compassion, excellence, kindness, hope, integrity, dedication, service, and respect. However, it was gratifying to also see the concepts of equality, justice, human rights, and charity, which reflect an awareness of current social ills that nurses need to recognize and to which they can respond. Although an emphasis on human rights is in keeping with contemporary concerns, it is interesting to note that Ellen White wrote about human rights in the early part of the 20th century, saying: "the Lord Jesus demands our acknowledgement of the rights of every person. People's social rights, and their rights as Christians, are to be taken into consideration. All are to be treated with refinement and delicacy, as the sons and daughters of God."[7]

Along with these values, researchers identified beliefs and assumptions that provided a platform for the concepts and framework presented here. For example, belief in the sanctity of life, that God is the giver of life, that human bodies are the temples of the Holy Spirit, and that each person is a child of God. Closely associated with these beliefs and values were ethical principles such as the following: Every human being is worthy of dignity and respect; nurses should promote and preserve human dignity; and every human being has a right to live. These deep values and ethical principles were prominent in the data and viewed as foundational to Adventist nursing.

The Metaparadigm Concepts

The metaparadigm concepts *humans, health, environment,* and *nursing* were present in statements by informants. This provided substantive meaning to define them from an Adventist perspective. Excerpts from the data and our definitions are provided below:

• *Humans* were described as created by God and designed to have a personal relationship with Him. Christ admonished His disciples to "'Abide in me as I abide in you. Just as the branch cannot bear fruit by itself unless it abides in the vine, neither can you unless you abide in me. I am the vine, you are the branches. Those who abide in me and I in them bear much fruit, because apart from

me you can do nothing'" (John 15:4, 5 NRSV).[8] Based on the data, and on Scripture, the researchers define humans as *complex integrated beings—bio-psycho-social-cultural and spiritual—created as interactive beings for the purpose of connecting with God, humans, and all of God's creation.*

• Comments about *health* described it as wholistic, including physical, mental, social, spiritual, and cultural well-being, and that communion with God affects health. Ellen G. White advised that it is our responsibility to cooperate with God in restoring health to the body as well as the soul.[9] In this article, we define health as *integrated well-being nurtured by interconnectedness with God and the whole of creation.*

• *Environment,* according to the respondents, reflects God's laws of beauty and harmony (aesthetics), and impacts healing. In the data, nurses were viewed as having a responsibility to conserve the environment, and as being capable of creating a healing environment. Ellen White had much to say about the environment. For example, "The pure air, the bright sunshine, the flowers and trees, the orchards and vineyards, and outdoor exercise amid these surroundings, are health-giving, life-giving.[10] Also, "Nature testifies that one infinite in power, great in goodness, mercy and love, created the earth and filled it with life and gladness."[11] Accordingly, in this article, environment is described as *reflecting God's laws of beauty and harmony; creating a healing environment that inspires hope; and promoting respect, care for and conservation of the environment.*

• In the responses, *nursing* is described as a sacred calling and a selfless service manifested in providing wholistic care (see Table 2). Ellen White wrote that in ministering to the sick, "success depends on the spirit of consecration and self-sacrifice with which the work is done."[12] In this article, the researchers define *nursing* as *a sacred calling for service to humanity, and a human science that facilitates healing and restoration to well-being through connecting and caring.*

Nursing Education and Practice

In the data, nursing education and practice were described as a calling and a ministry. Nurses and nurse educators were described as interdisciplinary, functioning as advocates and agencies of change, empowering the client/student for change, and as role models. The belief that nursing is a call to ministry implies that a nurse educator not only accepts the call but also has an added responsibility to nurture that call in students. Nurturing implies empowering students to grow and develop into caring professionals. Empowerment happens when students feel respected, when learning is facilitated rather than hindered, and when teachers reflect God's unconditional love. Familiarity with the legacy of Adventist nursing education will influence the educator's commitment to maintaining and promoting the underlying values and ethic of extraordinary caring for which Adventist nursing education is known. Therefore, Adventist nursing education is built on a foundation of beliefs that humans are sacred because they are cre-

Table 2. Quotes Related to the Core Concepts of Nursing Identified During Selective Coding

Concepts	Quotes
Humans	"Created in the image of God"
	"Human body is the temple of God"
	"Deserving of dignity and respect"
	"Respect each person's priorities"
Health	"Strong focus on prevention and change of total lifestyle"
	"Healing comes from God"
	"Health promotion and wellness"
Environment	"Promoting an aesthetic environment that will show God's laws of beauty and harmony"
	"Creating a friendly spiritual environment will enable translation of values"
	"Promoting the conservation of the environment"
Nursing	"To imitate Jesus' model, who healed the physical and spiritual component of the individual"
	"Hope is a vision: where science fails, Adventist nursing has the opportunity to offer care, strengthened by hope and faith"
	"The management of integrated health care for the individual, family, and community"
	"Wholistic care—taking into consideration the physical, mental, cultural, socio-economic, and spiritual aspects of the person for promoting a high quality of care"
	"Love and compassion, integrity, manifested through a vocational sense to others and dedication to Christ"
	"To re-establish God's image in human beings"

ated in God's image, that health is wholistic, and that nursing is a call to ministry. Accordingly, Adventist nurse educators must respect the diversity and uniqueness of each student; reflect God's unconditional love; facilitate healing and well-being in students; and role-model as well as promote wholistic health. Based on these elements in the data, this document suggests that nursing education integrates values, knowledge, and skills; promotes development of clinical judgment and professional competence; and prepares the student for interdisciplinary practice.

In addition to the comments about nursing practice mentioned above, other descriptors in the data portrayed nursing as providing humane, wholistic care; promoting connectedness among humans and their environment; and empowering the client for change through education and role-modeling. Along with comments that related to the metaparadigm concepts, informants' responses contributed keen insights about the distinctiveness of Adventist nursing. These ideas and concepts were clustered according to their meaning and significance. Overarching key constructs and sub-concepts emerged, which appear in Tables 4 and 5. In summary, the distinctiveness of Adventist nursing as seen in the mission, education, and practice of nursing is a focus on the sacredness of God's creation, and on nursing as a call to ministry to promote well-being in all aspects of that creation through *caring*, *connecting*, and *empowering*.

Key Constructs

Caring

Caring has long been the primary focus of nursing practice and has been described as the essence of nursing. Although not limited to one profession or culture, caring is recognized as the fundamental value associated with the discipline of nursing. The fact that Adventist nurses repeatedly referred to "caring" as a primary concept underlying their nursing practice and education affirms the validity of caring in the profession and its centrality in Adventist nursing. The concepts of empathy, compassion, sensitivity to the needs of others, caring beyond the ordinary, and selfless service were among the most frequently mentioned aspects of Adventist nursing by people participating in the study.

A number of theorists have selected caring as the core concept from which to develop a theoretical framework for the discipline of nursing.[13] In spite of varying theoretical perspectives, most agree that *care* is a powerful and distinctive attribute of the discipline, and that one goal of nursing education is to develop the capacity to care.

In today's health-care systems, although the ethic of caring is challenged, it is what keeps them human.

Table 3. Key Constructs Supported by the Data

Key Constructs	Terms and phrases from the data
Caring	Empathy
	Compassion
	Going beyond the ordinary
	Sensitivity toward others
	Going the extra mile
	Compassionate care with the fruits of the Spirit
	Valuing each individual
	Selfless service
Connecting	Communion
	Prayer
	Personal relationship with God
	Social interaction
	Compassion
	Presence
	Therapeutic communication
	Active listening
	Connectedness
	Mentoring and facilitating learning
	Coordinating and managing care
Empowering	Lead by example in teaching and student interactions
	Professors role-model their beliefs and values to students
	Role-model compassionate patient care
	Demonstrate caring in personal life
	Practice a healthy lifestyle. Promote healthy living in patients
	Advocate for the patient through inter-professional collaboration
	Nurture students' critical-thinking skills

Table 4. Quotes Related to Sub-concepts Identified During Selective Coding

Sub-Concepts	Quotes
Mission	Restoration of the image of God in human beings Reflect Christ's healing ministry to the whole person—including the spiritual
Values	▪ Love, Empathy, Excellence, Kindness, Integrity, Respect, Loyalty, Hope, Service, Trustworthiness, Commitment, Equality, Justice, Human rights, Charity
Beliefs	We believe in the sanctity of life. ▪ God is the giver of life. ▪ We are temples of the Holy Spirit. ▪ Each person is a child of God.
Ethics	▪ Every human being is worthy of dignity and respect. ▪ Every human being has a right to live. ▪ Nurses should promote and preserve human dignity. ▪ Nurses advocate and act for the welfare of others.

According to Sara Fry,[14] "The very nature of nursing requires and reinforces the ethic of caring"; in order for caring to survive, the values that underlie nursing have to be realized—for example, advocacy and respect for other human beings. Roach[15] emphasizes the dual nature of caring—attitudes and values on the one hand, and action on the other. She describes the six C's of Caring as *Compassion, Competence, Confidence, Conscience, Commitment,* and *Comportment.* Roach argues that caring is the human mode of being, and that nursing is the professionalization of human caring.[16] *Compassion* brings sensitivity to the experiences of another person, *Competence* brings the knowledge and skills necessary to respond appropriately, *Confidence* fosters trust, *Conscience* implies moral awareness, and *Commitment* leads to investment of time for the person being helped. *Comportment* reflects a sincere attitude and demeanor of concern for the patient's total well-being—including the spiritual component.

Wikberg and Eriksson[17] maintain that caring is not only the essence of nursing care, but also the subject of nursing science. They believe that the reason for caring is suffering and the motive of caring is to alleviate suffering. To these authors, caring is not behavior, but a way of living demonstrated in the spirit of the relationship between the caregiver and the care receiver. They describe that spirit as *caritative*.

Eriksson[18] explains that caring is not limited to one discipline such as nursing, and that each brings its own understandings and methods to how caring is practiced. The assumptions underlying her theory are compatible with Adventist beliefs. For example, she describes the human being as a religious entity composed of body, soul, and spirit; and says that caring is an act of compassion and love in response to human suffering. The mission of the human being, according to Eriksson, is to serve, to exist for the sake of others.[19] Caring is manifested in a relationship to another human being; and such relationships involve ethics, respect, and regard for the dignity and rights of the other.

In nursing education, students learn best about caring by experiencing caring interactions with their mentors. Students defined instructor-caring as an "awareness of a mutual and reciprocal connection between the self and the instructor that enables them to search for meaning and wholeness and grow as caring professional nurses."[20] Caring is communicated subtly by faculty through their teaching and interactions with students.[21] Beck described caring interactions as mutual simultaneous dimensions of intimacy, connectedness, sharing, and respect.[22] Tools have been developed to measure perceptions of instructor caring.[23] Faculty caring behaviors can also be rated by nursing students according to the six C's of Caring by Roach[24] described earlier. When nursing students perceive a strong caring connection among nursing faculty and between faculty and students, they are empowered to strengthen the caring connection with their patients and to provide spiritual care.[25]

Connecting

The idea of *connecting* as an overarching construct for Adventist nursing practice and education emerged from statements and conceptual elements in the data—for example, references to social interaction, therapeutic communication, presence, active listening, and a personal relationship with God (see Table 3). From these statements, and in agreement with Eriksson, the researchers believe that "To connect is, arguably, one of the most fundamental human needs . . . and a significant dimension of what it means to be human."[26] Whether it is connecting in a family or a community, connection with others is basic to human well-being. Furthermore, healthy relationships on all levels require authentic connecting with the self. And, above all, connecting with God is essential, for through that connection we are empowered to connect

with others. Even individuals on the autistic spectrum, for whom connecting is difficult, acknowledge the need for connectedness with God.[27]

Ellen G. White wrote that "Christ came to the earth and stood before the children of men . . . that through our connection with Him we are to receive, to reveal, and to impart."[28] "Our growth in grace, our joy, our usefulness—all depend on our union with Christ. It is by communion with Him . . . that we are to grow in grace."[29] One nursing author has described life as a journey of connections and disconnections—physical, psychological, and spiritual.[30] Another pointed out that evidence is strong that connection to others is linked to positive outcomes, particularly in times of stress and trauma.[31]

The concept of *presence* was specifically mentioned in the data. Although hard to describe, most nurses know that being fully present for a patient can have a healing effect on the spirit and body of the person needing care. Similarly, therapeutic communication and active listening may be healing interventions. The nurse's personal relationship with God influences and contributes to this presence, and can be communicated through prayer or even silence.

Connecting is a powerful factor in the teacher-student relationship as well. In the data, it was clear that mentoring, facilitating, and coordinating learning experiences are necessary. In order for teachers to facilitate learning and to mentor effectively, interactive exchanges are vital for the teacher and student to connect deeply, and for the student to feel heard and understood.

Feely and Long[32] developed a theory of connectivity to guide nursing practice with patients experiencing depression. They describe *connective care* as a process of using the self to connect human beings to one another; similarly, they describe the *self* as the soul or spirit of the person—the being, seeing, thinking, and feeling aspects of the person. Connecting with family members is an important intervention for nurses who are caring for individuals, and connecting family members with one another is an effective intervention in family nursing practice. Connecting clients with the human and technical resources needed to facilitate wellness empowers clients and increases their energy for growth, recovery, and wholeness.[33]

Empowering

Empowering nurses to provide quality care and improve patient outcomes has been propagated since the beginning of modern nursing by Florence Nightingale.[34] Empowerment—possessing the power to have influence over someone or something—is a dynamic concept that permeates all aspects of nursing practice and education. Nurses need to not only be empowered themselves[35]; it is also their responsibility to empower clients for self-care and wholistic health improvement.[36] Nurse educators similarly need to empower students for lifelong learning and ongoing professional development.[37] A continuous cycle of empowerment is thus created.

Types of power described in the literature include legal, coercive, remunerative, normative, and expert. Nursing is particularly interested in expert power.[38] Although knowledge is one of the first steps toward developing expert power, much more is required for empowering than an accumulation of knowledge. In the model presented in this article, empowering involves inspiring and motivating patients and students to reach their goals of being healthy, to challenge existing paradigms, to embrace change, to face adversity, and to persist, overcome, and conquer difficulties in the path to wholistic well-being. Much of the inspiration and motivation needed for empowerment is done through role-modeling and mentoring.

Students and clients need to feel valued. Advocating, inspiring, and motivating (concepts important in the process of empowering) require connecting with the Source of life and with the individuals one desires to empower. According to Ellen White, Christ revealed the secret of a life of power, which was communion with His heavenly Father. He frequently went away to the sanctuary of the mountains to be alone with God, and when He returned, the disciples noted a look of freshness, life, and power that seemed to pervade His whole being.[39] Ellen White also admonished Adventist nurses that "if you have a living connection with God, you can in confidence present the sick before Him. He will comfort and bless the suffering ones, molding and fashioning the mind, inspiring it with faith and hope and courage."[40]

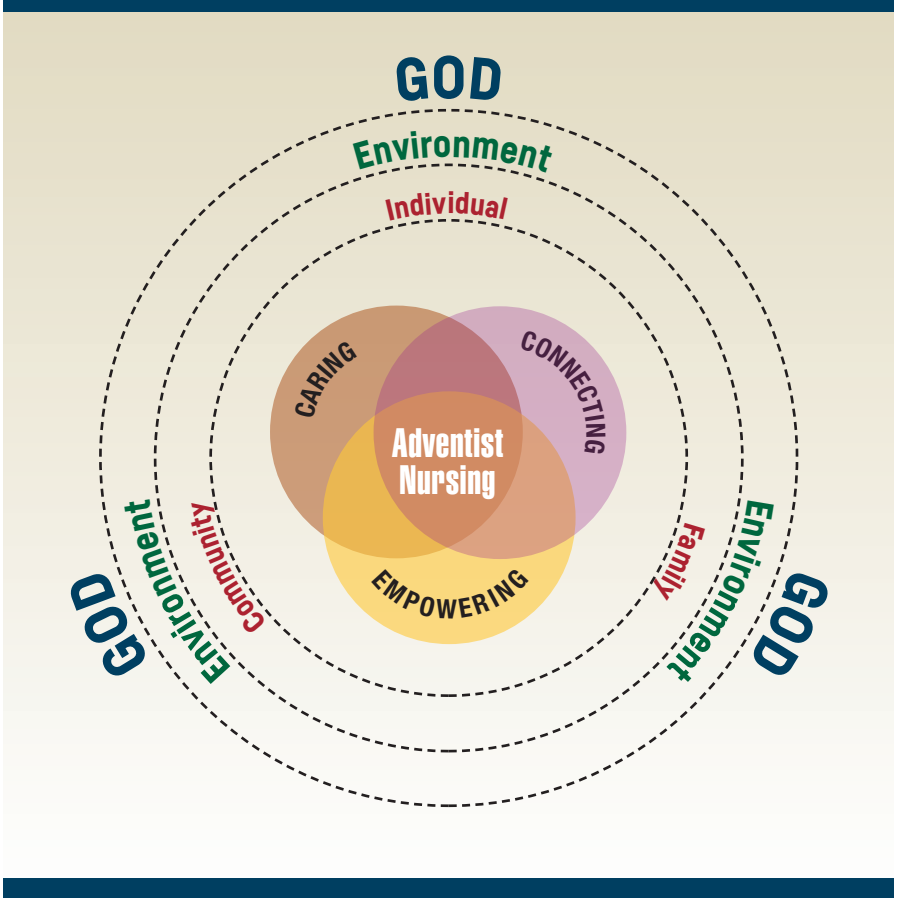
However, in certain situations, change is still dependent on the availability of resources. For example, students need mentors, scholarships, and role models. Clients need facilitators to connect them with resources specific to their health needs. In each case, as wholistic beings, an increase in one resource can inspire, provide hope, and empower energy in another area of health or growth. Thus, connecting with resources can increase energy and empower growth toward a higher level of health potential.[41]

The Model

The three constructs just described, *caring*, *connecting,* and *empowering*, are actually three processes in which nurses and nurse educators engage when caring for the sick, promoting well-being, and when educating nursing students to become professional nurses. The informants in this research project represented nursing practice and nursing education. Thus, the relevance of these constructs for both nursing care and nursing education is part of the significance of the model as a framework for Adventist nursing.

When these three constructs are placed together in overlapping circles,

Figure 1. An Integrative Global Framework for Nursing Education and Practice



the central component area that they share can be interpreted to represent Adventist nursing (see Figure 1). However, these constructs don't stand alone. Nursing practice, and education, occur in an environment that incorporates the individual human being, the families with whom the individual interacts, and the communities in which individuals and families live. All exist and function in an environment that encompasses natural, socio-cultural, political, and material aspects. Beyond the individual and environmental contexts is the overarching power of God, the Creator of human beings, the environment, and indeed the universe. Thus, Adventist nursing is viewed from a philosophical perspective that is grounded in a Christian view of the inherent spiritual nature of human beings who interact with their environment and with God in achieving well-being and wholeness. Accordingly, the constructs depicted in this model provide a framework that can guide the practice of nursing as well as the process of educating students to engage in the ministry of wholistic nursing care (see Figure 1).

Caring, for example, reflects the heart and soul of nursing practice. In the data, caring was described as over and above the usual level of care that is expected from a health professional, and as "caring beyond the ordinary." Such caring emanates from a profound respect for the individual as a child of God, and a deep desire to show God's love to the person in need. The same is true for the teacher who views students as sons and daughters of God, and respects their potential to grow and become all that God intended. This level of caring implies faith in each student's ability to learn and a commitment to invest time and energy to help him or her achieve success.

Connecting is perhaps the most concrete of the three concepts. Because humans were created as social beings, connecting is crucial to their survival. Being connected with another human being—family, friends, community, and other sources of support—can make the difference in learning, growing, healing, and well-being; however, the ultimate source of all power is connection with God and the Holy Spirit.

Empowering, or empowerment, results from assisting the client or student to access the resources needed for recovery from illness, or to achieve healing, learning, or growth. Depending on the individual, resources may include one or more of the basic human needs for food, water, rest, finances, or a place to live. But beyond physical and material needs, it can include a need for hope, faith in oneself, and insights on how to solve a problem. One-on-one mentoring can inspire this hope, as well as clarify or role-model a skill. Beyond the power of human connectedness, whether it be the nurse, educator, client, or student, when the spiritual core of the human being is connected with God, the individual is empowered for healing, growth, and wholeness.

Application of the Model as a Curriculum Framework

The significance of this integrative model and its constructs in relation to nursing education lies in its potential to guide the educational process, including curriculum development, to enhance the relationship between teachers and students, and to reinforce the values on which curricula are based. When integrated into a conceptual framework, these constructs reflect an Adventist perspective of nursing and nursing education, which can have a pervasive influence on the entire educational experience of the student.

Therefore, program administrators who seek to prepare new nursing professionals who are ethically grounded

in the values identified by Adventist nurses globally, who subscribe to the constructs derived from the data in this research project, and who desire to maintain the legacy of Adventist nursing, can examine this framework for its potential to contribute to achievement of their program goals.

For example, in May 2016, the faculty and administrators at Southern Adventist University School of Nursing (SAU) in Collegedale, Tennessee, U.S.A., went through the process of reviewing the mission, philosophy, and framework of their program in preparation for an upcoming accreditation. In so doing, they considered how the proposed new model, although early in its formation, would fit with their mission and guide the achievement of their program goals while simultaneously maintaining the legacy of Adventist nursing.

The faculty found the constructs of caring, connecting, and empowering to be entirely congruent with their beliefs about nursing and, as a result, voted to adopt this evidence-based Adventist nursing model as the foundation of their new curriculum framework. After this step, the faculty engaged in the process of adapting it to the specific objectives of their program, focusing on what is essential in the preparation of not only an "Adventist nurse" but specifically a "SAU Nurse," a step that is congruent with the original intent of the model. In other words, each school that adopts the model has the opportunity to adapt it to focus on the unique qualities of the professional nurse it aims to prepare while maintaining the legacy of Adventist nursing.

Summary

The evidence-based model presented in this article represents the perspectives of Adventist nurses and nurse educators from 10 divisions of the world church of Seventh-day Adventists. It captures the legacy and mission of Adventist nursing and provides a framework that, when applied, has the potential to guide the development of Adventist nursing education and the preparation of exceptional professional nurses globally.

This article has been peer reviewed.

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Core Components of the Nursing Curriculum

Knowledge, whether cultural or professional, is passed from one generation to the next. This is true in families, in societies, and in professions like nursing. However, knowledge of the art and science of nursing cannot be "passed on" without some type of structure. When formal, systematic methods are used to transmit knowledge, especially in an academic setting, the process and product are often referred to as the *curriculum*. This article will provide both novice and veteran nurse educators with the core components of nursing curricula such as stakeholders, paradigm shifts, curricular models, levels of education, and evaluation. Other articles in this issue of the Journal will give more attention to specific curricular content such as spiritual and cultural care (see pages 20 and 26).

Definitions

Before discussing nursing curriculum, key terms need to be defined. The American Nursing Association defines nursing as "the protection, promotion, and optimization of health and abilities, prevention of illness and injury, facilitation of healing, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, groups, communities, and populations."[1] The International Council of Nurses builds on this definition by adding that nursing encompasses autonomous and collaborative care of individuals of all ages, sick or well, and in all settings; the promotion of a safe environment; research; as well as participation in shaping health policy and in-patient and health-systems management.[2]

Education has employed curriculum definitions for almost 200 years.[3] The traditional definition includes the regular course of study in a school or college or the group of courses of study given at a school, college, or university[4]; although, over time, the definition has greatly expanded to encompass all of the planned learning experiences, both in school and out of school.[5]

The nursing curriculum has traditionally been skills-based and test-driven, relying heavily on behavioral objectives to assess techniques and processes. Over time, curricular goals have changed, and nurses are now trained and prepared to engage in critical decision-making and innovative practice. As a result, nursing as a professional practice needs curricula that can articulate learning experiences with goals, theory, and evidence-based content, as well as ethical and philosophical underpinnings,[6] in order to address contextualized and current public-health priorities and community needs.[7]

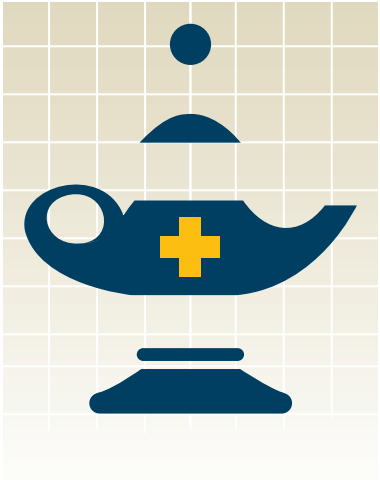
Curriculum is conveyed in several different ways. There is the legitimate or official curriculum which Bevis and Watson[8] assert is "the one agreed on by the faculty either implicitly or explicitly" containing the ethical framework that incorporates the philosophy and mission of the university/college and school/department. This framework is implemented through agreed-upon program- and student-learning outcomes, competencies, individual courses, course outlines,

BY DOLORES J. WRIGHT and JACQUELINE WOSINSKI

and syllabi. The official curriculum is formalized into written documents that are sent to accrediting agencies and shared with faculty, students, curriculum committee members, and other committees as appropriate.

Beyond the legitimate curriculum, there are other types of curricula. In the late 1960s and into the 1970s, Jackson and Snyder observed that students often acquired unintended lessons while in school (college or university), referring to these lessons as the *latent* or *hidden* curriculum.[9] However, educators recognize that students also absorb norms, values, and beliefs from the social environment of the school, such as when they engage in planned activities such as service learning.[10] These complementary features of curriculum demonstrate the dynamic and varied aspects in the field of education in general and nursing education specifically.

Thus, several common components, both stated and assumed, coexist in the definitions of *curriculum*. There are preselected goals or outcomes to be achieved. Content is selected and presented in a specific sequence in the program of study to achieve the desired levels of mastery or degree. Processes and experiences that facilitate learning for the traditional learner as well as the adult learner are identified. Resources must be identified and made available. Responsibility for learning is determined by the learner and the teacher, and where and how learning occurs may be identified.[11] Because of the variety of perspectives, another way to interpret curriculum may be as follows: "1) knowledge organized and presented in a set of subjects or courses; 2) modes of thought; 3) cognitive/affective content and process; 4) instructional set of outcomes or performance objectives; 5) everything planned by faculty in a planned learning environment; 6) interschool activities, including extracurricular relationships; 7) individual learner's experiences as a result of schooling."[12] A faculty, then, in consultation with professional, accrediting, and government associations, must make decisions about how each component of the curriculum will be conveyed and implemented.



Since faculty have individual teaching styles and academic freedom, there must be an *operational curriculum*. This is what each teacher is required to transmit in areas of knowledge, skills, and attitudes. This is the curriculum that is communicated to the students. The *assessed curriculum* is that which is tested and evaluated, and the *learned curriculum* is what the student actually learns, which is sometimes not what the teachers think they taught.

In nursing, as in other fields, not everything can be taught to students. Some content and skills are intentionally or inadvertently left out, possibly because there is not enough time in the schedule, or the content has not risen to a level of significance to warrant inclusion in the curriculum, or the content is deemed controversial by decision makers and intentionally excluded from the curriculum. Many nurse educators refer to this as the *"null" curriculum*.[13] Bevis and Watson[14] assert that, in addition to factual content, faculty also attempt to teach certain behaviors such as caring and compassion. However, dispositions such as caring and compassion are not quantifiable into behavioral objectives that can be measured adequately or easily evaluated. For this reason, Bevis and Watson[15] call this the *"illegitimate" curriculum.* Illegitimate not because they are illegal or unsanctioned behaviors that should not be taught, but because these dispositions do not lend themselves to be described as behavioral objectives and are difficult to measure and assess.

Stakeholders

Curriculum stakeholders include the educational institution, its board of trustees, individual schools within the institution, faculty, students, and the public who support the institution. Equally important are government regulatory bodies, accrediting agencies, hospitals and clinics that partner with nursing programs, and professional organizations. Each of these groups may define curriculum differently. For example, for a number of years, state boards of nursing in the U.S. evaluated a school's curriculum using a behaviorist model, so nursing schools had to define their projected learning outcomes using behavioral language such as this: "By the end of this course, the student will be able to demonstrate sterile technique." While this is just one example, it shows that curriculum can be influenced by government requirements, professional standards, societal needs, institutional goals, faculty plans and purposes, and students' interests and needs. Some of these layers of influence may unintentionally conflict with others in curriculum development.[16] Because the faculty are usually the ones tasked with curriculum development or revision, they must consider and contend with all of the stakeholders and groups who influence a curriculum.

One might consider humanity at large as one such stakeholder because many issues that humans face are generated and experienced on a global scale. These include natural disasters, changing demographics, increase in use of technology, emerging diseases, war and terrorism, climate change, and drug-resistant organisms. In previous times, these issues were rarely part of any course a nursing student would take. However, nursing education must now include topics in its courses (curriculum) that address not only local but also national and international issues relating to the health of those cared for by its graduate nurses.[17]

The Goals of Curriculum

Nursing faculty instruct and train on the premise that the goal of curriculum is to facilitate the learning processes that

enable students to acquire a knowledge base and develop confidence regarding their competence to implement appropriate strategies to adapt to the complex and shifting environment of the health-care industry.[18] In other words, they believe nursing students and graduates need a knowledge base from which to rationalize and verify their nursing interventions when providing care. However, nursing faculty also agree, and have long since concluded, that the necessary knowledge base is broader than merely the nursing course content. It must also include foundations in natural science, social science, the humanities, communication, nutrition, physical education, and bioethics and/or religion.[19]

Paradigm Shift

A major paradigm shift has occurred in nursing education. While nurses used to be "trained" to perform certain skills, they now receive an "education," which includes training in how to think critically, analyze situations, and collaborate with physicians and other medical professionals in managing and making decisions about patient care. Nurses, more than any other medical professionals, are with patients 24/7. For this reason, they have a significant role and must be involved in the decision-making process. The paradigm shift includes a change from the memorization of specific techniques to understanding the rationale behind each step of the process; from memorization of content to developing the skills and wisdom to make appropriate clinical decisions based on sound judgment; from product thinking (focusing on the task and process) to values-based human caring (focusing on the person), and from maintenance-adaptation learning (doing things the way they have always been done) to anticipatory-innovative learning (intentionally seeking creative, innovative solutions to problems.)[20] Thus, rather than being static, modern nursing curricula are dynamic and fluid, and will continue to change.

Four major recommendations emerged from a recent study funded by the Carnegie Foundation[21]: (1) Students should be taught how to "think like a nurse"; (2) Classroom and clinical teaching should be integrated in order to replicate the realities of nursing practice; (3) Students should be taught multiple ways of thinking, including scientific reasoning, clinical reasoning, and use of the imagination; and (4) Students should learn to internalize what it means to be a professional. These recommendations, when put into practice, would focus nursing educators toward new ways to think about curricula.

Curricular Models

The organization of curriculum is usually based on one of three models: *block, concept-based,* or *competency-based*:

1. A *block curriculum* is the most traditional, with content being taught according to medical condition, specialty, or age of the patients.[22] However, in some areas of the world, *block curriculum* has another meaning. Not only does it refer to content organized by medical condition, specialty, or developmental age, but it also refers to all content (theory) being taught in the classroom for several weeks, after which nursing students spend several weeks at various facilities for their clinical experiences. This may be necessary due to the constraints of the available hospitals or clinics, but it is often simply a matter of tradition.

In keeping with the report on nursing education by Benner and colleagues,[23] which emphasized the integration of nursing theory and clinical experience, some U.S. states currently do not accept transcripts from countries whose nursing education uses a block curricular structure. Nurses from these countries who immigrate to the U.S. may be asked to repeat certain nursing courses to meet the American requirement for integrating theory and clinical experience.[24]

2. A *concept-based* curriculum-design model focuses on integrating core nursing concepts into the curriculum at the planning stage. Concepts such as *pain, inflammation, elimination, human development, addiction*, etc., are used to develop the curriculum.[25] These concepts become the foci of courses. Faculty guide students through learning experiences that demonstrate how the concepts are expressed in various settings with different populations. For example, the concept of *pain* may be woven through several courses, where the student learns about the pathophysiology of pain, the causes and primary characteristics of pain, situations that may exacerbate pain, and how to evaluate and treat or relieve pain. Each core concept could likewise be woven as a thread through various courses in this type of curriculum.

3. A *competency-based* curriculum-design model has observable and measurable goals that the student must reach to be deemed competent. This type of curricular structure allows students to progress at different speeds but may be daunting for students transitioning from a behavioral learning-theory approach to a more cognitive and constructivist theoretical perspective of learning.[26] All nursing curricula incorporate some type of measured competencies, but the whole curriculum is not always built around them. The World Health Organization (WHO) has chosen a competency-based approach for its prototype curricula for nursing and midwifery.[27]

Levels of Nursing Education

Many areas in the U.S. allow high school graduates to complete a short nursing program that qualifies them to become licensed practical or vocational nurses, who work under the supervision of a registered nurse or a physician.[28] In the U.S., these programs usually require from 12 to 14 months of coursework before the student is eligible to take the examination to become a licensed practical nurse (LPN) or licensed vocational nurse (LVN). Similar programs in other parts of the world lead to the title of nursing assistant, technical nurse, or A2 nurse. An LPN/LVN can continue education toward becoming a registered nurse (RN) by enrolling in hospital-based RN programs, where available, to prepare for the RN licensing exam, or in two- or four-year nursing programs to earn an associate degree in nursing (ADN) or baccalaureate degree in nursing (BSN).

Box 1. Resources and Recommendations for Professional Development

Resources

American Nurses Association offers several free resources that can be used in the classroom and adopted into the curriculum. Tools for Nurse Educators: http://www.nursingworld.org/EspeciallyForYou/Educators/Educator-Tools.

National League for Nursing provides curriculum resources and toolkits on a variety of topics such as Effective Interprofessional Education, Faculty Preparation for Global Experiences, Faculty Toolkit for Innovation in Curriculum Design, and more. For additional information, visit http://www.nln.org/professional-development-programs/teaching-resources/toolkits.

The American Association of Colleges of Nursing offers several resources for nurse administrators and educators that provide guidelines and suggestions for curriculum design and development. This includes toolkits, Webinars, courses, curriculum guidelines, and much more. For more information, visit: http://www.aacnnursing.org/Education-Resources/CurriculumGuidelines.

Recommendations

Provide Opportunities for Advanced Training

Colleges and universities should consider providing opportunities for faculty to pursue advanced studies that include training in curriculum and instructional design and development. This could range from short, intensive courses to full-degree programs. For example, Loma Linda University offers an off-campus Master's program that focuses on nursing education for faculty from sister schools around the world, and the program includes training in curriculum development.

Retain a Consultant

Colleges and universities should consider retaining a curriculum design and development consultant who can help train faculty and assist with curricular components such as implementation, assessment, and evaluation.

Even though the International Council of Nurses has as one of its goals to achieve standardization in professional nursing education worldwide,[29] significant variation still exists: In the U.S. from the 1930s to the 1970s, hospital-based RN diploma programs were quite common. The programs, which usually took three years to complete, were developed by hospitals to ensure a constant supply of nurses for their facilities. However, advancement in the profession was difficult for their graduates, as the programs offered no transferable credit.[30] Although most hospital-based programs have been gradually phased out or have partnered with colleges to offer either an associate (ADN) or a baccalaureate degree (BSN), some still exist without any academic partner. In the U.S., diploma programs can obtain accreditation by the National League for Nursing, making their graduates eligible to take the licensing examination and become registered nurses.

Schools in many parts of the world still offer two- or three-year postsecondary professional programs that do not offer transferable credits.[31] In many African countries, where the prevalence of chronic diseases is increasing, curricula are shifting from a focus on curing communicable diseases to providing care for patients with chronic illnesses.

In the early 1950s, the U.S. faced a nursing shortage concurrent with a rapid increase in the number of junior or community colleges.[32] These were the two main factors that prompted the development of associate degree nursing (ADN) programs. Graduates from these programs were eligible to take the RN licensing examination. Because ADN graduates had earned college credit, they could enroll in a four-year college or university to complete a baccalaureate or higher degree. The ADN program is often referred to as a two-year degree. While their students do study nursing for two years; in order to be accepted into the program, they must have taken certain prerequisite courses that require a year or two to complete. Thus, although the student has spent at least three years acquiring an associate degree, he or she will have earned only lower-division credits, acquired during the last two years of the program.[33]

Baccalaureate nursing programs have been available in the U.S. since the 1920s but did not achieve significant growth until the 1950s. These programs are based in senior colleges or universities and generally take four years to complete. The student usually must complete one to one-and-a-half years of prerequisites before being accepted into the nursing program, although some nursing schools integrate their general-education courses throughout the curriculum. After completing the designated prerequisites, the student studies basic nursing courses, including leadership/management. Historically, the hallmark of the baccalaureate nursing program has been the inclusion of a course in public-health nursing.[34]

In 1999, the education ministers of the European Union decided to apply a credit transfer system akin to the one used in the U.S. to the whole education system.[35] After a time of adjustment among nurse educators, BSN programs are gathering momentum across the continent for two complementary reasons: (1) the undergraduate program appeals to students who appreciate being able to earn transferable credits; (2) the health-care system needs more nurses due to the aging of the current practitioners.

Since 2000, the WHO has been pushing for the worldwide upgrading of nursing and midwifery education[36] as a means to improve worldwide health. Among others, the authors of a comparative study in China and Europe have demonstrated that baccalaureate nursing education increases the quality of care, cost-effectiveness, and the retention of nurses as well as patient satisfaction.[37] Thus, schools in more and more countries around the world offer the Bachelor of Science in Nursing (BSN) degree. As a corollary, while nursing research has been historically limited to English-speaking countries, it has gained momentum in Asia and is on the rise in Europe and Africa.

Curriculum Evaluation

For the past 50 years, nursing educators have incorporated an in-depth system for curriculum evaluation that takes a broader view than simple measurement of how

many of their students become registered nurses and whether the programs achieve ongoing accreditation. One of the early curriculum evaluation systems, proposed by Stuffelbeam in 1971, examined the "relationship of curriculum elements . . . reflecting the integrated nature of nursing curricula."[38] This model, known by the acronym CIPP, looked at planning (Context), structuring (Input), implementing (Process), and recycling (Product). Stuffelbeam expanded the system in 1983 to include more in each of the four areas in order to ensure a more wholistic examination of the curriculum from the perspective of the stakeholders, faculty, and students. Although Stuffelbeam's system has been used and taught throughout the world, nursing schools can adopt a number of other approaches that similarly ensure a systematic evaluation. Iwasiw and Goldenberg[39] list 13 different models.

A specific model is useful to guide the evaluation process so that a program's merits and weaknesses can be identified and due consideration given to identifying areas that need extra attention. Curriculum evaluation is time-consuming work, so many nursing schools have adopted a process of "ongoing" evaluation.[40] They identify certain aspects of the curriculum that must be evaluated yearly, while other areas receive attention every three to five years. For example, yearly evaluations might include students' exam pass rates (entitling them to become registered nurses) and exit interviews with graduating students. Similarly, every three to five years, schools may choose to collect information from employers about their satisfaction with graduates, as well as information from graduates about how prepared they felt for their first job as a registered nurse.

Curricular evaluation by faculty tends to be beneficial in several ways. It may increase teachers' awareness and appreciation for the curriculum, expand their ability to design and implement their curriculum, help them develop a deeper understanding of a variety of concepts in the curriculum, encourage their commitment to evidence-based nursing education, and give them a sense of empowerment. Taking part in the curriculum development and review process will be relevant throughout their careers as a nursing educators.[41]

Nurses who earn a baccalaureate degree are qualified to continue their education at the graduate level.[42] In the U.S., college graduates from other disciplines may enter a nursing program at the Master's level, although they may need to take certain pre-requisite courses. Several specialties are available for nurses seeking advanced-practice degrees at the Master's level including nurse practitioner (NP), nursing educator, and nursing administrator. There are also two types of doctoral education in the discipline: the doctor of nursing practice (DNP), which is seen as a practice degree that allows graduates to pursue a specific specialty area, and the doctor of philosophy (PhD), which is understood to be a research degree. In most situations, graduate education is necessary to enter the field of nursing education.

Conclusion

Many nurses enter the field of nursing education having first been a preceptor for nursing students or a clinical instructor.[43] Because they have discovered a love and talent for teaching, they look for opportunities to do more in the field of nursing education. Other nursing faculty are recruited by a nursing school's administration because of their clinical expertise or the degree they already hold. Some nurses choose to enter the field of nursing education because they want to share what they have learned or because they have the appropriate degree. In most of these cases, the prospective faculty member has not had course work or a background in the underpinnings of the nursing education system: curriculum development.

A novice nurse educator may feel utterly lost or overwhelmed when appointed to the curriculum committee or asked to serve on some aspect of the curriculum-evaluation process. For this reason, opportunities for in-service education and training in the area of curriculum design and development should be made available to nursing faculty who are actively engaged in these tasks. For the veteran nurse educator as well as the novice, it is hoped that this article's definition of curriculum and of key areas involved in developing and assessing it will be helpful when developing or revising a nursing curriculum.

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Teaching Spiritually Sensitive Nursing Care: Recommendations for an Ethical Adventist Approach

For almost a century and a half, Seventh-day Adventists have provided spiritually sensitive health care to the sick and suffering. Providing health care allows us to extend the compassion of Jesus Christ, thereby bringing benefit to others as well as joy for ourselves through our service to God. In light of Adventism's wholistic understanding of being human, care promoting physical or psychological well-being inherently implies supporting spiritual wellness. Consequently, in addition to the myriad of Adventist hospitals, outpatient clinics, skilled nursing facilities, and home-health and hospice agencies around the world, there are dozens of educational institutions training thousands of students to provide whole-person health care.

Among these Adventist institutions of higher education are 75 Adventist schools of nursing. Europe and Australasia each have two; the rest are distributed throughout Africa, Asia, and North, South, and Inter-America.[1] These schools of nursing, influenced by their Adventist distinctiveness, seek to prepare their graduates to provide wholistic nursing for body, mind, and spirit. Adventists are not unique in this regard—other Christian nursing schools (of which there are many) likewise may teach their students to provide spiritually sensitive care. Furthermore, many secular nursing programs (at least in several English-speaking Western countries) are including curricular content about spiritual care because of professional mandates.

Thus, the purpose of this article is to briefly describe how spiritual care is taught in and outside of Adventist nursing schools. This exploration prompts conclusions that diverge from what some Adventist nurse educators assume. Recommendations are offered that can guide nurse educators and administrators in Adventist schools of nursing as they plan curriculum and provide instruction about spiritual care. First, however, in order to provide context, nursing perspectives about spiritual care will be reviewed.

BY ELIZABETH JOHNSTON TAYLOR

Nursing Perspectives

The work of nursing (and care of the sick, in general) has often occurred in the context of religion.[2] Nursing care was provided by temple attendants in ancient times and by religious orders in medieval times; more recently, it has often been situated in faith-based health-care organizations. Indeed, nurses are often prompted by spiritual or religious motives to enter the profession.[3]

It may be these religious roots in nursing, in combination with other motivations (e.g., reaction to increasingly technological and medicalized care, a desire to increase professional boundaries, and an increase in societal exploration of spirituality as it relates to well-being), that have led nurses to explicitly view spiritual care as within their purview. The rationale usually offered, however, for why nurses should provide spiritual care is that it is essential to wholistic care.[4]

Regardless of causes, the notion of nurse-provided spiritual care is embedded deeply within the discipline. This is manifest in several ways. The International Council of Nurses' Code (ICN 2012) states that "In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected."[5] This intention is mirrored in nursing ethics codes in various countries, the goals of which are to preserve the rights of patients and prevent unwelcome care. Consequently, nursing programs must seek ways to teach and model spiritual care within the context of these guidelines.

The inclusion of spiritual care within nursing care is more pragmatically recognized in nursing nomenclature for identifying patient concerns ("diagnosis") and labeling nursing therapeutics. For example, the North American Nursing Diagnosis Association in its international listing of diagnoses—which is widely used by nurses—includes six diagnoses that relate to patient spirituality and religiosity (e.g., *Spiritual Distress* and *Risk for Impaired Religiosity*).[6] Nurses typically understand spiritual care to include "interventions" such as supporting patients' religious beliefs and practices, facilitating values clarification when faith intersects with treatment decision-making, empathic communication about spiritual struggles, and so forth.[7]

The nursing literature is replete with discussions about the significance of supporting patient spiritual well-being. A November 2016 search of the database *Cumulative Index to Nursing and Allied Health Literature* (CINAHL) identified nearly 3,500 citations for publications since 1980 that included "spiritual*" OR "religio*" with "nurs*" in their abstract. (The asterisk allowed for searches to include variants of the search term such as *religion, religiosity,* and *religiousness*.) Some of this literature is pragmatic, describing how nurses can provide spiritual care; other documents explore spiritually related concepts in theoretical ways. Many nurses have included spiritual or religious concepts in research studies using both qualitative and quantitative methods.

Teaching Nurses to Provide Spiritual Care

The nursing program accreditation standards in several nations (e.g., Canada, United Kingdom, Australia, and the United States) include stated expectations that pre-licensure students will learn about assessing and addressing patients' spiritual needs. For example, the 2006 Australian *National Competencies* stated that Registered Nurses (RNs) ought to: "Practice in a way that acknowledges the dignity, culture, values, beliefs and rights of individuals/groups."[8] It also then advised that RNs must learn to "collect data that relates to . . . spiritual . . . variables on an ongoing basis."[9] The 2008 American Association of Schools of Nursing *Essentials of Baccalaureate Education for Professional Nursing*

Practice likewise expected undergraduate nursing education to teach students to: "Conduct comprehensive and focused . . . spiritual . . . assessment of health and illness parameters"; "Provide appropriate patient teaching that reflects . . . spirituality . . ."; "Develop an awareness of patients as well as health care professionals' spiritual beliefs and values and how those beliefs and values impact health care."[10] Given the AACN mandate, the Registered Nurse licensure examination test bank consequently includes questions about spiritual care.

Nurse educators in several countries (e.g., Israel, Korea, Malta, Netherlands, Taiwan, United Kingdom) have documented in published articles how they taught nurses about spiritual care. These reports often are either descriptions of workshops provided to hospital nurses with pre- and post-testing or descriptions of undergraduate courses or curriculum. Typically, content for such training includes a description of spirituality (which distinguishes it from religion), encouragement of personal spiritual self-awareness and well-being, spiritual needs of patients, assessment of patient spirituality, and an overview of spiritual-care therapeutics (e.g., presence, referral and collaboration with spiritual-care experts, empathic communication, respect for religious diversity). Assessment of these educational sessions or courses has often concluded that they increase nurse or student nurse spiritual well-being and improve attitudes toward providing spiritual care.[11] However, although attitudes about spiritual care are often assessed, spiritual care-related skills and/or knowledge are rarely evaluated.

Nursing schools employ a variety of approaches for teaching spiritual care. While some integrate it throughout the curriculum, others (probably most) teach it during selected lectures or assignments (often in the context of health challenges where death is imminent).[12] Diverse and creative teaching and learning strategies include journal writing, evaluating spiritual themes in artwork or patient case studies, shadowing chaplains, lectures (including guest lectures from representatives of faith traditions and chaplains), and various reading and writing assignments.[13] Indeed, several books by and for nurses discuss spiritual caregiving, including three by Adventist author Elizabeth Johnston Taylor (the author of this article).[14] Although recently critiqued as lacking in this area, many core nursing textbooks include chapters about patient spirituality and religiosity.[15]

Diverse and creative teaching and learning strategies include journal writing, evaluating spiritual themes in artwork or patient case studies, shadowing chaplains, lectures (including guest lectures from representatives of faith traditions and chaplains), and various reading and writing assignments.

Even though spiritual-care education may be mandated, and various modalities and educational resources for teaching spiritual care exist, numerous studies document that nurses at the bedside perceive themselves as inadequately trained to provide it.[16] These studies also find that the nurse's personal spirituality or religiosity is correlated with positive attitudes. It appears, however, that there may be a disconnect between positive attitudes and implementation of spiritual care.)[17]

Teaching Spiritual Care in Adventist Nursing Schools

Although a few descriptions of how spiritual care is taught to undergraduate nursing students within a religious school exist,[18] only one publication, to date, presents an Adventist example.[19] In 2014, Taylor and colleagues described how the Loma Linda University School of Nursing (LLUSN) baccalaureate curriculum intentionally seeks to prepare its graduates to provide spiritual care. It does this in several ways, including adopting a conceptual framework that explicitly recognizes a spiritual dimension; integrating pertinent content about spirituality throughout the curriculum (e.g., learning spiritual assessment in the introductory fundamentals of the nursing course, and honing spiritual-care communication skills in a capstone course); using various teaching strategies (e.g., assigning a "blessings" journal, case studies, patient-care plans, self-reflection paper); modeling of spiritual care by clinical faculty while providing direct patient care; biannually holding a four-hour mandatory workshop on spiritual care, and creating a spiritually supportive environment (e.g., prayers offered with and for students, weekly chapel attendance, devotional time at the start of each didactic or clinical class).

What may be unique about the LLUSN program is that it purposefully evaluates graduating students' perceptions of their spiritual-care competence in a brief quantitative survey; it also evaluates how these exiting students perceive their university experience in terms of nurturing their personal wholeness (including spirituality).

To better understand how Adventist nurse educators around the world teach students to provide spiritual care, an e-mailed query was distributed to all program directors by the LLUSN Office of Global Nursing. (Since this was not a systematic in-

vestigation, no ethics committee approval was necessary.) Twenty-one schools responded from four regions of the world (the Americas, Africa, Asia, and North America). The schools represented had student populations that were 20-99 percent Adventist (nine were lower than 50 percent) and (except for four schools) all had faculty who were predominantly Adventist. Responses suggested that Adventist nurse educators assume that spiritual care is taught by nurturing students spiritually or religiously as well as by providing didactic instruction and clinical experiences.

Adventist educators would likely readily agree with positions argued by other nurse educators such as Lewinson, McSherry, and Kevern[20] that nurses cannot be expected to be aware and present, never mind therapeutic, to patients' spiritual needs if they are not to some degree spiritually self-aware and intentional about their own moral development. Thus, Adventist nurse educators provide spiritual nurture through religious and spiritual experiences during school time (e.g., devotional experiences in class, Week of Prayer); faculty modeling (e.g., "I model how to pray with patients by praying with students," or "Sharing experiences of God . . . students can sense that we have been with God for it is seen in our thoughts, actions, and words"); and encouraging religious behaviors outside of school time (e.g., visiting patients as part of a church-related "outreach" activity, engaging in *Voice of Prophecy* [Adventist] Bible lessons). Illustrating all these methods is an activity that one South American nursing school schedules each month. Students are invited to draw the name of a classmate, pray specifically for him or her for a week, and then at a Sabbath meal provided by their professor, share their recent spiritual experiences or prayer requests and offer a gift to the classmate for whom they prayed.

Nearly all program directors also indicated that their programs included lectures on spiritual care (from nursing faculty and/or spiritual-care experts such as chaplains and clergy), assigned readings about spiritual care, case studies, and other course activities that taught spiritual care. Likewise, nearly all respondents acknowledged having a curriculum guided by a conceptual framework specifically recognizing spirituality. Most programs also had clinical assignments that gave students practical experience with spiritual care (e.g., spiritual assessment, developing care plans, praying with patients, listening to spiritual concerns without judging). Many described including spiritual care in community health fairs or projects (e.g., having a spiritual talk after a lifestyle presentation, praying with those seeking health or hygiene services).

Prayer was central to much of the spiritual care taught; students were often taught to offer a prayer after other nursing care was completed or as an "intervention" for those in emotional distress. One school teaches nursing students to instruct patients in meditation and prayer techniques, as well as activities that allow emotional expression. Schools in countries with a strong Roman Catholic influence typically include not only prayer, but also singing ("serenading") a Christian song and reading a Bible verse during visits with the sick.

Observations and Recommendations

These illustrations of how spiritual care is taught in Adventist nursing schools around the globe portray how a Christian's beliefs and behaviors often align, and how Adventist nurse educators live and teach compassionate service. Whereas the article in this issue by Mamier et al. (see page 26) describes what motivates Adventist nurse-provided spiritual care, this article will focus its observations and recommendations on factors that enhance and strengthen spiritual caregiving and teaching. Although the following points could be misinterpreted as admonitions to refrain from sharing God's love, they are actually suggestions about how to more sensitively, respectfully, and ethically live out God's love in practical ways.

Teach Spiritual Care in Context

1. Adventist approaches to teaching nursing students how to provide spiritual care vary with the cultural context in which each school is situated. In schools in Western pluralistic and individualistic cultures, content includes knowledge about many faith traditions and how nurses can respect and support patients of diverse faiths. In contrast, schools in Asia, Africa, and South and Inter-America often equate spiritual care with sharing Christian or Adventist beliefs.

This raises the question of how cultural mores interrelate with ethical imperatives. I recommend that all Adventist schools teach students not to confuse spiritual care with evangelism, and to prepare students to sensitively acknowledge the unique spiritual needs of clients from diverse backgrounds. In any cultural context, wholistic care—indeed, care that reflects the compassion of Christ—should include laying a groundwork through empathetic conversation that opens up shared spaces of trust, respect, and genuine caring. Only then can a readiness be established for genuine spiritual care arising from the patient's initiative. Once the client acknowledges an openness to receive spiritual care, the sincere ministry of the nurse in sharing God's unconditional love and providing hope and comfort is more likely to be accepted and effective.

2. Prayer is frequently an Adventist nursing therapeutic. Adventist nurses who have prayed with patients tell many stories about its efficacy. Adventists, like most Americans, pray colloquially. Although times of physical or emotional extremis are often occasions when patients most appre-

ciate prayer, they are not always conducive to colloquial prayer. As one nursing director reported, perhaps all nursing schools should teach students about the various ways to pray and meditate, and how to tailor prayer experiences to patient circumstances.

Model Ethical Spiritual Care in Practice

3. Although teaching spiritual care undeniably requires supporting student nurses as they mature spiritually, it also raises the question of how to do this ethically. When students enroll in an Adventist school, they implicitly agree to place themselves in an environment where they may be shaped by Adventist religious beliefs and practices. Schools ought to state their expectations in this regard (e.g., about attending weekly chapels, and religious emphasis in classes) for all prospective students.

Faculty pressure on a student (no matter how sweetly applied) to attend a Friday night Bible study or other religious activity unrelated to school expectations, however, is inappropriate. It abuses the faculty-student relationship and suggests a self-serving religiosity. I recommend that faculty be sensitive to the possibility of students feeling coerced to participate in religious extracurricular activities and make such invitations in a way that avoids the potential for creating student discomfort.

4. Nurse educators also must be careful not to coerce students through assignments or obligations that are inconsistent with their beliefs (e.g., grading a student on whether he or she prayed colloquially with 10 preoperative patients during a clinical rotation, if that student does not believe in prayer or prays in a manner that differs from the instructor's expectations).

5. Instruction about spiritual care must include a recognition of its potential for harm when it is coercive or unethical. When nurses provide care, they are in a powerful position of caring for someone who, inherently in the role of being a patient, is vulnerable. Because of this power imbalance, some ethicists have argued that prayer or self-disclosure of religious beliefs should not occur unless a patient initiates a request for it.[21] As Christian theologian and nurse ethicist Marsha Fowler stated, "by refraining from offering faith where it is not welcome, [nurses] affirm the freedom that must exist in faith."[22] Furthermore, the role of nursing is to address health problems; if a patient's spirituality contributes to the problem or if it is a resource for addressing the health problem, then it is within the purview of nursing to provide care that is spiritually sensitive and supportive. The role of the nurse, therefore, is not that of a theologian, evangelist, or pastoral counselor.

Instruction about spiritual care must include a recognition of its potential for harm when it is coercive or unethical. When nurses provide care, they are in a powerful position of caring for someone who, inherently in the role of being a patient, is vulnerable.

I recommend that the goals of Adventist nursing schools include not only helping students to clarify and mature their own spirituality, but also teaching them to support patients' spiritual journeys in a manner that avoids any appearance of coercion.

6. Last, if they are given such ethical instruction, graduates of Adventist nursing programs will be unlikely to face difficulty when practicing in non-religious contexts. I recommend that students be educated not only with theory, but also with evidence upon which to practice spiritual care so that they can explain their spiritual care in "the real world."

Although a thorough discussion of these issues is beyond the scope of this article, it is hoped that this brief discussion will prompt readers to reflect further. An in-depth discussion on the ethics of religious nurses sharing their personal religiosity is found in *Religion: A Clinical Guide for Nurses*.[23]

Conclusion

Teaching nursing students to provide spiritual care is a salient feature of Adventist nursing programs. It may be that this emphasis as well as the religious context of the teaching that make Adventist nursing education unique. The concern arises, however, about whether the spiritual care should be taught as evangelism. For Christian nurses, the answer varies: "No, if evangelism means trying (even subtly) to persuade vulnerable patients to believe the same way as do I. Yes, if it means reflecting the compassion of Christ in the holy work of nursing—being the hands of Jesus."[24] Indeed, Adventist nurse educators will benefit from continued reflection with their students about what it means for health-care workers to take the gospel into all the world. While it must be acknowledged that the distinction between spirituality and conventional religion (and thus between spiritual care and religious nurture) varies from culture to culture, there are certain universally recognized ethical considerations that will apply anywhere.

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This article has been peer reviewed.

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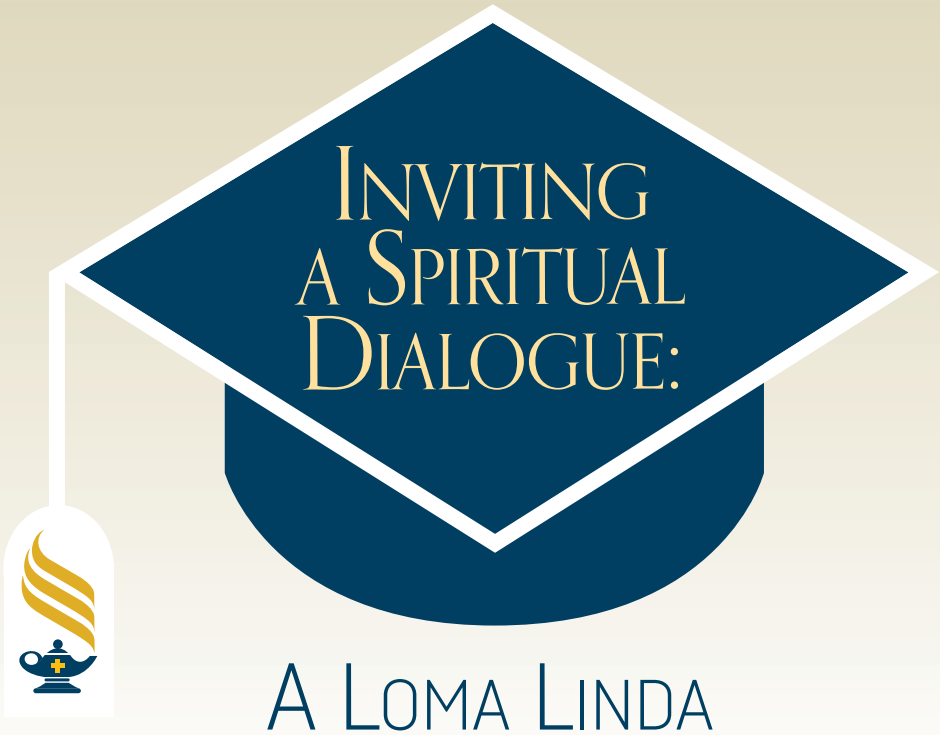

Inviting a Spiritual Dialogue: A Loma Linda University Perspective

Two experiences contributed to this article. One was a colleague's loss of her elderly mother just before the close of the academic school year. During her mother's preceding hospitalization in an Adventist medical center, our colleague found herself torn between attending to the demands of work and her mother's needs. Although she faithfully checked on her mother several times a day, she was shocked when her mother died unexpectedly. During the hospitalization, her mother's medical needs had taken precedence, and she had not had a chance to explore her spiritual needs. When she heard that two of her nursing students had prayed with her mother just prior to her passing, she found solace in knowing her mom had been supported as she passed.

The second experience came from a qualitative research study conducted a few years ago at Loma Linda University (California).[1] The first author surveyed registered nurses working in acute tertiary care about a significant encounter they had experienced with spirituality while at work. Although most respondents reported positive encounters in offering spiritual care, one staff nurse expressed doubts about the educational preparation she had received at an Adventist university to equip her for the role of spiritual-care provider. She shared that she had been taught to offer prayer (and a backrub) during her evening rounds. This had not created any difficulties until she started working outside of a faith-based hospital. One day, she found herself in the uncomfortable situation of being reprimanded by her supervisor because a patient had complained.

These two situations warrant reflection. One interaction was received as a precious gift and gratefully remembered; whereas the other, at minimum, ended in a patient's irritation and a nurse's discouragement. Clearly, nursing students need to be equipped with tools to navigate patients' spiritual needs in multi-faith societies. As educators, we have a responsibility to prepare them to recognize spiritual cues and teach them how to invite a spiritual conversation in diverse patient-care contexts. Our students need to be sensitized to potential pitfalls and taught how to connect with people of all walks of life in a way that ensures that each patient always feels respected and honored. Therefore, teaching students about spiritual care deserves thoughtful preparation on the part of the nurse educator.

Adventist health care embraces a wholistic approach to care, one that is inclusive of patients' spirituality. Given its longstanding legacy, it is easy to assume that professionals in this field who have been educated in and work for Adventist institutions are therefore trained in spiritual care. Yet there is scant literature—aside from Ellen White's writings to medical professionals—that clearly explains an Adventist perspective on spiritual care and how it should be taught. If indeed spiritual care is core to Adventist health care, then a

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more overt discussion of these questions seems warranted.

The purpose of this article is to provide Adventist nurses and nurse educators with a practical guide for inviting a spiritual conversation. In what follows, we review two significant encounters from the Gospels and draw on advice given by Ellen White in her book, *The Ministry of Healing*, to set the stage. Reflecting on our own experiences and the insights of those who have mentored us, we situate these recommendations in the context of collaborative interdisciplinary practice at Loma Linda University Health and suggest that the combination of experience, research, and guidance from inspired sources provides a unique perspective on how to teach nurses to offer wholistic care. We hope to stimulate more thought and reflection in practice and academic settings.

Biblical Encounters of Wholistic Healing

Jesus' life and ministry exemplified how spiritual care is integral to caring for the sick. His actions in healing two paralytic men reflected a true "whole-person-care" approach that connected physical, mental, and spiritual well-being.

Healing at Bethesda

John 5 reports on the restoration of a paralyzed man. Bethesda, meaning "House of Mercy," was a site of concentrated misery in Jerusalem where crowds of sick, blind, lame, and paralyzed individuals awaited care and sought healing. Jesus deliberately visited this "hospital" one Sabbath, unaccompanied by His disciples.[2] He was drawn to a man who had been paralyzed for a very long time. After nearly four decades of suffering, feeling lonely, friendless, and discouraged, he had almost lost all hope. To get the man's attention, Jesus stooped down, looked into his eyes, and asked a question that may have seemed obvious but that invited the man to share his story: "'Do you want to be made well?'"[3]

The man's response informs us about the lament of his soul. "'Sir, I have no one to put me into the pool when the water is stirred up; and while I am making my way, someone else steps down ahead of me.'"[4] His expectation for healing was focused on a magical cure supposedly resulting from getting into the pool at the right time. He had no idea to whom he was speaking. Jesus then summoned him to do the impossible: "'Stand up, take your mat and walk!'"[5] Empowered by these words, the man complied and was healed. He then quickly left the place and headed straight to the temple—still carrying his mat—intending to praise God for his recovery.

But no sooner had the jubilant man arrived at the temple

than the Jewish leaders confronted him for breaking the Sabbath. According to them, he had sinned again; how distressing this must have been to the recipient of Jesus' miracle. But just then, Jesus initiated a second encounter at the temple: Healing, part two!

Addressing the real issues, Jesus shared with the man how he could stay well: "'See, you have been made well! Do not sin anymore so that nothing worse happens to you.'"[6] Having experienced physical restoration, the man had reason to trust that Jesus had his best interest in mind and that His advice mattered.

The question: "What keeps you from getting trapped and helpless again?" remains relevant for us today. The man needed an external power sufficiently strong and reliable to keep him from sin—a power that we as Christians believe comes only from a relationship with God. The success of spiritually based programs, such as Alcoholics Anonymous and similar programs directed at other addictions, testify to this reality. They have been successful because they connect patients to a "higher power" and reestablish spiritual values.[7]

As soon as the religious leaders found out who the healer was, they confronted Jesus sternly about His healing on the Sabbath. Jesus calmly responded: "'My Father is still working, and I also am working.'"[8] Here Jesus explained the larger perspective of spiritual caregiving: Ever since humans chose to distrust their Creator, God has been working tirelessly—and especially on the Sabbath day[9]—to restore a trusting relationship. "The Father's ongoing redemptive involvement on this earth is then the basis for Jesus joining the Father in His work."[10]

Because Jesus operated on the basis of following the Father, we too should focus on the signs of God's work in a patient's life. Spiritual cues may surface as expressions of worthlessness, shame, guilt, fractured relationships, hopelessness, etc., pointing to a spiritual need for forgiveness, acceptance, hope, or reconciliation. These will often not be evident unless the health-care provider first meets the physical needs in an empathetic and competent manner. Once these have been addressed and trust has been established, patients may reveal deeper concerns about their lives and their illness. The expressed lament of the soul then provides direction for spiritual caregiving and/or referral to specialists (e.g., pastoral care).

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Healing at Capernaum

The second story, recorded in three of the four Gospels, is about the paralytic at Capernaum (Matthew 9:1-8; Mark 2:1-12; and Luke 5:17-26). This paralyzed man was so helpless that he depended on his friends' determination and strength to bring him to Jesus. When they realized it was impossible to navigate the crowd, they removed parts of the roof of the house in which Jesus was preaching and lowered him into the Master's presence. The man's misery was likely compounded by carrying the stigma of being a sinner abandoned by God,[11] adding mental anguish and spiritual hopelessness to an already devastating physical condition. Therefore, Jesus' first words to him were received as a healing balm: "'Take heart, son; your sins are forgiven.'"[12]

We can take inspiration from this case. For example, when we ask patients how an illness has influenced the way they view themselves or God, it is not unusual for them to express remorse, guilt, or shame. Some attribute their illness to God as punishment for past misdeeds. Such an understanding of God makes it very difficult for suffering people to imagine that God will regard them with love rather than contempt and rejection. Guilt and shame therefore prevent them from accessing the most valuable resource they might otherwise access: refuge in the loving presence of a forgiving God who knows them personally and welcomes them into a trusting relationship with Him. For the paralytic man, Jesus' assurance of forgiveness told him that God had not rejected him and instead loved him infinitely.

With a renewed identity as a beloved child of God and his sense of self-worth restored, the man began to experience emotional and spiritual healing. Therefore, when Jesus spoke the powerful words "'Get up, pick up your bed, and go home,'"[13] the man was made whole spiritually, physically, and mentally. What was deemed a blasphemous act by the religious authorities actually revealed Jesus' divine power and authority as the Son of Man, evidenced by the man's restored physical health.

Application to Modern Health Care

In both of these accounts, Jesus is portrayed as a spiritual caregiver. Whether or not these men were aware of their spiritual needs before their healing, or focused mainly on their felt needs for physical healing and hope, Jesus viewed them wholistically, connected with them authentically, and worked to restore them—not only physically, but also spiritually and mentally.

As Adventist health-care providers, we are reminded that the Holy Spirit works in people's lives before, during, and after the patient encounter. Our experience and perception of a patient and his or her situation is limited. By contrast, God knows each patient's life story and current need. As nurses

become aware of patients' spiritual needs and respond to them, they, in essence, are stepping on "holy ground."[14] When following Jesus' model, nurses look for evidence of God working in the life of a patient. Freed of any agenda and guided by the Holy Spirit, they listen for the lament of the soul, empathizing and validating underlying needs. Nurses cannot force this process, nor should they be made to feel that their primary duty is the spiritual restoration and salvation of the patient. Instead, nurses can ensure that they are personally attuned to the Holy Spirit by surrendering to God and submitting to His guidance. The foundation of spiritual caregiving, therefore, lies in connecting with God through prayer and the study of His Word to detect the felt and at times disguised needs of patients. This was Jesus' method, and it can be ours.

The Savior's example in healing the paralytic men also demonstrates that spiritual care is not about debating doctrine, but about revealing the love of the Father. Ellen White put it this way: "At the bedside of the sick no word of creed or controversy should be spoken. Let the sufferer be pointed to the One who is willing to save all that come to Him in faith. Earnestly, tenderly strive to help the soul that is hovering between life and death."[15] The wisdom needed for this approach to spiritual caregiving is promised to all who ask. "The Savior is willing to help all who call upon Him for wisdom and clearness of thought. And who needs wisdom and clearness of thought more than does the physician [or nurse] upon whose decisions so much depends? Let the one who is trying to prolong life look in faith to Christ to direct his or her every movement. The Savior will give the necessary tact and skill in dealing with difficult cases."[16]

How Do We Teach It?

Adventist nurse educators take pride in training competent and qualified health-care professionals. We leave little to chance. Curricula are designed to address all aspects of physical and mental health. As educators, we are intentional about what we teach in the classroom; in practice environments, we test and evaluate students' knowledge and skills, and carefully monitor program outcomes. We also invest much effort in nurturing students' spirituality because we believe that their spiritual life and personal relationship with God will shape all aspects of their future, including their professional practice.

Therefore, students at Adventist colleges and universities generally take a minimum of one religion course for every year of their professional education. We believe that as a graduate's spiritual awareness and faith experience grow, he or she will be more sensitive to the spiritual needs of others. We must ask, however, "Is this enough for students to be equipped to provide whole-person care? Will they have the skills needed to invite a conversation about patients' spiritual needs? What frameworks, tools, and principles can we provide that nurses can use to guide their practice?" Spiritual care is an art, and just as with development of other nursing skills and competencies, proficiency is gained as the practitioner grows from novice to expert.[17]

Approaches Explored at Loma Linda University

Scholars at Loma Linda University have wrestled with these questions. Drs. Harvey Elder and Wil Alexander[18] have specifically asked how we might transform an art—led by the Holy Spirit—into practical and applied principles that students can develop into skills, confidence, and expertise. Their approach has pioneered whole-person care at Loma Linda University Health and mentored countless health-care providers over the past decades through workshops and patient rounds.

- *Spiritual Care in the Context of Whole-person Care*. Rather than reducing the patient to a disease process, a whole-person care approach tries to understand patients as individuals with their own stories, and in their complex physical, emotional, relational, and spiritual dimensions. The spiritual core is seen as the integrating dimension of all other dimensions of personhood. Drawing on more than four decades of caring for patients with HIV/AIDS, Dr. Elder has reflected extensively on practical and biblically based approaches to teaching spiritual-care techniques to Christian health professionals.[19] He recommends that educators model and encourage students to commit to following a series of steps in their practice. These include (1) asking the Holy Spirit for passion, love, and genuine care for one's patients; (2) remaining committed to listening to and hearing what one's patients and the Holy Spirit say; and (3) inviting patients to tell their stories, while staying attuned to hearing the "anguish of their cry" or the pain associated with their experiences. After a patient has shared his or her story, he advises health-care providers to ask questions that invite a spiritual dialogue. In the following paragraphs, we share a practical approach to soliciting and listening for spiritual themes that has been used at Loma Linda University Health.

- *Applied Training in Spiritual-care Practice*. During the past 10 years, Drs. Harvey Elder and Carla Gober-Park, at the Center for Spiritual Life and Wholeness at Loma Linda University (http://www.religion.llu.edu/wholeness), have conducted multiple spiritual-care workshops for health-care professionals. These typically involve a practicum in the patient-care units of the Loma Linda University medical facilities. The goal of the activity is to invite a spiritual conversation with patients who are willing to talk to a group of two to three health professionals.

The unit charge nurse provides direction regarding which patients to approach—and not to approach. Upon entering a patient's room, the group introduces themselves as health-care professionals who are not part of the patient's treatment team but who are attending a conference. The practicum leader informs the patient that the group wants to learn to really listen to the patient's concerns, and asks if he or she is willing to talk with them. If the patient declines, the group wishes him or her well and leaves. If the patient agrees to talk with the group, the leader asks if they may sit while they speak with him or her. (The rationale is to avoid a posture of looking down at the patient during the conversation.) The practicum leader proceeds by saying: "If at any point you are

uncomfortable and do not want to continue talking to us, just say 'I'm tired!' and we will leave." These simple and practical steps are important in establishing consent and giving the patient control over the interaction.

During the workshop, the participants receive a sequence of questions to guide the conversation (see Box 1). The opening question: "How long have you had this illness/injury?" focuses the conversation on the individual's experience with the illness/injury rather than the details of his or her diagnosis and its implications. It allows patients to reveal as much or as little as desired about their medical history and take the conversation in the direction they choose. They can refocus the question to their preferred timeframe. For example, during one conversation, a middle-aged woman told us how she had suffered a stroke while honeymooning on a houseboat in a neighboring state. She then expressed her sense of gratitude for her husband, who ensured that she received the medical help she needed, and supported her through the ordeal.

Box 1. Questions to Guide a Spiritually Focused Conversation.

1. How long have you had [or been living with] this illness/injury?

2. What about your illness/injury concerns you most?

3. What is your source of strength?

4. How has this experience changed the way you see yourself?

5. How has this experience affected how you see God/Higher Power/life?

The second question, "What about your illness/injury concerns you most?" seeks to explore and understand the patient's primary lament, or the "chief complaint." It is easy for nurses, like other health-care professionals, to assume that they understand patients' primary concerns. Yet asking this question has repeatedly revealed that these concerns are not necessarily related to the diagnosis or treatment plan. We have discovered that a nurse can go through an entire shift while remaining unaware of the patient's primary source of distress. For example, in one conversation, when we asked this question of a muscular young man who was sitting up in his bed, his response was, "Will God forgive me?" Unbeknownst to the small group, he had been involved in a shooting altercation and had lost his lower leg. Rather than focusing on his immediate physical suffering or loss, his unspoken distress stemmed from feelings of guilt and condemnation. Strikingly, when invited to share, he instantly conveyed his spiritual lament.

This model of inquiry then asks about patients' source(s) of strength and/or support: "What helps you get through hard times?" At this point, patients often refer to their support system: family, friends, or colleagues. Some mention their church, a club to which they belong, or a particular person. God may or may not be in the picture.

A follow-up question can probe further: "Do you have a religious heritage or a faith community that is relevant to you?" Followed by, "Is that a source of support to you right now?"

While the first author (Iris Mamier) shadowed Dr. Elder in an HIV/AIDS clinic as he saw a man with Kaposi sarcoma, it became apparent that the patient was not taking his antiretroviral medications. During their interaction, Dr. Elder asked about his religious heritage. The patient explained that he had grown up in a Protestant denomination but figured that God didn't like him because of lifestyle choices he had made. This encounter illustrated how underlying spiritual beliefs (e.g., guilt, feelings of worthlessness, a punitive picture of God) can have a significant impact on patient health-care decision-making (e.g., medication adherence). In this case, the spiritual dimension was key to understanding why this patient had stopped caring for himself, and addressing his spirituality was vital for effective treatment to occur.

Likewise, when patients identify as atheist or agnostic, there is typically a story in the background, often one of disappointment with a particular religious person or faith group that explains why they have given up on God altogether. Patients may find it therapeutic to be given the opportunity to share this without being judged. Similarly, patients who are believers may appreciate sharing how their faith helps them cope with life's challenges, giving the health-care provider a chance to affirm their faith.

The fourth question asks: "How has this experience changed the way you see yourself?"

This question allows patients to reflect on how the illness experience has affected them personally. Facing their own vulnerability, they may share: "I've always felt like I am strong and independent. It's scary to be so weak and helpless all of a sudden!" Or: "After this fall, I am afraid I am becoming a burden to my family!" Both of these responses reveal that the patient's sense of self-worth has been shaken, reflecting the paradigm: "I'm worthwhile only when I'm strong, when I'm a productive member of the family or community." It is not uncommon for illness experiences to generate questions about one's life course, purpose, and sources of meaning. Allowing oneself to be vulnerable and to receive gracious nursing and medical care can lead to renewed perspectives on life and what really matters, which patients may wish to share.

Finally, depending on whether or not the individual has acknowledged a belief in God, we may follow up by asking: "How has this experience affected the way you see God or whatever ultimate meaning you hold in life?" This question openly probes the patient's conception or picture of God and the existential questions in his or her life. These beliefs have the potential to greatly shape the illness experience. In a study aimed at exploring religious coping, Kenneth Pargament[20] surveyed 310 Christian church members six weeks after the Oklahoma bombing tragedy. Using factor analysis, he categorized underlying religious beliefs as "helpful" ver-

sus "harmful" religious coping. While helpful coping drew on spiritual support and benevolent religious reframing, harmful religious coping was characterized by religious pain and turmoil, discontent with God, the church, and reframing of negative life events as punishment from God. Pargament found that those who primarily engaged in helpful religious coping held benevolent beliefs about God and grew spiritually and psychologically in the aftermath of this trying life situation, while negative religious coping was associated with more callousness toward others.

For patients who welcome such a discussion, these five questions can generate substantive and meaningful conversations that validate their experiences. The sequence is not designed as a rigid structure but rather as prompts to steer the conversation in a meaningful direction. Based on our experience, patients and/or family members appreciate being able to have the undivided attention of health-care providers. This in itself can be experienced as a gift and as therapeutic.

When patients thank us for taking the time to talk to them, we know that the conversation has meant something to them. However, generally the blessing goes both ways. For this reason, the practicum leader always thanks the patient and/or family member for sharing with the group. If deemed appropriate, the leader may also ask: "Would it be helpful to you if we prayed with you before we leave?" Not only do we believe that it is imperative that patients be asked to consent before we pray with them, we also recommend wording the offer in such a way that the patient knows that prayer is not driven by the health-care providers' needs. The suggested wording keeps the focus on the patient and what would be supportive for him or her. The alternative, "Can I pray for you?" risks placing the patient in a situation where he or she worries about disappointing or hurting the feelings of a well-intended health professional. Our recommended phrasing allows the patient to say, "No thank you, I don't think that would be helpful for me." Recognizing that prayer is an intimate, personal, as well as communal practice, we also recommend a working knowledge of world religions and diverse faith-traditions[21] to be more attuned to patients' perspectives. If requested or welcomed by the patient, a short prayer such as the following may be helpful:

Dear God, thank you for the privilege of talking with [Mrs. Smith]. She is your beloved daughter—thank you for being with her through these trying times. We are grateful that she is recovering from her surgery and that her son has been so supportive through this experience [mention things that the patient named as being important]. Please be with her as she goes to rehab tomorrow [include specific concerns or requests that the patient mentioned]. Bless her, Lord, and continue to grant her healing and Your peace. In Your name we pray. Amen.

The debriefing process allows students and participants to identify emerging spiritual themes. These sessions also provide an opportunity to affirm participants' individual strengths, provide feedback, and suggest alternative approaches. Finally, they provide a framework from which to evaluate one's own effectiveness.

Once the group has left the patient's room, the practicum leader should take them to a quiet corner or small conference room to debrief the experience. This is an essential part of the practicum, as much of the learning often occurs after the patient encounter. The practicum leader and the group reflect on what they heard and observed, and discuss cues they followed or missed. Suggested questions that can be directed to the group include the following: How does the person who asked the questions feel? What spiritual needs did the patient identify? Should there be a referral/follow-up? The debriefing process allows students and participants to identify emerging spiritual themes. These sessions also provide an opportunity to affirm participants' individual strengths, provide feedback, and suggest alternative approaches. Finally, they provide a framework from which to evaluate one's own effectiveness.

Final Thoughts

The two stories at the onset of this article illustrate that meeting *patients'* spiritual needs is what ought to drive any spiritual care. While in the first case, spiritual support allowed the patient to pass peacefully, and this knowledge comforted the bereaved daughter, the second scenario raised concerns because prayer was offered without prior assessment and regard for context. We suggest that the context in which prayer or any other spiritual care is offered matters: Has the nurse connected genuinely with the patient? Assessed and explored the patient's wholistic needs? And, fundamentally, does the spiritual intervention meet the actual expressed needs of the patient? The suggested questions inviting a spiritual conversation can provide helpful guidance. The art of listening for spiritual cues can be taught best in the clinical environment in small-group patient encounters followed by debriefings or post-conferences.

In conclusion, when modeling spiritual caregiving and teaching students how to become spiritual caregivers, instructors would do well to communicate the deep joy and sense of calling that comes from intentionally engaging in this sacred work. As we become increasingly attuned to the unique opportunity and privilege nurses have to "step on holy ground," we are reminded that the most powerful posture and truth from which we can approach our patients is to view them as beloved children of God. This love is transformative: "The love Christ diffuses through the whole being is a life-giving power. Every vital part—the brain, the heart,

and the nerves—it touches with healing. By it the highest energies of the being are roused to activity. It frees the soul from the guilt and sorrow, the anxiety and care that crush the life forces. With it come serenity and composure. In the soul it implants joy that nothing earthly can destroy—joy in the Holy Spirit—health-giving, life-giving joy."[22] This is the optimal outcome of spiritual caregiving; that through our interactions with patients, they experience this life-giving love, and recognize the Great Healer at work in their lives.

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This article has been peer reviewed.

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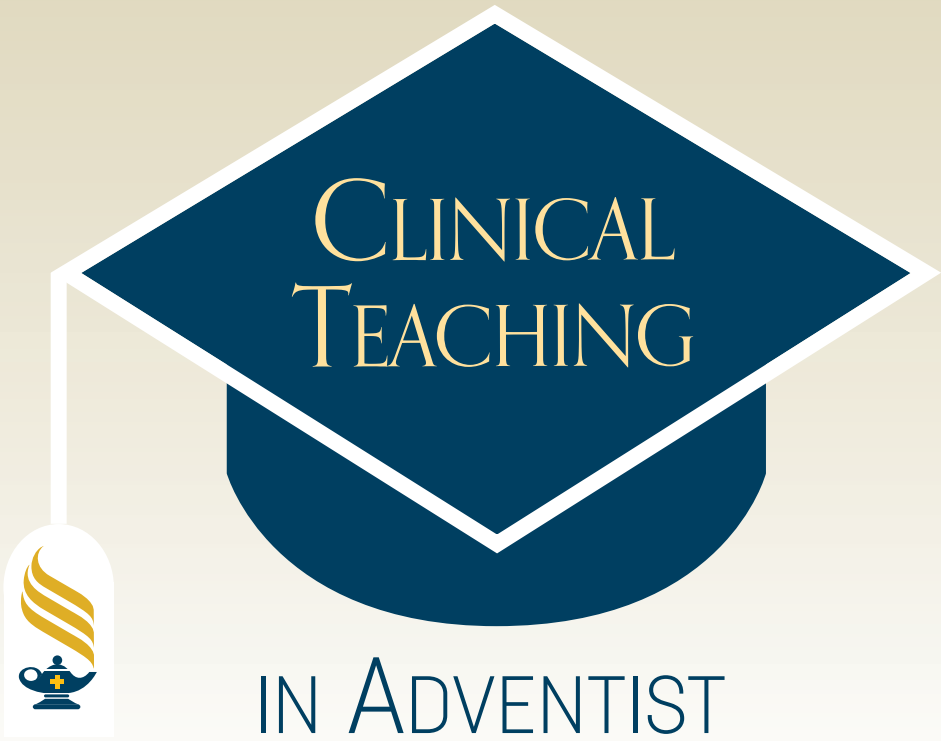

Clinical Teaching in Adventist Nursing

Clinical teaching is as important to nursing education as classroom teaching. Interpersonal and inter-relational teaching-learning activities in clinical settings create opportunities to develop the clinical knowledge and clinical reasoning competencies of students. It is in the clinical setting that student nurses practice their practical skills and develop clinical reasoning by caring for multiple patients with complex needs. Clinical instructors must be carefully chosen and strategically positioned to supervise practice and to prepare students for efficient, effective, and safe practice as they perform and acquire new clinical skills.

Aggregate data from a 1995-2004 competency assessment using the Performance Based Development System involving 31,401 nurses from 180 health-care agencies in the United States revealed that newly graduated Registered Nurses, regardless of educational preparation, have adequate psychomotor skills and good knowledge content but lack the ability to use clinical reasoning to deliver effective and safe care.[1] Benner, Sutphen, Leonard, and Day[2] noted that in acute health-care situations, nurses are increasingly challenged to make quick decisions based on sound reasoning.

Regardless of where they work, nurses need to become more responsible, autonomous, and accountable for patient care. Shorter hospital stays, advances in technology, and increasing complexity and severity of patients' clinical conditions require nurses to think clearly, exercise good judgment, and initiate action to resolve problems. Clinical reasoning, which focuses on the nurse's use of thinking strategies, is the precursor to decision-making and informed action. Decision-making under conditions of risk, uncertainty, and complexity have become standard professional practice.[3] Therefore, the role of clinical instructors and preceptors (hospital staff nurses) in helping students develop and apply clinical reasoning along with clinical skills is very important.

Clinical instructors should mentor students to quickly recognize the nature of the whole clinical situation and prioritize the most-pressing and least-pressing concerns.[4] Progressive development of clinical reasoning skills is critical to this ability in order to avoid adverse events or failure to save a patient's life.[5] Clinical reasoning can strengthen nursing practice by improving decision-making, reducing risks, promoting safety (including

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fewer medication errors), and improving patient outcomes, all of which can result from good clinical teaching.[6]

Nurse educators have many questions related to clinical teaching. Drs. Susy Jael from Adventist University of the Philippines (AUP) and Lucille Krull from Walla Walla University (WWU) in the United States sat down with Dr. Patricia Jones of Loma Linda University to compare and contrast key points related to clinical teaching in nursing education from two diverse parts of the world.

Question 1: How much clinical time is required for the bachelor's degree in nursing, and how is it computed?

Dr. Jael: At AUP, the required clinical units in each professional course are mandated by the Philippine Commission on Higher Education (CHED).[7] The current Bachelor of Science in Nursing curriculum requires a total of 46 Related Learning Experience (RLE) units. RLE is composed of nursing-skills laboratory hours and clinical practicum. Nursing-skills laboratory requires 12.5 units (637.5 hours) and 33.5 clinical units (1,708.5 hours), a total of 2,346 hours for the whole program. One clinical unit is equivalent to three clock hours a week or 51 clock hours over an 18-week semester, which does not include exam week.

Dr. Krull: In the United States, a precise number of clinical hours is not always explicitly mandated by our accrediting agency, but minimums may be set by individual state boards of nursing. Each school is free to design its own curriculum and number of required clinical hours based on its mission, setting, and desired outcomes. At this time, WWU requires a total of 900 hours of clinical experience for a bachelor's degree in nursing, although the State of Washington mandates a minimum of 600 clinical hours for the same degree. WWU exceeds the minimum because it offers several clinical courses not typically found in other programs, including a course in critical care and another in chronic illness.

In the United States, the qualifications of clinical instructors are often mandated by state boards of nursing and national nursing-accreditation agencies. The typical expectation is that clinical instructors be an RN with a degree higher than the students being taught.

North American colleges and universities structure their academic year in either quarters or semesters. Walla Walla University uses the quarter system, which is usually 10 weeks plus an exam week. Therefore, one credit of clinical lab is equal to three hours each week, for a total of 30 clock hours per term. Other universities use a 15- or 16-week semester; therefore, one unit of credit for clinical practice is equal to three hours per week for a total of 45 clinical-experience hours.

Question 2: Who should facilitate the clinical instruction? What qualifications are necessary? Do all clinical instructors need to be Seventh-day Adventist employees?

Dr. Jael: At AUP, a clinical instructor is a full-time faculty member who teaches professional courses and takes responsibility for both classroom and clinical instruction. He or she is required to have academic and clinical preparation specific to his or her clinical assignment. Based on CHED requirements for BSN programs in the Philippines, faculty members teaching professional courses must be a Registered Nurse (RN) and have a Master's degree in nursing, with at least one year of clinical experience.

All employees, including the clinical instructors, must be Seventh-day Adventists so that they will be able to integrate and model an Adventist caring and healing philosophy. It is important that clinical instructors have a full-time appointment to ensure quality and consistent clinical supervision of students. Hence, at AUP, clinical instructors are full-time, regular denominational employees with benefits. Benefits add value to service rendered and usually contribute to retention of faculty.

Dr. Krull: In the United States, the qualifications of clinical instructors are often mandated by state boards of nursing and national nursing-accreditation agencies. The typical expectation is that clinical instructors be an RN with a degree higher than the students being taught. For example, in Associate in Science Nursing programs, clinical instructors must have a bachelor's degree in nursing; whereas in bachelor's degree programs, the clinical instructor must have a Master's degree in nursing. Depending on the state in which the program is located, the clinical instructor must also have two to three years of full-time experience in the specific clinical area where he or she will be teaching.

At WWU, clinical instruction is done by both full-time and part-time faculty. Each clinical course is taught and coordinated by a full-time lead instructor who has several part-time instructors assisting with clinical instruction. All full-time faculty must be members of the Seventh-day Adventist Church, but this is not always possible for part-time clinical instructors. While Seventh-day Adventist clinical instructors are strongly preferred, a sufficient number cannot always be found. The few non-Adventist part-time clinical instructors are carefully selected and are often alumni or an

employee at the agency where the clinical experience is being taught. These non-Adventist instructors must subscribe to a Judeo-Christian belief system and be well oriented to Adventist philosophy and practices. Many part-time clinical instructors are also employed full-time as staff nurses in another health-care agency that provides employment benefits.

Question 3: How do you verify that clinical instructors are spending the required time in direct supervision of students?

Dr. Jael: A clinical-instruction plan for every professional course is in place. It includes the objectives and activities, tasks and responsibilities for both the clinical instructor and students in their assigned clinical area. This serves as a guide to the clinical instructors. The nursing administration of the school has a monitoring device to ensure that clinical instructors are directly supervising the students in their clinical activities. This includes clocking in and out by both clinical instructors and students. Moreover, the charge nurse of the hospital or clinical facility is expected to evaluate the performance of the clinical instructor at the end of the clinical rotation and submit a report to the school of nursing administration.

Dr. Krull: At WWU, there is no monitoring procedure for clocking in or out for clinical instructors. Each clinical instructor reports directly to the lead full-time nursing faculty member and develops a trust relationship with that instructor. Most full-time faculty members meet weekly with the clinical instructors in person, by phone, or electronically to discuss student performance.

Question 4: How do you ensure consistency in clinical supervision by different clinical instructors in the same course?

Dr. Jael: The clinical instruction plan and the course syllabus describe the clinical activities for each professional course, serve as a guide to the clinical instructor, and, to the extent possible, ensure consistency in clinical supervision among clinical instructors.

During faculty meetings, all concerns and policies are discussed and accepted. Each faculty member is aware of what is expected, and works in an environment of trust and honesty. However, an unannounced spot check or area visit by the clinical coordinator, department chair (or dean) happens occasionally.

Dr. Krull: Each lead instructor is responsible for orienting, monitoring, and evaluating his or her clinical instructors. He or she is responsible for building a team and ensuring that grading and other evaluations are done consistently by all clinical instructors for that course.

Question 5: Is there a structured orientation program for new clinical instructors? If so, what is included?

Dr. Jael: Yes. A structured orientation program is done at the start of every semester. When the new assignments are announced, a shadowing period of at least two weeks (or however long the hospital requires) is arranged for immersion to the agency's protocols and policies.

The clinical instructor should undergo orientation to the course and to the clinical practicum site before being allowed to supervise students. The dean or the department chair should orient the clinical instructor to the policies, standards, guidelines, activities, and expectations of the course in the clinical area. The nursing-administration office of the clinical agency should conduct a clinical orientation to ensure safe, effective, and quality practice by both the clinical instructors and the students. This should include an orientation regarding the policies of the hospital/agency, the hospital administration, the key personnel and staff of the specific clinical area, the clinical forms to be used by the students, routine procedures and activities in the specific clinical area, its facilities and equipment, and an orientation to the physical setting. The clinical instructor should also undergo clinical duty for at least two weeks to have a feel for the specific clinical area.

Dr. Krull: Orientation of clinical instructors is done individually, and typically includes three areas: orientation to the university and school of nursing, orientation to the course, and orientation to the clinical agency where instruction will occur. Orientation to the university is conducted by the school of nursing dean, and includes information about Seventh-day Adventist beliefs and practices if the clinical instructor is not an Adventist or an alumnus. Policy manuals are shared, and key policies regarding payroll, expectations, and evaluation are reviewed. Orientation to the course is conducted by the lead instructor for that course. This includes orientation to the syllabus, course, and clinical expectations; as well as evaluation forms and clinical assignments to be graded. If a newly hired clinical instructor is already an employee at the agency where the lab will be taught, immersion at the agency is not necessary. If not, he or she may be requested to shadow an agency employee or the lead instructor before the class begins.

Question 6: What is the role of the clinical instructor in integrating theory into clinical practice?

Dr. Jael and Dr. Krull: Clinical practicum should be offered simultaneously or immediately following completion of theory. The clinical instructor must ensure that clinical activities are congruent with the objectives of the course and implement the clinical activities as outlined in the syllabus. Ideally, the faculty member teaching the didactic part should supervise students in their clinical practicum. However, in the case of team teaching, the clinical instructor coordinates and collaborates with the lecturer of the course.

For supervision in the clinical area, what has been taught in lecture should be enhanced or reinforced as it is applied in the clinical setting. Ideally, the theory instructor also does the clinical instruction; but if that is not possible,

another member of the team-teaching group does it and sees that the principles are put into practice. An important aspect to remember is that clinical experience related to the theoretical content of the course needs to be offered during the same academic term in order for it to be recognized and accepted internationally.

Question 7: How should performance in clinical practice influence the course grade?

Dr. Jael: Credit for the completion of the course is based on the fulfillment of the curricular requirements in both theory and clinical practicum. The grade for the professional course is based on the course credit (theory units and clinical units). A student will not be permitted to enroll in the next professional course unless he or she has a passing grade in the prerequisite professional course.

Dr. Krull: Theory performance is points-based and graded with a letter grade of A-F based on percentage of points earned on tests, quizzes, and assignments. Clinical instruction is competency-based and is graded as pass/fail. Absolute minimum clinical performance is identified, and students must demonstrate that they can safely care for patients according to these standards. Standards increase in expectations as the student progresses through the program. It is possible for a student who is performing well in theory to fail in the clinical portion of the course and vice versa.

Question 8: What happens when a student fails in clinical practicum?

Dr. Jael: When a student fails in the clinical practicum, he or she is advised to obtain additional supervised practice and given a repeat performance of the skill/checklist. If still unable to pass, the student is required to repeat the whole course—both theory and practice. A student is allowed to repeat the whole course one time. Mastery of the knowledge and skill(s) on one level prepares him or her for more complicated clinical tasks on the next level.

The grade for the professional course is based on the course credit (theory units and clinical units). A student will not be permitted to enroll in the next professional course unless he or she has a passing grade in the prerequisite professional course.

Dr. Krull: If a student fails in the clinical practicum, he or she fails the whole course and must repeat both theory and clinical portions at a passing level to progress in the program. Only one nursing course can be failed for the student to remain in the program. If a student fails a second course, he or she is no longer eligible to be a nursing major.

Question 9: What policies should be in place to promote safe clinical practice by nursing students?

Dr. Jael: The Related Learning Experience (RLE) is composed of skills laboratory hours followed by practice in the clinical area. Before going to the clinical area, students are required to practice and perform the specific clinical skills in the skills laboratory that they will be assigned in the clinical area the following week.

A clinical pre-conference should be conducted by the clinical instructor before exposing the student to the specific clinical area to ensure that the student is ready to safely perform nursing skills on actual clients.

Dr. Krull: There should be specific policies about safe practice specifically oriented to the area of medication administration; also, certain skills should not be allowed for lower-level students. For example: Beginning students cannot administer any medications without direct supervision. More-advanced students may administer some oral medications once their medications are checked by their instructor or the RN assigned to the patient. No student can ever administer chemotherapy or conscious sedation.

Question 10: What is the difference between clinical instructors and preceptors?

Dr. Jael and Dr. Krull: Clinical instructors are faculty members employed by the nursing school assigned to supervise, guide, and implement structured clinical-learning practicum to a group of students. Clinical instructors allow students to apply knowledge gained in the didactic portion of a professional course to clinical practice.

Clinical preceptors are hospital-employed practicing nurses who mentor the clinical learning experience of a specific nursing student. Most of the time, it is a one-to-one guided clinical practice.

Question 11: What requirements of clinical instructors can be described as applicable worldwide?

Dr. Jael and Dr. Krull: Around the world, the role of clinical instructors is to supervise students in the clinical area during their clinical practicum. They are expected to perform pre- and post-conferences, orient students to the clinical area, ensure that clinical activities are congruent with the objectives of the course; assist students in the performance of nursing care, medication administration, nursing procedures, carrying out doctors' orders, writing nursing care plans and nurse's notes; and evaluate student performance.

The clinical instructor and the

nursing-service personnel of the hospital/affiliating agencies should collaborate in the planning, implementation, and evaluation of the clinical experience of the students.

Question 12: What is an accepted ratio of students per instructor in the clinical area?

Dr. Jael: Faculty-to-student ratio, and student-to-client ratio policies should be in place and carefully followed. In the Philippines, the general guidelines for ratio of faculty to students in the clinical setting depends on the year level of the students as mandated in the Philippine Commission on Higher Education Memorandum Order. CHED limits the ratio to eight students per instructor for first- and second-year levels, 12 students per instructor for the third-year level, and 15 students per instructor for fourth-year-level students. The nursing school and the clinical facility have the option to further limit the ratio considering the complexity and severity of patients' clinical conditions, particularly in areas like intensive care, critical care, dialysis, emergency, operating, and delivery units for quality clinical supervision.

Dr. Krull: In the United States, the maximum legal student/teacher ratio is mandated by the state board of nursing. The State of Oregon limits the ratio to eight students per instructor at any one time. The State of Washington allows 10 students per instructor. Both of these states have policies requiring a lower limit if needed to maintain patient safety. While schools are not allowed to exceed the legal student/teacher ratio, the actual ratio can be further limited by the clinical facility based on factors such as number of patients available, the complexity of a patient's condition, unit staffing shortages, or newly hired staff being oriented. From my personal experience, clinical supervision is much easier when students are located close to one another rather than spread over several floors or units. Another factor to be considered is the level of experience of the student. Groups need to be smaller for beginning students as opposed to students who are more advanced.

Summary

In spite of slight variations in laws and accreditation standards from one state or country to another, the overall approach to clinical teaching remains similar around the world. With increasing numbers of schools of nursing within and outside of the Seventh-day Adventist educational system, the demand for access to clinical sites for student practice is becoming a challenge. Documentation of adequately supervised student practice by qualified clinical instructors or preceptors, and demonstration of safe performance with minimum errors are standard expectations by accrediting agencies and even more for Seventh-day Adventist Christian nurses who are called to provide care. Programs may be judged as "out of compliance" by accrediting agencies if the adequacy or qualifications of clinical instructors, or any other aspect of the clinical instruction, are deemed below what is expected. The day when schools of nursing could assume that hospital nursing staff would be available to assist or supervise students is past. Therefore, the availability and cost of expert clinical instructors needs to be considered when establishing a nursing program. Clinical instructors should develop expertise in clinical teaching not only to prevent loss of accreditation, lawsuits, and adverse patient outcomes, but to educate future nurses who will exhibit safe levels of clinical practice.

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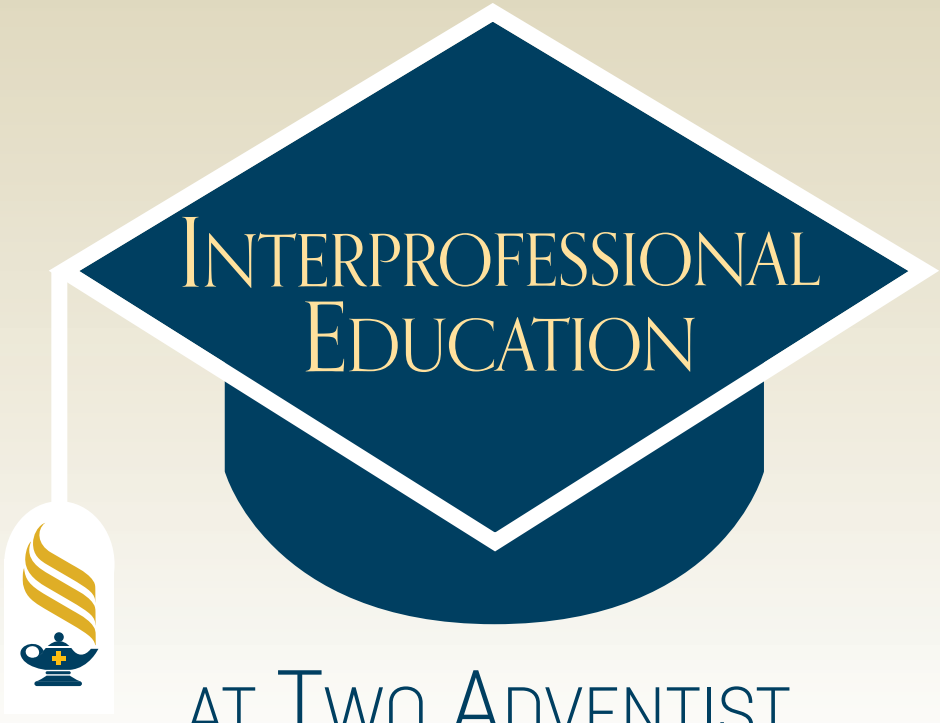

Interprofessional Education at Two Adventist Universities

In 1999, the Institute of Medicine (IOM) published a landmark report on the quality of health care in America, which shocked the nation when it revealed that more than 98,000 patients die each year as a result of medical error.[1] A follow-up report, "Crossing the Quality Chasm," discussed the problem that educating health-care students in the isolation of the various "silos" (insular functioning that discourages reciprocity and communication across disciplines) of their professions contributes to quality-care concerns, and outlined steps to address the issues raised, which included the need to focus on evidence-based practice and interdisciplinary training.[2] In addition, the World Health Organization (WHO) in 2010 issued a report, "Framework for Action on Interprofessional Education and Collaborative Practice," with the goal of providing guidance to key elements of interprofessional education (IPE) and collaborative practice.[3] Just one year later, the Interprofessional Education Collaborative (IPEC) identified Core Competencies for interprofessional collaborative practice.[4]

In 2012, the Institute of Medicine's Global Forum on Innovation in Health Professional Education was formed (now known as the National Academies of Sciences Engineering and Medicine's Global Forum on Innovation in Health Professional Education). Along with the Robert Wood Johnson Foundation, it developed reports on the importance of educational entities working together in partnerships to educate health-care students on the importance of teamwork, collaboration, and dialogue. The Josiah Macy Jr. Foundation has taken an active role in funding research on interprofessional education by providing grant funding while disseminating information regarding best practice in IPE for practitioner use including curriculum, modules, and professional development.[5]

The international community has clearly identified and affirmed IPE as a foundation for effective health-care education, yet many challenges remain. Health-care education still predominantly occurs in silos, with little day-to-day critical thinking and problem-solving across professional boundaries, further complicated by each profession having its own language.[6] Other challenges include the cost of funding such education, having a faculty trained in IPE skill sets and procedures, providing adequate time and resources for IPE training for students, and the problem of collaborating amid varying academic schedules and calendars.[7] Finally, finding validated, reliable assessment measures of IPE has also been a concern.[8]

In spite of these challenges, certain factors can facilitate IPE in health-care education such as having faculty champions who become catalysts for positive change, institutional support, shared interprofessional vision, and faculty-development programs.[9] Some universities have sent teams of interprofessional faculty to IPEC conferences to begin or further develop their IPE plans, and gain insight and support from seasoned professionals. Adopting a foundation of equality, willingness to listen to others, and a commitment to minimize

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turf battles are also key contributors to IPE success.[10] Encouraging faculty to co-teach with other colleagues in clinical settings, modeling by colleagues with experience in the field, and being flexible when faced with challenges are also important.[11] Another avenue to enhance interprofessional education curriculum is for various accrediting bodies to develop standards that target IPE skills, values, and competencies.[12]

IPE and collaborative practice have been an area of inquiry for more than 40 years, yet further research is needed to examine the effect of IPE and collaborative practice on health-specific outcomes.[13] The WHO Framework for Action on Interprofessional Education and Collaborative Practice Framework[14] outlined a process that starts with having health and education systems examine the context of local health needs, then developing quality IPE programs that will train health-care workers to implement collaborative practices. The result will be collaborative practice by health-care professionals, a strengthened health-care system, and improved health outcomes.[15]

Adventist universities and health-care centers are moving forward in promoting interprofessional education and collaboration among their university partners. IPE is necessary to equip future health-care professionals with skills such as communication, joint problem-solving, and teamwork to optimize patient safety and enable quality service in ever-changing health-care systems worldwide.

Interprofessional Education Experiences at Loma Linda University (LLU)

Shortly after the Medical Simulation Center opened at LLU Centennial Complex in 2010, a PhD in nursing student, Janice Palaganas, partnered with medical-simulation staff and representatives from other disciplines to explore health-care simulation. This platform provided a foundation for IPE to compare the effectiveness of high- and low-technology simulation and also provided students from different health-care backgrounds the opportunity to apply collaborative communication skills and participate in group problem-solving tasks.[16]

In working with students from a variety of health-care programs, the team found that high-technology approaches were more effective than non-simulated, low-technology modalities. For example, high-technology simulations provided students with immediate feedback on patients' vital signs (as well as other forms of data), and allowed them to make decisions, thus mirroring a real-world context. Today, LLU continues this effort through the Interprofessional learning (IPL) experience, which is open to all of the university's schools.

Students from the schools of nursing, medicine, pharmacy, allied health (departments of radiology technology and physician's assistant), public health, dentistry (dentistry and dental hygiene), and behavioral health (child-life department) participate in IPL. All of the participating students complete the Readiness for Interprofessional Learning Scale (RIPLS) survey[17] prior to and after their IPL experience.

During the four-hour IPL session, groups of eight to nine students from three to five different LLU schools rotate through three stations at the university's Medical Simulation Center. Before starting the activities at each of the three rotations, the students engage in a 20-minute learning experience designed to prepare them to use TeamSTEPPS® communication strategies[18] as they encounter, problem-solve, and intervene in a variety of patient scenarios. In two of the rotations, students are able to take advantage of the simulation patient suites with high-fidelity manikins. During their "immersive" rotation, students are able to observe and intervene as they experience a simulated patient emergency.

Students from Loma Linda University's Schools of Nursing, Pharmacy, Allied Health, and Medicine work together to respond to a patient emergency during interprofessional experiences at Loma Linda University's Medical Simulation Center.

A second rotation is designed to expose the students to a variety of commonly encountered patient and staff issues requiring optimal team communication and problem-solving. In each of these rotations, students are able to debrief following the learning experience, ask questions, and practice and review key concepts.

In the third rotation, students review case studies of an acute-care situation and the accompanying long-term or community-based follow-up. The scenarios were developed to stimulate participation from all the disciplines involved as students discuss assessments, key interventions, referrals, and concerns that each of the professions would address. A guided one-to-one interview also occurs during this "scope of practice" rotation, which promotes sharing, understanding, and communication amongst the student participants.

Each fall, LLU's School of Allied Health coordinates a half-day interprofessional workshop that involves all the departments preparing allied-health professionals (cardiopulmonary sciences, clinical lab sciences, communication sciences and disorders, health informatics and information management, occupational therapy, orthotics and prosthetics, physical therapy, and radiation technology). Prior to the workshop, the students study a case scenario so they are prepared to share their profession's scope of practice and clinical context.

During the 80-minute rotations, the students from the various departments interact to provide collaborative, whole-person care. Before the experience ends, the students receive a presentation from participants who were involved in the real-life case the students had been studying throughout the session. The culminating debriefing allows participants to reflect on how collaboration facilitated quality patient care as they discuss how to preserve life and maximize function.

Critical Event Response Lab

Each spring quarter, students from the schools of medicine, pharmacy, nursing, dentistry, and the emergency medical care department within the School of Allied Health participate in a half-day "Critical Event Response Lab," which is designed to prepare health-care professionals from various backgrounds to work collaboratively when faced with various disasters or multi-casualty situations. Prior to attending an assigned half-day lab, students complete a multi-module, online interactive course covering topics such as basics of disaster medicine, disaster triage, public-health response to disasters, TeamSTEPPS® communication strategies and mental-health concepts of disaster, along with specialty modules designed for each school. They also complete pre-assessments prior to attending the onsite course and, with participants from the various schools, rotate through five stations—a triage station, decontamination simulation, and three scenarios in the LLU's interprofessional Medical Simulation Center suites where they encounter various disaster scenarios requiring teamwork, communication, and effective interprofessional intervention. Following each experience, the students are given an opportunity for debriefing and reflection.

At the conclusion of the Critical Event Response Lab, the students take post-surveys to assess their understanding of teamwork, communication procedures across health-care disciplines, and the relationship between the context of their scope of practice and problem-solving in real-world contexts.

Survey results showed that statistically significant growth occurred in students' ability to work in and contribute to teams and to facilitate communication. In addition, student comments from the survey showed that they developed more positive perceptions regarding team communication and management.[19] Throughout the IPL experience, students reported that their own perceptions of positive interdisciplinary experiences were strengthened as they were able to learn from the expertise of other disciplines.

Additional Lab Experiences

In addition to these events, schools within LLU are working to provide opportunities and broader contexts in which interdisciplinary experiences can occur. For example, the schools of dentistry and pharmacy have created opportunities for students and professors to collaborate on case studies in order to provide a context in which students can apply their learning. This process encourages students to reflect on how the attitudes, communication styles, and skill sets inherent to their discipline contribute to collaboration and better patientcare.

The LLU School of Nursing has created an Ethical Dilemma Lab where groups of seven to nine nursing and pharmacy students partner to interview a "family" struggling with an ethical issue. Prior to the lab, each participant is assigned a role, sent a scenario overview, and given journal articles to review. After their preparation, each team conducts a 20-minute interview with actors portraying a family to provide guidance and support, and aid in problem-solving. These interactions are videotaped and reviewed prior to debriefing and reflection. Teams discuss their effectiveness in guiding the ethical conversation, showing empathy, providing evidence-based information, and increasing their level of professionalism.

LLU's Center for Interprofessional Education Research (CIPER) team has also begun to develop frameworks and methodologies to guide interprofessional work, conduct research, and inform future IPL opportunities. This team, under the guidance of Christiane Schubert, PhD, involves professionals from the schools of medicine, dentistry, nursing, and pharmacy, as well as representatives from Loma Linda's Veterans Administration Hospital. This work is designed to promote foundational research in clinical settings in order to examine ways that interdisciplinary professionals can collaborate to achieve optimum outcomes for patients.[20] By guiding work in these areas, the team hopes to encourage a higher quality of whole-person care, ensure better patient outcomes, and contribute to a more resilient health-care system.

Interdisciplinary Learning at Universidad Peruana Union (UPeU)

Interdisciplinary learning began at UPeU in 2012 with a three-year project titled: "Responsible Parents, Healthy Children," which focused on early stimulation and healthy nutrition of children from birth to 5 years of age who lived in a community close to UPeU. The project involved the nursing, psychology, nutrition, and theology departments. Together, administrators and faculty developed a six-point action plan to decrease infant morbidity/mortality and improve the quality of life for the local children:

1. Increase the level of parental knowledge and attitudes so that they can provide early stimulation to their children from birth to age 5.

2. Teach parents about the principles of nutrition and how to prepare healthful and appetizing foods for their children from birth to age 5.

3. Help ensure that parents bring their young children

(from birth to age 5) to well-baby clinics and healthy child checks as established by the country's Ministry of Health.

4. Enrich the affective interactions between couples to improve relationships among family members.

5. Improve mothers' and fathers' implementation of healthful lifestyle habits in personal hygiene and cleanliness in their living areas.

6. Establish a Community Center for Early Stimulation.

A team of faculty members from the participating departments mentioned above developed an action plan based on the project's objectives and the desired learning outcomes for each participating department. Nursing, psychology, and nutrition students collaborated on the project and jointly conducted home visits and educational programs. Similarly, psychology and theology students worked together to enhance marital relationships in their clients.

This collaborative work experience generated a shared inter-professional vision among the faculty and administrators of the participating departments, which offered improved outcomes in the health care of individuals and families in the community.

The following year (2013), the School of Health Sciences, with the participation of the nursing, psychology, and human nutrition faculties, implemented the following project: "Healthy Girls and Boys for a Secure Future" in several communities. This second joint project reaffirmed the need for a coordinated interdisciplinary plan of action in the community because previously, students in each of these departments had conducted their community practice independently. This led to duplication of effort and cost, and frequently did not produce the desired outcomes in the community. For this reason, since 2013, the School of Health Sciences has implemented an Interdisciplinary Community Internship for its nursing, human nutrition, and psychology programs. The faculty responsible for the community internship meet at pre-determined times to develop a joint work plan that takes into account the desired competencies and learning outcomes, and course content, and to arrange for a needs assessment of the community.

During the first week of the practicum, the students participate in an induction and orientation program. Next, they conduct a community needs assessment. Then, together with community leaders and administrators, as well as local representatives from the Ministry of Health, a multidisciplinary team develops an action plan. The team, in coordination with faculty from the participating disciplines, plan the students' clinical practice according to the competencies they want the students to acquire. This experience with interdisciplinary learning has enriched and increased the capability of students, faculty, and administrators.

Students learn teamwork; acquire/develop skills related to negotiation and conflict resolution; learn assertive communication; and learn respect and tolerance for others' opinions. They also develop leadership skills as they coordinate with institutional leaders and community-center personnel within the municipality; acquire knowledge regarding the roles of the other professions participating in the project; and prepare for their year of government-required social service upon completion of their degree.

Faculty acquire expertise in curriculum development and revision and identify courses or content that will enable students to develop the necessary competencies to engage successfully in interdisciplinary work. They also identify methodologies and strategies to address community and interdisciplinary practice, learn terminology unique to each of the professions involved, and build competency in areas of concentration. Above all, they learn to role-model teamwork and develop practice guidelines.

As a result of this experience, UPeU is expanding student-intervention scenarios. For example, the school has established a strategic alliance with some of the hospitals and clinics throughout the country to work on a project called "Total Health" in which nursing, nutrition, and psychology students will participate, and as of 2018, medical students as well.

Even though the value and outcomes of interdisciplinary learning are positive and promising, a variety of barriers and challenges such as scheduling must be overcome. However, great benefits could be achieved from the following collaborations: integration of medical and nursing students into acute-care situations; engaging nursing, medical, and psychology students in emergency situations and disasters; and teaching nursing and psychology students to collaborate in managing adolescent pregnancies. The areas of health care where interdisciplinary practice would increase the benefit to the client,

Figure 1. Outcomes for Quality IPE Programs

community, and society, while at the same time increasing career satisfaction for the health professional, are many.

These illustrations show how Loma Linda University and Universidad Peruana Unión are creating opportunities for student interaction across disciplines to mobilize energy and facilitate collaboration on various health issues. These opportunities help students to acquire and develop effective communication skills, teamwork, collaborative problem solving, and reflective insights to navigate through ethical challenges. In addition, these interdisciplinary experiences enable students to broaden their skillsets as they collaborate with fellow clinicians to improve and implement patient care. The simulated and real-world projects modeled by these two schools provide a greater insight into ways that university departments can collaborate to prepare an interdisciplinary workforce with the diverse strengths and expertise to ensure a more responsive and effective health-care systems. ✐

This article has been peer reviewed.

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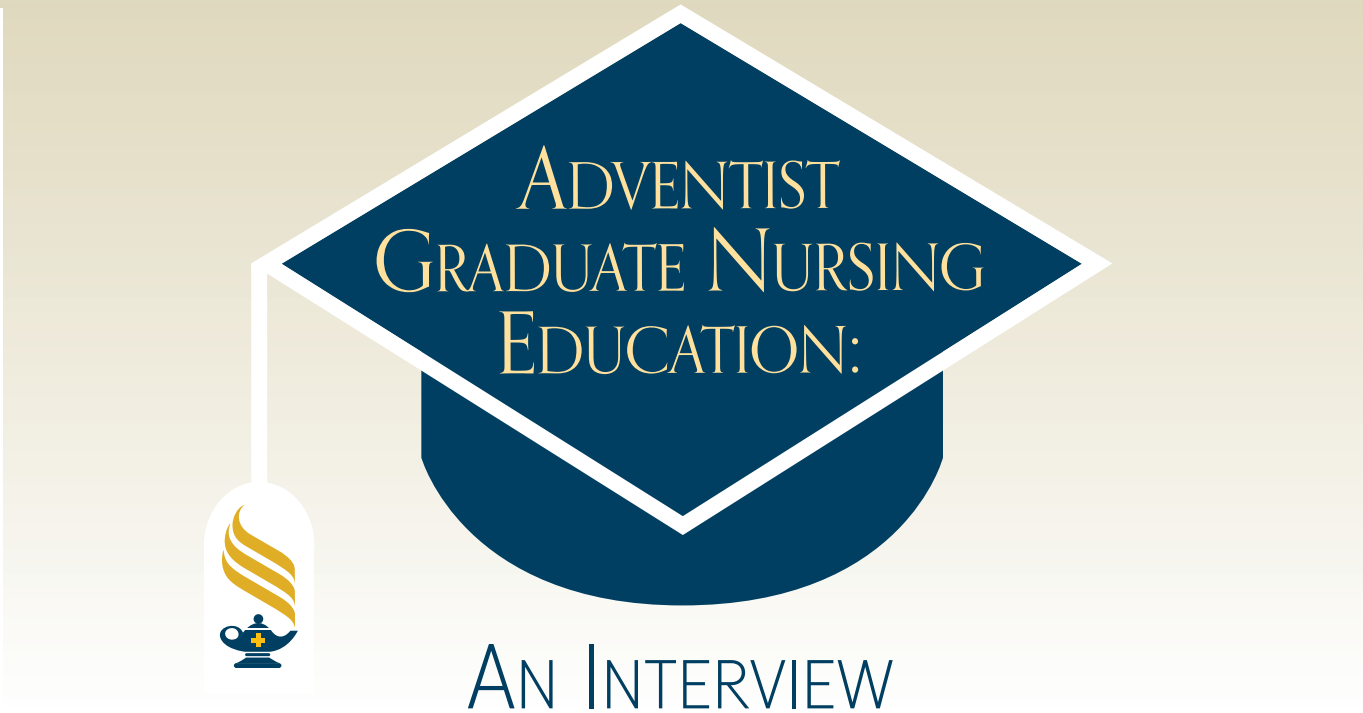

Adventist Graduate Nursing Education: An Interview

Globally, there is increased demand for graduate nursing education. In this interview, Dr. Patricia S. Jones sits down with three administrators of graduate nursing programs to discuss the demand for advanced programs, the need for qualified educators, types of certifications, and opportunities for online graduate education.

Dr. Jones: The first question I have for each of you is in regard to the current demand for graduate education in nursing. How would you describe that demand?

Dr. Lloyd: In our graduate department at Loma Linda University (Loma Linda, California, U.S.A.), we are seeing a demand for Advanced Practice Registered Nurse programs (APRN). Most students are interested in DNP (Doctor of Nursing Practice) roles. Many of these students are nurses from the workforce who are eager to get their doctorate to validate and give credibility to what they have been doing in practice for a number of years and to provide additional career opportunities.

Dr. Gadd: There is certainly a lot of demand here on the East Coast where I live as well. We know there is a national demand for nurse practitioners based on the research and epidemiologic information about the aging of America, the increased demand for health care, and the inadequacy of the medical system to meet that demand. We also experience a loss of nurses in an aging workforce. So there are many opportunities for advanced-practice nurses. As was mentioned previously, many nurses who are mature in their nursing role are anxious to move forward professionally to provide primary-care services in different settings from what they have been used to. We see health care moving into the community more, so advanced practice nurses have the opportunity to meet some of those needs. The demand is there, and a lot of people are signing up to go to school.

Dr. Bristol: The other thing I would mention is that within hospital settings the cost of care—with an increased focus on quality—and changes in how health-care institutions are paid are big issues. It is important to have advanced-practice nurses in the health-care system who are able to achieve or maintain accreditation and professional criteria, such as the American Nurses Credentialing Center's (ANCC) magnet status, direct the kind of programs needed to demonstrate quality patient outcomes, and to take the lead in working within the organization to accomplish these goals. In today's environment, even the viability of the organization is at stake because reimbursement for care is based on patient outcomes.

Dr. Gadd: I think it is super important to have these quality health-care providers because research has shown for 15 or 20 years that the survival rates of hospitalized patients are better when the nurses have higher levels of education. This occurs at the undergraduate level when you compare associate degree- to bachelor's-level prepared nurses. The outcomes are better for patients cared for by a nurse with a bachelor's degree. This is also true of

BY SUSAN L. LLOYD, HOLLY GADD, SHIRLEY TOHM BRISTOL, and PATRICIA S. JONES

higher levels of care from nurses with Master's and doctoral degrees, and in various settings. When you look at the acute-care settings, graduate-level nursing education is very important and really makes a difference.

Dr. Jones: Yes, that is very clear from the remarks you have made thus far. What would you say about the increasing need for qualified educators?

Dr. Gadd: Here at Southern Adventist University (Collegedale, Tennessee, U.S.A.), we do have a nursing-education track in our program; but unfortunately, it has a very low enrollment.

Dr. Lloyd: The challenge at Loma Linda University (LLU), and across the nation, is that many nursing educators will be retiring within the next 10 years. We are working to "grow our own" faculty now so that they will be ready to carry on the work.

Dr. Bristol: In keeping with what I mentioned above, many graduates from our Master's and doctoral programs are choosing to be employed in clinical areas due to financial and other incentives. Educational institutions also need to recruit some of these highly qualified individuals to maintain the level of education that produces qualified practitioners. We need competent faculty at all levels of nursing education, from the undergraduate level all the way through doctoral programs. As educators, we currently allow APRN faculty time out from their academic workload to maintain practice skills. This collaboration between service and education will continuously improve lines of communication and enhance the educational opportunities for both students and nurses.

Dr. Lloyd: Many of our students who enter the Master's level Nurse Educator concentration later change to the Clinical Nurse Specialist (CNS) concentration due to the large education component in the CNS role. Also, CNS students are able to receive advanced-practice state and national certification, thus expanding their role as well as providing increased clinical and educational opportunities. Either concentration can lead to a faculty role.

Dr. Jones: Yes.

Dr. Gadd: It is very well documented that there is a shortage of nursing faculty. Many nursing institutions take significant time to find qualified faculty and have a number of unfilled faculty positions. It is a problem that affects the whole nursing practice area because fewer educators means you take in fewer students and have fewer graduates. We need doctorally prepared faculty to prepare nurse educators to teach, and there are insufficient numbers of those faculty. As you mentioned, retirements plus other factors like discrepancies in wages and salaries are very challenging. Nurses who finish an associate degree can often earn as much as I do with a PhD. But I've never gone hungry, and there is a special blessing in doing what God calls us to do—particularly teaching in the Adventist system. So, when I talk with nurses who are considering preparing for a faculty role, I emphasize mission and what we do with the talents God has given us. There are rewards other than money.

Dr. Bristol: Not all students completing an APRN program have the knowledge and skills to immediately become a competent educator. It is, in fact, an entirely new learning curve. Early identification of a student's interest in an academic career can lead to a strong mentorship and supportive relationship for developing competent faculty.

Dr. Gadd: I totally agree with that. I was educated at Loma Linda as a nurse educator. I really valued courses related to curriculum development, classroom and clinical instruction modalities, testing, measurement, and evaluation—how to do these things correctly. There is a science to what we do as educators.

Dr. Lloyd: It's not just "if you can do it, you can teach it." We have found that's not always the case.

Dr. Gadd: That's exactly right. I'll use an even broader example. My husband began teaching accounting after being an accountant and auditor for years. He has expressed many times his envy of the classes I had in my graduate program because I learned how to teach and wasn't having to try to figure it out on my own. Teaching is not necessarily a natural thing, so it is really important that we have these graduate nurse-educator programs.

Dr. Jones: Thank you. Is there anything you would like to add regarding opportunities for graduates with an advanced-practice education?

Dr. Bristol: The nationally recognized programs for advanced practice include the Clinical Nurse Specialist (CNS), Nurse Practitioner (NP), Nurse Anesthetist (CRNA), and Nurse Midwife (NM). At LLU, we have the CNS concentration, which includes Adult-Gerontology or Pediatric specialties. Within the Nurse Practitioner concentration, we have the following specialties: Family Nurse Practitioner, Adult/Gerontology Nurse Practitioner, Psychiatric Nurse Practitioner, and Pediatric Nurse Practitioner. We also offer the Nurse Anesthetist concentration. The Neonatal Nurse Practitioner and the Nurse Midwife, although not offered at LLU, are available nationwide.

Dr. Jones: There is also acute care, right?

Dr. Lloyd: Yes, a few schools nationally offer the Acute Care Nurse Practitioner (ACNP) specialty as well.

Dr. Gadd: Those are the four major advanced-practice roles noted in the national guidelines. Within those roles, the nurse practitioner—and to some degree the CNS—then divide into acute- and primary-care roles, and then further into lifespan (e.g., neonatal, pediatric, adult, geriatric), gender (e.g., women's health), and other specialty areas (e.g., cardiology, dermatology, and orthopedics).

Dr. Bristol: APRN graduates are highly encouraged to seek both state and national certification for all of those areas. In fact, APRN graduates are considered to have a generalist degree. The expectation is for further specialization within one's initial specialty practice, particularly for CNSes. This trend will probably continue.

Dr. Gadd: There are advantages and disadvantages to specialization. One of the things that nurse practitioners have done exceptionally well is to begin filling holes in the medical system as physicians have specialized. Physicians are filling less of the general and family-practice roles. Nurse practitioners are filling many of those primary-care roles and meeting a very important national health-care need. It may not be advantageous for nurse practitioners to push to become specialized, as that may again leave gaps in primary-care services.

Dr. Lloyd: Nationally, the FNP role is in the greatest demand by students at this time. At LLU, the FNP and CRNA concentrations are the largest areas in our graduate program.

Dr. Gadd: We see that in our program demographics at Southern as well. I would say about 90 percent of our graduate students are enrolled in the FNP emphasis. The next biggest demand is for the acute-care nurse practitioner emphasis, which is adult/gerontology. Many students like this area, as they have worked in critical-care and high-acuity inpatient settings and feel most comfortable there. The acute-care nurse practitioner role is growing across the country. Psychiatric-mental-health nurse practitioner is another big demand area with many job openings across the nation. This is a very specialized focus and attracts students with experience in this area who are interested in an expanded role in the care of patients with mental-health problems.

Dr. Jones: So do you also have a Psychiatric-Mental Health Nurse Practitioner (PMHNP) program?

Dr. Gadd: Yes, Southern's graduate programs include the PMHNP track. This was added a couple years ago, and we just graduated our first students. There are tremendous gaps in mental-health care across the U.S., in Tennessee, and in our local community. There are no other programs in our immediate area to address those needs. So far, we have had steady interest and enrollment in this emphasis, which is good.

Dr. Jones: When it comes to the level of education for these advanced-practice roles, is it at the Master's-degree level or are they rapidly expecting DNP-level preparation?

Dr. Gadd: I think we are all aware that there was a big push to have the doctorate to be the entry level into advanced nursing practice by 2015. That date has come and gone, but the goal remains and is important. It is a complicated thing, however, because you have to be able to get the certifying agencies, the state licensing agencies, and the colleges and universities on the same page. It's a mammoth endeavor.

Dr. Lloyd: Nationally, major nursing organizations are working toward standardization of advanced practice between the states through a national initiative.

Dr. Bristol: The DNP is becoming a well-accepted degree. We have seen a rise in the number of DNP programs nationally throughout the past several years. It remains to be seen just when that absolute deadline for DNP entry into practice will occur.

Dr. Gadd: As I've attended meetings, it doesn't seem that anyone wants to set a date right now for the DNP to be the entry level for advanced practice.

Dr. Lloyd: No, we haven't seen that either.

Dr. Bristol: Anecdotally, students entering the program from a variety of backgrounds are recognizing the need to reach the doctorate level to achieve their long-term goals. Although there is still a demand for the Master's degree, many more are seeking the DNP.

Dr. Lloyd: Our Master's program is focused on the Nurse Educator or Nurse Administration concentrations. The DNP and PhD programs are structured to admit post-baccalaureate and post-Master's students. For information regarding entrance requirements for various graduate specialties, consult the school Website.

Dr. Jones: So, is it the Board of Registered Nursing (BRN) in each state or the professional associations that grant the certification?

Dr. Lloyd: Depending upon the state, it may be the BRN or the professional association. Students are encouraged to obtain both certifications if applicable.

Dr. Bristol: It's a competitive advantage to have national certification. In fact, our most recent accreditation visitors wanted to ensure that faculty in charge of all the clinical courses were nationally certified as well as having doctoral degrees.

Dr. Lloyd: Our graduate program consists of Master's and doctoral degrees.

Dr. Gadd: That is correct for entering into practice. We, too, have kept the Master's program at Southern because a DNP is not required for advanced-practice certification or licensure. The MSN is a shorter program, and for many nurses that has a lot of appeal. It is a good option for those who don't yet have a vision for a terminal degree.

Dr. Jones: Is national certification done by specific organizations?

Dr. Gadd: There are several certifying bodies. The national certification for Family Nurse Practitioners (FNPs) can be from the American Association of Nurse Practitioners or the American Nurses Credentialing Center. There are others for other specialties.

Dr. Bristol: The various concentrations are linked to their professional organizations, which in turn are linked

to a national accrediting agency. For us, it is the Commission on Collegiate Nursing Education (CCNE), the accreditation arm of the American Association of Colleges of Nursing (AACN).

Dr. Gadd: Nurse Educators also have a certification exam.

Dr. Bristol: Yes, Nurse Educators may be certified through the National League of Nursing (NLN).

Dr. Jones: Maybe we should talk about the differences in the DNP and PhD educations.

Dr. Gadd: When we started this conversation, we were talking about the demand for advanced-practice nurses. A lot of nurses who come into our graduate programs are very practice oriented, wanting to work directly with patients. That is where the DNP originated—as a practice degree. DNP programs are generally shorter than PhD programs and have a very different focus. Research is included in the DNP program because a good clinician needs to interpret and demonstrate evidence of meeting various practice guidelines. The PhD program is much more focused on research. In our area, the demand for DNP education is greater because more nurses are oriented to clinical-practice settings than to research.

Dr. Lloyd: Yes, and the PhD degree in nursing, which currently is being overlooked somewhat, is essential to the education of our nurses. The development and implementation of original research to contribute to nursing knowledge is necessary to provide evidence for DNP graduates to translate into Evidence-based Practice (EBP) at the bedside for improved outcomes.

Dr. Bristol: That's why it's so important to have collaboration between the PhD and DNP roles. There is a discrepancy between the knowledge that exists and what is needed for expert clinicians in the implementation of EBP to improve quality patient outcomes. It is important for both roles to work seamlessly in this process.

Dr. Lloyd: At this time, it is more difficult for us to recruit students into the PhD program.

They are not sure what they are going to do; it is more expensive, it takes longer, and it is also more challenging. Traditionally, it has not been online or hybrid, although there were a few such programs. We started a BS to PhD program at LLU in the fall term of 2017 to see if a hybrid or online format can raise the level of competitiveness in terms of drawing students into both programs and keeping them going. We are working hard on that; it's a hard go, but we are getting there. We are hoping to start off with a few students and build as we go along.

Dr. Gadd: We struggle with the same things. We have talked about our struggle to enroll nurse educators. We haven't yet talked about advanced-practice roles in nursing administration. There is also a dearth of Master's and doctorally educated Adventist nurses to fill leadership roles in the Adventist health-care systems. Many people go into nursing to work directly with patients and don't desire to step away into either educator or administrator roles. The education needed to effectively accomplish those roles is just not part of their vision. We have many conversations about this at Southern. How do we attract students into these roles early in their career? How do we recognize their leadership traits and direct or encourage them toward leadership and administration?

Dr. Bristol: Hospital administrators have seen the need for their nurse leaders to obtain advanced nursing education. Clinical nurse leaders are required to have a minimum of a Master's degree in nursing administration.

Dr. Gadd: We have similar requirements from health-care facilities around Southern. Several of the chief nursing officers have graduated from our MSN-MBA program. They were forced to seek graduate education. For those employed at magnet hospitals, the doctorate is additionally appealing. We are making that available, and including residence time in management and leadership which we hope will build strong leaders. As part of the advanced-practice roles, there are needs in these leadership areas and certainly huge needs in our Adventist health-care systems.

Dr. Jones: Are graduate programs promoting the administration track?

Dr. Lloyd: We have a Master's-level administration concentration at LLU. Many nurses working in our hospital are required to have the Master's degree for practice or for the manager's role. We have also developed a Master's externship program in collaboration with the medical center to allow students to take their DNP while they are also practicing in a clinical-leadership role.

Dr. Gadd: It's hard to be everything to everybody. We have an MBA program at Southern. So what we have done is team up with the School of Business to create a dual-degree MSN-MBA. As we have been developing our DNP programs, we have added it as an emphasis in the DNP program as well (DNP-MBA). Now we just need to get more students enrolled.

Dr. Jones: That should help in terms of meeting the need for qualified administrators. Thank you very much. We have covered almost all of our topics, but let's touch on the final one: What about offering graduate education online?

Dr. Lloyd: When we surveyed students in the process of doing a needs assessment for the different programs, the overwhelming response was an interest and request for some type of online learning. We are using the hybrid method for our online programs.

Dr. Jones: Can you describe the hybrid method of online education?

Dr. Lloyd: Hybrid programs feature primarily online learning with

Adventist Graduate Programs in Nursing

Institution	Country	Graduate Programs	Degrees
Adventist University of Health Sciences	United States	Master's	MSNA[1]
Adventist University of the Philippines	Philippines	Master's	MSN, MN
Andrews University	United States	Doctoral	DNP[2]
Antillean Adventist University	Puerto Rico	Master's	MSN
Avondale College of Higher Education	Australia	Master's, Doctoral	MN, MPhil, PhD[3]
Babcock University	Nigeria	Master's	MSc
Loma Linda University	United States	Master's, Doctoral	MS, DNP, PhD
Lowry Adventist College	India	Master's	MSc
Peruvian Union University	Peru	Master's, Doctoral	MSc, Doctorate[4]
Sahmyook University	Korea	Master's, Doctoral	MSc, PhD
Southern Adventist University	United States	Master's, Doctoral	MSN, DNP
University of Eastern Africa, Baraton	Kenya	Master's	MSc
Washington Adventist University	United States	Master's	MS, MSN

1. Master of Science in Nurse Anesthesia
2. Doctor of Nursing Practice (Practice focus)
3. Doctor of Philosophy (Research focus)
4. Doctoral degree (Research focus)

once-per-quarter on-campus face-to-face interaction with the instructor. The length of time the students are on campus is determined by the number of classes they are taking. We work to make it convenient and user friendly for the students.

Dr. Bristol: Some courses may require more personal contact with students. Courses such as health assessment, statistics, or clinical courses may require extra sessions either face to face or by a computer Zoom session (online video-conferencing session), as decided by course faculty.

Dr. Gadd: We provide online education to meet the needs of people who do not have good access to graduate education or who prefer online learning for convenience. Online education is not for everybody. There are some individuals who just don't possess the right personality, study skills, technical skills, support, or whatever it takes to do online education. There are challenges on the student's end that need to be weighed when the student is trying to choose a program. There are also huge challenges for an institution offering quality online education. You can't just take a class you teach face to face and turn it into an online class with the flip of a switch. It takes much more time and effort, and a lot of preparation. There are best-practice guidelines for high-quality online education. Some of our faculty prefer not to teach online because it requires a lot of daily attention and is different from the classroom—sometimes difficult and challenging.

Dr. Lloyd: It takes an immense amount of work and infrastructure support to do it well. There is a huge demand for using educational technology, which will probably only increase. It just requires those of us who started teaching a long time ago to really step up to using the technology piece.

Dr. Jones: How do you think online delivery is going to affect our ability to educate faculty for sister schools in other countries, since we are a global system?

Dr. Gadd: Online education is really an advantage in relation to educating those from other countries if they have the capability and technology to be a part of a class. Time-zone differences make asynchronous delivery modes ideal. Education where they can learn at their own best time of day is really helpful. Individuals in other countries can take advantage of a wealth of educational resources.

Dr. Jones: Do you have some international students in your programs?

Dr. Gadd: One of our recent DNP graduates was an American nurse educator living and doing her program in Korea.

Dr. Bristol: Applicants must have their RN license in the United States to enter and complete the DNP program. That may be a hindrance to international students.

Dr. Lloyd: There is also a visa issue. All international students must first be vetted according to their type of visa and whether their country will recognize an online degree prior to acceptance into the program. LLU requires all student visas to be processed through the campus international student office, and difficulties arise for some students who want to register for online programs.

Dr. Gadd: There are definitely a lot of challenges with student visas and other immigration laws. However, distance-education programs, if totally online, circumvent most of these issues and provide an advantage.

Dr. Jones: Is there anything that was not touched on that you would like to share?

Dr. Gadd: I would just like to say that there are a lot of exciting opportunities for students and faculty in graduate education. I often say I have the best job on campus here at Southern. I work with mature students who are highly motivated and really want to achieve professionally, and who have so many opportunities, given our current health-care climate. There are

many challenges involved in what we do in the graduate area as professors—to keep up with clinical practice, teaching and educational modalities, and to engage in and promote scholarly activities. We need to continue to develop and promote cutting-edge programs that meet the needs of nursing practice, nursing education, and administration for our local and church constituents as well as for those in our global society. It is both personally and professionally rewarding.

Dr. Bristol: As students enter their undergraduate program, faculty may assist them in their career planning to identify potential mission opportunities and those who might be interested in becoming nursing faculty or administrators.

Dr. Lloyd: Advanced-practiced nurses have great potential to make a difference within their sphere of influence. An advanced-practice education résumé tops any employer's stack of applications. Our purpose is to train students to take the Seventh-day Adventist message to their communities and the world.

Dr. Jones: Thank you so much.

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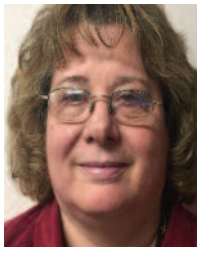

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Developing Presence and Faith in Online Teaching

BY PEGI FLYNT, FLOR CONTRERAS CASTRO, and TAMMY OVERSTREET

Online delivery of nursing education provides learners with access to academic content through a virtual learning environment. Learning experiences also include activities that take place under supervision in clinical settings such as hospitals and clinics. While academic content and clinical experiences provide the foundation for most online nursing curricula, programs offered by Seventh-day Adventist schools build on an additional foundation—the development of faith in Christ. Educators in the Seventh-day Adventist system recognize that integrating faith with learning is a primary goal, a vital consideration when developing online programs and courses. In this article, two universities provide a description of how this primary goal is approached within their nursing programs.

Reflections From Southern Adventist University (Southern), Collegedale, Tennessee, U.S.A.

The School of Nursing at Southern Adventist University has several fully online programs, including one for BS completion, a Nurse Educator Master's degree, an MSN/MBA, and a Doctor of Nurse Practice. As Seventh-day Adventist educators, regardless of the context or program in which we work, our primary goal is to point learners to Christ and encourage them on their path toward spiritual maturity as members of the body of Christ (Ephesians 4:11-14). Spiritual growth is realized through prayer, daily encounters with Scripture, and the power of the Holy Spirit.[1] The ultimate goal is complete restoration to the image of our Creator.[2]

We, the authors, believe that: "In the highest sense the work of education and the work of redemption are one, for in education, as in redemption, 'no other foundation can anyone lay than that which is laid, which is Jesus Christ' 1 Cor. 3:11."[3] For this reason, teaching processes should lead students to trust the Author and Finisher of our faith, Jesus Christ. The curriculum, then, must be Christ-centered. This type of curriculum—one based on a biblical foundation—is a critical aspect of planning and instruction that we believe makes our nursing programs unique and valuable. By cooperating with the Holy Spirit, instructors and their learners can become instruments that share heavenly solutions with people and societies that comprise this broken, fallen world. This can be accomplished by inviting the Holy Spirit to influence the planning and teaching of each course. Learning experiences are designed to help learners reflect on big ideas; to recognize, accept, and act on truth; and to invite and welcome others into a relationship with Jesus Christ. Use of this approach in traditional face-to-face education has demonstrated its ability to transform the lives of students.[4] Such a curriculum is based on a biblical worldview that orients instruction to probe questions such as these: *Why am I here? What is my purpose in life? What does the Lord require of me? Where am I going? Who can I help along the way? How can I spread the gospel of Jesus Christ?* To these questions, the Bible provides direction, guidance, and answers: "He has told you, O man, what is good; and what does the Lord re-

quire of you but to do justice, and to love kindness, and to walk humbly with your God?" (Micah 6:8, ESV).[5]

Community of Inquiry

Chickering and Gamson[6] outlined seven research-based principles of good practice in higher education. Effective teachers:

1. Interact with their students;
2. Encourage their students to interact and cooperate with one another;
3. Purposely plan for active learning and encourage their students to think and talk as well as to write and question;
4. Accentuate the importance of staying on task;
5. Provide quality and timely feedback;
6. Expect the best from their students and model what that looks like; and
7. Appreciate the diverse talents and learning styles of their students.

When teachers attempt to apply these principles in online education, they face some unique challenges.[7] Research has indicated that learning occurs most effectively within a community of inquiry.[8] Theorists Garrison, Anderson, and Archer[9] created a framework of "presence" (teacher presence, social presence, and cognitive presence) to describe how communities of inquiry can be used to increase learning effectiveness in online learning.

- *Teacher presence* is an umbrella term that refers to the entire learning experience from planning through execution. This includes the design and facilitation of the course and the careful, intentional, and purposeful planning of interactive components.[10] Interaction—the currency of online learning environments—occurs with the content, with other learners, and with the instructor.[11]
- *Social presence* in an online course provides a way for learners to concretely identify with the instructor and one another in ways that empower all participants to feel known and significant.[12] Because people are social beings, the development of social presence allows the learners to work together as actual human beings rather than as a collection of usernames or e-mail addresses. [13]
- *Cognitive presence* in online courses refers to the teaching methods used in the online classroom to intellectually engage the learner in ways that encourage understanding and the creation of meaning.[14] Garrison, Anderson, and Archer[15] pointed out that this is done through sustained reflection and discourse—an absolute necessity in online learning. Through the mental processes of inquiry, deep thinking, and reflection, learners maintain engagement and strengthen their intellectual ability.[16]

The Living Faith Presence

In faith-based institutions, where both curriculum and instruction are rooted in a biblical worldview, a fourth presence can be considered foundational to course development. At Southern Adventist University's Online Campus, we call that presence the *"living faith" presence*. According to Ellen White: "A living faith means an increase of vigor, a confiding trust, by which, through the grace of Christ, the soul becomes a conquering power."[17]

Professors at Southern Adventist University are trained by members of the Online Campus team to develop the three presences through university-wide, department/school-level, and individual training sessions. The Online Campus team provides professors with information regarding best practices; and their use of those practices is facilitated by the work of an online coach, one of whom is assigned to each professor. Online coaches are members of the Online Campus team and they provide training and professional development in the use of instructional technologies, academic course planning and creation, academic and technical support for teaching faculty and students, and media and course design assistance. The coaches are trained in online learning, instructional technology, curriculum and instruction, and media and Web design; they also possess years of experience working in their fields of expertise and teaching in their areas of specialty.

Each summer, Southern holds training sessions for professors, which help them develop courses with a biblical foundation. When the university's professors are assigned to develop an online course, they are assisted with all aspects of course development, including the living faith presence.

The experience gained from years of offering fully online courses and programs for nursing learners has enabled Southern's Online Campus to identify a number of best practices for building the living faith presence. First, curriculum developers utilize intentional planning to establish a biblical foundation for the course, and throughout the course assignments, biblical principles relating to the academic discipline are reinforced and developed. Next, weekly devotionals are created that connect to the subject content. Through online video-conferencing, learners are encouraged weekly to regularly connect with God as the Creator and Author of truth through prayer and Bible study. Perspectives from various Christian scholars in the field of nursing are used to shape integrative questions for reflection.

Other intentional practices include active prayer forums and referencing Scripture in projects, assessments, and group work. Throughout the learning experiences, learners are encouraged toward greater civic responsibility with the goal of promoting social justice from a Christian point of view. An example of this type of learning experience occurs in a course in which students work with patients who wish to make lifestyle changes, assessing and coaching them throughout the semester. This work is based on student learning outcomes that include teaching learners to examine biblical themes that support the use of a coaching approach for motivating and educating patients to adopt lifestyle change. During the final week of the course, the learners are encouraged to reflect upon their spiritual growth and ways that the course has influenced their faith, as well as

their plans for implementing truth principles in their current and future practice.

Forum discussions and live virtual meetings encourage learners to reflect, apply, analyze, and/or synthesize content from a biblical point of view. The learning activities in the course encourage them to think deeply and to evaluate sources of information. Students may be asked to critique content resources, comparing and contrasting the information with the Adventist health message. Ellen White stated that "There is nothing more calculated to energize the mind, and strengthen the intellect, than the study of the word of God. No other book is so potent to elevate the thoughts, to give vigor to the faculties, as the broad, ennobling truths of the Bible."[18]

Recently, the university conducted an informal survey of Southern Adventist University's online nursing professors to learn how they are establishing the living faith presence in their teaching. They provided the following statements:

- "I honor and value being a Seventh-day Adventist Christian professor and consider it a privilege and a responsibility to promote biblical principles in all of the courses I teach."
- "We spend significant time with the inspired text. I also make an effort to model a Christlike spirit in the way that I relate to my students. The goal is not simply the accumulation of information, but life transformation."
- "The discussion questions in my online course relate the content to Christian calling and service. The assignments give opportunity to plan how learners will encourage others to develop a relationship with God through nature and Scripture, and to serve Him as a way of life."
- "The online video conference each week is a vital component for building and nurturing a community of faith."
- "Students often comment on the spiritual blessings that they receive from the learning experiences in the online course that I teach. The assignments call for practical methods of creating a Christ-centered curriculum and opportunities for character development and service."
- "Last week a student mentioned that the online course, more than any of the face-to-face courses she had ever taken, was helping her focus on making Christ the center of her life."
- "More than anything else, I intend to let students know through all of my interactions that I am a serious and grateful disciple of Jesus."

Included in each end-of-semester digital course evaluation instrument are several open-response questions that allow students to provide feedback regarding the learning experiences and how the course transformed their lives.

- "To everyone involved in this course—Thank you for sharing your hearts. Not only have I learned from the professor and the content, but I have also learned from YOU, my classmates."
- "This online course gave [me] opportunity to know the Lord more intimately. I am grateful."
- "Taking this online class has been one of the most rewarding experiences I have ever had. A university with a foundation in Christ makes all the difference in the world."
- "I have opened my eyes and heart more since taking this course. Little did I know that an online college course could lead to my salvation. That's priceless tuition."
- "I cannot begin to tell you how much the assignments in this online course are challenging not only my worldview but my view as an Adventist Christian. I have never had to give so much thought to my work, to think this deep, or challenge other points of view."

By partnering with the Holy Spirit, instructors and their learners can be instruments that carry solutions to a broken and fallen world. This can be accomplished by inviting the Holy Spirit to direct the planning and teaching of each course.

By partnering with the Holy Spirit, instructors and their learners can be instruments that carry solutions to a broken and fallen world. This can be accomplished by inviting the Holy Spirit to direct the planning and teaching of each course. Learning experiences should be designed to help learners reflect on big ideas; to recognize, accept, and act on truth; and to welcome others into a relationship with Jesus Christ.

Reflections From Universidad Peruana Unión (UPeU), Lima, Peru

At UPeU, part of our educational mission is the integration of faith in the teaching-learning process. The Master's in Nursing program at UPeU, the only such program in the South American Division, was designed for online delivery to make it accessible to the vast territory it serves. Students in this program interact with their instructors and classmates through a synchronous virtual platform. In the multimedia environment of the virtual classroom, where the instructor and students are in different locations, integration of faith and learning (IFL) is more challenging than in the traditional classroom.

Nevertheless, we agree with Korniejczuk[19] that the integration of faith in the teaching-learning process should be evident in all aspects of the curriculum, and involve the entire academic community and beyond. However, achieving this goal in virtual Christian education requires extra effort.

Integration of Faith

Each cohort begins with a 15-day face-to-face session during which national and international students are in-

structed on the use of the virtual classroom, practice using the technology, and complete two assignments. They are also introduced to the institution's Adventist philosophy of education, which will be integrated throughout the curriculum. This gives the students an opportunity to share their opinions and ideas with faculty and classmates. During these sessions, students often express gratitude for the institution's attempts to strengthen the spiritual dimension of their education.

A 10-minute devotional based on a Bible text related to the day's topic is presented at the beginning of each online class. Students discuss the application of the text to the topic and share their prayer requests. Students who are not Seventh-day Adventists have the opportunity to observe how the power of prayer and faith in God can help to solve problems. At the beginning of the program, non-Adventist students rarely make prayer requests; however, as they see the fervor of their Adventist classmates, little by little, they also begin to express their requests based on their needs. These devotional and prayer experiences reaffirm the power of prayer and faith in God in all students—Adventist and non-Adventist alike. As the semester progresses, the instructor consistently allows time for the students to comment on some lived experience related to a previous class prayer request.

On one occasion during the prayer request time, a student of another faith commented on her sadness and anguish because of the sudden death of her physician husband due to a cerebral aneurism. Adding to her pain was the attitude of her oldest son, who had become rebellious and angry at God. During each virtual class, the instructors and classmates prayed for her and her family. The nursing team supported her during the grieving process by calling her and praying with her over the phone, e-mailing her inspiring and comforting Bible texts, and mentoring her so she could successfully complete her course work. Later, she expressed her profound gratitude for the prayers and the help received. She reported that her heart was filled with peace, and that her son had asked for forgiveness and promised to improve his behavior. She completed her degree and is now defending her thesis.

It is important to mention that prayer is not only offered by the instructor, but also others participating in the course such as the program coordinator, the informatics engineer, and students, giving the opportunity for all to participate in this privilege.

Throughout the program, as the classes and workshops progress, many occasions arise when it is appropriate to consider God and His Word. For example, students in small groups analyze portions of Scripture along with scientific literature to extrapolate conclusions regarding the topic being studied. The parable of the Good Samaritan (Luke 10:25-37) is used to analyze the characteristics of caring of the Christian nurse. The story of Abigail (1 Samuel 25) is used to analyze assertive leadership in nursing, and the relationship between Christ with His disciples exemplifies the management of human resources.

Participation in the Week of Spiritual Emphasis at UPeU

During the campus week of spiritual emphasis at UPeU, special attention is given to spiritual growth. This special event provides an opportunity to rest from the daily academic activities and to reflect upon personal communion with God. We include our virtual classroom students by inviting them to participate online in the events of the week.

The program coordinator takes time to explain the importance of the week of spiritual emphasis to the online students' lives and provides a link that enables them to access the presentations' live stream. At the end of the week, the students are invited to reflect in writing on the themes that had a major impact on their lives, and some students share their experiences verbally during the virtual class time.

Christian education provides faculty and students with an opportunity to strengthen their faith in God, our Creator and Redeemer. Therefore, we must ensure that neither technological nor pedagogical challenges inhibit this mission. To do so, we must ask for wisdom and claim God's promises. This will enable us to put aside our anxieties and show genuine interest in the problems of our students, as we individually pray with and for them, and strengthen their trust in God.

Christian faculty have the responsibility of leading their students to Christ. Both the bricks-and-mortar and the virtual classroom in an Adventist university can provide this opportunity, so that students will be able to say with John Fowler,[20] "Adventist education made me aware that life has meaning and a destiny," and that prepared them for success in their professional lives both now and throughout eternity.

Conclusion

As Seventh-day Adventist Christians, we believe Ellen White's assertion that "Every human being, created in the image of God, is endowed with a power akin to that of the Creator—individuality, power to think and to do. . . . It is the work of true education to develop this power, to train young people to be thinkers, and not mere reflectors of other people's thought."[21] Educators who embrace this ideology purposefully and iteratively will examine each aspect of teaching and learning, and build a community of inquiry to capitalize on every method possible to open learners' minds to the influence of the Holy Spirit.

Thus, designing an online course represents both an opportunity and a responsibility because it also allows us to share our faith with people who cannot access face-to-face graduate programs, in addition to offering excellent quality academic instruction. The challenge of teaching other human beings to think, explore, and accept new ideas/values, and to allow their lives to be transformed is great in any educational setting and even greater in the virtual classroom.

Christian faculty, whether in a face-to-face setting or an

online classroom, have the opportunity to lead their learners to Christ. This indeed requires wisdom and creativity. Let us all claim the promise in James 1:5: "If any of you lacks wisdom, let him ask of God, who gives to all liberally and without reproach, and it will be given to him" (NKJV).[22]

This article has been peer reviewed.

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Guest Editorial *continued from page 3*

sionals? Will the education we provide transform the lives of students and prepare them to be transforming agents in health care? Can we innovate by demonstrating interprofessional education and practice? Or will we take the easy route and continue our separate approaches to the detriment of more effective health care?

As we consider these challenges, our global network of Adventist schools of nursing continues to expand rapidly, now totaling 75 from Papua New Guinea to Africa, Asia, and North and South America. The global shortage of nurses ensures a demand for nursing education, and Adventist universities around the world are quickly adding nursing to their academic offerings. In many of these colleges and universities, there is no history of Adventist health care, and no Adventist nursing tradition on which to build. While these new programs faithfully follow government standards for accreditation, there may be little that is identifiably Adventist other than requiring courses in religion.

These conditions generate vital questions such as "What is unique about Adventist nursing education and practice?" and "What is our mission?" This issue of the JOURNAL includes research by Jones and Ramal et al., involving 212 nurses and nurse educators from 33 countries and 10 of the 13 world divisions of the church. From them, we learned what they described as the core elements of Adventist nursing, and we crafted a distinctive framework that can guide both the educational process and practice of Adventist nurses in providing care (p. 4). Johnston Taylor (p. 20) and Mamier et al. (p. 26) discuss the church's responsibility to prepare nurses to provide ethical spiritual care.

Because national requirements and culture influence curriculum content and structure, Wright and Wosinski address principles of curriculum development that are relevant across geographic and cultural boundaries (p. 14). Clinical instruction also varies greatly in different parts of the world, so Jael and Krull address issues related to clinical teaching that reveal differences and similarities in two diverse settings (p. 33). With interprofessional education the theme of the future, Wild and Molocho share examples of how it is done at the Loma Linda University School of Nursing and at Universidad Peruana Unión (UPeU) (p. 38). As distance education takes the place of face-to-face instruction, the question of how to transform the lives of students through the integration of faith and learning via the Internet becomes even more urgent. The need for graduate study to prepare for advanced practice, research, or teaching presents a complex challenge with many different paths to take. Lloyd, Gadd, Bristol, and Jones describe these options (p. 43).

Adventist nursing continues to be a dynamic force for change in the church and in the world. The question, however, remains: Will we *again* be leaders of change? Are we ready to develop and engage in transformative, interdisciplinary education while maintaining our distinctive focus and values? The global nature of our large and diverse network presents an opportunity to be a dynamic, globally connected system building upon an outstanding legacy, a shared mission, and a passion for service.

Our heritage summons us to demonstrate courage, commitment, and innovation as we consider these issues. Our response needs to be equally passionate.

Patricia S. Jones, PhD, RN, FAAN, *is Distinguished Emerita Professor at Loma Linda University School of Nursing (LLUSN) and Associate Director of the Department of Health Ministries in the General Conference of Seventh-day Adventists in Silver Spring, Maryland, U.S.A. Dr. Jones has also taught at Adventist University of the Philippines, Hong Kong Adventist College, and Vanderbilt University. She completed a bachelor's degree in nursing at Walla Walla College (now University), a Master's degree from Andrews University, and Master's and doctoral degrees from Vanderbilt University in Nashville, Tennessee.*

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The coordinators for this special issue, Patricia S. Jones and Edelweiss Ramal, acknowledge the contribution of Carla Jones, PhD, at the University of Colorado for reading earlier versions of some of these manuscripts.

Drs. Jones and Ramal undertook the responsibility of planning this issue with enthusiasm and vision, from selecting topics and soliciting authors to recommending reviewers and providing input and feedback to questions. The Editorial Staff of the JOURNAL *express heartfelt appreciation for their assistance throughout the planning and production of the issue.*

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Seventh-day Adventist Nursing Programs[1]

Table 1. Degree programs accredited by the AAA[2]

Division	Institution/Country/State	Degrees
ECD	Adventist University of Central Africa, Rwanda	Bachelor's
ECD	Adventist University of Lukanga, Democratic Republic of Congo (DRC)	Bachelor's
ECD	Bugema University, Uganda	Bachelor's
ECD	University of Eastern Africa Baraton, Kenya	Bachelor's, Master's
EUD	Friedensau Adventist University, Germany	RN to Bachelor's
IAD	Adventist University of Haiti, Haiti	Bachelor's
IAD	Antillean Adventist University, Puerto Rico	Bachelor's, Master's
IAD	Central American Adventist University, Costa Rica	Bachelor's
IAD	Colombia Adventist University, Colombia	Bachelor's
IAD	Dominican Adventist University, Dominican Republic	Bachelor's (C)[3]
IAD	Linda Vista University, Mexico	Bachelor's
IAD	Montemorelos University, Mexico	Bachelor's
IAD	Navojoa University, Mexico	Bachelor's
IAD	Northern Caribbean University, Jamaica	Bachelor's
IAD	University of Southern Caribbean, Trinidad and Tobago	Bachelor's (C)
NAD	Adventist University of Health Sciences, Florida	Bachelor's, Master's[4]
NAD	Andrews University, Michigan	Bachelor's, Doctoral
NAD	Kettering College, Ohio	Bachelor's
NAD	Loma Linda University, California	Bachelor's, Master's, Doctoral
NAD	Oakwood University, Alabama	Bachelor's
NAD	Pacific Union College, California	Associate, Bachelor's
NAD	Southern Adventist University, Tennessee	Associate, Bachelor's, Master's, Doctoral
NAD	Southwestern Adventist University, Texas	Bachelor's
NAD	Union College, Nebraska	Bachelor's
NAD	Walla Walla University, Washington	Bachelor's
NAD	Washington Adventist University, Maryland	Bachelor's, Master's
NSD	Sahmyook Health University College, Korea	Bachelor's
NSD	Sahmyook University, Korea	Bachelor's, Master's, Doctoral
NSD	Saniku Gakuin College, Japan	Bachelor's (C)
SAD	Bolivia Adventist University, Bolivia	Bachelor's
SAD	Brazil Adventist University, Brazil	Bachelor's
SAD	Chile Adventist University, Chile	Bachelor's
SAD	Northeast Brazil College, Brazil	Bachelor's
SAD	Parana Adventist College, Brazil	Bachelor's
SAD	Peruvian Union University, Peru	Bachelor's, Master's, Doctoral
SAD	River Plate Adventist University, Argentina	Bachelor's
SID	Adventist University Zurcher, Madagascar	Bachelor's
SID	Rusangu University, Rusangu	Bachelor's
SPD	Avondale College of Higher Education, Australia	Bachelor's, Master's, Doctoral
SPD	Pacific Adventist University, Papua New Guinea	Bachelor's
SSD	Adventist Medical Center-Illigan City, Philippines	Bachelor's
SSD	Adventist University of the Philippines, Philippines	Bachelor's, Master's
SSD	Asia-Pacific International University, Thailand	Bachelor's
SSD	Central Philippine Adventist College, Philippines	Bachelor's
SSD	Indonesia Adventist University, Indonesia	Bachelor's
SSD	Klabat University, Indonesia	Bachelor's
SSD	Manila Adventist College, Philippines	Bachelor's
SSD	Mountain View College, Philippines	Bachelor's
SSD	Northern Luzon Adventist College, Philippines	Bachelor's
SSD	South Philippine Adventist College, Philippines	Bachelor's
SUD	Lowry Adventist College, India	Bachelor's, Master's
SUD	METAS Adventist Hospital, Ranchi, India	Bachelor's
SUD	METAS Giffard Memorial Hospital, India	Bachelor's
WAD	Adventist University Cosendai, Cameroon	Bachelor's
WAD	Babcock University, Nigeria	Registered Nurse, Bachelor's, Master's (C)
WAD	Valley View University, Ghana	Bachelor's

Table 2. Degree programs that have not yet received AAA accreditation

The following programs may apply for evaluation and accreditation by the AAA.

SAD	Paraguay Adventist University, Paraguay	Bachelor's
SSD	Karachi Adventist Hospital College of Health Sciences, Pakistan	Bachelor's
SUD	Ottapalam Seventh-day Adventist Hospital, India	Bachelor's
SUD	Scheer Memorial Hospital, Nepal	Bachelor's
WAD	Adventist University of West Africa, Liberia	Bachelor's

Table 3. Certificate and diploma programs

In October 2017, the AAA approved criteria for accreditation of postsecondary certificate and diploma programs in nursing, among other areas. The following programs may now apply for evaluation by their respective Division Commission on Accreditation (DCA), and if approved, be accredited by the AAA.

ECD	Heri Nursing School, Tanzania	Nurse Technician
ECD	Ishaka Adventist Hospital, Uganda	Enrolled Nurse
ECD	Kendu Adventist Hospital, Kenya	Registered Nurse
ECD	Songa Adventist Hospital, DRC	Registered Nurse
EUD	Waldfriede Berlin Hospital, Germany	Registered Nurse
SAD	Misiones Adventist College, Argentina	Registered Nurse
SID	Malamulo College of Health Sciences, Malawi	Nurse Technician
SID	Mwami Adventist Hospital, Zambia	Registered Nurse
SID	Kanye Seventh-day Adventist College of Nursing, Botswana	Registered Nurse[5]
SID	Maluti Adventist Hospital, Lesotho, South Africa	Registered Nurse[5]
SSD	Adventist College of Nursing and Health Sciences (ACNHS) Penang, Malaysia	Registered Nurse (C)
SSD	Bangladesh Adventist Nursing Institute, Bangladesh	Registered Nurse (C)
SSD	Surya Nusantara Adventist College, Indonesia	Registered Nurse
SUD	METAS Adventist College, India	Registered Nurse

1. Tertiary-level nursing programs owned and operated by the Seventh-day Adventist Church.
2. The Accrediting Association of Seventh-day Adventist Schools, Colleges, and Universities (AAA).
3. (C) indicates candidacy status for AAA accreditation.
4. Subject to a regular visit scheduled for 2018.
5. Site visited and recommended by the DCA for AAA accreditation.

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