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THE LIVED EXPERIENCE OF FAITH COMMUNITY NURSES LIVING THE CALL
TO HEALTH MINISTRY

A Dissertation submitted in partial fulfillment of the requirements for the degree of Doctor
of Philosophy at Virginia Commonwealth University.

by

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Dedication

To my husband Jerry, who promised more than 33 years ago to love me for better and for worse, and who continues to love me through everything. I am so very blessed to have him as my spouse.

To my family, my sister, Gina, and my nephews, Matthew and Robert. May you be blessed for all of your love and support. I pray that I give each of you the gifts you have given me as you continue on your journey.

To those family members who have passed on during my dissertation journey; my mom, Barbara, my dad, Ed, my brother, Herb, my mother-in-law, Geneva, and my brother-in-law, Jimmy. Each of you taught me so much about life and death. It was my humbling honor to care for you. I pray you will always know the depth of my love.

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Allow me to count my blessings. I offer thanksgiving to God for His constant companionship in this endeavor. I believe this work is part of His plan for me as there were times when I could feel His very presence, especially as He blessed me with just the right people along this journey.

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Abstract

THE LIVED EXPERIENCE OF FAITH COMMUNITY NURSES LIVING THE CALL
TO HEALTH MINISTRY

By Deborah Darlene Simpson Mobley

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University.

Virginia Commonwealth University, 2009

Major Director: Inez Tuck, Ph.D., R.N., M.B.A., MDiv
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Faith community nursing is one of the newest specialized practices of professional nursing. A faith community nurse is an actively registered professional nurse, who serves as a paid or volunteer staff member in a faith community. The faith community nurse promotes health and wholism of the faith community, its groups, families, and individual members. A faith community, as in a church, synagogue or mosque, is an organization of individuals and families who share common beliefs, values, religious doctrine, and faith practices that influence their lives. The faith community functions as a client system for the faith community nurse.

The purpose of this study was to gain an understanding of the experiences of Protestant faith community nurses “living the call” to health ministry. Previous researchers have explored the roles of the faith community nurse, but have not specifically investigated

the experience of living the call. A hermeneutical phenomenological methodology was used to answer the question, “What is the lived experience of faith community nurses living the call to health ministry?” The participants were ten Caucasian female faith community nurses residing in four regions in the Commonwealth of Virginia. All participants acknowledged receiving a “call” to health ministry. A structured interview of 60 to 90 minutes was conducted with each participant. The interview consisted of structured and semi-structured questions and explored the meaning of living the call to health ministry. Data were analyzed using the phenomenological method of Max van Manen. Five themes emerged including: 1) the calling; 2) relating to God in living the call; 3) practice in living the call; 4) challenges in living the call; and 5) blessings in living the call. Participants described the experiences of the callings to health ministry, consistent communications with God and the challenges and blessings of faith community nursing. The practices of faith community nurses were also described by the participants. The findings provide a glimpse into the *lifeworld* of the faith community nurse living the call to health ministry. This study may be helpful to others wanting to gain a deeper understanding of the meaning of the calling to health ministry as well as the experiences of relating to God, practice, challenges, and blessings.

CHAPTER 1

STATEMENT OF PURPOSE

The purpose of this investigation was to gain an understanding of the experiences of Protestant faith community nurses “living the call” to health ministry. Previous studies explored the roles of the faith community nurse, but such studies did not specifically investigate the experience of living the call. Using hermeneutical phenomenology, I searched for meaning of living the call within the practice of faith community nursing. The findings of this research may support future investigations regarding the impact of the presence or absence of the call within faith community nursing practice while also increasing our understanding of the experiences of faith community nurses in health ministry.

Background

Faith community nursing is a specialized practice of professional nursing. A faith community nurse is a registered professional nurse, actively state licensed, who serves as a member of the staff of a faith community. The faith community nurse promotes health and wholism of the faith community, its groups, families, and individual members. The faith community nurse does so through the practice of nursing as defined by the nurse practice act in the jurisdiction in which he or she practices and by the standards of practice set forth by the Health Ministries Association (HMA) in collaboration with the American Nurses Association (ANA).

The faith community is defined as an organization of groups, families, and individuals that share common values, beliefs, religious doctrine, and faith practices that influence their lives. The faith community, such as a church, synagogue, temple, or mosque, functions as a patient system, providing a setting for faith community nursing (HMA & ANA, 2005, p. 36).

Solari-Twadell & McDermott (2006) have identified that faith communities have become natural settings for preventive healthcare:

1. Faith communities are everywhere.
2. Faith communities have long histories of serving communities through social activities and continuing education programs.
3. Faith communities underscore the need to take seriously the problems of the human spirit that are often related to the causes of illness.
4. Faith communities provide a remarkable reservoir of dedicated people who are willing to volunteer their services to assist in humanitarian endeavors.
5. Faith community members have a growing appreciation for the opportunity to model in their own church buildings and for the need for cooperation between scientific medicine and religious faith.

Having the ability to integrate individual needs and religious beliefs with preventive healthcare or other health needs provides the faith community nurse with the opportunity to minister to the mind, body, and spirit. The cooperation between scientific medicine and religious faith is a key component of preventive healthcare (Solari-Twadell & McDermott, 2006, p. 9).

Assumptions of Faith Community Nursing

The HMA and ANA (2005) identified five underlying assumptions of faith community nursing:

1. Health and illness are human experiences.
2. Health is the integration of the spiritual, physical, psychological, and social aspects of the patient promoting a sense of harmony with self, others, the environment, and a higher power.
3. Health may be experienced in the presence of disease or injury.
4. The presence of illness does not preclude health nor does optimal health preclude illness.
5. Healing is the process of integrating the body, mind, and spirit to create wholeness, health, and a sense of well-being, even when the person's illness is not cured. (pp. 2-3)

Historical Context of Faith Community Nursing

“Faith community nursing,” a term which is used interchangeably in literature and practice with “parish nursing” and “community health nursing,” is one of the newer recognized nursing specialties. For the purposes of this paper, the term “faith community nursing” is used except in instances in which the interview participant, literature or research cited uses “parish nursing,” “community health nursing,” or alternate term.

Faith community nursing has become interdenominational and interfaith in scope, with faith community nurses practicing in other religious settings. The HMA and ANA recognized the growth of faith community nursing beyond the Judeo-Christian communities and that the term “parish nursing” was not universally acceptable in many other faith traditions; thus, the HMA and ANA changed the title from “parish nurse” to

“faith community nurse” to embrace all faith traditions and establish expectations across faith traditions (HMA & ANA, 2005, p. 2).

Faith community nursing is consistent with the basic assumptions of faiths which believe care for self and others are expressions of God’s love. Faith community nursing focuses on the intentional care of the spirit as part of the process of promoting wholistic health and preventing or minimizing illness in a faith community (HMA & ANA, 2005, p. 1). Wholistic health is the understanding that a patient is an interconnected unity and that the physical, mental, social, environmental, and spiritual factors need to be considered in any intervention. The whole system, whether referring to a human being or a faith community, is greater than the sum of its parts. “Wholistic” is the preferred term when referring to the type of care provided by a faith community nurse (HMA & ANA, p. 39).

Health in faith community nursing is defined as the experiences of wholeness, salvation (as appropriate to the belief system), and shalom. It is integration of the spiritual, physical, psychological, and social aspects of the patient to create a sense of harmony with self, others, the environment, and a higher power. So according to faith community nursing’s definition, health may be experienced in the presence or absence of disease or injury (HMA & ANA, 2005, p. 37). Faith communities are where the faith community nurse and healthcare meet in the practice of wholistic care.

Florence Nightingale anticipated the wholistic theory of health which now persists in faith community nursing during the 19th century when she defined healing as the process of bringing together aspects of oneself—body, mind, and spirit—at deeper levels of inner knowledge, leading towards integration and balance, with each aspect having equal

importance and value. The process of healing can lead to more complex levels of personal understanding and meaning; it may be synchronous, but not necessarily synonymous, with curing (Dossey, Selanders, Beck, & Attewell, 2005, p. 341). Nightingale's concept of healing is compatible with the definition proposed by the HMA and ANA. The HMA and ANA (2005) defined healing as the process of integrating the body, mind, and spirit to bring about wholeness, health, and a sense of spiritual well-being, whether or not the person's disease is cured (p. 3). This process, which is closely aligned with the concepts of wholism, caring, health, and healing upon which faith community nursing focuses, aims to integrate the many parts of the whole individual human being.

In the publication *Healthy People 2010*, the United States Department of Health and Human Services (USDHHS) identified a comprehensive, best practice for public health planning. In *Healthy People 2010*, the first goal of public health planning is to help individuals of all ages increase life expectancy and improve their quality of life. This goal is accomplished by helping individuals gain the knowledge, motivation, and opportunities they need to make informed decisions about their health. At the same time, the USDHHS encourages local and state leaders to develop communitywide and statewide efforts that promote healthy behaviors, create healthy environments, and increase access to high-quality healthcare. Because individual and community health are virtually inseparable, both the individual and the community need to do their parts to increase life expectancy and improve quality of life (*Healthy People 2010*, 2002, p. 10). The second goal identified by the USDHHS is to eliminate health disparities among segments of the population, including differences that occur by gender, race or ethnicity, education or income,

disability, geographic location, or sexual orientation. Diversity may be one of the greatest assets in the United States; it also gives rise to a range of health improvement challenges that must be addressed by individuals, the community, the state, and the nation (*Healthy People 2010*, p. 16). Each of the two goals outlined in *Health People 2010* is monitored through 467 objectives in 28 focus areas. Faith communities have been identified as one kind of organization that plans and delivers community health promotion programs (*Healthy People 2010*, pp. 7-22 – 7-23). After careful review of the 28 focus areas, I determined that each area can be addressed through committed and organized health ministry programs with the leadership of faith community nurses. Within the faith community nurse's various organizational and educational roles, there exist many excellent opportunities to impact others in improving health and life expectancy and reducing health disparities. The roles of the faith community nurse assist parishioners in connecting the mind, body, and spirit; thus, the roles help achieve the goals outlined in *Healthy People 2010*.

Faith community nursing can impact the health and wholeness of faith communities by utilizing knowledge of the current health system issues and by implementing the goals set forth by agencies engaged in improving the health of the nation. It is important to acknowledge that there are more uninsured working Americans today than ever before; hence, limited access to and poor appropriation of healthcare resources have become problems of concern. Besides not having timely access to healthcare, many Americans do not have access to continuous care or appropriate and adequate treatment. With the exception of nurse practitioners, providers within the healthcare system focus on disease

states and spend little time in prevention and patient education. Education and disease prevention remain foundational for nurse practitioners. Further problematically, healthcare delivery continues to be provider-centered and/or payer-centered, not patient-centered. The need for faith community nursing has become increasingly apparent in healthcare, as so many individuals have limited resources and access. These limitations restrict attention to prevention and result in healthcare consumption only during illness or disease. The need for preventive healthcare remains largely unaddressed. Similarly, the ability of a healthcare provider to care for an individual wholistically is limited, due in part to time restrictions and volume of patients. Faith community nursing can participate in the care of individuals by supporting them with prevention information, education, advocacy, and access for acute care.

As previously stated, “faith community nurse,” “parish nurse,” and “congregational health nurse” are terms used interchangeably which describe the same role. The most recent term, “faith community nurse,” resulted from a collaborative revision between the HMA and the ANA of the 1998 *Parish Nurse: Scope and Standards of Practice* (HMA & ANA, 2005, p. viii). This revision began in 2004, and in 2005, the second edition of *Faith Community Nursing: Scope and Standards of Practice*, which reflected the revision, was published. This document superseded the 1998 publication of the *Parish Nurse: Scope and Standards of Practice*. The movement from using the term “parish nursing” to using the term “faith community nursing” promotes the understanding that this specialized practice occurs in the multidisciplinary practice arena of faith communities, which is inclusive of rural, urban, and suburban areas as well as other faith traditions. The HMA is the

nationally recognized professional organization representing faith community nurses and others working in the expanding faith community (HMA & ANA, p. viii). The term “faith community nurse” is used in this investigation unless otherwise specified or referenced differently by authors of cited literature or research.

The origin of faith community nursing as a distinct practice began in 1979 when the Reverend Dr. Granger Westberg conceived an idea of a healing treatment team and received grant funding from W. K. Kellogg Foundation to create wholistic health centers in Christian congregations. A treatment healing team comprised of a physician, nurse, social worker, and pastoral counselor staffed the centers. The nurses in these centers were referred to as “parish nurses.” Westberg reported that outside observer evaluations of these settings over a period of ten years indicated that the quality of care offered by the healing team was measurably more whole-person oriented than in the average doctor’s office. Westberg and the outside observers determined that the nurses were the catalysts that bound those professions together in a common appreciation of the healing talents of each. Westberg stated that nurses seemed to have one foot in the humanities and one foot in the sciences and thereby were able to bridge the unnecessary gap between these two very old and esteemed professions (Westberg, 1990, p. 17). Articulating this belief, Rev. Westberg wrote:

Long before anyone wrote articles on wholeness, wellness, and preventive healthcare, nurses were already practicing whole-person care, at least for the few moments they were allowed to escape from the technical aspects of their work. Nurses are national treasures, reservoirs of compassion and strength, and pearls of great price that have been hidden from view for far too long. For more than forty years, nurses have pleaded with the medical profession that it becomes oriented toward preventive medicine that it concentrates on teaching people how to stay

well. Now is their chance to reach thousands of people in the informal setting of an institution that is ready to rethink its role in motivating people toward healthy living. (Westberg, pp. 19-20)

During the first few years of the parish nurse project it became clear that parish nurses practiced within five roles: health educator, personal health counselor, referral agent, coordinator of volunteers, and developer of support groups (Solari-Twadell & McDermott, 2006, p. 6). It is the role of the faith community nurse to involve people in their own healthcare as a part of the responsible stewardship of one's life (Westberg, 1990, p. 17). Granger Westberg stated, "It gradually dawned on us that churches are actually the one organization in our society most suited to lead in the field of preventive medicine" (Solari-Twadell & McDermott, p. 7).

The International Parish Nurse Resource Center (IPNRC) established curricula for education and preparation of faith community nurses and faith community nurse coordinators in order to provide a more transformative curriculum which supplies knowledge, skills, and attitudes necessary to develop a parish nurse practice. The content includes core concepts of professional nursing, including attention to person, health, environment, and nursing. As a specialty practice of health ministry, faith community nursing education also embraces the additional concepts of spiritual care, professionalism, shalom as health and wholeness, and community (incorporating culture and diversity). Learning modules are written at the baccalaureate level and are organized within four units:

1. Spirituality (includes history and philosophy of parish nursing, prayer, self-care, healing, and wholeness);

2. Professionalism (includes ethical issues, documentation practice, legal aspects, organization of ministry, communication, and collaboration);
3. Wholistic Health (includes health promotion, transforming life issues—family violence, suffering, grief, and loss); and
4. Community (includes assessment, accessing resources, advocacy, and care).

The IPNRC offered the first continuing education program for parish nursing in 1987 (Deaconess Parish Nurse Ministries, LLC, 2009). The annual Westberg Symposium for parish nursing evolved from the first continuing education program and continues annually in Saint Louis, Missouri. In 1996, the IPNRC conducted a needs assessment with a convenience sample of 50 parish nurse coordinators. The results served as a basis for a three-year collaborative effort between Marquette and Loyola Universities and the IPNRC. The outcome of these efforts was the development of national curricula by leaders and educators in faith community nursing for use in the basic preparation and coordinator roles (McDermott, Solari-Twadell & Matheus, 1999). It has been estimated that over 10,000 nurses have been prepared as parish nurses/faith community nurses. In a separate role, a faith community nurse coordinator oversees faith community nurse practices in one or multiple settings. A faith community nurse coordinator is a liaison between an institution, parish nurse, pastor, and/or congregation for the purposes of developing, supporting, and maintaining the ministry of parish nursing practice. An institution may include a hospital, home care agency, health department, school of nursing, hospice, or other community agencies (Solari-Twadell, 1999, p. 5). For example, a denomination may have one faith

community nurse coordinator supervise multiple faith community nurses in multiple churches within a specific geographical area and liaise with appropriate institutions.

The Call to Serve

James W. Fowler's (1987) book, *Faith Development and Pastoral Care*, explored the word "vocation," which comes from the Latin *vocare*, "to call", and *vocatio*, "call" or "calling." Fowler stated:

It is a word with particular relation to biblical religion. Traditionally, it has referred to God's calling of particular persons or groups into a special relation with God. God's call to Abraham brought him into a covenant relation that eventually formed a partnership people. God's call to Moses led to the liberation of Israel from slavery and a new covenant, under Torah, at Sinai. . . . In the New Testament the term for calling is the Greek word *klesis* which means a 'calling, invitation, summons' usually of God, and to religious life. It is related to the verb form *kalio*, 'I call, summon, or invite.' The *klesis* refers to the special relationship to which all who became followers of Christ were called to a relationship of fidelity to God and reliance upon God's promises. (Fowler, pp. 27-28)

Fowler also explained that vocation cannot be reduced to one's work or occupation because "vocation is bigger than our careers or our professions, though it may include both." Fowler explained that his view promotes "a refocusing of leisure, relationships, work, private and public lives and the resources we steward in the service of God and in the love of the neighbor" (Fowler, 1987, p. 32).

Fowler further stated:

In the tradition of *vocation* there is the conviction of our place, our office, our vocation, in not merely a destiny to which God assigns us but a place of creative partnership to which God calls us and in which God chooses to meet us and bring our work to some significant contribution to the purposes of God. Vocation is the response we make with our total selves to the call of God (acknowledged or unacknowledged) and to God's calling to partnership. . . .Vocation and covenant go together. In a covenant of community, persons with different callings are bound together with common loyalties to a cause or to beliefs and values that are bigger

than they. In a covenant community, for the sake of shared loyalty to the cause from which the community came into being, they work at relations of mutual trust and loyalty with their companions in community and with the cause that animates its purpose. (Fowler, 1987, pp. 31-32, 35)

The Protestant tradition understands the call in two dimensions—an internal call from God and an external call from the community. Fowler further clarified the call or vocation:

Vocation derives from that profound sense that we are called into existence in this time and this place and among these people for the sake of investing our gifts and potentials in furthering some cause that is of transcending importance. (Fowler, 1987, p. 32)

One of the first nurses who acknowledged a call to the profession was Florence Nightingale. She viewed nursing as a “calling” and a work of service to others. Nightingale recognized several experiences which she called “inner awakenings” when she felt called by God. When Nightingale was 16 years old she had her first experience of a calling. As she developed interests in theology, she experienced a second call to care for the sick. She did not believe that she received specific instructions from God; however, she did feel a sense of inner certainty that her life would be devoted to God (Widerquist, 1992; Macrea, 2001). Florence Nightingale’s nursing practice validated the origin, the call, and the practice of the nursing profession in its early development. Nightingale stated that spirituality “is not an intellectual belief, but an actual experience” (Macrae, p. 21). Just as nursing was recognized by Florence Nightingale as a spiritual practice, it has also been described as such by many nurse authors (Watson, 1979; Shelly & Miller, 1999; O’Brien, 1999; 2001; Macrea 2001; Dossey, Selanders, Beck & Attewell, 2005; Hickman, 2006).

Nursing literature does not offer one clear definition of spirituality. Verna Benner Carson (1993) wrote, “Definitions of spirituality represent a variety of worldviews and the opinions of people from divergent walks of life” (p. 25). Most definitions of spirituality in nursing literature cite various elements of love, a relationship with God, a sense of caring, transcendence, compassion, and the connection of the mind, body, and spirit (O’Brien, 1999, p. 6). Nightingale believed that nursing’s concerns were the restoration and promotion of health (body, mind, and spirit), the prevention of disease, and the assistance to patients and families with their needs. She emphasized that nurses’ concerns included the patient’s experience and that spiritual and social support, along with a comfortable and healthy environment, influenced all factors in healing. The active participation of the nurse was part of the healing process (Dossey et al., p. 8). Nightingale’s understanding of the role of the nurse was also influenced by her definition of healing. Nightingale described nursing as healing. Nightingale viewed healing from a wholistic perspective as a process of bringing together all aspects of oneself—body, mind, and spirit. According to Nightingale, such integration of the parts of the self was critical to achieve and maintain wholism and balance. She saw spirituality as a driving force for healing. Healing was the essence of nursing and of her work for humankind. Her source of strength and guidance for doing her work was in service to God and others (Dossey et al., p. 7).

Florence Nightingale wrote a series of thirteen letters over a 28-year period to student nurses training at St. Thomas’s Hospital in London. In these letters she stressed Christian values while performing everyday activities. Although she wrote these letters from a Christian perspective, Nightingale began to express an ecumenical sense of

“religion and a universal sense of spirituality” (Dossey et al., 2005, p. 203). It is believed that her views began to evolve as she continued to read the literature of world religions. Nightingale taught and practiced appreciation for other cultures, different beliefs, and rituals. The letters continually shared her vision.

After reading Nightingale’s experiences of the call to nursing, I was prompted to have conversations with other faith community nurses regarding their entries to nursing and faith community nursing. I became interested in the experiences of faith community nurses and their health ministries in relationship to the call. As I listened to individuals tell about their experiences, I noticed a wide variety of differences in how the call was received. For instance, some individuals observed experiencing a call only once while others observed experiencing a call multiple times. Individuals also expressed differing perceptions of the source of the call (from others or God or both), the intensity of the call, and emotionality of the call. I knew I also wanted to learn more about living the call in health ministry. Along with consultations with my dissertation chair, these initial observations lead to this study. In this study, the exploration of the call in relationship to health ministry was explored using a phenomenological hermeneutic approach. As I wanted to understand more about the origin of the call and each faith community nurses’ understanding of self within the call, I selected the ontological approach. Ontology is the philosophical study of the nature of being (Webster’s II, 1988, p. 822). Martin Heidegger is credited with reviving ontology and the reflection on the question of ‘being’ or *Dasein*, which refers to the aspect of humanness capable of wondering about its own existence and inquiring about its own Being. As a phenomenologist, Heidegger was an assistant to

Edmund Husserl. He was drawn to Husserl's endorsement of the objectivity of truth. To Heidegger, truth's objectivity seemed to be compatible with Aristotle's philosophy, which had become the basis for Heidegger's work. For years, Husserl and Heidegger battled over their divergent thinking—Husserl favored the concept of internal time consciousness while Heidegger favored the theory of fundamental ontology. Heidegger's *Being and Time* merged hermeneutics with Husserl's descriptive phenomenology to produce hermeneutical phenomenology. Heidegger believed that in order to pose a question or inquiry, something about the nature of the subject matter of the question must already be understood. Hans-Georg Gadamer acknowledged this introduction of the hermeneutic nature of human being as well. He believed that in interpreting a text we cannot separate ourselves from the meaning of the text. According to van Manen, Gadamer believed that the reader belongs to the text he or she is reading. Understanding relies on an interpretation, and so the problem of understanding necessarily involves interpretative dialogue with the text. In other words, because interpretation is subjective, the reader is an active participant in the construction of the meaning of the text.

Max van Manen (1990), a hermeneutical phenomenologist, wrote, "Every project of phenomenological inquiry is driven by a commitment of turning to an abiding concern. This commitment of never wavering from thinking a single thought more deeply is the practice of thoughtfulness, of the fullness of thinking" (p. 31). Max van Manen's method is in search of the depth of meaning of the phenomena in which the writer can dwell. The lived experience is the starting point and the end point of phenomenological research. Van Manen explained the aim of phenomenological research:

[T]o transform lived experience into a textual expression of its essence—in such a way that the effect of the text is at once a reflexive re-living and a reflective appropriation of something meaningful: a notion by which a reader is powerfully animated in his or her own lived experience. (van Manen, p. 36)

The methods of Max van Manen guided the work of this research to intimately examine the lived experience of the faith community nurse living the call to health ministry.

In published research, the nursing profession has indicated a renewed interest in personal spirituality as well as the spiritual needs of patients and families (O'Brien, 2001, pp. 4 -5). However, nursing literature contains minimal discussion of the concept of nursing as a calling or vocation as the recent citations date to the mid-1990s. The following chapter presents the research literature that contributes to the understanding of the call to nursing and faith community nursing.

Conclusion

This chapter explored the purpose of this investigation, which was to gain an understanding of the experience of Protestant faith community nurses living the call to health ministry. Faith community nursing was introduced as a specialized practice of professional nursing in which the nurse serves as a member of the staff of a faith community. The faith community nurse promotes health and wholism of the faith community, its groups, families, and individual members, and the community it serves. This chapter also briefly chronicled the history of faith community nursing and explored the call to serve through the work of James Fowler and through illumination of Florence Nightingale's calls from God to serve the sick. The chapter also introduced the research methods of Max van Manen, which are further discussed in Chapter 3.

CHAPTER 2

REVIEW OF THE LITERATURE

This chapter is devoted to a review and analysis of the research related to the study of the lived experience of faith community nurses living the call to health ministry. In general, the nursing literature describing faith community nursing is expansive; however, the majority is not based in research. Much of the research explores one or more of the nursing roles and/or interventions in the delivery of care in faith community nursing. Additionally, in some research studies, faith community nurses have acknowledged a call to health ministry. This review includes the significant literature for parish nursing/faith community nursing in relationship to living the call to health ministry.

Many faith community nurses have expressed their service to their faith community as a received calling. As part of her dissertation, Dr. Margaret Myers published, *Parish Nursing Speaks: The Voices of Those Who Practice, Facilitate, and Support Parish Nursing*. Dr. Margaret Myers recognized the void in the research literature that captured the “voices” of parish nurses. Her goals in conducting the research were threefold: 1) to use the findings to structure education and practice; 2) to implement research into an existing nursing theoretical framework for parish nurses; and 3) to later develop a new theoretical framework for parish nursing from the ‘meaning experience.’ She explored the meaning of the role with 22 practicing parish nurses by utilizing a qualitative research methodology. Through the constant comparison process of grounded theory, Myers found that those nurses believed that the process of calling was a ‘beckoning’ or a ‘calling to

care.’ The parish nurses believed that they were ‘being called or invited’ into one of the most special and intimate of professions. Myers further stated:

Participants believed that this calling allowed them ‘a glimpse of the sacred,’ ‘a means to be on a journey with other persons,’ and ‘to be in a position of immense importance in people’s lives when they are most vulnerable.’ Calling was described as ‘a calling from God or the Supreme; ‘a calling to be an instrument of gentleness and compassion; ‘a calling to nurse with a kind of depth that includes attention to spirituality; ‘a commitment across the board to the kind of nursing described by Nightingale’. They felt their calling was ‘to express whole person nursing care which includes spiritual care.’ (Myers, 2002a, pp. 106-107)

In Myers’ research, parish nurses expressed that they experienced ‘a call within a call’— initially a call into nursing, and later, a call into parish nursing. Parish nurses spoke of the call to parish nursing as ‘a way of being.’ Parish nurses explained the call as “embracing all aspects of their lives, and they talked about providing nursing actions in all areas of their lives” (Myers, 2002a, pp. 106 – 107; 324 - 326). Myers’ research and the research of Tuck & Wallace (2000), Tuck, Pullen & Wallace (2001), and Wallace, Tuck, Boland & Witucki (2002) were the impetus for my research interest in faith community nursing and the phenomenon of living the call.

Van Dover and Pfeiffer (2006) used grounded theory to explore and describe the processes experienced and used by ten American parish nurses who provided spiritual care within their faith communities. The study was conducted to develop a consensus on how spiritual care should be conceptualized and provided. ‘Bringing God Near’ emerged as the core category and became a Basic Social Process theory, encompassing five sequential phases: trusting God, forming relationships with the patient or family, opening up to God, activating or nurturing faith, and recognizing spiritual renewal or growth. Concepts were

revealed in each of the five phases through coding and constant comparative analysis (Van Dover & Pfeiffer, p. 215). Although the number of participants was small, the authors believed that 50 spiritual caregiving incidents supported the development of theory. The spiritual caregiving incidents were communicated by the authors as how parish nurses come close to people who need spiritual caregiving. The authors stated that parish nurses conveyed the love and power of Jesus. The parish nurses acknowledged that the link to God and patients in moments of elation, joy, distress or suffering were both the mystery and reality of an encounter with God and the healing that results (p. 216). The authors acknowledge that each participant was interviewed only once. Additional communications through the telephone or other communications technology may have strengthened Van Dover and Pfeiffer's results. The report of this study does not indicate the ethnic diversity of participants. Further research is necessary to test the theory of 'Bringing God Near.' Pertinent to my research is the theory that 'Bringing God Near' means that the nurse's focus is on both the patient and God. Nurses expressed being used by God as a conduit, bridge, ambassador, or vessel through which the presence of God is brought to the patient or family experiencing illness or crisis. One of Van Dover and Pfeiffer's study participants described her work as a parish nurse as "[her] mission or [her] calling from God to bring His presence to others" (p. 216). This study is pertinent to my research as it has given meaning to the intentionality of spiritual caregiving by parish nurses. Beyond prayer and other forms of worship 'Bring God Near' is living the call to health ministry.

Tuck and Wallace (2000) conducted ethnographic research to examine parish nursing as an evolving nursing specialty. The descriptive, exploratory study consisted of

structured and semi-structured interviews with those involved in the practice of parish nursing including spiritual leaders (n=5), program administrators (n=3), congregational members (n=17), and parish nurses (n=7). One of the most pertinent findings supporting my research was taxonomy of parish nurse concepts which reflected the perspectives of parish nurses and described parish nursing as a “calling,” “privilege,” or “blessing.” This research supported the term “calling” as a description of parish nursing practice. A strength of this research was the use of a well-defined method for what could be perceived as a nebulous exercise. The research also developed beginning taxonomies for future use in research to measure intervention and outcomes. This research also acknowledged that the parish nurses were employed and trained by the same hospital system and reported to the same program coordinator, which may account for similarities in program implementation and less variation in informant views and perceptions (Tuck & Wallace, p. 297).

Tuck, Pullen, and Wallace (2001) conducted a comparative study of the spiritual perspectives and interventions of mental health and parish nurses. Spiritual perspective was defined as how one views a relationship with God or a higher power and how meaningful spirituality is in one’s life. The Spiritual Perspective Scale (SPS) was utilized to indicate the importance of spirituality to the individual. Mental health nurses (n=91) and parish nurses (n=95) completed the study, and both groups reported high spiritual perspective scores, with the mean score for parish nurses being significantly higher than mental health nurses (Tuck et al., p. 599). Spiritual interventions were defined as self-defined activities performed by nurses to meet the spiritual needs of their clients. The spiritual interventions reported by mental health and parish nurses included: praying,

listening, touching, being present, being available, teaching, supporting, referring, encouraging, offering self, talking, and counseling (Tuck et al., p. 601). Of interest, the spiritual intervention of prayer was utilized by both groups with parish nurses reporting prayer as the most frequent intervention and with parish nurses reporting prayer performed more frequently than mental health nurses. Overall, parish nurses reported twice as many spiritual interventions as mental health nurses over a two-week period (Tuck et al., pp. 600-602). This triangulated study brought forward spiritual beliefs, attitudes, and practices of parish nurses and mental health nurses. Although the study did indicate the level of nursing education of participants, it did not indicate whether the parish nurses had specifically received parish nurse education. The presence or absence of parish nurse education may provide additional insight in which to evaluate the findings. This study highlighted the need for my study to the inclusion criterion for participants of having completed a basic parish nurse education course.

Wallace, Tuck, Boland, and Witucki (2002) examined parish nursing from a client's perspective. A convenience sample from two separate churches in the same geographical area totaled 17 participants. Site One was primarily an African American, inner-city church with 780 members, and Site Two was primarily Caucasian in a suburban/rural area with 2200 members. Both churches had paid parish nurses. Seventeen clients had face-to-face interviews where three types of questions were asked: descriptive, structural, and contrasting. A sample of a descriptive question was, "Tell me about your experience with the parish nurse." A sample of a structural question was, "Tell me about how you know about what the parish nurse is doing." A sample of a contrast question was,

“Tell me about how the parish nurse experience is related to your regular health or medical care.”

Five major themes of client perception of parish nursing emerged from the data: 1) being available; 2) integrating spirituality and health; 3) helping parishioners to help themselves; 4) exploring parish nursing; and 5) evaluating parish nursing. Participants tended to recognize the personal spirituality and spiritual growth of the parish nurse. In addition, participants observed that spiritual growth correlated with duration of time spent at the position—the longer a parish nurse stayed at her position, the more spiritual growth occurred (Wallace et al., p. 131). The authors asserted that according to the perceptions of the clients in this study, parish nursing may be an approach to successfully meet the goals of *Healthy People 2010*. The authors expressed that parish nurses are equipped to provide services that are culturally appropriate, credible, and accessible within the community. This research was interesting as it developed client observations about the practice of parish nursing. The average age of the clients was 65.6 years at Site One and 55 years at Site Two. It would be interesting to compare the results of this research with a less mature, younger population. This study provided perceptions of the mature client as related to their experiences and observations of parish nurses.

Weis, Schank, and Matheus (2006) sought to describe the services of parish nurse empowerment, of client empowerment, and the empowerment outcomes for both nurses and clients. Empowerment was defined as an enabling process arising from a mutual sharing of resources and opportunities that enhanced decision-making to achieve change at the individual, congregation, and community levels (Weis et al., p. 18). A qualitative

structure with a semi-structured interviewing group discussion format was utilized.

Twenty-eight paid parish nurses participated in the study. The participants represented six different Christian denominations with congregations ranging in size from fewer than 100 congregants to 1,000 congregants in both rural and urban areas. Trends were identified that described parish nurse empowerment. The factors identified for parish nurse empowerment included being valued, implementing one's role, engaging with a higher power, gaining experience and education, reciprocally interacting with patients, and working with mentors. Of these factors, the research specifically highlighted the trend among parish nurses to rely on a higher power as a source of empowerment. Other research has also indicated that the relationship with a higher power is central to the practice of parish nurses (ANA, 1998). Empowerment was found to be a reciprocal process that resulted in an enhancement of the nurse-client relationship. The client experienced empowerment through increased knowledge, self-esteem, and decision-making. The parish nurse experienced empowerment through self-worth, recognition of expertise, and a development of partnership with the client and faith community (ANA, p. 24). This research provided insight into the sources of empowerment for faith community nurses. It is worth noting that all 28 participants completed the same parish nurse education program, producing at least in part a homogenous sample thus impacting the findings, particularly in the area of recognition of expertise. The report of the study does not indicate the ethnic diversity of participants. Of interest to me would have been the inclusion of another variable—the call and its relationship to parish nurse empowerment.

Mosack, Medvene, and Wescott (2006) published preliminary research that explored the educational background of parish nurses and parish nurse associates as well as the extent of the members' communal orientation. This study was one of the first studies to include parish nurses who had completed the basic preparation course as well as parish nurses who had not completed the course. Therefore, parish nurse associates were defined as registered nurses not having received basic parish nurse education. Communal orientation was characterized by a desire to give and receive benefits in response to the needs of and out of concern for others. This research was conducted to assist the Center for Congregational Health Ministry (CCHM) in the State of Kansas to better understand its participants. The CCHM is an ecumenical network of congregation-based parish nursing programs statewide. Data were collected from a cross-sectional survey of 165 participants (100 parish nurse coordinators and 65 parish nurses or parish nurse associates). The survey instrument was constructed following personal interviews with ten local parish nurses and with the help of an advisory committee. The first set of questions asked participants about their reasons for becoming a parish nurse. In answering, participants were offered four options: invitation by family, friend or another parish nurse; approach of clergy or church member; a calling; or other. The findings for this question revealed that almost half of the parish nurses entered because they were motivated by church or by family and/or friend's encouragement. Specifically, 27.0% of parish nurses cited they were motivated by church while 22.7% of parish nurses cited encouragement from family, friend, or another parish nurse. The other half (47.9%) indicated they were motivated to become a parish nurse because of personal interests, including a calling to become a parish nurse. The second set

of questions asked participants about the completion of a basic preparation education course, demographic information (both personal and congregational), and the model of practice (paid versus unpaid). The findings revealed over half (53.3%) of the participants had completed a basic preparation course approved by the IPNRC. Less than half (46.7%) of the nurses had no formal parish nurse education. The final set of questions explored the extent of participants' communal orientation. This measurement assessed the degree to which a person likes to help others and enjoys being helped. A fourteen item, 5-point Likert scale was utilized by participants to rate the statements as extremely uncharacteristic to extremely characteristic. The findings suggested that parish nurses perceive themselves as people who like to help others as well as receive help (Mosack et al., p. 350). Communal orientation positively correlated with the number of activities in which parish nurses participated or provided to congregations.

A new finding in Mosack et al.'s (2006) study was that approximately half of the parish nurses came to this specialty through church contacts and friendships (p. 350). In past studies, parish nurses revealed that they experienced a calling from a higher power to this service. Of interest would have been the publication of the data separating the parish nurse and parish nurse associates responses as to the reasons for becoming parish nurses or parish nurse associates. This would have added a dimension for further research and discussion regarding the receipt of a call and educational preparation. Nonetheless, this study is important to the parish nurse research because it established some differences of those prepared through basic education (parish nurses) and those who have not received basic education. This finding confirmed the research of Solari-Twadell (1999), which

indicated that there is a group of self-identified parish nurses who have not received basic parish nurse education and who work less than 20 hours/week. According to this particular study, those parish nurses who had completed basic parish nurse education worked twice as many hours per week as the parish nurse associates. An additional finding was that parish nurses tend to see themselves as people who like to help and be helped. “This characteristic—called communal orientation in the social psychological literature—has been associated with positive outcomes for helpers and patients. This finding contributed to the understanding of who parish nurses are as people” (Solari-Twadell, p. 350).

In summary, faith community nursing is an emerging specialty with just over half having formal faith community nurse education. Faith community nursing has been described as a calling, privilege, or blessing with some faith community nurses coming to the specialty through church contacts and friendships. Faith community nurses have identified a personal commitment to God and a higher power as a source of empowerment. This affirms the reliance on a higher power for practice. Faith community nurses have expressed their service to the faith community as a received calling. Faith community nurses revealed that the calling was “a beckoning,” “calling to care,” or “an invitation” into one of the most special and intimate professions. James Fowler (1987) asserts that vocation is a place of creative partnership by which God chooses to meet us and bring the work to the purposes of God (p. 31). Faith community nurses fulfill this notion of vocation in part, through prayer and spiritual intervention. Prayer is utilized as a spiritual intervention by faith community nurses more frequently than mental health nurses. Additionally, according to a two-week study, faith community nurses reported twice as many spiritual interventions

as mental health nurses. This finding highlights that faith community nurses adapt their role and responsibilities to approach healthcare more holistically than mental health nurses.

The above literature review focused on the published research pertinent to my research interest of living the call to health ministry. I acknowledged the existence of other research that focused on the role of the faith community nurse, educational, and spiritual interventions provided, and the clients' or patients' response to the care rendered by the faith community nurse in both urban and rural settings. Although research literature exists examining the experiences of the faith community nurse, I focused on investigating living the call to health ministry. The major limitation in the research literature is an exploration of the lived experience of the faith community nurse living the call to health ministry.

Ultimately, gaining insight into the experience of living the call will help to form a foundation for further research in the areas of spiritual and wholistic practice, basic faith community nurse educational requirements, and the call to the practice of faith community nursing. This study also provided training in conducting phenomenological research and assisted in contributing to the literature of the experiences of living the call in health ministry.

Conclusion

This chapter was devoted to a review and analysis of the research related to the study of the lived experiences of faith community nurses living the call to health ministry. Many faith community nurses have expressed their service to their faith community as a received calling. A major limitation was identified in the literature for the emerging

specialty of faith community nursing, namely the lack of exploration of the lived experience of the faith community nurse living the call to health ministry. Gaining insight into the experience of living the call to health ministry may promote further research in the areas of spiritual and wholistic practice, basic faith community nurse educational requirements, and the call to the practice of faith community nursing.

CHAPTER 3

METHODS

This study focused on the lived experience of faith community nurses living the call to health ministry. Given the limited research literature in this topic area, I first elected to gain an understanding of the lived experience. The qualitative research method of phenomenology was used for generating data. Specifically, a phenomenological and hermeneutical approach was utilized to generate and analyze data. The methods of Max van Manen were followed. In van Manen's (1990) book, *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*, van Manen described a human science research approach, showing a semiotic employment of the methods of phenomenology and hermeneutics. The aim of this study was to describe the meaning of living the call to health ministry as experienced by faith community nurses. The phenomenological research question was, "What is the lived experience of faith community nurses living the call to health ministry?"

Research Design

Max van Manen's qualitative research methods were appealing to me as I searched through phenomenological research methods. Van Manen captured my commitment after reading his 1990 book *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy* and noting in particular, the following passage:

From a phenomenological point of view, to do research is always to question the way we experience the world, to want to know the world in which we live as human beings. And since to *know* the world is profoundly to be in the world in a

certain way, the act of researching – questioning – theorizing is the intentional act of attaching ourselves to the world, to become more fully part of it, or better, to *become* the world. Phenomenology calls this inseparable connection to the world the principal of “intentionality.” In doing research we question the world’s very secrets and intimacies which are constitutive of the world, and which bring the world as world into being for us and in us. Then research is a caring act: we want to know that which is most essential to being. To care is to serve and to share our being with the one we love. We desire to truly know our loved one’s very nature. And if our love is strong enough, we not only will learn much about life, we will also come face to face with its mystery. (pp. 5-6)

The essence of van Manen’s philosophy helped me to view my connection with this research. I too am a practicing faith community nurse. As van Manen stated, researching is a caring act, and I anticipated that interviewing my colleagues about their call to health ministry and their personal journey would be a very intimate and private experience, one that would require a caring attitude, sensitivity, and a secure environment. Reading van Manen’s work, I began to envision the bond of his methods with my research topic. The bond of caring and serving is at the very core of faith community nursing practice.

Van Manen communicates meaning using several forms of writing. For instance, he explained that when the research involves in-depth interviews, the interviews may be reworked into reconstructed life stories or the conversations may be analyzed for relative anecdotes. Additionally, one may use participant’s stories described in the interviews for constructing fictionalized anonymous accounts that bring out contrasting ways of seeing or acting in concrete situations (van Manen, 1990, p. 170). Faith community nurses connect with one another through the sharing of experiences through storytelling. Much teaching takes place in and through the sharing of experiences. The anonymity of the parishioner is preserved as the stories are told. I sought existing research using van Manen’s research

methods to explore aspects of nursing. Topics addressed in research using van Manen's methods included the lived experience of being comforted by a nurse, nurses' experiences of the death of their patients, and the nursing moments experienced. The nursing moments experienced included the various moments in nursing such as understanding, comforting, being present, encouraging, touching, and reflecting. Van Manen's method is briefly outlined in the appendices (See Appendix A – "Max van Manen's Qualitative Research Methodology"). I was guided by each step in van Manen's method and describe below my implementation of his methods:

1. Turn to the nature of lived experience by orienting to the phenomenon, formulating the phenomenologic question, and explicating assumptions and pre-understandings.

In orienting to the phenomenon, I have acknowledged that I am a faith community nurse and meet all the criteria for inclusion in this research. I completed both the basic faith community nurse and faith community nurse coordinator education courses. I oriented to the phenomenon of living the call by studying, listening, speaking, practicing, and teaching in and through faith community nursing. The phenomenological question, "What is the lived experience of faith community nurses living the call to health ministry?" arose through discussions and explorations of my interest in faith community nursing with the chair of my dissertation committee. My assumptions, beliefs, biases, judgments and pre-understandings prior to engaging in research are listed below:

1. Qualitative research methodologies are ideal for many types of investigations, including nursing.

2. Realities cannot be studied independent of their context, which affirms the legitimacy and significance of qualitative research.
3. Language is historical and can provide truth in expressions of the lived experience.
4. One's experience of the world does not solely rest in language; preverbal experiences such as gestures, movements, and expressions communicate nonverbal clues to the lived experience.
5. Health is a constantly changing process that affects an individual's well-being in the physical, mental, social, or spiritual realms.
6. Faith community nursing is an opportunity to practice wholistic care rather than isolating practice to "a part" versus the whole being of an individual composed of many physical, mental, social, and spiritual parts.
7. Faith community nurses will be able to articulate their reason(s) for entering into health ministry.
8. The phenomenon of living the call in faith community nursing will manifest itself in the practice of health ministry.
9. Living the call to health ministry impacts the individual spirituality of the faith community nurse.
10. Individual spirituality impacts the experience of living the call to health ministry.

These assumptions, beliefs, biases, judgments, and pre-understandings were best acknowledged before beginning research in an effort to limit their influence during data

generation and analyses of data. As the research process progressed, additional assumptions, beliefs, biases, judgments, and pre-understandings were documented as a part of journaling.

2. Engage in existential investigation, which involves exploring the phenomenon, generating data, using personal experience as a starting point, tracing etymologic sources, searching idiomatic phrases, obtaining experiential descriptions from participants, locating experiential descriptions in the literature, and consulting phenomenologic literature, and so forth.

I used my personal experience as a starting point with a description of my lived experience as a faith community nurse living the call to health ministry in experiential terms that focuses on specific situations or events. This material is recognized to be data or material on which to work; it is not a phenomenological description (van Manen, 1990, p. 55). I refrained from explaining the experience but rather described it and placed more emphasis on the telling/writing of the actual personal experience. Max van Manen explained that “to be aware of the structure of one’s own experience of a phenomenon may provide the researcher with clues for orienting oneself to the phenomenon and this to all the other stages of phenomenological research” (van Manen, p. 57). In tracing etymological sources, the researcher ought to be attentive to the origins of words as a way of reconstructing life. It is a willingness to live the language of our lives more deeply, to become who we are when we refer to ourselves as faith community nurses.

In order to become more experienced with the phenomenon of living the call to health ministry, I sought experiences and reflections regarding lived experiences as a faith

community nurse. I proceeded by obtaining experiential descriptions from each faith community nurse in a face-to-face interview process. I sought out the phrases and origins of words recognizing that they are born out of the lived experience. I considered protocol writing or having faith community nurses scribe their experiences. However, people often find writing more difficult, often producing much less text, and people may become too reflective in writing, leaving the lived experience untold. Conducting face-to-face interviews has cautions as well. The usefulness of the interview depended on my understanding of the research question and the specific purpose of the interview. Hence, the research question was kept in front of the researcher at all times during the interview. The interview was used to explore and gather experiential narrative material for developing a richer and deeper understanding of the human phenomenon. The interview served as a conversation with an interviewee about the meaning of the experience and was more reflective in nature. The following interview questions guided this study (See Appendix B – “Research Interview Questions”):

1. Tell me about your ministry as a faith community nurse.
2. What does the call mean to you in the context of a faith community nurse in health ministry?
3. How do you know you are living the call to health ministry?
4. Tell me about some of your experiences in living the call in health ministry.
5. How does having the call matter to you as a faith community nurse?
6. How does living the call to health ministry manifest in your personal spirituality?

7. Some nurses have stated that they felt “a call” into nursing. If you experienced this as well, would you describe any differences between the call into nursing and the call to health ministry?

8. Is it possible to practice faith community nursing without a call?

9. Would you share your thoughts regarding paid and unpaid health ministry as it relates to the call?

During the interviews, if the interviewee became quiet and non-responsive, I repeated the last sentence said by the interviewee in an inquisitive tone or asked for an example or what it was like. I used patient silence as a prompt for the interviewee to respond. I used close observation as another method of collecting experiential material. This method was described as “the human science researcher [trying] to enter the *lifeworld* of the persons whose experiences are relevant study material for his or her research project” (van Manen, 1990, p. 69). This method requires the investigator to be a participant and observer at the same time. The investigator must constantly step back and reflect on the meaning of the situation. Reflections were explored through journaling. Close observation must be conducted with rigor. Close observation also requires that all accounts be trimmed of extraneous although interesting, but irrelevant aspects of the stories (van Manen, p. 69). I documented observations in field notes during interviews.

3. Engage in phenomenologic reflection, which involves conducting thematic analysis, uncovering thematic aspects in the life-world descriptions, isolating thematic statements, composing linguistic transformations, and gleaning thematic descriptions from artistic sources.

I recognized phenomenological reflection as a method of finding essential meaning in the subject. Theme analysis is the process of recovering the theme or themes that are embodied and dramatized in the evolving meanings and imagery of the work (van Manen, 1990, p. 78). Max van Manen presented three approaches for isolating thematic aspects through the text:

1. The sententious approach attends to the text as a whole and seeks to capture the fundamental meaning or main significance of the entire text;
2. The selective approach involves reading or listening to a text several times and highlighting the statements or phrases that seem essential or revealing about the phenomenon or experience being described; and
3. The detailed or line-by-line approach looks at every single sentence or sentence cluster to determine what is revealed about the phenomenon or experience. (van Manen, p. 93)

I used the transcribed interviews and the selective approach for isolating the thematic aspects of the phenomenon. The selective approach required reading and listening to the text several times and determining the essential and revealing statements or phrases that described the phenomenon. After writing thematic statements, I illuminated the statements in more phenomenological sensitive paragraphs. As I reflected on the experiences of faith community nurses living the call to health ministry, I began to understand how the four existential components—the lived the space (spatiality), lived body (corporeality), lived time (temporality), and lived human relation (relationality or

communality)—can be differentiated but not separated. In differentiating each existential component, each component is influenced by another in the *lifeworld*.

Van Manen (1990) explained, “*Lived space* is the existential theme that refers to the world in which human beings move and find themselves at home” (p. 102). For me and other faith community nurses, this can be the place where we minister. A place of ministry may be a church, hospital, home, car, parking lot, or many other places as well.

“*Lived body* refers to the phenomenological fact that we are always bodily in the world” (van Manen, 1990, p. 103). When we meet a church member in his or her world, we see that person first through his or her own body. However conscious or unconscious it may be, we both reveal and conceal something about ourselves when the body is the object of someone else’s gaze.

“*Lived time* is subjective time as opposed to the clock time or objective time” (van Manen, 1990, p. 104). Lived time is personal; it is our temporal way of being in the world as with the anticipation of a young child for the first day of school or the reflection on life in the past as experienced by many elderly. Lived time for a new faith community nurse may be expected to vary from the lived time of an experienced faith community nurse. The new and young faith community nurse may be filled with nervous anticipation that he/she has the knowledge and wisdom required by the church. The experienced faith community nurse may reflect on previous experiences, personal or professional, and have a sense of confidence when ministering to others in the church.

“*Lived human relation* is the lived relation we maintain with others in the interpersonal space that we share with them” (van Manen, 1990, pp. 104-105). As we meet

others, we do so in a corporeal way through impression, hug, handshake, or other similar gestures. We become informed about others by transcending ourselves and engaging in a relationship, either directly or indirectly. This human communal experience allows for a sense of purpose in life, a sense of meaningfulness, or grounds for living, such as the religious experience of the absolute Other, God (van Manen, p. 105). Together, all four of the “lived” experiences form an intricate unity called the *lifeworld*. In the discussion of my research, I analyzed these four experiences for existential meanings. The descriptions of the *lifeworld* revealed additional researcher assumptions.

Max van Manen (1990) has written that the most difficult and controversial element of phenomenological human science may be to differentiate between essential themes and themes that are more incidentally related to the phenomenon under study (p. 107). He suggested that the researcher reflect on the following questions to differentiate between essential themes and those themes that are incidental to the phenomenon: Is this phenomenon the same if it is imaginatively change or delete this theme from the phenomenon? Does the phenomenon without this theme lose its fundamental meaning? I reflected on each of these questions as themes emerged. I developed narrative elaborations of each theme reflecting the lived experience of faith community nurses living the call to health ministry.

4. Engage in phenomenologic writing which includes attending to the speaking of language, varying the examples, writing and rewriting.

I understood that creating a phenomenological text is the objective of the research process. Van Manen contended that writing requires sensitivity to the subtle undertones of

language, the way the language speaks when it allows the things themselves to speak. This required a commitment to listening to words spoken by each faith community nurse. As I dwelled with the data, I engaged in literal silence, epistemological silence, and ontological silence. I explored each participant's interview data. I sought to discover how the participant came to know living the call to health ministry. I reflected on the *lifeworld* of each participant's experiences as related in the interview. I recognized that phenomenological writing requires a high level of reflectiveness, attunement with the lived experience, and patience. Phenomenological writing often takes the form of narratives such as stories and anecdotes. Anecdotes are a methodological device in human science to make comprehensible a notion that easily eludes us. The significance of the anecdotal narrative in phenomenological research and the writing is situated in its power to compel, to lead us to reflect, to involve us personally, to transform, and to measure one's interpretive sense (van Manen, 1990, p. 121). According to van Manen, varying the examples in writing aimed to elucidate those phenomenological structural features of a phenomenon that help to make visible that which constitutes the nature or essence of the phenomenon (p. 121). Fundamentally, an anecdote is an example composed of examples. This process was arduous. Many writings and re-writings were required to explore the phenomenon described by the participants. This resulted in one succinct anecdote for each essential theme.

5. Establish and maintain a strong relation with the phenomenological question.

I followed the recommendations of van Manen in establishing and maintaining a strong relation with the phenomenological question. This task involved keeping the text oriented in a reflexive and ontological sense. The text needs to aim for the strongest interpretation of the phenomenon by formulating an understanding that is exclusive of other interests. The text needs to be rich with descriptions that are concrete, exploring the phenomenon in all its experiential ramifications. Van Manen's methods allow the life experiences of being a faith community nurse living the call to health ministry to be told in story, since the story retrieves what is unique, particular, and irreplaceable. The text needs to be deep, as depth is what gives the lived experience its meaning and its resistance to our fuller understanding. Max van Manen (1990) stated, "To represent research by way of reflective text is not to present findings, but to do a reading of a text that shows what it teaches. One must meet with it, go through it, encounter it, suffer it, consume it and, as well be consumed by it" (p. 153).

6. Balance the research context by considering parts and whole. Constantly, measure the overall design of the study/text against the significance that the parts must play in the total textual structure.

I considered the object of the human experience to be studied, which is living the call to health ministry. The significance of the parts of this research to the total textual structure was considered. The research involved face-to-face interviews. I recognized that the constraints may have included the availability of persons to be interviewed, the timing of the interviews, location of the interviews and the willingness of participants to engage in the work. I was aware that one of the challenges of human science research is the

experiential situation in which the researcher enters. Faith community nurses have different experiences to share; therefore, it was important to keep the research question present to maintain focus on the purpose for the interview. Once interview audio tapes were transcribed, I studied the interview texts analytically—analyzing the conversations for relevant anecdotes and describing incidents in order to rework the interviews into reconstructed life stories. I also paid particular attention to constructed fictionalized contradictions and conflicting accounts which emphasize contrasting ways of seeing or acting in concrete situations. Focusing as described, better highlighted the various themes that each narrative or set of narratives revealed.

Succinctly, van Manen's (1984) method of phenomenology followed in this research is outlined below:

1. Turn to the lived experience by: a) orienting to the phenomenon; b) formulating the phenomenological question; and c) explicating pre-understandings and assumptions.
2. Begin the existential investigation by: a) exploring the phenomenon through data generation as in using personal experience, tracing etymological sources, searching idiomatic phrases, and obtaining experiential descriptions from participants.
3. Through phenomenological reflection, conduct thematic analysis by a) uncovering thematic aspects; b) isolating thematic statements through the wholistic or sententious approach and the selective or highlighting approach; c) composing linguistic transformations; and determining essential themes.

4. Attend to phenomenological writing by: a) attending to the language as spoken; b) varying examples; c) writing; and d) re-writing.

Recruitment of Participants

Prospective faith community nurse participants were sought through four professional faith community nurse networks. An email advertisement was issued by the researcher to the administrator of the four professional ecumenical networks for emailing. The professional networks included the Virginia United Methodist Parish Nurse Network Yahoo Group, Women's Missionary Union Parish Nurse Network Group, Shenandoah University Faith Community Nurse email network, and the Richmond-based Bon Secours Faith Community Nurse Email Network. These networks were best suited to recruit faith community nurses representing various religions, different ethnicities and both genders. Given the variety of recruitment postings and word-of-mouth advertisement, the participants represented various religious denominations. Perspective participants contacted me directly by phone using the contact information provided in the recruitment email. The perspective participant had access to the information about the research study prior to agreeing to participate through the review of the inclusion criteria, demographic information form, and consent form during the initial telephone conversation. Prospective participants were also informed during the initial telephone conversation whether or not he/she met the inclusion criteria for the study. Those prospective participants who did not meet the inclusion criteria were thanked for their willingness to participate in the research and advised that the inclusion criteria were not met. No interview appointment was arranged with unqualified participants.

Sampling Criteria and Sample Size

“Phenomenology does not use sampling techniques since it does not aim at empirical generalizations to some population” (Max van Manen, personal communication, December 20, 2006). I was unable to identify any other specific recommendations regarding sampling techniques from Max van Manen’s work. When using the phenomenological method, the researcher cannot determine the exact size or number of the sample. The sample size was guided by the members of my dissertation committee. It was recommended that I include between eight and ten participants in this study. Therefore, I sought repetition and confirmation of previously collected data. A purposive sample of ten faith community nurses participated in this study.

Inclusion criteria

Male and female and ethnically diverse faith community nurses were sought for this research study. Criteria for inclusion in this study were:

1. English speaking;
2. Believe they have received a call to health ministry;
3. Actively practicing within a faith community;
4. Currently practicing in a Protestant faith community;
5. Have one or more years experience in health ministry;
6. Have completed at least a basic faith community nurse core curriculum course as prescribed by the IPNRC;
7. Licensed in the State of Virginia as a Registered Nurse;
8. Practices and resides in the state of Virginia; and

9. Interested and willing to be a participant in this research project.

Exclusion criteria

There were no exclusion criteria for the participants in this study.

Protection of Participants' Rights

I successfully completed all training requirements in the protection of human research subjects through Virginia Commonwealth University. Each participant was informed of the purpose of the study, the specific expectations regarding participation, the voluntary nature of participation, the potential risks and benefits of participation, and the ability to withdraw from participation at any time without fear of reprisal. Written consent from the participant was obtained prior to beginning any research. Informed consent ensures that participants have adequate information regarding the research, are capable of comprehending the information, and have the power of free choice, enabling them to consent voluntarily to participate in the research or decline participation. All research materials were de-identified, coded, and handled confidentially for each research participant. Interview data was maintained in a locked, fireproof cabinet when not being used for analysis.

Setting

All interviews occurred in the Commonwealth of Virginia. I travelled to the city/town/county locations convenient to the participants. Participants secured comfortable interview locations that were conducive to conducting a quiet, private interview without interruption and in a conversational setting and atmosphere. No interviews took place in private homes of the participants to avoid interruptions such as telephone calls and also to

allow participants the freedom to stop the interview at any time without the complication of asking the researcher to leave their home. No participant withdrew from an interview.

Data Collection

The face-to-face interview meetings began with the participant and researcher getting comfortable in the interview setting and creating a warm, open atmosphere through introductions, using the restroom, obtaining water, and settling into the seating. The participant provided written consent at the time of the interview by submitting a signed copy of the consent form approved by the Institutional Review Board for Virginia Commonwealth University (See Appendix C – “Consent Form”). The participant completed basic demographic information before the interview begins (See Appendix D - “Participant Basic Demographic Information”). I reviewed the completed demographic data from the participant. Interviews were structured and semi-structured and lasted approximately 60-90 minutes. Each interview was audio taped.

The faith community nurse was asked to share thoughts, feelings, and experiences related to living the call to health ministry through a prescribed list of interview questions. Open-ended questions dominated the interview process to encourage each participant’s self-expression. I made field notes of non-verbal expressions and any verbal responses that were difficult to clearly hear on an audio tape. Additionally, I made field notes of any personal thoughts or feelings experienced during the interview. The field notes were used along with the transcribed interviews as I absorbed the data and sought to interpret meaning of the phenomenon of living the call.

As previously stated, all research materials were de-identified and coded to protect the confidentiality of each research participant. Interview data was maintained in a locked, fireproof cabinet when not being used for analysis. I transcribed all audio tapes to maintain confidentiality. At no time was any actual individual name used in the research analysis or reported in the findings.

Bracketing

Husserl used the term “bracketing” to describe how one must take hold of a phenomenon and then place it outside of one’s knowledge about the phenomenon. Max van Manen (1990) asked how one puts out of play everything one knows about an experience that one has selected for study:

If we forget or ignore what we already “know” we may find that the presuppositions persistently creep back into our reflections. It is better to make explicit our understandings, beliefs, biases, assumptions, presuppositions, and theories. We try to come to terms with our assumptions, not in order to forget them again, but rather to hold them deliberately at bay and even to turn this knowledge against itself, as it were, thereby exposing its shallow or concealing character. (p. 47)

The challenge for the phenomenological researcher was to not allow his/her personal beliefs, values, and perspectives to cloud or interfere with the search for the meaning as communicated by the participant. It is naïve to believe that the researcher conducting the interviews was uninvolved. However, prior to engaging in the interviews, the researcher sought to understand and acknowledge her personal understandings, beliefs, biases, assumptions, presuppositions, and theories. In addition to acknowledging my previously stated beliefs, biases, judgments, pre-understandings, and assumptions, I wrote my personal experiences of living the call to health ministry as a faith community nurse. If

we forget or ignore what we already “know,” we may find that the presuppositions persistently creep back into our reflections. It was better to make explicit my understandings, beliefs, biases, assumptions, presuppositions, and theories. I tried to come to terms with my assumptions, not in order to forget them again, but rather to hold them deliberately at bay as much as possible and even to turn this knowledge against itself, as it were, thereby exposing its shallow or concealing character (van Manen, 1990, p. 47). Any assumptions, biases, beliefs, and pre-understandings that surfaced were documented by journaling.

Data Analysis

Max van Manen (2002) stated that analyses and writing requires seeking, entering, traversing, drawing, gazing, and touching. In seeking, one is seeking a certain space, a “writerly” space. In this space, the writer is no longer himself/herself. The writer seeks to find physical and mental spaces that are conducive to writing. “The writer dwells in an inner space, an inner self and outer self. . . in the space that words can open up” (van Manen, p. 2). As expected, writing spaces varied to allow for a solitary experience. When the writing began, the words drew me in. Writing and rewriting evoked insights, emotions, and understandings. It is common that written language can profoundly move the reader in the realization of being touched by a human insight. The insight might not have affected the reader this deeply if he/she had undergone the experience in the light of day, rather than in the realm of the novel, story, or poem (van Manen, 2002, p. 7). In addressing the phenomenological question, the researcher explored and interpreted many sources of meaning and mobilized many techniques. Phenomenological writing does not produce

absolute truths or objective observation. The writer may gain an occasional glimpse of the meaning of human existence, as no interpretation is ever complete or final or beyond challenge (van Manen, p. 7).

Creating a phenomenological text was the object of the research process. By conducting thematic analyses, I determined the experiential structures that made up the lived experience of the faith community nurse living the call to health ministry. Theme analysis was the process of recovering the themes that were embodied and dramatized in the evolving meaning of the work. Making something of a text or of a lived experience by interpreting its meaning is more accurately described as a process of insightful invention, discovery, or disclosure. Grasping and formulating a thematic understanding is not a rule-bound process but a free act of “seeing” meaning. Ultimately, the concept of theme is rather irrelevant and perhaps better considered simply as a means to communicate the notion being addressed. Theme gives control and order to research and writing (van Manen, 1990, pp. 78-79). The themes may be understood as the structures of experience. Aware of this, I sought out essential themes of the interview texts for analyses and compose linguistic transformations. The main task was to hold on to the themes by lifting appropriate phrases or by capturing in singular statements the main thrust of the meaning of the themes. As more themes and thematic statements form, it was important to capture the thematic statements in more phenomenologically sensitive paragraphs. This is referred to as composing linguistic transformations. It is not a mechanical procedure but rather a creative, hermeneutic process. Max van Manen (1990) warned that the most difficult and controversial element of phenomenological human science may be to differentiate between

essential themes and themes that are more incidentally related to the phenomenon under study. To this end, van Manen advised that the researcher's concern is to discover aspects or qualities that make a phenomenon what it is and without which the phenomenon could not be what it is. A process of free imaginative variation can be used to determine or verify whether a theme belongs to a phenomenon essentially rather than incidentally. This verification was applied by asking: Was the phenomenon still the same if the theme was changed or deleted from the phenomenon? Did the phenomenon without the theme lose its fundamental meaning? Hermeneutic phenomenological writing is a form of writing. Creating the text of the phenomenon is the object of the research process. Van Manen provided methods, tools, and processes that give rise to creation of a text of the study phenomenon. The researcher must first attend to the speaking of language. This involves being sensitive to the subtle undertones of language, a task which requires a true listener. This listening is the ability to capture the tones of language that are ignored through the customary way of hearing. Second, the researcher must recognize that silence makes the human science research and writing both possible and necessary. Van Manen pointed out that silence is not just the absence of speech or language, but that speech rises out of silence and returns to silence.

I used anecdotal writing to illuminate each theme. Each interview text included the faith community nurse's anecdotes. Anecdotes are a special kind of story. Anecdotes make comprehensible that which eludes and should not be considered mere illustrations.

"Anecdote" is defined by Webster (1988) as "a short, often oral, interesting or humorous account of a real or fictitious incident" (p. 107). Anecdotes are significant in

phenomenological writing and research. Anecdotes have the power to compel the reader; to lead the reader to reflect; to involve the reader personally; to transform the reader; and to measure one's interpretive sense through response to the narrative (van Manen, 1990, p. 121). The use of anecdotes in this research sought to give language to identified themes within the research phenomenon of living the call to health ministry. The writing in phenomenological research required me to constantly question the narrative and to write and rewrite.

Rigor, Credibility, Trustworthiness, Transferability and Confirmability

This research was conducted utilizing face-to-face interviews. One researcher conducted all interviews. The participants met all inclusion criteria. This purposive sample of ten faith community nurses produced data that reached redundancy. I sought to describe to the extent possible the human experience of living the call to health ministry from research participants' stories, not my own. Van Manen (2002) encouraged researchers to always be open to new insights and possibilities:

Some may be skeptical of the rigor and depth of these texts. Admittedly, as human science researchers we should be modest in claiming special status for our insights. In point of fact, all interpretive phenomenological inquiry is cognizant of the realization that no interpretation is ever complete, no explication of meaning is ever final, no insight is beyond challenge. Therefore, it behooves us to remain as attentive as possible to life as we live it and to the infinite variety of possible human experiences and possible explications of those experiences. (p. 7)

I proposed for this study the following elements for rigor as described by Denzin & Lincoln (2000): credibility, trustworthiness, transferability, and confirmability. Credibility in a study occurs when others can recognize the experience in subsequent encounters (Denzin & Lincoln, 2000, p. 393). In this study my dissertation chair read the constructed

themes and reviewed actual interview transcripts. I conversed with her regarding the emerging themes. She has conducted multiple qualitative research studies with parish nurses. I utilized her expertise and the expertise of my research committee as confirmation of credibility. Additionally, my findings were supported by previous research findings as noted in this chapter.

Trustworthiness is the second measure of rigor. In this study, trustworthiness was determined by the use of audit trails (Denzin & Lincoln, 2000, p. 230). The intention of testing for trustworthiness was to bring about strength in the understanding of the theme and to achieve trustworthiness and credibility. Audit trails for each theme provide quotations of study participants (See Appendix I - Audit Trail). Additionally, each transcribed interview was read while listening to the audio tape to ensure the accuracy of transcription.

Transferability is obtained when the findings fit in other contexts as judged by readers and when readers determine the findings are meaningful in regard to their own experience. Transferability is yet to be determined; however, the inclusion of thick descriptions and verbatim quotations increase transferability (Munhall, 2001, p. 300).

Confirmability refers to objectivity or neutrality of the data (Polit & Hungler, 1997, p. 454). Confirmability was obtained as I described to the extent possible the human experience of living the call to health ministry from research participants' stories, not my own. I continually reviewed my personal biases, assumptions, presuppositions, and beliefs prior to, during, and between interviews to obtain the purest descriptions of the

phenomenon. The pre-planned questions asked during the interview allowed for consistency among all participants.

Ethical Considerations

I followed Max van Manen's guidelines regarding the researcher's ethical considerations:

1. The research may affect participants who are concerned and interested in the research topic. There may be feelings of discomfort, anxiety, false hope, superficiality, guilt, self-doubt, and/or irresponsibility. Conversely, there may be feelings of hope, increased awareness, moral stimulation, insight, a sense of liberation, certain thoughtfulness, and/or renewed spirit for the research topic.

The consent form for this research anticipated the risk of introspection as participants were asked to describe thoughts, feelings, and experiences. Participants were made aware of this possibility prior to engaging in the research (See Appendix C – Consent Form). However, I recognized that the consenting process does not eliminate the possibility of positive or negative personal feelings. A benefit of participating in this research was sharing thoughts, feelings and experiences.

2. The research topic may be challenged or changed as a consequence of increased awareness by the researcher or participant during the interview process.

I was conscious of the possibility of the research topic changing or being challenged, and therefore, I had all interview questions written and present during the interviews. I asked the defined questions in the order written. If I noted any deviation from

the research topic, I verbally recognized the situation and brought the participant back to the question or gently asked the next planned question.

3. The research methods may lead to new levels of self-awareness, possible changes in the researcher's lifestyle, and shifting priorities of the research topic area. Should the researcher conduct the process poorly, the participants and/or researcher may have feelings of anger, disgust, defeat, intolerance, and/or insensitivity.

I followed the planned sequence of the interview questions and engaged the participants with visible signs of interest such as eye-to-eye contact and appropriate expressions (nodding, encouraging smile) during responses. I engaged the participant and monitored the progress of the interview. It was anticipated that each interview would take at least 60 minutes. However, even after all questions were explored, some interviews ended in less than 60 minutes. No interview exceeded 90 minutes.

4. Phenomenological projects and methods may have a transformative effect on the researcher, leading to a transformation of consciousness, heightened perceptiveness, increased thoughtfulness, and tact (van Manen, 1990, pp. 162-163).

The ethical considerations described by van Manen were of concern to me. I engaged my dissertation committee chair to review my interviewing skills and questions. I evaluated my active listening skills and my facial and body expressions. I evaluated participants for feelings of discomfort, anxiety, and self-doubt by paying attention to their body language, hesitation in answering questions, and any signs of inattention during the interview. I was prepared to communicate my observations with the participant and asked

the participant to reflect on my observations. I sought to understand and provide comfort and assurance as appropriate. If necessary, I was prepared to remind the participant that he/she may withdraw from the study at any time without any penalty. Pre-determined questions and skills in listening and reflection worked to guard against any changes in research topic. In an attempt to prevent a participant's feelings of anger, disgust, defeat, intolerance, and/or insensitivity, I acknowledged and affirmed with reflection the textual messages during the interview.

Data Security

Following the completion of this research project, all data will be saved for three years. Materials to be stored include audio tapes, transcripts, and analysis writings. While in my possession, I maintained the research tools in a locking file when not in use. In keeping with university policies, following the completion of the research, the principal investigator of this study will maintain all data materials in a locked cabinet. The principal investigator will be the only person with access to the key and cabinet. At the end of three years, all participant data will be appropriately destroyed. The paper materials will be shredded and the audio recordings will be erased or the tapes will be cut and discarded.

Conclusion

This chapter discussed the phenomenological and hermeneutical methods of Max van Manen. I have described how these methods were used to research the lived experience of faith community nurses living the call to health ministry. The procedures and efforts for collecting and analyzing the data and maintaining a credible and trustworthy research project were described. Chapter 4 will provide individual participant demographic

profiles and thematic writings of the findings of the interview participants' lived experience in living the call to health ministry.

Chapter 4

FINDINGS

This chapter describes the analysis of the individual interviews with ten Caucasian faith community nurses who professed a call to health ministry. The phenomenological and hermeneutic processes of Max Van Manen were used to answer the following research question: What is the lived experience of faith community nurses living the call to health ministry? This chapter introduces the participants collectively, and then individual profiles follow. Each profile includes excerpts from the actual interview transcripts. Later, in this chapter the researcher introduces the five themes that emerged during data analysis. Each theme is introduced and is followed by an anecdote that succinctly conveys the essence of the theme. The anecdotes provide a glimpse into the *lifeworld* of faith community nurses living the call to health ministry.

Description of Recruitment and Interview Process

Ten participants were recruited to participate in this research study by an advertisement sent through four internet faith community nurse professional network listservs and subsequently by word of mouth (See Appendix E – “Written Ad for Participation in Research Study”). The professional networks were the Virginia United Methodist Parish Nurse Network Yahoo Group, Women’s Missionary Union Parish Nurse Network Group, Shenandoah University Faith Community Nurse email network, and the Richmond-based Bon Secours Faith Community Nurse Email Network. Each participant contacted the researcher by telephone to express interest in participating and to initiate a

review of the inclusion criteria for the study (See Appendix F – “Participant Inclusion Criteria”). Telephone discussions included the content of the consent form and the items of demographic data that would be collected at the time of the interview. Appointments were made for interviews with participants who met all inclusion criteria. Each participant was informed of the interview setting needs (quiet, private space conducive to interviewing without interruptions, electrical outlet, comfortable seating, and restroom availability), and each made the interview setting arrangements. Prior to each interview, participants signed the consent form approved by the Virginia Commonwealth University Institutional Review Board for Human Subject Research (See Appendix C – “Consent Form”). Each participant completed the Participant Inclusion Criteria as final verification that all criteria were met. Additionally, each participant provided demographic information regarding their nursing education, career, and their faith community nurse education and practice (See Appendix D – “Participant Basic Demographic Information”).

Each participant was interviewed once. Face-to-face interviews took place over a span of five days at mutually agreed upon meeting sites. Sites included offices and conference rooms in churches, a hospital office, a university office, a parsonage/church office, and an office in an office building. Interviews occurred throughout the Commonwealth of Virginia in six different cities/towns. The regions included east, central, north and west within the state and over 1500 miles were travelled by the researcher. Each interview was audio taped and the audio tapes were transcribed by the researcher. The researcher dwelled with the data by listening to each audio tape multiple times, analyzing the transcripts with the audio tape playing, and studying the transcripts in silence. Each

participant description contains a sententious representation that captures the fundamental meaning or main significance of the text as a whole. Additionally, excerpts that capture a lived experience in living the call to health ministry are included following the descriptions.

Description of Participants

All participants were practicing faith community nurses. All participants met all inclusion criteria for the research study. All participants were Caucasian and female. The age range of participants was 37 to 70 years with a mean age of 57.9 years. Participants' nursing education preparation included one faith community nurse with a diploma education, four faith community nurses with associate's degrees, two faith community nurses with bachelor's degrees, one faith community nurse with a master's degree, and two who reported no undergraduate degree but were certified nurse practitioners. Several faith community nurses had additional degrees. Three faith community nurses had master's degrees in education and one had a bachelor's degree in social work. The number of years in nursing practice totaled 325 years for the 10 participants with a range of 4 to 47 years in nursing practice. The number of years in faith community nursing totaled 66.50 for the 10 participants with a range of 1 to 13 years and a mean of 6.7 years. Religious denominations represented included Assembly of God, Baptist, Church of the Brethren, Episcopal, Lutheran, Southern Baptist and United Methodist. Individual church memberships ranged from 50 to 1000 parishioners. The average number of weekly hours practiced by a faith community nurse was 20.25, ranging from less than 1 hour to 40 hours. All 10 faith community nurses were practicing as volunteers or paid staff; 6 were in unpaid health

ministry programs within their membership church, and 4 were in part-time paid health ministry programs. No two participating nurses were in the same church. Three faith community nurses were in paid models, while also practicing in unpaid part-time models as faith community nurses. Of these three faith community nurses, one was employed part-time by a church in which she was not a member and also volunteered in her own church. Two faith community nurses were employed by their denomination to practice outside their church (one full-time and one part-time), and each volunteered in their own church as well. A fourth faith community nurse practiced in two part-time paid models as a university faith community nursing education coordinator and faith community nurse coordinator in her church. Of note, the four paid faith community nurses totaled 118 hours per week, ranging from 18 to 40 hours per week (median 20 hours). The hours for seven unpaid models totaled 84.5 hours per week, ranging from 1 to 30 hours per week (median 12 hours). It should be also noted that hours per week for two of the unpaid models were not indicated and therefore not included in the calculation. When a range of hours was indicated by a participant, the average of the range was used for calculation purposes in both the paid and unpaid models (See Appendix H – Demographic Data of Participants).

Individual Profiles

Each faith community nurse is introduced by describing her practice as a nurse and faith community nurse. To maintain confidentiality, information that could potentially identify the individual has been removed or altered. Pseudonyms have been used to protect identity. Any information altered for this protection has been evaluated for its impact in analyses such as age appropriate pseudonyms and terms used specifically in one

denomination and not another Protestant denomination. Each profile is a composite of the faith community nurse's expressions of her own stories.

Participant 1

Ellie is a 37 year-old registered nurse who has been practicing as a nurse for four years and as a faith community nurse for one year and three months. Ellie has an associate's degree in nursing and a bachelor's degree in social work. Her clinical practice experiences include renal and pulmonary intensive care nursing. Ellie has also worked in family, drug, and alcohol counseling as a social worker. In her church, Ellie is the only faith community nurse. The health ministry is unpaid in her 200 member church. Ellie volunteers five to ten hours per week. Ellie is an energetic and organized person who juggles husband, children, extended family, friends, and a full-time job while volunteering to provide health ministry in her church. Ellie talks with God openly. Ellie believes she was called into nursing and faith community nursing. The call to nursing was ignored initially, and Ellie pursued her education in social work. Ellie describes her feelings when God calls to her:

When I feel called to do something it is almost compelled—being compelled to do it. It is almost like you know we breathe and we don't think about breathing but if I am feeling called to do something and I don't do it— it is almost like I am holding my breath. . . . But anytime I have been called to do something it has not necessarily been easy and it does not mean you are not supposed to do it though. . . . I think you do have to have a certain "uncomfortability" about any call that you live because He is the one with all the answers and I know how to get to the answers and sometimes that means waiting and I am not always a patient person and He knows that. (Laugh)

She believes that her previous professional experiences including counseling as a social worker and critical care nurse were God's preparation for her faith community nurse role:

I was a counselor for a long time. I did family counseling, I counseled with drug addicted teens but it was different, it was doable and I did it and I did it well but I am not passionate about that. I truly believe I was only a counselor to help me with my parish nursing. I truly believe that was a component that I needed, I think this was a plan from all along and that my counseling component has only aided to my parish nursing.

Ellie experiences the struggles of a new ministry, but when asked how she knows she is living the call to health ministry, she responds:

Well, I can't say (pause) that I ever really know because I feel like I have a whole lot to do and not enough time to do it in. Um, I am very (pause), part of it is the fact that it is not an easy job and not having any money or any easy resources and starting something for the ground up, takes a whole lot of faith and (pause) it is almost like I am never finishing the job—that there is always work that I need to do or more things, I can't say that I am not meeting the needs, but it is almost like I could certainly give more than I have given so far, that there is always more things to do, more things to focus on, more people to help.

Ellie celebrates her call to parish nursing through open conversations with God, urging and coaching others out of their comfort zones to promote their personal spiritual growth, and she struggles to develop a new health ministry amid all of the needs she perceives around her.

Participant 2

Eleanor is a 70 year-old registered nurse who has been practicing as a nurse for 47 years and as a faith community nurse for 12 years. She has a bachelor's degree in nursing and a master's degree in education. Her clinical practice experiences include psychiatry, pediatrics, and hospice. She is also a bereavement counselor. In her church, Eleanor is the

only practicing faith community nurse. The health ministry is unpaid in her 600 member church. Eleanor volunteers 20 – 40 hours per week. Eleanor serves on several of her denomination's regional health ministry programs. She works directly with the church staff and serves primarily through home, nursing home, and hospital visitations. Eleanor is considered an expert in bereavement counseling and offers her knowledge through education, counseling, and consultation with other faith community nurses, churches, and individuals. Her call came at a time when she was not convinced the church needed a faith community nurse. Eleanor related that following her education as a faith community nurse, her very first experience was a defining moment:

I sort a feel like there are no coincidences ever in life and so to be sent to an end of life care when bereavement and that kind a of thing is my thing and later I said to clergy is that why you sent me and he said no that's the name of the person I was going to go visit in the afternoon and I decided we needed to get you going.

Eleanor knows she is living the call through the affirmations of others. She serves people in vulnerable situations and times, and they express gratitude for her ministry.

Eleanor is sensitive to the nudges from God that put her into action just in time. She related several instances that demonstrated her connection to God directing her ministry:

I spent a lot of time with Ann and Bob and Ann had lots of questions. When do you think it is going to be over? And I said I think urine has shut down completely, we looked at everything and I said, you know Ann, I think probably within the next two days and she said, would you come back when it is over and I said yes but I said we need to let our clergy know and she said oh that is fine but I feel so comfortable having you around. So that was mid-afternoon and I went home and [husband] said so how was it and I said it was fine and about 8:30 or so I felt like I'm gonna go back so I went back to the nursing home and went in and she was sitting there and she said you know I haven't gone home. It is very hard for her to move because she said I think the end is going to come sooner than two days. I looked at him [Bob] cold feet, cheyne stokes respirations and I said you are right. So I called our clergy and said I think the end is coming so he came and he hadn't

been in the room ten minutes when it was finished and I really felt called that night. I don't know why—been in lots of room. (Small laugh, smile with tear)

Eleanor is devoted to time with God and finds energy in her experiences:

. . . sitting down with special time three times a day, but there are other times too, but doing some kind of biblical study, some kind of reading from whatever I decide I am going to do my devotions for the year and those might be more than one book I read at a pace where I feel I am getting something out of it I keep a journal and if that book finishes then I just start another one. But probably for the about the last ten years I have a journal that I have kept and also three times a day devotions and I need that and if I don't get it about middle of the afternoon I am tired and I just need to have the rejuvenation.

Eleanor's spiritual life is strengthened by multiple daily devotions, prayer, and the care and service she renders to others through health ministry. Eleanor is open to the urgings of God. She has an unwavering dedication to the parishioners.

Participant 3

Val is a 48 year-old registered nurse who has been practicing nursing for 27 years and faith community nursing for six years. She has a master's degree in nursing. Her clinical practice has been in pediatric nursing. Val serves as the coordinator of the health ministry in her church, where there are a total of five faith community nurses. She is the only paid faith community nurse in the church, which has a membership of 600. She works 20 hours per week coordinating a large health ministry team. Other faith community nurses volunteer in the health ministry providing ministries such as a large health library and regular church newsletter articles. Val also works part-time directing a faith community nurse education program. Val was preparing to leave nursing and begin preparing for entry into education for ministry or psychotherapy/counseling when she was urged by a colleague to attend a basic faith community nurse course. She acknowledged that her

previous life experiences have been God's preparation for her faith community nursing ministry:

I really do feel like it is my purpose in life. I think it was why I was created. I do believe that God through all the stuff I went through personally and professionally the different areas that he was preparing me for such a time as this. I mean I really do believe that he was preparing me to be able to have this educational job here [university] to educate faith community nurses but only after I had been over there [church] and done it for four and one-half years and have seen a ministry grow the way it did.

Val receives affirmations of her ministry when she sees "things set-in motion" and when she sees the "results." She acknowledges that a faith community nursing ministry can be demanding, requiring personal sacrifice. Val relates that she is:

. . . passionate about having this role be elevated to the level in the profession so that [faith community nurses] are paid when [faith community nurses] are doing that kind of role in a faith community—I think it is critical if [they] are going to be professionals.

Val values the relationships with the pastoral church staff. She believes that the call to faith community nursing is a connection with clergy:

I think it is critically important to have a good relationship with your pastor if it is going to be a valued part of church but as far as the call if a person is called I think the minister can relate a lot more because ministers can relate to that concept—if someone is called they know what that means that is their same language that is the real basis for dialogue and connection with clergy.

Val firmly believes that she is exactly where God wants her to be. Her focus is the professional specialty of faith community nursing as she teaches nurses to connect their faith and health and encourages paid health ministries. Val sees a connection between clergy and faith community nursing in the call to ministry.

Participant 4

Lynn is a 48 year-old registered nurse who has been practicing nursing for 20 years and faith community nurse for seven years. She has an associate's degree in nursing. Her clinical practice experiences have been in adult medical/surgical nursing. She is one of five faith community nurses in her church and serves as coordinator of the health ministry. The health ministry is unpaid at her 900 member church. Lynn volunteers 12 hours per week at her church. Lynn believes she was called to the health ministry:

. . . and then when you go through the class, you know, you just feel like you are in His will and you are in the right place at right time and this is right and it is suppose to be this way. Called to serve is just taking that humble servant to whole new plateau when you give Him your career as part of that. And yes my career was Christian and I felt it was bumped up a notch.

Lynn knows she is living the call as she states, "Peace and the joy that endures—it is amazing. The continual growth of Christian maturity, wisdom, and knowledge and experiences that are beyond me, it is so bigger than me." She believes that the health ministry is Holy Spirit led as related in the following story:

I am at the office at the church just doing some paperwork stuff, a parish nurse pops in to drop off something, and she says I am heading down to the hospital to see church member but I really don't know why I am going but I am going. In comes another parish nurse who said I just came by the church for some reason I really don't know why I am here and the other parish nurse asked her if she would go with her to see a church member and they leave to see the member. I stayed at the office. They just leave and five minutes later I get a call from the case manager and asked if a parish nurse is available please she needed her to come down to talk to this family and to the patient. I started to weep over the phone and (crying and wiping tears) she asked what is wrong and I said the parish nurses are on their way down there and the parish nurse said she did not know why she was going down there. She is already on the way. Those moments are when you know you have been called to ministry because it is so much huger than you. Because there is no way and she [patient] had just been given some really bad news and so when they got down there because there were two parish nurses, one could be with the family

and the other could be with patient. I was in the office to receive the call, and we have story after story after story like that.

She believes God calls one out of one's comfort zone:

Meaning that if the Lord has totally taken over your life and you have given Him everything you have got then you're just relying on Him for every step you take and yes, in the flesh and your humanness you will take the wrong steps and the Good Shepherd will come get you and He will pull you back and trusting in Him that He will do that. Sometimes He allows you to take the wrong steps but He will still come and get you so just trust in Him more.

Lynn realizes that being a parish nurse is not without difficulties. She believes that parish nursing can be undefined and all encompassing at times. She is grateful to have more than one parish nurse in the church health ministry:

It is hard to be a nurse on Sunday and you just want to go get fed and filled up and there are people in parking lot before you can even get your feet out of the car. We [parish nurses], as a group are blessed because we talked about that. I don't mind I am single. I don't mind being at church on Sunday morning and I get out there because Miss Granny who can't walk fast and I got on her because she was not bringing her Bible to church anymore so she says if I bring it you have to carry it because it is too heavy so that means I have to wait for her to get from one end to the other because I am carrying her Bible back to the car and she knows everybody in the church. She is 85 so I end up being there an hour after the service is over now if I had a husband or if I had kids that would not work for me so I think a lot of people don't realize how undefined and how all encompassing parish nursing can be (said with a sigh and raised eyebrows).

Lynn openly shares her faith community nursing journey and the journey of her church. She trusts that the health ministry is led by the Holy Spirit. Lynn believes she is in God's will. She recognizes that being in His will does not mean the ministry will not be without challenges however she trusts that God will place her where He wants her to be as long as she trusts in Him.

Participant 5

Barb is a 61 year-old registered nurse who has been practicing nursing for 36 years and faith community nursing for 11 years. She has an associate's degree in nursing. Her clinical experiences include geriatric, occupational health, and community health nursing. In her church, she is the only faith community nurse. The health ministry is unpaid in her church. The church has a membership of 50 congregants, and she volunteers four hours per week. Barb also directs her denomination's health ministry for the region in a full-time paid position. Barb found she had denied the call to faith community nursing long enough, and she decided to move ahead:

I guess it was in '98 when I decided. I kept putting off taking the parish nursing education program it was still in my mind but the Lord just kept nudging me on and I procrastinated because I did not see how I could any more than I was already doing. And so then, I finally said ok Lord I will do this.

Barb believes that her call "is to reach everyone in the name of Christ." She stated, "I cannot reach everyone in the name of Christ but if people can see Christ in me and I can help to meet their needs in some way it may help to bring them to Christ." Later she commented, "I am happy doing what I feel the Lord is leading me to do. I don't think I would be happy if I was not making Him happy."

Barb related story after story about how God had provided for the health ministry:

Communication is a major thing trying to do something broad like this and it just was not working. So I wanted to do the lay health promoter program so January, a year ago I was in a meeting in (names city) and the person who writes the grants for health services, and we had talked about wanting to do the lay health promoter program before and this time she approached me and asked if I was still interested in doing it? And I said yes I would love to do in our denomination but there is just no money to do it. And she said if I write a program are you willing to do it? If I get a grant, so she wrote it and got the grant. . . . I considered it a real God send.

Barb is joyful in her work. She has seen God working as His plans become reality. Barb gives much of herself to her work as she hopes that people can see Christ in her and she can help to meet their needs and in some way to bring them to Christ.

Participant 6

Irene is a 66 year-old registered nurse who has been practicing nursing for 45 years and faith community nursing for 13 years. She has a diploma in nursing. Her clinical experiences include geriatric administration and psychiatric nursing. She volunteers as a faith community nurse in her membership church. She works part-time 20 hours per week in her denomination's outreach ministry. Four volunteers, who are not faith community nurses, offer assistance with the various activities and programs in the outreach ministry. The ministry is also a community health clinical site for a nearby school of nursing where the RN to BSN students spend part of their clinical hours with the health ministry. The inner-city church outreach program offers a food pantry, clothing closet, various screening programs (blood pressure, foot care), and referrals for healthcare or social needs. Irene states that the ministry "basically listens" to those who seek assistance. The health ministry program has a following of approximately 100 community members at any given time.

Irene explains that she began to explore faith community nursing mainly because it was a good deal for her financially:

Anyway that parish nursing was interesting to me but I would have not gone to that [Parish Nurse Education Program] had it not been so financially beneficial for me to go. How do I turn that down? You get a week off with pay! So I went. Had been a Christian 20 to 25 years and a committed Christian but that was not my primary—I was not going to be called by God—I went because it was a good benefit for me and God got a hold of me there. I can't remember exactly but

anyway I am very stoic. It is just in (pause) my family was very stoic. I am not as stoic as I use to be because of parish nursing. But found myself in a class on humor in tears and could not figure it out. Very embarrassed I did not want anybody to know that this super woman could cry and at the end of the class I sat there for a few minutes and [she] came over and I don't remember what she said but that was a breaking point of being real and being human and apparently a lot of excess baggage got spilled over part and I found acceptance by her and the class members and found that acceptance and the world did not come to an end because I became humble. (teary with slight smiling)

Irene relates that she was still finding her way while in the faith community nursing education course:

But any how I found myself one morning just needing to spend some time with God and I left my room and went out at the University and sat under a tree on a bench with my Bible and I was looking to find the Word of God in that scripture that morning and nothing clicked I was looking through my Bible and nothing clicked. I sat there and thought well what have you got to show me God and there was a duck, mother duck who came waddling up with about five or six little teenage ducks whose feathers were just beginning to come in and I sat I looked at that mother duck and she was taking care of those ducks because it was innate in her and she was picking the—cleaning—picking the dirt and insects off of them and when one of the little ducks would get out of her boundary she would nudge them back in and it hit me God is using - can use me like that mother duck. It is innate in me and it is not something I have to make happen—I just trust God like the mother duck.

Irene continues:

I said, “I don't have a clue God how to do it.” But, I said, “I will trust you, I will trust you to show me.” About at that time, no it is was not a hallucination, because I saw the poopie (slight smile) on the side walk but about that time a flock of geese and ducks walked across in front of me on the sidewalk there was a pond not far away. And what I saw in those ducks—some of them had warts, some of them are great big proud swans, some of them were biracial, obvious they were not a pure breed. It was like humanity walking by in front of me and it was like, “Irene that is where I am calling you through parish nursing and that is what I want you to do and I will show you how and show you the way but all you've got to is just be who you are and I will show you how to do that.” And there was a sense of freedom and I thought I don't know how in the world I am going home and do this but I am going to trust God. And about that time two wild ducks just flew over and it was like freedom—it was so real that I know the details here and it is 15 or however many

years later. That was the call and there have been other calls since but that was the initial call and I knew without a shadow of doubt that parish nursing was what I was to do but I did not have clue how to do it. (gestures with hands raised)

The call to faith community nursing matters to Irene:

Well like that incident—it matters in the outcomes that you have, the director and I were going to teach budget with our wisdom and abilities and when God came in, he showed us that this needs to go to a deeper level. It was God who opened those women to talk about this secret they had because they just don't do that. It was God who enabled the outcome and that is why it is so humbling because I know it was God it was not me but He used me. You know I think that happens all along and the joy I don't know any greater joy than walking with God and having ministry opportunities there is no greater joy personally. And to know you are. The almighty God is right there beside you and enabling making it happen I mean—Good Grief! (enthusiastic voice and repositioning in chair)

Irene's call to faith community nursing was very strong. It was a life changing experience when she least expected it. In her practice today, she works following God's lead. She has been humbled and has great joy in her life now. She knows God is right beside her, and she describes it as a very freeing experience.

Participant 7

Jean is a 57 year-old registered nurse who has been practicing nursing for 37 years and faith community nursing for three to four years (as indicated on her demographic form). She is a nurse practitioner. Her clinical experiences include pediatrics, public health, and travel medicine nursing. She is one of two faith community nurses in her church. The health ministry is unpaid in her church. The church has a membership of 1000 congregants, and she volunteers 15 to 20 hours per week. Jean faced a personal illness and had to leave her nurse practitioner practice. Soon Jean received an invitation to attend a faith community nurse meeting from two friends who were faith community nurses. She

had thought about becoming a Christian educator but soon found that faith community nursing “was like one of those doors closing and another one opening kind of thing all along and I just did not see the other one opening for awhile.” Jean spoke kindly of the complementary relationship she shared with Lyda, the second faith community nurse. Lyda had been a faith community nurse at the church approximately three years before Jean. Now, they often work together but also work independently in providing classes, support groups, visitation, etc. Jean laughingly says “we both do some of everything.” Jean and her colleague Lyda have a large health ministry program and many people become involved in the programs. She is pleased to see positive outcomes:

We did the Walk to Jerusalem program last year—had 90 some people involved in that and I had most of them on email so I would give them an email thing every week and I have kept that up every three to four months and kind of followed up with them and discovered that a couple of them have lost a significant amount of weight since that program and it has been really great and several have lowered their blood pressure and cholesterol and so we work with that a little bit. (said with confidence)

Jean explains how she began a program out of her own personal need when caring for her mother-in-law, and she explains that the program continues to support many people who are caring for others today:

And that is how the caregivers thing got started because I knew I needed that and she [mother-in-law] died the week before I started that group so I had been planning on starting that group—I had been working for a year trying to build it up and get my materials going and figure out how to do it so it was planned to start when she died and it was really good timing on that too because that helped my grieving process. And I could share what I had learned those three years taking care of her because I really started from ground zero and reinvented her when she came here with doctors, teeth, eyes and everything you know—we had to do it all. We learned a lot—learned a lot. (moment of reflection)

Jean can see and feel the intensity of needs:

I think it becomes overwhelming sometimes in that we are kind of expected to be on and to be asked to help with every committee, you know with everything that goes on, what is your opinion? Will you help me on this committee? Sometimes that gets pretty overwhelming and now after every meeting there is always three to four people with some kind of question which is great—I just can't always remember because you don't have [a] notepad with me—so once in a while it gets a little overwhelming. And you want to make sure you don't forget anything or forget anybody or miss anybody and sometimes that does happen.

Jean answered God's call to faith community nursing after leaving her nurse practitioner practice. She serves others through personal experience as well as planned health ministry programs. She is conscientious about meeting the needs of all.

Participant 8

Sharon is a 64 year-old registered nurse who has been practicing nursing for 42 years and faith community nursing for two years. She is a nurse practitioner and has a master's degree in education. Her clinical experience is family nursing. She is one of three faith community nurses in her church. The roles of the other two faith community nurses were not voiced. The health ministry is unpaid in her church. The church has a membership of 250, and she volunteers 10-15 hours per week. Sharon feels affirmed in her call to faith community nursing:

I think it is more of a feeling of peace. I mean it is not like somebody is putting a gold star in your crown, or somebody is waiving a flag for you. It is just a sense that you are doing the right thing; that you are helping other people that you might otherwise do as a nurse but yet it is a little bit more wholistic. And I know we were educated to be wholistic to be mind, body, spirit and I think the spirit part got left out [of nursing] a lot.

Sharon relates that she helps families work through the difficult times in life and death:

I had a family ask me to go with them to see a dying family member and to see how the end of life experience should be. I mean to talk about that with physicians and when is it time to let go. And we also had prayers with her and I was able to talk with the physicians and with the family and network with hospice . . . the family was not really ready for hospice, they did not quite understand what hospice was all about. And we had talks about that and when it was time to bring in hospice and when was it time to let go. And this one particular lady did end up being released from the hospital to go home with hospice and there were several times that I did go by and read prayers with her from our prayer book. And that was very comforting for her and the family.

Sharon explains that she and the minister visit parishioners together and share in the sacrament:

Our minister and I took communion to four different ladies, three in a nursing home and one who is fairly homebound in an apartment—and it just—maybe because especially this is Holy Week there were just beautiful prayers and collects and the scripture of course reading the gospel to them was just very affirming it just felt really nice and they were so grateful. I know the ladies in the nursing home won't get to church but to be able to bring Christ to them during Holy Week felt really good. (stated in a peaceful voice)

Sharon has found freedom in being a faith community nurse. She feels she can better care for and minister to the mind, body, and spirit. She finds working with ministerial staff satisfying and holds bringing Christ to those away from church very satisfying. Sharon feels affirmed in her call to health ministry.

Participant 9

Janice is a 63 year-old registered nurse who has been practicing nursing for 23 years and faith community nursing for six years. She has an associate's degree in nursing. Her clinical experience is in home health nursing. Janice is employed part-time as a faith community nurse; however, she is not a member of the employing church. Janice received this position after answering an employment ad she found in the newspaper. Janice is the

only faith community nurse in the employing church. The church has a membership of 200 congregants, and she works 18 hours per week. She also is the only faith community nurse for her home church where she volunteers approximately four hours per week.

Janice describes her call to faith community nursing:

After I finished home health which was probably in the year 2003, the Lord spoke to me and said, “I want you as a parish nurse” (voiced with confidence) because I had been very active in my home church. And I said “parish nurse, wow, I don’t know anything about that” and the Lord lead me right to the computer and I typed in parish nursing and there it was—just as plain as day and oh this is sort of interesting. (voiced with excitement). Where is there any around here, you know where do I go to learn about it and of course this website told about it and how to contact, where to go so I clinked on it there it was—university but that is in—that is the closest? (expressive with a frown). And the more I thought about it—it was an intensive one week session, I don’t know what it is now well, my niece lives right on the road going right to [names city], I wonder if I could stay with her? You know it was the Lord. (smiles). So I called my niece and she said sure I would love to have you. So I stayed for a week and our classes were from 8 to 5, Monday through Friday. And so that is what I did. (smiling)

Janice describes enjoying visiting parishioners and she celebrates their abilities:

My oldest parishioner, in fact he was 100 and I enjoyed it so much going there because he reads to me and I would ask him if he would like [me to read]; he was a professor many years ago, and he would read to me and I would think it was the greatest thing to have a 100 year-old to read to me.

She takes pleasure in bringing the church service to those not able to attend. She strives to make them feel as though they were present on Sunday:

Once a month the service is taped and we have CD recorders that we lend the parishioners if they are interested in the tape ministry which is sort of neat. I would take the tape or CD to the parishioner so that they can take their time in listening to it, so we do that once a month. And flowers and flowers are so important. We have new flowers out on the altar every Sunday and I would get these flowers if they are not taken by the parishioners who have donated them and I would separate them and take them to each parishioner. And they really like the flowers, fresh that brightens their day.

Janice indicates that she understands the needs of being a caregiver and provides referrals and assists those who need to make decisions about the living arrangements of loved ones:

I have done some research on different facilities that could take care of them [those needing around the clock care] and I have found a couple of private homes that one parishioner in particular, the husband was taking care of this parishioner [his wife] who had dementia and she had gotten too much for him. So he called me one day and asked me to come over and check out his wife and he could no longer take care of her. I told him about a few places so I stayed with the parishioner one day while he went to check on these places. And he came back and said “Yes, I can put her in this one and I really feel great.” So then I would go to the home where she was at and he was very pleased with the home and she lived there probably a good six months before she passed away.

Janice expresses amazement at the gratitude others have for her even when she thinks what she is doing is so simple and natural:

One just recently, one of the dear ladies here in our church she is in her 80’s she had a stroke and was devastated over the stroke that she had and it affected her speech and I went to see her for the first time in the cardiac intensive care unit—but just to see her smile and those eyes light up when I walked in that room it was a real gift for me to do that. I mean that is just one little tiny experience (laughs lightly) just the gratitude that people have for me in this position.

Janice enjoys the practice in health ministry. She speaks of her call to parish nursing as a matter of fact, however her voice and expressions would indicate a more personal experience. She strives to keep her parishioners informed about health and the life of the church. She spends some of her time visiting those away from the church. Janice believes she is called to the health ministry in both the church where she is paid as a faith community nurse and her membership church where she volunteers.

Participant 10

Shirley is a 65 year-old registered nurse who has been practicing nursing for 44 years and faith community nursing for five years. She has a bachelor's degree in nursing and a master's degree in education. Her clinical experiences include community health nursing, home health nursing, and diabetes education. She also has experience as an educator in nursing. She is one of five faith community nurses in her church; however, she is the only active faith community nurse at the time of this interview. The health ministry is unpaid in her church. The church has a membership estimated at 500 congregants, but because university students are transient members, determining actual church membership is difficult. Although Shirley reports her volunteer work to be less than one hour per week, her description of her practice makes this is a very modest estimate. During the interview, she spoke of coordinating a Walk to Jerusalem for 12 weeks for 100 parishioners with weekly updates and encouragements, providing bulletin boards monthly based on relevant topics, providing diabetic education, and assisting in the coordination of a large health conference.

She reports that the church leadership has reorganized into a congregational care model placing other church leaders in the role of coordinating ministries such as transportation, home bound visitation, hospital visitation, food provision, and bereavement counseling. Shirley desires to have a functioning parish nurse ministry, but she voiced that she has some reservations following the reorganization by the church leadership:

And so I felt like if we [parish nurses] try to do anything else it might interfere with them getting these teams off the ground and functioning well when eventually they

might become a part of the parish nurse ministry if we can ever get it going completely. But I wanted to start with an assessment of the congregation.

Shirley describes her call into faith community nursing:

Almost as soon as we got here I was approached by a little lady in a wheel chair and she said, we want you to be our parish nurse. What's a parish nurse? (laugh) I had never heard of such a thing. We did not have them in (names state) and I had no idea. And then just a couple weeks later I had a phone call from a (names a church leader title) who talked on and on and said we want you to be our parish nurse. I guess my cousin had been here for like forty years and she must have told them something about me before we got here. And they knew I was a retired nurse so any way - that got me to thinking about well what is a parish nurse? So I started to look on the internet and reading about it and thought oh that sounds interesting and I believe my background in community health and home health and teaching at the university and so on baccalaureate students and all has been basic preparation for this all my life and I did not know it. So I started thinking about it and the longer I sat there thinking about it, I started thinking well let's see what we can and about that time another nurse at this church said hey do you want to go to the parish nurse group that meets here in town once a month?

It couldn't be circumstance all these things come together at the same time. And in my life, I have seen that occur in several different areas mostly related to Christian endeavors that I have been involved in. But I've seen these things kind of happen and I know it this is something I can do and feel like that that was the meaning behind all these people. Just kind of urging and coaxing me saying go on and do it you can do it. (voiced with excitement)

When Shirley was asked how faith community nursing has impacted her spirituality, she replied:

Well, I am sure it has but I don't know that I can verbalize it. (long pause and sigh) I guess it really helped pull, um, without going into a whole lot of detail pull us out of some of the doubt that we had developed over the years since '97 in (names a state other than Virginia) when the pastor at our church didn't even want to do the funeral for our son and my mother died on Good Friday and they were concerned about parking for the Easter service rather than helping us to make arrangements for her funeral and so and getting her back up to Virginia for her situation and then you begin to wonder well you know these are the leaders of our church and plus all the grief that you go through began to doubt and drift away a little bit and then you kind of feel like this kind of pulls you back in and yes there is a higher power directing all this. (said with thoughtfulness)

Faith community nursing has given Shirley a sense of being directed by a higher power. Shirley expresses that she enjoys her role as an educator and finds her expertise in diabetes to be very useful:

Some of the people would come up after the diabetes programs and say wow, nobody ever told me that I wish I had known all this years ago and we have information for them. Many of them have no clue where their numbers should be or what to do if they are not there. And they don't check their blood sugars because many different reasons but they have never known what to do with those numbers when they look at the numbers and it has no meaning for them and then the doctors don't look at them when they go to see them so it still has no meaning for them so we have to talk about why numbers are important and how you can use your information trying to really empower them to take better care of their health and to know they are in charge 24/7 and the rest of us are there to coax and encourage, coach whatever, help them to accomplish what they determine they want to accomplish with their health.

Shirley had a difficult time answering some of the interview questions. Her answers were at times short, and several times she would respond that she was not sure she could answer the question. However, she was able to express her call to faith community nursing. Shirley feels blessed by faith community nursing, and she believes she has answered the call to health ministry. Shirley communicated that the church health ministry is slow to develop but that each endeavor has been successful. She is waiting for God's direction on where to take the ministry.

In summary, information provided in each profile demonstrated that each participant met the inclusion criteria for the research study. The individual profiles allow the reader a glimpse into the *lifeworld* of each faith community nurse. As should have been expected during data collection, some interviews were easier than others, and some interviewees were more expressive and articulate when speaking about living the call to

health ministry. Some interviews were filled with stories and anecdotes while others centered on information about programs and activities. Each one provided a unique and interesting experience for the interviewer and added rich text for the analysis. All faith community nurses expressed interest in the research, and many asked how they would come to know the results.

Presentation of Themes

Following the methods described in Chapter 3, the search for the essential meaning of the data began with data collection. Reflection on the data occurred while listening to the audio tapes over and over again as transcription was performed, listening to the audio tapes during data analyses on paper, studying only the written interviews, and finally while dwelling in silence without paper, pen or audio tape. Conducting thematic analysis occurred by uncovering thematic aspects and isolating thematic statements through the sententious and highlighting approaches and finally, composing linguistic transformations and determining essential themes.

With data analysis, five major themes emerged—1) the calling; 2) relating to God in living the call; 3) practice in living the call; 4) challenges in living the call; and 5) blessings in living the call to health ministry. Themes emerged by obtaining the experiential descriptions from the ten faith community nurses who participated in research interviews.

I selected Max van Manen's method to explore the experiences of the faith community nurses. Van Manen (1990) stated that anecdotes are a methodological device in human science to make comprehensible a notion that easily eludes us. The significance of

the anecdotal narrative in phenomenological research and the writing is situated in its power to compel, to lead us to reflect, to involve us personally, to transform, and to measure one's interpretive sense (van Manen, p. 121). The aim of anecdotal narratives is to elucidate those phenomenological structural features of a phenomenon that help to make visible that which constitutes the nature or essence of the phenomenon.

I have composed anecdotes to demonstrate the themes identified in living the call to health ministry. These anecdotes are an example composed of examples. The composition of each example is based on common threads heard and seen during data collection and data analyses of the ten interviews. The anecdotes are constructed composites of the common elements for each theme as described by the participants. The text aimed for the strongest interpretation of the phenomenon by formulating an understanding that was exclusive of other interests. This was accomplished through the emersion of the physical and mental self to the data. And finally, I have asked if the phenomenon would be the same without this theme.

Theme One: The Calling

Faith community nurse participants revealed several ways and many instances in which they have experienced the calling to health ministry. Faith community nurses' experiences of God's calling occurred during faith community nursing education, while at the bedside of those they visited, through the voices and urgings of others, and in quiet time with God:

I sort a feel like there are no coincidences ever in life and so to be sent to an end of life care when bereavement and that kind of a thing is my thing and later I said to [my] clergy is that why [he] sent me and he said no that's the name of the person I

was going to visit in the afternoon and I decided we needed to get you going.
(Eleanor)

It [faith community nurse education] was just an amazing experience and I knew that I was—that that was what God was calling me to do. When I was in the class—sitting there and listening to these lectures, I can remember sitting there crying and going (nodding head) this is it—this is it. (Val)

Some faith community nurses reported the calling to faith community nursing occurred more than once, at different times, and in different places. Some reported not being able to affirmatively respond immediately due to life circumstances as in illness, caring for aging parents or young children, and/or a demanding job. In these instances, the calling never seemed to totally disappear. The calling remained persistent and later was answered when complicating life circumstances changed:

I guess it was in '98 when I decided—I kept putting off taking the parish nurse education program it was still in my mind but the Lord just kept nudging me on and I procrastinated because I did not see how I could do any more than I was already doing. And so then I finally said, “Ok Lord I will do this.” (Barb)

And I really wasn't ready to do that [faith community nursing] just really wasn't ready but I was and I had backed off a lot of things. . . . So I checked in to it and finally did it and I have loved it I really do love it—I really do—it was like one of those doors closing and another one opening kind of thing all along and I just did not see the other one opening for awhile, for a couple of years. (Jean)

Early responses to the calling included praying, relating to God, taking the professional faith community nurse education course, visiting parishioners, and communicating with and educating clergy regarding health ministry. Faith community nurses consistently reported an “inner” knowing that health ministry was what they were meant to do.

It is almost like you know we breathe and we don't think about breathing but if I am feeling called to do something and I don't do it— it is almost like I am holding my breath. (Ellie)

You just feel like you are in His will and you are in the right place at right time and this right and it is suppose to be this way . . . to be called means to represent Jesus in a way you have never represented Him before to let Him use your gifting and your skills and your experiences. (Lynn)

And I don't feel that this is a natural progression from this [nurse practitioner practice], not a career progression, a call to parish nursing is not. It is more personal, it is more inward. (Sharon)

During the interview participants were asked if they thought it was possible to practice faith community nursing without a call. Most participants paused before answering this question. All participants stated that they did not think it was possible to practice faith community nursing without a call. Participants expressed the need to have a “one-on-one relationship with the Lord.” Some participants further stated that if faith community nursing was practiced without a call, “it would not be as effective” because the foundation would be “self-sufficiency” and because the faith community nurse would “not be fulfilled.” This was further described as a sense of “being put upon” or feelings of “frustration” or “disgruntle[ment].” The participants clearly expressed that the call is foundational to the practice of faith community nursing.

Additionally, each participant was asked if she received a call into nursing and if so, if she would describe any differences between the call to nursing and the call to faith community nursing. Two participants stated they could not remember if they received a call into nursing. Seven participants stated they did not receive a call into nursing. One participant stated she did receive a call into nursing and that the only difference between

the call to nursing and the call to faith community nursing was that she responded to the latter call the first time.

The following is an anecdote of a calling experience:

I was initially asked to attend the basic faith community nurse education course by my minister. I had heard of faith community nursing but did not know much about it. I told my minister that I would go but I did not think we needed faith community nursing at our church. So I reluctantly attended the course at the university. The faith community nurse education course was just an amazing experience. I did not realize how much I did not know even though I had been a nurse for over 30 years. At the course that I knew that God was calling me to do faith community nursing. I could feel His presence. When I was sitting in the class listening to a presentation on health ministry, I can remember the moment when I found myself crying and realizing this was it - this was what God was calling me to do. Even today after seven years as a faith community nurse, I receive affirmations that this is what God has called me to do.

Callings can be received from external and internal sources. As faith community nurses described their calls, external and internal calls were experienced. Each faith community nurse who experienced external calls also experienced at least one internal call.

Theme Two: Relating to God in Living the Call

Most participants reported consistent communications with God which occurred at planned and unplanned times. The communications were described to be in the form of prayers, nonverbal and verbal conversations, and a strong “inner feeling” or “nudging” interpreted by participants as communication from God. Communications were expressed as being initiated by God:

And about 8:30 or so I “felt” like I’m gonna go back so I went back to the nursing home and went in and she was still there and she said you know I haven’t gone home. (Eleanor)

I started to weep over the phone and (crying and wiping tears) she asked what is wrong and I said the parish nurses are on their way down there [hospital] and the

parish nurse said she did not know why she was going down there [hospital]. She is already on the way. Those moments are when you know you have been called to ministry because it is so much huger than you. (Lynn)

Some participants depicted circumstances in which they knew God was relating and guiding their ministry. Participants described relating to God as fundamental to their ministries:

I am not one of these people—I am not good at praying out loud or expressing myself out loud in front of people very well. But God is everywhere and I talk to God all day long. (Jean)

I have quiet time every morning—most mornings where I read the Bible and pray. (Val)

I have an Anglican rosary in the car and I use it all the time when I am at a stop sign, when I am parked in the car waiting for someone to join me—it is just who I am now far more than when I was just a nurse. (Eleanor)

I do pray for everybody on the prayer list every day. . . special time three times a day, but there are other times too, but doing some kind of biblical study, some kind of reading from whatever I decide I am going to [do] my devotions for the year..I need that and if I don't get it about middle of the afternoon I am tired and I just need to have the rejuvenation. I keep a journal. (Eleanor)

I have prayed for something and I have the answer within hours. (Ellie)

When I am not connected to Him and more running on my own, things won't work as well, things aren't blessed as well they may be good things to do but it is not the same when God is involved it is like things take a life of their own and happen when it is on my own it is good things but it does not take a life of its own—it will die. I have done that in my parish nurse career. I have walked both places out of my lack of obedience. (Irene)

I talk to God all day long—I mean those trees and that blue sky and those new buds on the tree these are things that I see that I recognize and I appreciate all the time. (Jean)

The following is an anecdote expressing shared experiences in relating to God while living the call:

It was early in the morning before anyone in the house was awake when I felt startled and a need to get to the church right away. I quickly prepared for the day and went to the church. All seemed quiet but I knew I was at the church for a purpose. I had received urges from God before. The phone rang in the office and as I answered I could urgency in the voice. Mary, a member of our congregation was about to receive some difficult news regarding her illness and the doctor wanted someone to be with Mary as she heard the news. I was on my way following a quick call to the clergy. I prayed for wisdom and strength as I left to serve Mary. As I arrived I had a sense of impending doom for Mary. I remember asking God to help me. Later, when I was back at home, I processed the events of the day and I realized that there were times when I was able to respond in ways I did not know that I knew. I could not recall having learned the response or having an experience from which the knowledge would have come. God leads me through the unknown. He is all around. God is in all of my life. I have learned to trust Him even as uncomfortable as some situations maybe. I respond to His nudging to call someone or to go see someone. I have found that in doing so, I have always been just in time to help someone. God and I relate in so many ways. There are certainly times of prayer and meditation when I talk to Him and He talks to me. And there are times when we both just listen. There are times when He leads me, there are times when He is beside me, and there are times when He is behind me. Whatever His position, He is always present. When I go about my journey and ask Him to join me, it is no longer just me on the path. We are one.

This anecdote captures the essence of the theme, relating to God in living the call.

The faith community nurse meets the parishioner's needs directly through her knowledge that God is present. The situation was tragic and there were others with similar examples of human suffering that required the faith community to comfort and console others and do so through the presence and reliance and trust in God.

Theme Three: Practice in Living the Call

Participants discussed practice with ease, and most were eager to speak about their health ministry programs. The first request in the research interview of each participant was to, "Tell me [the researcher] about your ministry as a faith community nurse."

Participants began by describing their practice in the form of activities or ministries and

how long they had been a faith community nurse. The descriptions of their practices in many respects are similar to those activities of nurses who practice in other settings particularly in the community. Further in the interviews some participants described their practice by sharing actual experiences with parishioners or community members which reflected the uniqueness of practice in a faith community. Each faith community nurse interviewed had an active health ministry:

We have a health fair . . . write a small letter for our monthly newsletter . . . have a website . . . large number of books that can be loaned out . . . blood pressure checks after each service. . . Walk to Jerusalem . . . diet modification. . . I do a lot of counseling. . . I pray. . . I do go to visits (medical appointments). (Eleanor)

I was able to do what no one else from the church knew how to do including the pastor—[I] was [able] to mobilize resources—you know even though I have never walked through anything like that in my nursing career or in my life. . . I am on a prayer team. . . (Val)

I have developed a health committee. . . I write a small article with health issues, we offer Tai Chi on Wednesday mornings. . . So a lot of times in my role as a parish nurse I also take communion and that is really nice to be able to do that to people who are shut-in. And that is a really unique and spiritual experience and share with them and some of them are barely able to say the Lord's Prayer. (Sharon)

My main reason for being hired at this church was for outreach—visitation of parishioners, which I do on a monthly basis to make sure that any parishioner that is home bound I definitely see once a month if not more than once a month. Any parishioner who goes into the hospital I try to see sometimes it is only a one day admit so I don't get to see them but then I would visit them in their home. . . I do give communion. . . Once a month the service is taped and we have CD recorders that we lend the parishioners if they are interested in the tape ministry. . . I do a brief history. . . I will weigh them too. I have a list of their medications . . . health education . . . newsletter . . . blood drives . . . CPR classes. . . I do give communion that is a big part in my ministry and I usually have some type of a not actually a Bible study but specific books that we use. . . (Janice)

. . . a bulletin board ministry. . . We did the Walk to Jerusalem . . . blood pressures screenings . . . diabetes education for senior adults. (Shirley)

Reportedly, there is variation in faith community nurse practices and health ministries by size of congregation or health needs of a specific group of congregants. Some participants described activities that required clinical skills but were offered as Christian acts of faith:

I washed her clothes this morning and I will take them over tonight maybe sometime, um, she keeps saying, I would not have anybody if it wasn't for you guys (faith community nurse and spouse). And I am thinking that is probably a little bit outside your normal perimeter of your normal parish nurse. But what do you do when you've got someone who has no one. (Eleanor)

. . . do I change dressings; absolutely I can go to somebody's house and change somebody's dressing if it needs changing. (Lynn)

. . . do foot care . . . once a month. (Irene)

The descriptions by nine faith community nurses revealed well integrated health ministry programs with the church's mission including spiritual, educational, outreach, and financial resources. One health ministry program was reported to have very limited support through the church mission, due in part to church reorganization.

The following is an anecdote of practice in living the call:

I often recall my experience with John. John had been ill for some time. I was with him early on a Sunday morning while he was in the hospital. I had stayed overnight with his wife as John's time was drawing near. While his wife slept, John began to wake. He saw me and smiled and he said, "I am a mess, aren't I?" And I said, "Would you like to get cleaned up?" And he said, "Yes," so I went about bathing him and washing his hair and giving him a good clean shave. He said, "Thank you" when I was done. He said, "Today is Sunday, isn't it?" I said, "Yes," and he said, "It will be time for the Eucharist soon." I said, "Yes," but then I said, "John, you are not planning on having the Eucharist here, are you?" And he said, "No." And I said, "You are planning on having the Eucharist someplace else, aren't you" and he said, "Yes," and he simply said, "Goodbye." John died just after saying goodbye. It is in those kinds of incidents that I realize I am right where God wants and needs me to be. I have been at many bedsides at death but this was one I will never forget.

It was deeply spiritual. God's presence was tangible in warmth and peacefulness. With many of my experiences whether just sending a card, measuring a blood pressure or being with a person at the end of life, I feel the calling continues. I cannot imagine being a faith community nurse without having the calling.

Through this anecdote, practice was an experience of the faith community nurse attending to the needs of a parishioner. The attention is not directly on the physical bathing and shaving but on the intentional presence of the faith community nurse. The faith community nurse expressed to the parishioner her sense of his intention for the Eucharist as more than the mere act of offering the sacrament. The connectedness to the parishioner through God gives rise to the practice of caring for the mind, body and spirit and is an exemplar of the nature of the practice of these ten faith community nurses. .

Theme Four: Challenges in Living the Call

The challenges in living the call to health ministry were expressed as participants described their experiences as faith community nurses. This theme emerged even though the participants were not directly asked about any challenges they had experienced in living the call to health ministry. The reports of challenges came through as part of the story in living the call to health ministry. The theme of challenges in living the call became known as I listened and read the interview texts multiple times and sought out statements or phrases that seemed particularly essential or revealing about the experience being described. Participants openly discussed situations in their health ministries:

. . . feels very overwhelming. . . . I said you [God] this job is too big for me—take it back, I don't want it. (Ellie)

I just couldn't keep up the pace. It was affecting my health, my physical health, my mental health and I was getting resentful. . . . My husband was starting to complain. (Val)

. . . overwhelming sometimes in that we are kind of expected to be on hand to be asked to help with every committee . . . after every meeting there are three to four people with some kind of question. (Jean)

Sometimes [the health ministry] is misunderstood by certain folks. . . . Some folks don't want to understand it until they need us but when they need us they totally get it. . . . They aren't real sure if health education should take place in the church. But they listen . . . had to prove ourselves. . . . They did not want to trust us. (Lynn)

I felt I was not getting the support of the [denomination] I could not ask the secretary to do anything for me, I was given no money. (Barb)

I was asked to do parish nurse coordinator They were giving allergy shots and they were giving who knows what and they were going in and doing home health. (Irene)

Participants reported being overwhelmed by work volume complicated by expectations of continuous availability. Participants reported that parishioners did not trust or accept faith community nursing as a part of the church. Other issues included lack of resources in light of so many unmet needs. The following is an anecdote describing an experience of challenges in living the call:

When I first began as a faith community nurse in health ministry I had minimal resources. Health ministry was new to the congregation. I was in an unpaid position and without a budget. I funded most of the activities, books, and other things myself for the first few years. Some of the parishioners did not seem to want a health ministry in the church. They expressed that it was not the job of the church to teach about health. Now, almost seven years later, many parishioners have experienced the care of the health ministry and thus become advocates which is a blessing; still a few others remain unconvinced and this is discouraging. Sometimes I feel overwhelmed because the parishioners have so many unmet needs. At times, I do not appreciate my calling, especially when I have become physically tired and mentally stressed. I find at those times I have not stayed in communication with God. Once I bring myself to God in prayer and meditation, I am able to move forward.

Challenges emerged from a variety of internal and external sources. When challenges were present, faith community nurses expressed the need for time with God.

Theme Five: Blessings in Living the Call

The participants were not directly asked what benefits or blessings they had experienced in living the call to health ministry; however, the blessings of living the call to health ministry were expressed as participants described their experiences in faith community nursing. The reports of personal blessings came through as part of the participant's journey in living the call to health ministry. Participants reported personal blessings through faith community nursing in the forms of improved physical health such as more energy and less pain. Some participants reported improved emotional health such as the feeling of being blessed through experiencing the lives of others and finding acceptance. Some participants described the experiences of living the call as bringing together or making sense of previous professional and personal life experiences. Other participants reported a growth or positive change in their religious and/or spiritual life such as sharing religious services with spouse and removing doubt following personal difficulties within a church:

But He has definitely called me, without a doubt that's what I need to be doing so it is personal, it is as if He had said, "Ellie here is what I want you to do." (Ellie)

. . . just about ready to go home maybe 5:30 – 6:00 and the clergy would call and say, "I really need you to go out to the hospital, do you mind?" And I would say, "No, I will go." And from the university to the hospital I would think, "I am too tired to be doing this," and I would get out of the car and go into the hospital and spend time with the parishioner. It was always relevant and it was not something that he [clergy] could handle it was a medical issue and then we would pray and go on our way and I would go out the door, and I would have more energy and I would go home and do unbelievable things (smile). (Eleanor)

I don't hurt as much. My [disease] is better even though tests say it is worse. I really think the more I'm out with people and the more I am helping other people, their needs are so much greater than mine—whatever [faith community nurse ministry] has done it put it [personal disease] more in perspective. (Jean)

The children and the grandmother are just so full of love for the Lord . . . such a blessing to go there and to hear them talk and I come out more blessed than I think I deserve. (Barb)

God got a hold of me there [basic faith community nurse education program]. . . . That was a real breaking point of being real and being human and apparently a lot of excess baggage got spilled over. . . . I found acceptance. (Irene)

. . . feeling like you are ministering and doing God's work and how inspiring that can be. . . feeling of peace. . . helping other people. . . more wholistic. (Sharon)

All the different experiences that have happened to me personally, both traumatically, spiritually and psychologically different times in my life would just fit this ministry perfectly. (Val)

I believe my background in community health and home health and teaching . . . has been basic preparation for this all of my life and I did not know it. (Shirley)

I have done a lot of things in my 42 years from staff nurse to instructor to associate professor to nurse practitioner. . . . All these years you still have a lot to offer and here is another way to do it. (Sharon)

Peace and the joy that endures—it is amazing. The continual growth of Christian maturity, and wisdom and knowledge and experiences that are beyond me, it is so bigger than me. (Lynn)

This is one way the Lord has helped bring my husband into this congregation. . . . He comes with me every Sunday. (Janice)

Remarkably, each participant described positive personal experiences as she described her practice of faith community nursing. The following is an anecdote describing an experience of the theme, blessings in living the call:

I recall when I visited Henry at the hospital. Henry had been terminally ill for a long time and during this visit he was more talkative than usual. He spoke about

particular memories he had from childhood through late adulthood. I listened to his pleasant stories and asked a few questions but I mainly listened. As he was beginning to fade to sleep I asked if I could pray for him and he said, “Yes,” and I prayed. I was ready to release my hand from his when he said, “Just a minute” and he squeezed my hand more and he prayed for me. When he said, “Amen,” he looked up at me and said, “You don’t get many prayers, do you?” I said, “A few, I am not sure how many.” He smiled and slowly released my hand. I felt so blessed. Each of us has been blessed by serving in this ministry. We can share story after story of God’s grace. Each time I serve a parishioner I receive a blessing. I may not recognize the blessing immediately but I as reflect and I able to see blessing after blessing.

When caring for another, one received blessings. Faith community nurses acknowledged the receipt of blessings throughout their ministries.

Conclusion

Ten faith community nurses were interviewed to gain an understanding of the lived experience of living the call to health ministry. The faith community nurses were from four regions in Virginia and represented seven religious denominations. The faith community nurses in this research averaged 20.25 hours per week in service. Six faith community nurses were from unpaid models of practice, and four were from paid models of practice. Through conducting thematic analyses, I tried to determine the experiential structures that make up the lived experience of the faith community nurse living the call to health ministry. The theme became known as I listened and read the interview texts multiple times and sought out statements or phrases that seemed particularly essential or revealing about the experience being described. Five themes emerged through this process: 1) the calling; 2) relating to God in living the call; 3) practice in living the call; 4) challenges in living the call; and 5) blessings in living the call. Faith community nurses described practice as giving meaning to their chosen profession of nursing. The descriptions of how

each experienced the calling to faith community nursing were personal and unique as expected. Some experienced the calling through others (parishioners, clergy or colleagues), and some had experiences that gave an inner clarity to their life purpose. Each faith community nurse described feelings of relating to God. Faith community nurses expressed relating to God in the form of prayer, meditation, study, worship, music, fellowship with other faith community nurses and in service to parishioners. Several faith community nurses described an inner knowing or urging from God to be immediately in service to a particular parishioner.

Faith community nurses described active health ministries as reflected in the third theme. Wholistic practices included visitations, education, exercise, and diet programs. Faith community nurses described the use of prayer, biblical reading, music, and nature as part of their wholistic practice. Several participants administer the communion elements to parishioners unable to attend church. Faith community nurses maintained communications through newsletters and bulletin boards and working with clergy. Several faith community nurses maintained health libraries. Further faith community nurses provided assistance and advocacy for physical care through referrals to hospice, assessment of nursing and group home environments, and home health agencies. Some faith community nurses served as the coordinator of volunteers for services such as daily phone calls to homes, transportation for medical appointments, and meals. In telling about their journeys of living the call to health ministry faith community nurses described challenges along the way. Some challenges reported included difficulty balancing family, work, and faith community practice, lack of resources, lack of clergy and parishioner support, and

difficulty remaining within the scope and standards of faith community nursing when faced with unmet needs.

As faith community nurses described their journeys, they spoke of the received blessings, the final theme presented in this chapter. Blessings included the realization of how the pieces of their lives had come together—a catharsis, more energy, less pain from chronic illness when in service to others, and healing personal family difficulties. In summary, faith community nurses reportedly have very personal and varying experiences in living the call to health ministry.

This study is a hermeneutical phenomenology that followed the methods proposed by Max van Manen. Max van Manen advised researchers to come to terms with understandings, beliefs, biases, assumptions, presuppositions, and theories and to not forget them but to hold them at abeyance. He further advised to turn the knowledge against itself, thus exposing its shallow or concealing character (van Manen, 1990, p. 47). In an effort to follow van Manen's approach, I documented my personal story of living the call to health ministry prior to advertising for research participants (See Appendix G – "Researcher's Story of 'Living the Call' to Health Ministry"). I did not purposely use my story in the data analyses, however I recognize that it is impossible to totally remove oneself from a phenomenon of which one is a part. I also documented my assumptions of faith community nursing as part of the development of the research methods. These assumptions can be located in Chapter 3. Throughout the process of conducting the study, I documented any further assumptions or biases that became known to me in field notes and

by journaling. My bracketed materials allowed me to openly acknowledge my personal experiences and assumptions on paper as I continued to implement the research methods.

Through each interview I noted the thoughts, biases, or assumptions that emerged during the interview and documented them in the field notes. I deeply focus on the words and expressions of the participant through active listening. I continued to mentally acknowledge the purpose of the interview in order to minimize biases and avoid the departure from the prepared questions. At the conclusion of each interview, I would review my interview notes and document any negative and positive feelings in an effort to minimize investigator bias. Following each interview, I utilized the sententious approach described earlier in the text to capture the fundamental meaning or main significance of the entire interview.

I sought guidance from my dissertation chair by having her review the first two interview transcripts. In particular, she provided guidance by pointing out an instance of bias in which I asked a follow up question and used the word “opposition” to summarize a situation related to me by the participant. Her observation of this instance heightened my awareness to interviewer bias. As I reviewed and analyzed each transcript, I was attentive to the narrative text of the interview and my field notes to eliminate the possibility of interviewer bias. After analyzing a datum from an interview situation that I suspected to have been subject to interviewer bias, I, before further interpretation, determined if the datum was present in other participant descriptions which were not subject to interviewer bias.

As a faith community nurse, it was difficult to take the phenomenon of living the call to health ministry and suspend all knowledge and beliefs gained through course work, faith community nurse education, and personal health ministry practice. Van Manen described the suspension of beliefs as essential to study the structures of world, however complete suspension of beliefs is extremely difficult to achieve. During the time span between interviews, I read through my story of my personal journey in living the call to health ministry and my previously identified assumptions. Doing so assisted me in acknowledging my biases, beliefs, and assumptions and refraining to the extent possible from influencing the participant's responses or the investigator's interpretation of their lived experience.

I have provided the techniques utilized in this study to achieve bracketing. Complete bracketing is nearly impossible to achieve. Bracketing becomes more difficult when the researcher has knowledge and experience in the phenomenon being investigated, which is the usual case for studying a phenomenon. The bracketing procedures described above were useful in reducing the impact of my personal biases throughout the study.

Discussions in Chapter 5 include the findings related to the five themes emanating from the study and related research literature. Further, the chapter presents the strengths, weaknesses, and limitations of the study and the implications for future research.

Chapter 5

DISCUSSION AND IMPLICATIONS OF THE FINDINGS

This chapter discusses the findings of the research study. The five themes that emerged are: 1) the calling; 2) relating to God in living the call; 3) practice in living the call; 4) challenges in living the call; and 5) blessings in living the call to health ministry. A hermeneutical phenomenological research method as prescribed by Man van Manen was used to guide this research. Rigor of the study, including the benefits and challenges related to bracketing, will be discussed. The implications for further research, education, and practice will be explored. Finally, the strengths and limitations of this study will be described.

Summary of the Purpose and Results of the Study

The purpose of this study was to describe the lived experience of faith community nurses living the call to health ministry. Using Max van Manen's hermeneutical phenomenological method, five themes emerged from participants' stories. The themes are: 1) the calling; 2) relating to God in living the call; 3) practice in living the call; 4) challenges in living the call; and 5) blessings in living the call. These findings provided insight into the *lifeworld* of the faith community nurse. *Lifeworld* is a critical component of van Manen's work, and was useful in interpreting and understanding the findings. The four *lifeworlds* as previously discussed in Chapter 3 were helpful guides for reflection during and the writing process. Max van Manen (1990) guided the researcher in determining the universal or essential quality of a theme. As recommended by van Manen, the researcher

should be concerned with the task of discovering aspects or qualities that make a phenomenon what it is and without which the phenomenon could not be what it is. In other words, what is the theme which is essential to the phenomenon? Each theme will be measured against this criterion.

Discussion of the Findings

Ten faith community nurses provided descriptions of their experiences in living the call to health ministry. Each individual's story was distinctive and unique as expected in qualitative research. However, the stories collectively contained similarities that emerged as the five themes. The participants described the significance of the calling, their relating to God, meaningful experiences with parishioners, their health ministry program responsibilities and services, experiences that led to their personal growth, and the joys of serving others. It was from these shared experiences that five themes emerged as findings of this study; they are described below.

Theme One: The Calling

The faith community nurse's belief of having been called to health ministry was an inclusion criterion for this study. Because each participant met all inclusion criteria, the ten faith community nurses described their experiences with their call to health ministry. Faith community nurses expressed external callings as coming through clergy, parishioners, friends, and colleagues. This finding confirmed the observations of Mosack, Medvene, and Wescott (2006), which found that parish nurses often cited church contacts, encouragement of family and friends, and/or personal interest as a reason for entering into parish nursing. Other callings were experienced internally (from God).

Most participants reported not responding quickly to the initial external calls to faith community nursing, explaining that other life circumstances already required much of their time and energy. Such life circumstances typically included jobs, raising children, and caring for ill or aging parents. Others reported that they did not initially respond to external calls because they did not know about faith community nursing. Some participants explained that they had taken a basic faith community education course without any intended commitment to faith community nursing.

Participants also reported experiencing an internal calling. Some faith community nurses described a calling from God as a “nudging” or “coaxing” or “being in His will.” Myers’ work recorded findings consistent with those described by faith community nurses in this research. Participants in Myers’ research used words such as “beckoning” or a “calling to care” to describe the call. The words “nudging” and “beckoning” are similar by definition. Nudging is defined as “to urge, to give a signal” and beckoning is defined as “meaning to signal or summon” (Webster’s II, 1988, pp. 161, 806). The word “beckoning” in Myers’ research is consistent with the word “nudging” in this research study.

Several faith community nurses described internal callings as coming from God and evoking emotional experiences. Such callings from God occurred in different venues, such as during the basic faith community education course or during their first encounter with a parishioner. Those faith community nurses receiving initial callings from external sources articulated that they had received later callings from God or had experiences that affirmed God’s calling to faith community nursing. One faith community nurse described an internal calling from God as transformational. Faith community nurses reported that

God's callings were persistent; they described several memorable external encounters through clergy, parishioners, friends, and colleagues which were followed by the calling from God. Participants expressed a sense of faith and commitment when the call to faith community nursing was accepted. This experience is similar to Nightingale's sense of "inner certainty" that her life would be devoted to God following her call to nursing. Nightingale recognized several experiences which she called "inner awakenings" when she felt called by God (Widerquist, 1992; Macrea, 2001).

Participants described feelings of empowerment and confidence following the acceptance of the call. Weis et al. (2006) defined empowerment as "an enabling process arising from a mutual sharing of resources and opportunities that enhance decision making to achieve change at the individual, congregation, and community levels (p. 18). Weis et al. identified several attributes of empowerment for parish nurses including being valued, implementing one's role, engaging a higher power, gaining experience and education, reciprocally interacting with patients, and working with mentors (p. 19). The faith community nurses in this study described living the call to health ministry with attributes similar to the findings reported in the study by Weis et al., Specifically, participants in both studies reported being valued, being identified similarly by others as a faith community nurse, communicating with God, and benefitting from a basic faith community nursing course.

When examining the essential nature of the theme, as suggested by van Manen, living the call is an essential theme as it builds on the foundation of the call to health ministry. Participants overwhelmingly stated that the call was fundamental to living the

call to health ministry. Considered conversely, is living the call to health ministry essential to the call? As noted by several participants, living the call to health ministry was initiated by the receipt of a call. It would not be possible to live the call without having first received such a call. Arguably, the inclusion criteria make it difficult to fully appreciate this phenomenological question since each participant professed to having received a call to faith community nursing. The phenomenon of living the call to health ministry is not possible without a call.

Theme Two: Relating to God while Living the Call

Throughout the interviews, participants also described relating to God in living the call to health ministry. Relating to God was described as occurring in the forms of prayers, worship, devotions, Bible study, music, nature, and service and care to others. Participants described open communication with God. For instance, one participant observed, “I talk with Him all the time.” Another observed, “I pray for something and have an answer within hours.” Another participant related, “I have quiet time every morning— most mornings where I read the Bible and pray.” One participant stated, “When I am not connected to Him and more running on my own, things won’t work as well.” Another participant related a story in which she was sure God was asking her to do something she had never done before, thus taking her “out of her comfort zone.” She observed, “If you are living the call you have to have a willingness to be uncomfortable because that is where your leap of faith and your trust in God comes from.” Faith community nurses described their trust in God as the basis for their ministry.

Relating to God has given faith community nurses confidence and trust. The reliance on God is consistent with the research findings of Weis, Shank, and Matheus (2006)'s study of the process of empowerment, that found "one of the outcomes of empowerment for parish nurses was the centrality of higher power" (p. 22). The trust in a higher power brings inner strength and an increase in self-worth, which are critical to the practice of parish nursing.

Relating to God involves listening to Him. Participants related times when they felt a need to physically respond to a parishioner, however they were unsure of the needs at that time and could not determine how exactly how they knew to respond. One participant stated, "When I am awakened at night and something says get over to the hospital—it is not my nursing expertise that is sending me back to the hospital, it is something very different." Another participant told the story of a colleague who travelled to the hospital without being asked or knowing why, only to find that a parishioner had just received some difficult news. The faith community nurse was present to minister to the parishioner.

Relating to God is an activity described by van Manen as part of the *lifeworld* as related to the faith community nurse (van Manen, 1999, pp. 101-106). The *lived human relation*, per van Manen, is the human communal experience that gives a sense of life purpose and meaningfulness to the faith community nurse. The faith community nurse was able to develop a conversational relationship which allowed her to transcend herself in order to meet others and their needs. The *lived space* is the existential theme that refers to the world in which human beings move and find themselves at home. In the above cited experiences, the hospital was the *lived space*. But since faith community nurses often meet

parishioners wherever they may be, the *lived space* can be anywhere. The *lived time* and *lived body* is captured when the faith community nurse and parishioner come together in health ministry.

Relating to God was described by the participants as an essential part of living the call to health ministry. Relating to God was viewed as central to their ministry. Faith community nurses expressed trust in God which brings them inner strength and self-worth. The faith community nurses in this study professed to relate to God in many ways. One participant cautioned that failure to communicate with God might result in reliance on self-sufficiency.

Applying van Manen's method and turning the question around to see the interconnectedness of the themes and the phenomenon, one would ask the following question: Is the phenomenon of living the call essential to the theme of relating to God? The data indicated that living the call was an active process in which the faith community nurses expressed the need for guidance from God.

Theme Three: Practice in Living the Call

Practice is defined as the exercise of an occupation or profession (Webster's II, 1988, p. 923). The HMA and ANA (2005) reported that the practice of faith community nursing is wholistic, meaning the integration of the physical and spiritual aspects of the whole person. "The principles of wholistic health arose from the understanding that human beings strive for wholeness in relationship to their God, themselves, their families, and the society in which they live" (p. 2). The faith community nurse applies the nursing process to address the spiritual, physical, mental, and social health of the individual. The faith

community nurse has five major roles: health educator, personal health counselor, referral agent, coordinator of volunteers, and developer of support groups. Faith community nurses practice according to the guidelines outlined by the HMA and ANA in 2005 in *Faith Community Nurse: Scope and Standards of Practice*.

In this research study, practice was described by participants in significant detail as occurring through activities, ministries, and experiences. Practice or rendering care and service to others varied by faith community, and thus, practice varied by faith community nurse. Tuck and Wallace (2000) found that parish nurse actions are the result of recognizing the needs of the congregation, which help to structure the parish nurse practice. In my research, the activities and ministries were similar. Participants cited many activities including but not limited to the following: praying; reading from the Bible or other religious materials; listening for God and to parishioners; visiting with parishioners in homes, nursing homes, and hospitals; providing support groups and resources such as food and clothing; and assisting with community education through health fairs, classes, newsletters, and bulletin boards. Tuck, Pullen and Wallace (2001) reported that prayer was the most frequent spiritual intervention provided by parish nurses, which supports the finding in this research that prayer plays a significant role in the life of the faith community nurse. However, it should be noted that this research did not measure the frequency of the use of prayer as an intervention.

The participants in this research study shared some differences between practicing as a faith community nurse versus practicing as a nurse with faith. Participants expressed that practicing as a faith community nurse gave freedom to express spirituality.

Participants expressed that parishioners expected the faith community nurse to pray and read from the Bible even in a hospital setting. The participants reported many of their practice activities were faith based. However, in the usual role as a nurse with a strong faith working in a hospital setting, the participants perceived that any expression of faith, religion or spirituality was discouraged by administrators and they were unsure of the perceptions of patients. The freedom to share spiritually with a patient was also difficult due to time constraints. One participant expressed that the perceived value of spirituality in a hospital was limited to conducting a nursing admission assessment of a patient where the only required question was to ask about a religious preference.

Faith community nurses described 'The Walk to Jerusalem' as an example of holistic practice. This is an activity that focuses on biblical study and spiritual growth, combined with physical exercise. The Walk to Jerusalem is a shared ecumenical experience and was reported by the participants from two different regions of Virginia. As described in the narratives, it is in this activity and others like it that faith community nurses try to bring God's presence to others. The act of bringing God's presence is supported by the findings in the research of Dover and Pfeiffer (2006) in their substantive theory of "Bringing God Near." The theory indicated that the faith community nurse's focus is on the parishioner and God and that God is brought to the patient or family experiencing illness or crisis through the practice of the faith community nurse. This theory of "Bringing God Near" was evident in practices of faith community nurses in this research.

The theme of practice is essential to living the call because practice is the primary means by which faith community nurses live the call to health ministry. When inverting the question and asking if the phenomenon of living the call is essential to the theme of practice, the findings in my research would indicate the affirmative for the practice of faith community nursing.

Theme Four: Challenges in Living the Call

Faith community nurses expressed challenges in living the call to health ministry. The challenges were made known to me throughout the interviews as part of the stories and experiences in the faith community nurse's journey. The challenges were presented as incidental to the practice. Most faith community nurses described solutions found along the way in the experience. The challenges in living the call included lack of trust, overwhelming work volume, knowledge of many unmet needs, lack of resources, and meeting expectations of continuous availability. Weis, Schank, and Matheus (2006) defined empowerment as an enabling process arising from a mutual sharing of resources and opportunities that enhances decision making to achieve change at the individual, congregation, and community levels. Such barriers to the empowerment of faith community nurses were similar to those challenges expressed by participants in my research. The barriers to empowerment included a lack of time, high self-expectations, lack of support, inexperience, and poor organizational structure. Common to both studies are the findings of lack of time in light of unmet needs, high expectations of continuous availability, and lack of support.

Is the theme of challenges essential to the phenomenon of living the call? The answer is yes. One faith community nurse acknowledged the reality of challenges:

When you face the trials if you are called, you will continue to persevere through. . . . You just keep on, you press in and you get through those tough times and you don't deviate because it is about being in the will of God and if you are called then you are in His will and there is no better place to be.

Is the phenomenon of living the call essential to the theme of challenges? Challenges can be found in any vocation, irrespective of living the call. Challenges are inherent in life. Therefore, in the phenomenon of living the call, the theme of challenges may be considered incidental.

Theme Five: Blessings in Living the Call

All ten faith community nurses interviewed spoke of blessings, gifts from God, and positive experiences in living the call to health ministry. In the stories of their experiences, participants expressed blessings, despite the fact that no interview questions asked about blessings or positive experiences. Blessings were described by faith community nurses as unexpected and deeply personal. For instance, one participant related that a spouse began to attend church following her acceptance of employment as a faith community nurse. Another faith community nurse reported that she and her spouse, after being disappointment in the church's care of funeral services for loved ones, began attending church again as a result of her calling. Another participant shared that the experience of a debilitating illness that resulted in unemployment and sadness became less physically and emotionally painful since accepting the call to faith community nursing and serving others. One participant explained that faith community nursing has led to employment

opportunities in the missionary field after job loss due to hospital department closure. Another participant shared the experience of unexpectedly releasing long-standing stoicism during a basic faith community nurse education course. This participant shared that she now has the ability to sense passion and self-acceptance. Several participants expressed that in the midst of adversity, they found joy and pleasure in ministering to others. The experiences described above were viewed as blessings.

Many more blessings were recorded as shared through the experiences in the journey of faith community nursing. The blessings ministered to the mind, body, and spirit of the faith community nurses. As was often the case, when faith community nurses were caring for others, they were also being cared for by others. Such was the experience of one faith community nurse who was praying with a parishioner at his bedside when, at the conclusion of her prayer, he asked if he could pray for her. Such blessings were characterized as providing energy and rejuvenation.

The theme of blessings is essential to the phenomenon of living the call, given that the call has been acknowledged to be from God and that faith community nurses live the call to health ministry by trusting in God from whom all blessings flow. The phenomenon of living the call is essential to the theme of blessings, given that faith community nurses who are living the call to health ministry view their practice as a way to provide parishioners with blessings from God.

In conclusion, five themes emerged from the data which promoted a greater understanding of the lived experience of faith community nurses living the call to health ministry. The participants believed that they had been called to faith community nursing.

Important to living the call is the calling, relating to God, practice in the ministry of faith community nursing, and acknowledging the challenges and blessings. These findings provided a glimpse into the lived experiences of the ten faith community nurse participants.

Study Rigor and Summary of Bracketing

I proposed for this study the following elements for rigor as described by Denzin & Lincoln (2000): credibility, transferability, trustworthiness, and confirmability. Credibility in a study occurs when others can recognize the experience in subsequent encounters (Denzin & Lincoln, 2000, p. 393). In this study my dissertation chair read the constructed themes and reviewed actual interview transcripts. I conversed with her regarding the emerging themes. She has conducted multiple qualitative research studies with parish nurses. I utilized her expertise and the expertise of my research committee as confirmation of credibility. Additionally, my findings were supported by previous research findings as noted in this chapter.

Trustworthiness is the second measure of rigor. In this study, trustworthiness was determined by the use of audit trails (Denzin & Lincoln, 2000, p. 230). The intention of testing for trustworthiness was to bring about strength in the understanding of the theme and to achieve trustworthiness and credibility. Audit trails for each theme provide quotations of study participants (See Appendix I - Audit Trail). Additionally, interview transcripts were reviewed while listening to audio tapes to ensure the accuracy of transcription.

Transferability is obtained when the findings fit in other contexts as judged by readers and when readers determine the findings are meaningful in regard to their own experience. Transferability is yet to be determined; however, the inclusion of thick descriptions and verbatim quotations increase transferability (Munhall, 2001, p. 300). This report contains thick descriptions in the form of anecdotes and verbatim quotations directly from study participants.

Confirmability refers to objectivity or neutrality of the data (Polit & Hungler, 1997, p. 454). Confirmability was obtained as I described to the extent possible the human experience of living the call to health ministry from research participants' stories, not my own. I continually reviewed my personal biases, assumptions, presuppositions, and beliefs prior to, during, and between interviews to obtain the purest descriptions of the phenomenon. The pre-planned questions asked during the interview allowed for consistency among all participants.

The purpose of the bracketing process was to protect the integrity and trustworthiness of the research. One of the first techniques I used to become aware of my knowledge and experience before I started the interviews was to record my journey as a faith community nurse (See Appendix G - Researcher's Story of "Living the Call" to Health Ministry) for later reflection. Secondly, I collected my assumptions, pre-understandings, biases, suppositions, theories, and beliefs in a document that was shared with my committee. This document can be found in Chapter 3.

Another strategy used in this research was structured time between interviews to allow for the collection and recording of my thoughts following each interview. This was

an effective strategy as I was able to record my thoughts following the interview and to prepare for the next interview. I recoded these thoughts in my field notes. As I progressed in the research process, bracketing required an intense consciousness to avoid compromising the data and later the findings. I found the process of bracketing to be essentially important to the protection of the integrity and validity of this research.

Implications of Findings

The findings of this study have implications for research, education, and practice. This study is one of few phenomenological studies in faith community nursing. The processes of qualitative inquiry provided a vividness of experiences and richness in text. The method was effective in this study, and the lived experience of faith community nurses living the call to health ministry was illuminated. These findings help the researcher and the profession to better understand living the call to health ministry. The implications for research, education and practice are discussed below.

Implications for Research

Research in faith community nursing is slowly growing as evidenced by the recent studies such as Weis, Schank, and Matheus (2006); Mosack, Medvene, and Wescott (2006); Myers (2002a and 2002b); and Wallace, Tuck, Boland, and Witucki (2002). The majority of existing research is qualitative and investigates the basic practices and roles of faith community nurses. A few qualitative studies have utilized triangulation with established measurement surveys and investigator or committee developed surveys. Faith community nursing has also been the subject of several doctoral theses. The findings from this research have supported the significance of the calling and attributes of living the call.

Future research is needed to understand the implications of calling to the commitment to faith community nursing and impact of a calling on the practice of a faith community nurse. Ultimately, the significance of the call to faith community nursing is relevant to the health and well-being of the recipients of the nursing care. Finally, additional recruitment strategies are necessary in future studies in order to recruit a more diverse sample of faith community nurses.

Implications for Education

This study may provide educators with new or updated information into the lived experience of faith community nurses. This study clearly depicts the richness of the ministry of faith community nursing. Implications for education include the assessment of the impact of the basic faith community nurse education course on the practice of health ministry. In this study, all participants had completed at least the basic education course however other faith community nurses practice without the course. Are there measureable differences in practice in relationship to having completed a basic course? Additionally, several faith community nurses expressed having received an internal call while attending a basic faith community education course. Basic faith community education courses are available on-line however no faith community nurses in this study expressed receiving a call during the on-line course although several received education through on-line education. Is there a relationship between receiving a call and the face-to-face interactions that occur in the classroom basic course? The findings of this study raise questions for the delivery of education.

Implications for Practice

This research revealed that faith community nurses practice wholistically in health ministry. The structure of a health ministry varies from faith community to faith community. *The Faith Community Nurse: Scope and Standards* delineates expectations for the practice of faith community nurses utilizing the nursing process. Further study and the development of outcomes measurement of practice may provide data that would serve to organize the specialty of faith community nursing to collectively support public health efforts such as those outlined in the USDHHS' publication *Healthy People 2010*.

Strengths and Limitations of the Study

This study provides useful information regarding the experiences of faith community nurses who have been called to practice in health ministry. The findings of this study were supported by several previous studies. This study used the method described by Max van Manen. The strengths of this study are discussed as follows.

The participants in this study met all inclusion criteria. Each participant professed a call to faith community nursing, spoke English, was licensed and practiced in the Commonwealth of Virginia, completed a basic faith community course, actively practiced within a Protestant faith community, had one or more years experience in health ministry, and was interested and willing to be a participant in this research. Basic nursing education levels of the participants varied, as did the number of years in nursing and faith community nursing. This study had ten study participants, which is comparable to the sample size of other qualitative studies and all participants who volunteered for the study also completed the study. Each participant was able to articulate exclusive and similar experiences of

living the call to health ministry, and as expected in phenomenological research, each participant was recognized to be unique. Participants' experience in faith community nursing varied with regard to the number of years practiced. Additional strengths of this study include the variability of church membership size (ranging from 50 to 1000 parishioners), representation of six religions within Protestantism, and the inclusion of participants from four different regions of the Commonwealth of Virginia. The five themes emerged as illustrative of a shared experience of the call to faith community nursing although there was variability noted in Protestant denominations, church size and geographical regions in the Commonwealth of Virginia.

Limitations in this study include the lack of diversity of the participants, as all participants were Caucasian females. This research study findings were based on the experiences of ten Caucasian female participants. The researcher sought a diverse participant sample of persons by race and gender through the use of large faith community nurse listservs that have diverse membership. Potential participants responded to the posted recruitment ads over a period of several weeks. The first ten participants who met the inclusion criteria were accepted for participation in the study. The impact of the lack of diversity by race or gender is unknown in this study however the findings in an ethnographic study by Tuck & Wallace (2000) would suggest a minimal impact. Tuck & Wallace designed a study to illuminate differences in the parish nursing program by including participants from diverse groups. One site was African-American and the other site was primarily White. The differences noted in that study were the demographic characteristics of the populations, the health issues relevant to each group and the

differences in worship experiences. There were no differences reported in parish nursing culture between the two sites. The shared educational training and adherence to the scope and standards of the specialty might level practice differences for faith community nurses. However, the previous study did not specifically focus on the call to faith community nursing and the effect of diversity on the call remains unknown.

Recommendations for Further Study

The purpose of this study was to gain an understanding of the lived experience of faith community nurses living the call to health ministry. Through the analysis of participant's interview transcripts, five themes emerged: 1) the calling; 2) relating to God in living the call; 3) practice in living the call; 4) challenges in living the call; and 5) blessings in living the call. It is through these themes that *lifeworld* of faith community nurses was illuminated. Faith community nurses in this study experienced the calling from external sources and/or internally from God. Faith community nurses expressed that relating to God was foundational to their practice and some reported having experienced an internal knowing of being needed without receiving a phone call or other request. Practice was described as wholistic. Faith community nurses expressed that health ministry was not without challenges however blessings were experienced through ministering to others. The following is recommended for future research and is based on the findings and implications resulting from this study.

- 1) Conduct a study to determine the perceptions of clients as recipients of faith community nursing practice as it relates to the five themes evident in this study.

2) Conduct a comparative study with Protestant and non-Protestant faith community nurses from diverse backgrounds who do and do not profess a call to explore the essential requirement of the call to the practice of health ministry.

3) To establish faith community nursing as an entity for improving the health of others by conducting a longitudinal study of faith community nurses in health ministry and establish baseline data related to: care and service outcomes; and changing parishioner physical, mental, emotional and spiritual health conditions.

Conclusion

The phenomenon of living the call was explored with faith community nurses through the methodology of Max van Manen. Ten faith community nurses described their experiences in health ministry in structured interviews. Data analyses revealed five themes in living the call the health ministry. Those themes are: 1) the calling; 2) relating to God in living the call; 3) practice in living the call; 4) challenges in living the call; and 5) blessings in living the call. These themes provided insight into the lived experiences of faith community nurses living the call to health ministry.

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APPENDIX A

Max van Manen's Qualitative Research Methodology

Steps of Max van Manen's Qualitative Methodology

1. Turn to the nature of lived experience by orienting to the phenomenon, formulating the phenomenologic question and explicating assumptions and preunderstandings.
2. Engage in existential investigation, which involves exploring the phenomenon: generating data, using personal experience as a starting point, tracing etymologic sources, searching idiomatic phrases, obtaining experiential descriptions from participants, locating experiential descriptions in the literature, and consulting phenomenologic literature, art and so forth.
3. Engage in phenomenologic reflection, which involves conducting thematic analysis, uncovering thematic aspects in the life-world descriptions, isolating thematic statements, composing linguistic transformations, and gleaning thematic descriptions from artistic sources.
4. Engage in phenomenologic writing which includes attending to the speaking of language, varying the examples, writing and rewriting.
5. Establish and maintain a strong relation with the phenomenological question.
6. Balance the research context by considering parts and whole. Constantly, one needs to measure the overall design of the study/text against the significance that the parts must play in the total textual structure.

APPENDIX B

Research Interview Questions

The following questions will guide the interview:

1. Tell me about your ministry as a faith community nurse.
2. What does the call mean to you in the context of a faith community nurse in health ministry?
3. How do you know you are “living the call” to health ministry?
4. Tell me about some of your experiences in “living the call” in health ministry.
5. How does having the call matter to you as a faith community nurse?
6. How does “living the call” to health ministry manifest in your personal spirituality?
7. Some nurses have stated that they felt “a call” into nursing. If you experienced this as well, would you describe any differences between “the call” into nursing and “the call” to health ministry?
8. Is it possible to practice faith community nursing without a call?
9. Would you share your thoughts regarding paid and unpaid health ministry as it relates to the call?

APPENDIX C

Consent Form

RESEARCH SUBJECT INFORMATION AND CONSENT FORM

TITLE: What is the Lived Experience of the Faith Community Nurse Living the Call in Health Ministry?

VCU IRB NO.: HM12101

PURPOSE OF THE STUDY

The purpose of this research study is to gain an understanding of the lived experience of the Protestant faith community nurses “living the call” in health ministry. You are being asked to participate in this study to explore your experiences as a faith community nurse “living the call” to health ministry.

DESCRIPTION OF THE STUDY AND YOUR INVOLVEMENT

Participation in this research is completely voluntary. If you decide to participate in this research study, this written consent form will be read aloud as is to you and you will indicate whether you wish to sign, provide verbal consent or not participate any further. Should you decide to participate, the researcher will document by her signature and date the completion of the consent process. In this study you will be asked to participate in an individual interview. The interview will last approximately 60 – 90 minutes. You will be asked to talk about your decision of becoming a faith community nurse; how you experienced your call into health ministry; and examples of “living the call” in health ministry as a faith community nurse. The interview will be audio taped to allow for interview interaction and assurance of a record of your input. Should your name or the name of any individual be mentioned on the audio tape another name will be substituted during transcription to provide for anonymity.

RISKS AND DISCOMFORT

The only foreseeable risk or discomfort of participating in this study is the time away from work or family and the introspection in describing, thoughts, feelings and experiences. Should you decide you do not want to continue the interview, you may at any time withdraw from the study.

BENEFITS TO YOU AND OTHERS

You may not get any direct benefit from this study, however your participation may benefit others by enabling others interested or experiencing the call in faith community nursing to experience the practice of “living the call” to health ministry through your thoughts, feelings and experiences.

COSTS

There are no costs for participating in this study other than the time you will spend in the interview.

ALTERNATIVES

The alternative to participating in this study is simply not to participate.

CONFIDENTIALITY

Potentially identifiable information about you will consist of the inclusion criteria form, consent form, demographic information form, interview audio tape, data summary notes and transcript. Data are collected only for research purposes. Your data will be de-identified by using ID numbers instead of names. These items will be stored separately from the identifying key notation document which will contain your name and ID number. The identifying key notation document will be secured in a locked file cabinet, separate from all other research materials. Key access will be only with the Principal Investigator and the doctoral student researcher. During transportation the audio tape will be placed in a locked fire proof box. Tape access will only be available to the researchers. After the information from the tapes is transcribed, the tapes will be destroyed. All personal identifying information will be kept in password protected files and these files will be deleted five years following the research. Access to all data will be limited to study personnel.

The transcriptionist will be asked to signed a confidentiality agreement and to password protect all research transcription.

I will not tell anyone that you participated in the study or the information provided; however, information from the study and the consent form signed by you may be reviewed or copied for research or legal purposes by Virginia Commonwealth University.

The findings from this study may be presented at meetings or published in papers, but your name or the name of anyone mentioned during the interview will not be used in these presentations or papers.

IF AN INJURY HAPPENS

This research is subject to less than and no more than minimal risk as the interview has no questions that might put individuals at risk of psychological harm.

VOLUNTARY PARTICIPATION AND WITHDRAWAL

You do not have to participate in this study. If you choose to participate, you may stop at any time without any penalty. You may also choose not to answer particular questions that are asked in the study. Your participation in this study may be stopped at any time by the study staff and without your consent.

QUESTIONS

In the future, you may have questions about your participation in this study. If you have any questions, complaints, or concerns about the research, contact:

Inez Tuck, RN, PhD, MBA, Mdiv
Virginia Commonwealth University
School of Nursing
P. O. Box 980567
Richmond, Virginia 23298-0567
Office: 804-828-3474 E-mail: ituck@vcu.edu

If you have any questions about your rights as a participant in this study, you may contact:

Office for Research
Virginia Commonwealth University
800 East Leigh Street, Suite 113
P.O. Box 980568
Richmond, VA 23298
Telephone: 804-827-2157

You may also contact this number for general questions, concerns or complaints about the research. Please call this number if you cannot reach the research team or wish to talk to someone else. Additional information about participation in research studies can be found at <http://www.research.vcu.edu/irb/volunteers.htm>

CONSENT

I have been given the chance to read this consent form and the form has been read aloud to me. I understand the information about this study. Questions that I wanted to ask about the study have been answered. I received a copy of the consent form prior to the interview. I am willing to participate in this study and know that I may withdraw without penalty at any time. I understand that I may choose to sign or not sign this form and still participate in this research as verbal or written consent is acceptable.

Participant name printed

Participant signature

Date

 Name of Person Conducting Informed Consent
 Discussion / Witness
 (Printed)

 Signature of Person Conducting Informed Consent
 Discussion / Witness

 Date

 Principal Investigator Signature (if different from above)

 Date

APPENDIX D

Participate Basic Demographic Information

Basic Demographic Information

Age: _____years

Gender: Male Female

Select highest level of Professional nurse education: Associates Diploma BS BSN

MS MSN PhD Other _____

Years as a registered nurse: _____

Clinical areas of experience: _____

Years practicing health ministry: _____

Religious Affiliation: Yours _____ Practice site _____

Faith community nurse education: Year: _____ Program name: _____

Model of health ministry: Paid or Unpaid

Full-time hours/week _____ or Part-time hours/week _____

Budget available for health ministry? Yes No

Number of members active in the church practice site: _____

Church structure supporting health ministry: Cabinet Committee Team

or other _____

Total number of faith community nurses active in practice site health ministry: _____

Number with basic parish nurse education preparation _____

Number without basic parish nurse education preparation _____

APPENDIX E

Written Ad for Participation in Research Study

Faith Community Nurses Requested to Participate in Research

Dear Faith Community Nurse:

I am a doctoral student in the School of Nursing at Virginia Commonwealth University and a Faith Community Nurse. I am conducting research about the lived experiences of faith community nurses, parish nurses or congregational health nurses “living the call” in health ministry. If you are a faith community nurse, parish nurse, or congregational health nurse and meet the criteria, I would like to speak with you about participating in this study.

The criteria are:

- 1) English speaking;
- 2) Belief that you have experienced ‘a call’ to health ministry;
- 3) Actively practicing within a faith community;
- 4) Faith community in which you are practicing considered Protestant;
- 5) One or more years experience in health ministry;
- 6) Minimally completed a basic core curriculum education as prescribed by the IPNRC (this may have been taught in numerous locations and agencies);
- 7) Licensed in the state of Virginia as a registered nurse;
- 8) Faith community nurse practice is located in the state of Virginia; and
- 9) Interested or willing to be a participant in this research project.

This research will explore your experiences as a faith community nurse “living the call” in health ministry. This research is completely voluntary. This research will explore your thoughts, feelings, and experiences as they relate to “living the call” in health ministry. The interview will be audio taped and the transcript will be confidential. You will derive no personal benefit from this study, however your participation may benefit others interested in or experiencing the call in faith community nursing to learn about the practice of “living the call” in health ministry through your thoughts, feelings, and experiences.

Other than the time you will spend in the interview, there are no costs to you for participating in this study nor is there any compensation to you for your participation in this project.

If you meet the above criteria and would like to assist in advancing the knowledge of Faith Community Nursing, by participating in this research study, please contact:

Deborah S. Mobley, MS, RN, FCN

Home: (757) 442 – 3776

This telephone number is private with limited use and you may leave a message as it will only be retrieved by the doctoral student researcher. Thank you for your time and interest.

APPENDIX F

Participant Inclusion Criteria

During an initial telephone correspondence, the investigator will ask the faith community nurse the first five questions. Question 1 will become known during this correspondence.

- | | | |
|--|-----|----|
| 1. Is the faith community nurse English speaking? | Yes | No |
| 2. Do you believe you have received ‘a call’ to health ministry? | Yes | No |
| 3. Are you actively practicing within a faith community? | Yes | No |
| 4. Is the faith community in which you are currently practicing
Protestant? | Yes | No |
| 5. Do you have one or more years experience in health ministry? | Yes | No |
| 6. Have you completed at least a basic faith community nurse core
curriculum course as prescribed by the International Parish Nurse
Resource Center? | Yes | No |
| 7. Are you licensed in the State of Virginia as a Registered Nurse? | Yes | No |
| 8. Is your faith community nurse practice in the state of Virginia? | Yes | No |
| 9. Are you interested and willing to be a participant in this research
project? | Yes | No |

All questions must be answered “Yes” to be eligible for the investigation. If all answers are yes, the participant will be given further information for participation including an explanation of the interview process, written informed consent, and arrangements for the interview meeting.

APPENDIX G

Researcher's Story of "Living the Call" to Health Ministry

My call to faith community nursing came quietly and persistently. I had no idea what God was doing. I can see now.

The first invitation came in the form of a note written by a minister and grandfather to three of my godchildren. The note spoke of the work of Rev. Granger Westberg. The note went on telling me why I should consider this opportunity and all the attributes he thought I possessed that would make this a perfect vocation for me. He offered to talk about this with me. The note seemed to come out of nowhere. I had never received a note from him, and I was surprised by its delivery. I was appreciative of his kind words but did not give faith community nursing any further thought for several years. I was heavily involved in my nursing education, working full-time, and I liked what I was doing professionally. I was also caring for aging parents, and the realities of life seemed too much to consider another "job."

The second invitation came almost ten years later. I was given a gift from my employer following a successful accreditation survey. Gifts had not followed any other successful survey. The gift was that I could attend any continuing education program in the connecting 48 states at the expense of the health system. Time lapsed, and I forgot about the offer. Then one day I was reminded of the offer by Administrative Director and encouraged to make use of the funds as soon as possible. I was reading the *Virginia Nurse* that very night and saw a very small advertisement for a faith community nursing

education (then called parish nursing) program. I thought about faith community nursing and I was at a different place in my faith journey—perhaps this would be another opportunity to serve God and make use of my nursing education, training and experience, and my desire to practice with God and not ignore or be secretive about doing so. The course required two weeks away from work, but costs were less than \$1000.00 in registration, lodging, meals, and educational materials. It was the last day to register! When I contacted the program coordinator, she indicated that the program had already exceeded over capacity but said, “Well, maybe God intended us to have one more.” The class limit was 15 students but had progressed until I was the final registrant, number 30. I began to think God was in this.

I attended the educational sessions and learned so much. My classmates and I worshiped, laughed, and prayed together. We became lifelong friends. For the first time in my life, I experienced “real” time with God. He was present with me. From that time forward, I have never been the same in my spiritual life. God had spoken to me subtly but persistently. I felt that He wanted me to mature further in my spiritual life. Following this educational program, I tried to begin a conversation with my pastor about the role of faith community nursing in our congregation, but he did not comprehend the need. No further interest was given. Time passed. I continued my own spiritual self-study and prayed that God would help me with faith community nursing if that was still His plan.

One Sunday I was in church listening to the sermon. The church phone rang. It was not unusual for the phone to ring during the sermon. I guess the callers were sure someone was there during that time! Someone answered the phone and a while later came into the

pulpit and handed the minister a piece of paper. Everyone was quiet. Uncomfortably quiet. The minister turned away to face the choir rather than us. By the look on the faces of the choir members, we sensed the news was not good. The minister turned to face us, and he was crying. He said the phone call came from a family member of a mother, step-father, and three children who were members of our church. He slowly stated each person's name. It seemed they were visiting family in a nearby state when the car in which the mother, step-father, and two of the children were riding was hit by an ambulance responding to an emergency. The ambulance was going very fast. The grandparents and the remaining child were following right behind the family in another car and witnessed the accident. It was confirmed that the mother and step-father had died instantly during the accident and that the two children were in serious condition. While this message was being delivered it seemed surreal. I did not know the family. How could that be? I had allowed my mind to fade out to grasp all that I had just heard. I heard the pastor say he was leaving immediately after the service to be with the family. It was then that I knew I needed to travel with the pastor. I had a nervous energy inside that hardly allowed me to remain in the pew for the remainder of the sermon. I just wanted to pray and begin the travel to the children. Later, I would come to realize that this was another call to health ministry. Following the service, I asked the pastor if he would like some company during the trip, and I even offered to drive. He responded affirmatively and was genuinely grateful. I had no idea he would actually say yes.

We left immediately following the service and arrived in the late afternoon. We were taken to the children who lay side by side in an ICU. The family needed the

reassurance that God was present with them during this tragic time. They needed someone to explain what was happening medically. Many arrangements needed to be made. The pastor and I worked together.

The days and weeks that followed the accident were filled with opportunities to serve the family and the children. Our church mobilized to fill the needs—food, bedside sitting, answering of the telephone calls of concern, and much more. As the children healed and moved from the hospital to rehabilitation to home, the pastor and I were with the family, praying with them and helping with any needs.

This experience was amazing—so tragic yet as only God can do—good came from it. The church members served graciously. The church grew as family. The family united. The pastor and I began to work together in understanding how to care for the “wholeness” of each person. And faith community nursing was born at our church. Though the health ministry took years to become a functioning part of the church, it was present. I have been an active faith community nurse for approximately five years. I have served in three health ministries. It has been a wonderful journey. Each health ministry has presented with different needs and opportunities.

This was my call. God is so close especially when I am serving. I can feel His presence. When serving others He is in the faces I see; He is in the words I hear; and He is in the moment that I feel. This is when I know I am “living the call” to health ministry. This call matters to me because it has helped me to change my life. My spiritual life has become my life. It is now the foundation from which all has come to rest upon. It is no longer a part of me— it is me. I still stumble and fall because I still am very human. But I

know God is with me, helping me to recognize that my ways may not be His plans for me. He has taught me love, joy, gentleness, and kindness. He is teaching me patience, peace, faithfulness, humbleness, self-control, perseverance, and self-acceptance. He has taught me that if I rely on His Word (through my Bible study, prayer, meditation, and service), His plans will unfold before me; and those plans are so much more than I could possibly imagine. Praise be to God.

APPENDIX H

Demographic Data of Participants

Pseudonym	Age	Highest level of professional nurse education	Second degree	Years as registered nurse	Years as faith community nurse	Religious affiliation of FCN practice site	Model of ministry paid versus unpaid	FCN at practice sites	Hours per week	Members at practice sites
Ellie	37	Associates	Bachelors Social Work	4	1	United Methodist	Unpaid	1	5 - 10	200
Eleanor	70	Bachelors	Masters Education	47	12	Episcopal	Unpaid	1	20 - 40	600
Val	48	Masters	n/a	27	6	Church of the Brethren/ Ecumenical FCN Education Program Coordinator	Paid/ Paid	5/ 1	20/ 20	600/ n/a
Lynn	48	Associates	n/a	20	7	Assembly of God	Unpaid	5	12	900

Pseudonym	Age	Highest level of professional nurse education	Second degree	Years as registered nurse	Years as faith community nurse	Religious affiliation of FCN practice site	Model of ministry paid versus unpaid	FCN at practice sites	Hours per week	Members at practice sites
Barb	61	Associates	n/a	36	11	Southern Baptist/ Baptist Association Health Ministry Coordinator	Unpaid/ Paid	1/ 9	4/ 40	50/ 52 churches
Irene	66	Diploma	n/a	45	13	Baptist Inner city Program/ Baptist Association Health Ministry Coordinator	Unpaid/ Paid	1/ 1	Not documented/ 20	100/ 72 churches
Jean	57	¹ Certified NP	n/a	37	3 – 4	United Methodist	Unpaid	2	15 – 20	1000
Sharon	64	¹ Certified FNP	Masters Education	42	2	Episcopal	Unpaid	3	10 – 15	250

Pseudonym	Age	Highest level of professional nurse education	Second degree	Years as registered nurse	Years as faith community nurse	Religious affiliation of FCN practice site	Model of ministry paid versus unpaid	FCN at practice sites	Hours per week	Members at practice sites
Janice	63	Associates	n/a	23	6	Christian/ Lutheran	Unpaid/ Paid	1/1	Not documented/ 18	Not documented /200
Shirley	65	Bachelors	Masters Education	44	5	Baptist	Unpaid	5	² < 1	500

NOTES:

Demographic information was taken from demographic data forms and interview transcripts.

If a faith community nurse practices at more than one site, each site is indicated and the data are separated by a slash /.

Where ranges are indicated for years and hours, the average of the range was used in the aggregate calculations.

¹ Did not indicate highest nursing education, only certification.

² Faith community nurse has reduced hours until church leadership completes reorganization of ministries.

KEYS: Not Applicable = n/a

APPENDIX I

Audit Trail

Table 1

Theme One: The Calling

Pseudonym	Raw data
Ellie	It is almost like you know we breathe and we don't think about breathing but if I am feeling called to do something and I don't do it—it is almost like I am holding my breath.
Ellie	I truly believe I was only a counselor to help me with my parish nursing. . . . I think this was a plan from all along and that my counseling component has only aided to my parish nursing.
Eleanor	I sort a feel like there are no coincidences ever in life and so to be sent to an end of life care when bereavement and that kind a of thing is my thing and later I said to clergy is that why you sent me and he said no that's the name of the person I was going to go visit in the afternoon and I decided we needed to get you going and so I went.
Val	. . . it (Faith Community Nurse Education) was just amazing experience and I knew that I was – that that was what God was calling me to do. When I was in the class – sitting there listening to these lectures. I can remember sitting there crying and going (nodding head) this is it—this is it.
Lynn	This (faith community nursing) always felt like it was always what I wanted to do and then when you go through the class you know, you just feel like you are in His will and you are in the right place at right time and this is right and it is suppose to be this way. . . . To be called means to represent Jesus in a way you have never represented Him before to let Him use your gifting and your skills and your experiences.

Pseudonym	Raw data
Barb	I guess it was in '98 when I decided - I kept putting off taking the parish nurse education program it was still in my mind but the Lord just kept nudging me on and I procrastinated because I did not see how I could do any more than I was already doing. And so then I finally said ok Lord I will do this.
Irene	The Almighty God is right there beside you and enabling making it happen I mean—Good Grief! God had to put all those pieces together so it was kind of seeing God put the pieces together was affirmation of the call and enabled me to walk through it with more confidence.
Jean	So I checked into it (faith community nursing) and finally did it and I have loved it - I really do love it—I really do—it was one of those doors closing and another one opening kind of thing all along and I just did not see the other one opening for awhile.
Jean	It (the call) gives me purpose, it gives me that purpose that I had kind of temporary lost – temporary lost there and I think we all need to feel some kind of purpose....The nurse practitioner thing was just a natural progression of a career. And I don't feel that this is a natural progression from this, not a career progression, a call to parish nursing is not. It is more personal it is more inward and I had not thought about it.

Table 2

Theme Two: Relating to God in Living the Call

Pseudonym	Raw data
Ellie	I have prayed for something and I have like the answer within hours, that is kind of scary but it also um lets you know that me as a person, I am an important part of this whole equation , this bigger equation and in knowing that now and truly understanding that—if I, I don't think I could ignore anything He has called me to do anymore.
Ellie	I would have to say if you are living the call, any call that is—you have to have a willingness to be uncomfortable because that is where your leap of faith and your trust in God comes in.
Eleanor	. . . and about 8:30 or so I “felt” like I’m going to go back so I went back to the nursing home . . . I looked at him, cold feet, cheyne stokes respirations. . . . So I called our priest and said I said I think the end is coming so he came and he hadn't been in the room ten minutes when it was finished and I really felt called that night. I don't know why – been in lots of room (small laugh, smile with tear), I started hospice here in 1981 and but there was something about it was a spiritual experience
Eleanor	. . . I think those things are coming down. I just— when I am awakened at night and something says get over to the hospital, it is not my nursing expertise that is sending me back to the hospital, it is something very different.
Val	I belong to a women’s small group at my church and I go every Wednesday night. I have quiet time every morning —most mornings where I read the Bible and pray.
Lynn	I started to weep over the phone and (crying and wiping tears) she said what is wrong and I said the parish nurses are on their way down there and the parish nurse said she did not know why she was going down there. She is already on the way. Those moments are when you know you have been called to ministry because it is so much huger than you.

Pseudonym	Raw data
Irene	<p>But anyhow I found myself one morning just needing to spend some time with God and I left my room and went out at the University and sat under a tree on a bench with my Bible and I was looking to find the word of God in that scripture that morning and nothing clicked I was looking through my Bible and nothing clicked. I sat there and thought well what have you got to show me God and there was a duck . . . and it hit me God is using—can use me like that mother duck it is innate in me and it is not something I have to make happen—it is just trust God like the mother duck.</p>
Irene	<p>When I am not connected to Him and more running on my own things won't work as well, things aren't blessed as well. I have done that in my parish nurse career. I have walked both places out of my lack of obedience.</p>
Shirley	<p>I guess it (call to faith community nursing) really helped pull um (without going into a whole lot of detail) pull us out of some of the doubt that we had developed over the years . . . feel like this kind of pulls you back in and yes there is a higher power directing all this.</p>

Table 3

Theme Three: Practice in Living the Call

Pseudonym	Raw data
Eleanor	We have a health fair in the fall. . . . I write a small letter for our monthly newsletter . I have a website with a fairly large number of books that can be loaned out and also catalogs and reference material We do blood pressure checks .
Val	Then over the next few weeks. . . . I was able to do what no one else from the church knew how to do including the pastor was to mobilize resources you know even though I have never walked through anything like that in my nursing career or in my life.
Lynn	. . . do I change dressings absolutely I can go to somebody's house and change someone's dressing if it needs changing.
Irene	. . . standing clothes closet and food pantry for residents. . . . I have been doing nurse management there where we do screenings . . . do the referrals and basically listen . . . help these churches start FCN ministries , I go out and do talks to health education programs with these churches when asked, help do screenings when asked, health fairs when asked . . . do foot care .
Jean	We have a team that does meet every Monday morning . equipment from the health closet or whether they need meals we have a member care committee we notify that they need some meals . They need transportation to the next doctor's visit . . . a telephone committee if that person needs to be called everyday that kind of thing . . . blood pressures twice on the second Sunday once a month after the church services . . . class for balance for over 50 . . . caregivers support group .
Sharon	I know parish nursing is not a new concept but it is new to this church. I took the course last summer on-line and I started actually doing some health things before I took the course . I have developed a health committee . . . I write a small article with health issues , we offer Tai Chi on Wednesday mornings.

Pseudonym	Raw data
Janice	Once a month the service is taped and we have CD recorders that we lend the parishioners if they are interested in the tape ministry. . . Health education . . . blood drives . . . getting CPR classes lined up.
Shirley	We did go Walk to Jerusalem . . . We also did some blood pressure and blood pressure screenings . . . I have done some diabetes education programs for the senior adults.

Table 4

Theme Four: Challenges in Living the Call

Pseudonym	Raw data
Ellie	Life has changed drastically and so has the whole family's because of that and I would have to say that trying to meet the needs of that family and the needs of the church and the needs of my family feels very overwhelming and you almost, it had gotten so bad a couple of weeks ago, that I said you - this job is too big for me—take it back I don't want it and um, usually like just because of circumstances.
Lynn	Our pastor sees us as he sees the most important role we have is to be with clients and be with family in Christ members through surgery, cancer, health issues that client visit piece is huge in our church and they see the value in that but yet we continue to look for ways to do the preventive education and teaching and preventive medicine that type of thing in the church and we have not had as much success with that but we have continued to try. So I guess it is a blessed ministry and well thought of ministry but sometimes misunderstood by certain folks and they really some folks don't want to understand it until they need us but when they need us they totally get it.
Lynn	It is hard to be a nurse on Sunday and you just want to go get fed and filled up and there are people in parking lot before you can even get your feet out of the car.
Barb	I felt that I was not getting the support of the association although I had the support of the [gives title] Director; I was told that I could not ask the secretary, administrative secretary to do anything for me, I was given no money. I financed it in the early stages
Jean	I think it becomes overwhelming sometimes in that we are kind of expected to be on hand to be asked to help with every committee, you know with everything that goes on what is your opinion will you help me on this committee – sometimes that get pretty overwhelming and now after every meeting there is always three to four people with some kind of question which is great—I just can't always remember because you don't have your notepad with me – so once in a while it gets a little overwhelming. And you want to make sure you don't forget anything or forget anybody or miss anybody and sometimes that does happen.

Table 5

Theme Five: Blessings in Living the Call

Pseudonym	Raw data
Eleanor	And from the university to the hospital I would think I am too tired to be doing this and I would get out of the car and go into the hospital and spend some time with the parishioner and it was always very relevant and it was not something that he felt he could handle it was a medical issue and then we would pray and go on our way and I would go out the door and I would have more energy and I would go home and do unbelievable things.
Lynn	Peace and the joy that endures it is amazing. The continual growth of Christian maturity, and wisdom and knowledge and experiences that are me it is so bigger than me.
Barb	. . . it is just such a blessing to go there and to hear them talk and I come out more blessed than I think I deserve.
Irene	. . . God got a hold of me there. I can't remember exactly but – anyway I am very stoic, it is just in my family, was very stoic I am not as stoic as I use to be because of parish nursing. But found myself in a class on humor in tears. . . . That was a breaking point of being real and being human and apparently a lot of excess baggage got spilled over part and I found acceptance by her and the class member and found that acceptance and the world did not come to an end because I became humble. I was very anxious it was like how on earth is this going to happen. It (the call) was scary.
Jean	I really think that the more I'm out with people and the more I am helping other people their needs are so much greater than mine—whatever it has done it put it more in perspective. I am a much calmer person—I am more willing to listen, I am more willing to hear somebody completely out.

Pseudonym	Raw data
Sharon	I have done a lot of things in my 42 years from staff nurse to instructor to associate professor to nurse practitioner. . . . All these years you still have a lot to offer and here is another way to do it.
Janice	This is one way the Lord has helped bring my husband into this congregation. So he comes with me every Sunday.
Shirley	I believe my background in community health and home health and teaching . . . has been basic preparation for this all of my life and I did not know it.
Shirley	I guess it [call to faith community nursing] really helped pull um (without going into a whole lot of detail) pull us out of some of the doubt that we had developed over the years since 97 in (names state) when the pastor at our church (describes two hurtful events) and then you begin to wonder well you know these are the leaders of our church and plus all the grief that you go through began to doubt and drift away a little bit and then you kind of feel like this kind of pulls you back in and yes there is a higher power directing all this.

Vita

Deborah Darlene Simpson Mobley was born on January 25, 1957 in Richmond, Virginia. She graduated high school from Thomas Dale High School in Chester, Virginia in 1975. She received her Associate degree in Nursing from John Tyler Community College in Chester, Virginia in 1978. She graduated Summa Cum Laude. For the next ten years, she held many nursing and non-nursing positions including emergency department nurse in Level I and Level II facilities, quality assurance, marketing and community relations, staff development and college clinical instructor. She received her Bachelor of Nursing degree from Virginia Commonwealth University in 1989 and was inducted into Sigma Theta Tau International Honor Society – Gamma Omega Chapter. She received her Master of Nursing (Nursing Administration) degree from Virginia Commonwealth University in 1994. She continued her work in nursing education and research, quality, regulatory compliance and patient safety. She has also co-authored two articles:

Mobley, D. & Bodin, S. (1998). "Joint commission preparation in a large academic medical center: A framework for success." *Journal for Healthcare Quality*, 20(5), pp. 8-15.

Morrison, E. & Mobley, D. (1996). "Research and continuous improvement: The merging of two entities?" *Hospital and Health Services Administration*, 41(3), pp. 359-372.

She completed her basic and coordinator education in Faith Community Nursing from Shenandoah University, Winchester, Virginia in 1997 and 2005, respectively. She began her pursuit of her doctoral degree in 2000 at Virginia Commonwealth University. During this time

she continued to work in quality, regulatory compliance and patient safety. She continued as adjunct faculty in the VCU School of Nursing and affiliate faculty in the VCU School of Health Administration, Williamson Institute, Executive Patient Safety Fellowship Program.