Weaving for the future: Using rulers and roses

By Betty Davies

Editor's note

This paper was presented as the opening keynote address at the 2000 CANO conference in Victoria, B.C.

When I was invited to give this keynote address, I was asked to focus on the theme of the conference - Weaving tapestries for the future - and more specifically on the concepts of unity, creativity, and vision. I have been reading a lot of leadership literature lately where vision is looked upon as a necessary precondition for success. It is also a precondition for unity and creativity. And so, I will focus on the concept of vision.

Vision

What is the vision that guides us as we weave the tapestry of oncology nursing for this new millennium? What do we mean by vision? Essentially, vision is a mental journey from the known to the unknown, creating the future from a montage of facts, hopes, dreams, dangers, and opportunities. A vision is an image of a possible and desired future state. This image, this vision, may be as vague as a dream or as precise as a goal or mission statement. A vision always refers to a future state, a condition that does not presently exist and has never existed before. Just as the journeys of Canadians listed in a recent Maclean's magazine were said to have inspired the world, such journeys can dictate the success of a profession. And, just as these individuals, such as Terry Fox, adapted their original visions to changing conditions, so must oncology nurses adapt their visions to keep pace with a rapidly changing world.

We all have dreams and fantasies about the future. Most of us picture ourselves more successful, wealthier, and happier than we are now, but we will not reach those goals by idle dreaming. Unlike dreaming or fantasizing, vision helps us to position ourselves and our profession to create and take advantage of future opportunities. Vision is both an offensive and a defensive skill; on the one hand, helping us chart a course that creates changes, and on the other, helping us respond to external changes. Vision is a characteristic of individuals or groups of individuals.

Visionary leaders

Visionary leaders share a common trait - all have a compelling vision and a dream about their work. Clear vision results from a profound understanding of one's organization, of one's profession and

its environment. Vision takes the skill of a craftsman, not a technician. The craftsman can see exactly what work must be done to achieve it. She then puts her tools and materials to work in shaping the product, adjusting and adapting as she goes, keeping in constant mental view the look and feel of the goal. By contrast, if she were to operate as a technician, simply following a set of instructions without vision, a superior product would not result.

One night, the road was bright with the light of an oversized moon. I could not help but pause to admire it, and wonder at the distance between myself and that incredible reminder of space. I wondered at the marvel of having traversed that space, of having found a pathway between here and there, and of putting a man on the moon. I wondered about the vision that guided the journey through space to the moon. All the way home that night, and on many occasions since, the themes of space, vision, and weaving tapestries for the future have wandered in and out of my mind, causing me to think about them at different times, in different ways, and for different reasons.

There are many kinds of space and I imagine that in each of them there is something potentially awesome. There are the spaces between people and the spaces between buildings. There is the space we call time, as well as the space we call distance. And there is the space we know as feeling, interior space. But I suppose the most common of all is the space that is open for our discovery. It is the space through which we will journey toward surprise, disappointment, or simply journey's end. It is strange but true that there are those of us who must try to span space where ever we find it. I know there are some who simply feel they must be on the expansive sea if it's anywhere nearby. There's no way they can stand on the shore for long without finding a boat and getting out into the middle of that space. There are those who climb mountains, partly because it's a space they want to traverse. And, I imagine that in the heart of the explorer, much of what urges onward is a need to fill the voids of space. But haven't you ever wondered what it is that calls, and draws, and urges us to fill those spaces? Haven't you ever wondered why we would leave comfortable situations to venture out into territory that is uncertain and insecure? What is it that calls to the explorer to step out into strange, new, and sometimes hostile territory? What is it that took the explorer from the shore of great oceans to journeys beyond the horizon? A dream? A vision?

Creating vision

How do we develop that kind of vision? It may not always be easy to create powerful vision. New visions often suffer ridicule and laughter, other times they are ignored. That is not to say that one should not create a vision. But there is tremendous effort involved in gaining or creating vision. Most people attempt to develop vision from the circumstances in which they find themselves. In order to generate real vision, however, the vision must be conceived independent of the circumstances. The vision must also be conceived without reference to the apparent possibility or impossibility of its accomplishment. Since most people have been trained to think in terms of responding appropriately to circumstances, the unfortunate policy of limiting what one wants to what seems realistic and possible forms a counter-creative habit. Vision is not asking, "What do you want from the alternatives available?" Instead, vision asks, "What do you want?" It is actually astonishing to discover how little ability many of us have to simply describe what we want to create. And yet, the premier creative act is to conceive what one wants to create.

Real vision is the conceptual image of a result a creator wants to bring into reality. If this vision does not come from an assessment of needs, a definition of the prevailing problems, or an analysis of health care trends, where does it come from? Some people approach vision as if it were a deeply hidden treasure to be discovered and revealed. However, conceiving what you want to create is also not a process of

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revelation. Some people generate "brainstorms" which are designed to blitz through preconceived 'mindsets' with fanciful free associations. But free associations consistently miss the heart of the matter, which is the answer to the very simple question, "What do I want to create?" "What do I want nursing to be?" How one conceives of what one wants is deceptively simple and profoundly sophisticated. Creating a vision takes work, both consciously and unconsciously, but when it comes down to how it is done, the creator simply makes up the vision while thinking, observing, meditating, and pondering. For example, a sheet waving on a clothesline was the beginning of a great balloon, the forerunner of the Zeppelin. A spider web strung across a garden path was the inspiration for the suspension bridge. In their imaginations, creators see what isn't there. Then they start bringing into reality that which never existed before.

Creating visions of desired results is not something we have been encouraged to do. Most people have been trained to focus on method: follow procedures, fill out forms, and adhere to guidelines. These activities answer the question, "How do I bring what I want into reality?" This is a useful question once we know what we want, but a useless question until we do. Most education, however, attempts to train students to consider method first. Take the concept of evidence-based practice, for example. Evidence-based practice is a common theme in professional journals of all health care disciplines. Evidence-based practice is generally characterized as care for a particular disease or condition that is based on scientifically established best practices. In theory, greater use of evidence-based guidelines, particularly those calling for identifying and tracking high-risk patients, would not only cut down on errors within the system, but would result in better population outcomes by bringing in more patients earlier. While evidence-based practice is commonly seen as barely out of its infancy, there is no shortage of protocols, critical pathways, and clinical best practices for everything from expensive coronary bypass surgery to daily, at-home monitoring of patients with asthma and diabetes. The goal is to narrow the gap between what is known and what is practised. Indeed, a worthy goal.

Evidence-based nursing practice and vision

As nurses, we have an obligation to provide the best possible care we can. We have a social and professional responsibility to provide nursing care that is based on sound principles, and that is known to make a difference for patients. Instead of finding out what works by trial and error, or hit and miss, we must provide care based on evidence that what we are doing is safe and promotes patient comfort.

Despite all this, however, I remain a bit skeptical. Perhaps it comes from being in nursing for 30 years now - long enough to have experienced the promised magic of the nursing process, of nursing diagnoses, of nursing theories, and of nursing research itself to provide nursing with the basis for scientific practice for the benefit of patients, and with professionalism for the benefit of the discipline. I am not saying that these aspects have been misdirected, or wrong, or harmful; they are part of the history of the development of nursing, and they have served and continue to serve useful purposes. Each concept caught our collective imagination and carried us to another phase of growth and development.

The nursing process, for example, teaches a problem-solving approach to nursing care. You are all familiar with the four steps - assessment, planning, intervention, and evaluation. When I saw students methodically and systematically following their assessment guidelines, I was impressed with their thorough descriptions of patient situations. But, sometimes, students would follow those guidelines to the letter, without any ability or desire to loosen their hold on guidelines so that they could actually see and hear the person they were assessing. Focusing on information-gathering precluded realizing that the assessment in and of itself was an intervention. HOW a nurse gathers assessment data influences the data that he/she gets. Moreover, as instructors, we emphasized that the nursing

process was not a sequential process, yet we taught the four steps of the process in linear fashion. We didn't practise what we preached. We all know that children and students are alike - they learn much more from how their parents or teachers ACT than from what those authority figures SAY. The nursing process was not a problem in and of itself. The problem lay in conceptualizing complex processes as linear with the result that we focused on procedures and method.

And, herein lies the root of my concern about evidence-based practice. It too lures us into focusing on procedures and methods that provide quantitative evidence of the difference that certain interventions or treatments can make in the lives of patients/clients and their families; evidence that is "scientifically proven." Scientific evidence usually implies a quantitative approach to isolate causes and effects, to operationalize theoretical relationships, and to measure and quantify phenomena (Flick, 1998). Scientific evidence traditionally seeks meaning in numbers - the way of the ruler. It is usually based on a traditional view of "*what counts*." The Oxford Dictionary (1971) explains that *count* and *compt* were the same words, and they derived from the Latin *computare*. *Com* means *together*, and *putare* means *to think*. To count then means *to come together to think*. *What counts* involves the connecting of one human being with another to find shared meanings, not counting numbers. *What counts* is realizing that we have touched someone and that they have touched us. *What counts* to the dying woman is leaving a legacy of love for her new grandson by finishing the afghan she has woven for him.

We must find alternate approaches to finding evidence for *what counts*, especially since many of the obstacles to providing optimal care are not clinical in the traditional sense. Many are structural - like not having enough nurses to provide even basic nursing care. Solving these problems will require efforts far beyond the development of evidence-based protocols, beyond the development of instruments to measure differences in outcome.

Standing on the shore of the polluted and turbulent waters of health care systems, what makes us want to venture forth into this unknown space? What gives us hope and faith in believing that things will improve? Our vision. Our vision of what nursing can be. That's what keeps us going - even if sometimes it's only a faint candle's glow. In Alberta winters, my father always carried a candle in the car because the warmth of a single candle can keep a person from freezing to death. We must remember that it is not the light, but the warmth that sustains us.

Nursing and technology

In today's world, the warmth that nursing offers is threatened by the abundance of technology. Technologies have powerful consequences that are not neutral, but are both good and bad. I had the honour of serving as the president of the Canadian Nurses Foundation (CNF) during its 25th anniversary year. In tribute to this occasion, we conducted a financial campaign to raise funds that would ensure the viability of CNF. Our slogan was "High touch, high tech." This phrase captured our view that as the health care system was becoming more high tech, nursing continued to promote not only the high tech aspects of health care, but also continued to promote the high touch aspects.

What is high tech? Menu, mouse, web, net, Internet. Backup, virus, merge, purge, surge, connected, wired. Crash, shortcut, overload, shut down, back up. High tech is machinery, equipment, computer screens, monitor screens, and TV screens. High tech is a blood transfusion, an amputation, BMT, and prostheses. High tech is the genome project. High tech is innovation, progress, control, future advancements.

What is high touch? It's the love for a child, it's taking the arm of your mother as she steps off the curb because you notice that she's not as steady on her feet as she used to be, it's the sound of your lover's voice on the phone, it's the smell of homemade bread in the kitchen, it's the pink and purple sky of the setting sun, it's the awe of looking up at the mountains, it's the moment of shared laughter between children and grandparents. It's the tear in the eye of your patient who

has just been told her biopsy is negative, it's the hand on the shoulder of your next patient whose biopsy results are positive. It's the daughter's gentle voice that calms the restless old man, it's the quiet moment in the middle of the night when everyone is asleep, it's getting the impossible IV started on your first try. It's listening to the woman sharing her fears for the future, it's overhearing her "I love you" to her dying husband. It's the fresh sheets under the perspiring man with the temp of 40°C, and the gentle breeze blowing in through the open window. It's the look in the eye of your colleague after her patient dies when you say you will take over her patients while she goes for a cup of coffee. It's the feeling of a job well done at the end of the day.

A core feature of my career has been devoted to palliative care for children and families. It has always seemed to me that the core elements of palliative care - responsiveness in all dimensions of life to the whole person, to families, as well as individuals known as patients - more closely realizes my vision of nursing than any other experience so far. Palliative care feels good because I get to be the kind of nurse I always wanted to be. I have always considered myself an oncology nurse too. As we envision oncology nursing for the future, I would like to see oncology nursing more like palliative care than like the laying on of technology.

There is no doubt that high tech has enhanced the lives of our patients, promoted better outcomes for patients, and saved considerable nursing time. Think of even those simple glass mercury thermometers, and the time spent cleaning them, sterilizing them, shaking them, and squinting to see the fine silver line. Nostalgically, we tend to remember sitting quietly with the patient while the mercury crept up the glass stem. But did that really happen? Sometimes. But, most of the time, I remember making rounds, putting thermometers in all the patients' mouths, and then repeating rounds to remove the thermometers. Instead of envisioning what nursing should be and can be, we pine for what we think it used to be.

Old-fashioned technologies become reference points for us all. They mark a certain time in our lives, triggering memories. They evoke emotion. High tech has no reference point as yet. High tech holds the hope of an easier life, but it does not provoke memory. Is that when high tech becomes low tech, or more dramatically, is that when high tech becomes high touch?

High tech becomes high touch with longevity and cultural familiarity. Today a wooden shuttle loom warped with yarn is high touch. Four thousand years ago in Assyria and Egypt, the loom was the latest advancement in technology. Today, it's a high touch object in the museum. Let us be sure that nursing itself doesn't become a high touch notation in the museum of health care professions.

This may be our fate if we do not become technologically competent - just as it has for others who have not kept up. When this happens, destructive forces have a greater chance of flourishing. For example, high-tech crime, ranging from Internet child pornography to online fraud, is on the rise in Canada, but law enforcement agencies in this country are having a hard time keeping on top of this problem. So nurses **must** be technologically competent. Technology is the cornerstone of today's health care world. Technology extends an enticing and powerful invitation to join the process of discovery, and it is easy to get caught up in the excitement of hoping that this new drug or that new procedure may prolong life just a little while longer. However, with the hope that our high tech miracles will be at least 50% successful, we can be 100% sure that the patient is not living well anymore. My husband recently commented, "If I didn't know about hospice, when I think of dying in a hospital, my impression is that I would be about to go under a steam roller, a fear of being squished out of existence before I die." Many share his perception, believing that all hospitals do is offer technology. At the other extreme, nursing homes - the other institution where death occurs most often - are seen to use no technology, to give up on technology, focusing on only making sure that fluids are running. But, if nurses are doing their work, that is not what happens. Nursing tempers the

negative effects of technology. Nursing has a role in deciding when technology is no longer doing good. Nursing doesn't stop when technology can do no more. Nurses must use technology to its fullest advantage without themselves becoming technicians.

We are faced with technology that appears to be inevitable, as powerful as nuclear energy, possibly unpoliceable, still in its infancy, and changing the way we think and the way we spend our time. Pervasive technology makes us hyper-efficient time consumers. Standing in line at an ATM the other day, I noticed that all of my line-companions and I were standing with our heads upturned watching a television screen with news on it - I guess so that we wouldn't waste the 40 seconds of standing in line. To argue against this trend would be an act of silly nostalgia. Besides, there is nothing inherently wrong in making standing in line more interesting. But what about using our time to reflect on the day, to think about our spouses, the kids, our jobs? Indeed, our effort to make ourselves hyper-efficient consumers of time through pervasive informing and entertaining may, ironically, be materially deleterious. As the sociologist Max Weber (cited in Wright, 1999) wrote about the nature of idea formulation, ideas "come when we do not expect them, and not when we are brooding and searching at our desks." Rather, they come when "smoking a cigar on the sofa or when taking a walk on a slowly ascending street" (cited in Wright). Silence nourishes thought, reflection develops wisdom, and listening begets humanity. When there's no silence, there's no room for thought.

In the middle of the 19th century, Ralph Waldo Emerson (1847) registered a lyric complaint about the oppressive force of material goods, "Web to weave and corn to grind, things are in the saddle and ride mankind." If Emerson found such modest machinery as corn grinders dehumanizing, imagine what he would think of today's technology. Today, we are more the slaves of technology - tethered to computers, cell phones, and beepers. Meanwhile, we have to cope with unprecedented change. And the more tethered we become, the faster things change, because the tethers are plugging people into the very social collaboration that drives the change. Science, technology, music, politics - flux in all these realms is hastened by the new electronic synergy. The Internet and allied technologies make us neurons in a vast social brain, a brain that keeps enticing us into making it bigger, stronger, faster. We have, you might say, a Web to weave.

What are we to make of all of this in practical, philosophical, and even spiritual terms? How to comprehend an age in which we find ourselves enmeshed in a huge information-processing system, one that seems almost to have a life of its own and to be leading us headlong into a future we can't clearly see, yet can't really avoid? In the last issue of **Time** for the 20th century, Robert Wright (1999) noted that the unfolding of technology is a process of natural evolution. Not just since Emerson's day, when the telegraph - sometimes called the Victorian Internet - made long-distance contact instantaneous, but since the very dawn of the human experience. For tens of thousands of years, technology has been drawing humanity toward the epic, culminating convergence we're now witnessing.

Technological evolution

From the very beginning, technological evolution was a social enterprise, mediated by what Wright (1999) loosely calls a social brain. In the Middle Paleolithic Age, around 50,000 BC, earliest inventions took a long time - to go from a hand axe to axes with handles took hundreds of thousands of years. There were not many neurons (also known as people) scattered across the entire planet and they were not in contact with one another. But, with each advance in subsistence technology, survival grew more secure, hastening population growth; and as the population grew, advances came more quickly. By 10,000 BC, the rate of advance had moved from one major innovation per 20,000 years to one per 200! Farming was invented in 8,000 BC, and was a kind of information-processing

technology. By radically increasing the human population that a given acre could support, families sped up the synergistic exchange of cultural information, lubricating innovation. The results were epoch making. Within 5,000 years of the inception of farming, there were dazzling technological advances, including monumental temples, big dams, and a whole new information technology - writing.

Gutenberg's printing press, up and running in Europe by the mid-15th century, was by far the most Internet-like technology in history. Eventually, it would convey detailed news of inventions, allowing people in distant lands who would never meet to collaborate on new technologies. Innovations were often in information technology - the telephone, the phonograph, colour photography. And each advance - by easing the transmission of data, whether by sound, print, or image - only raised the chances of further advances. The story of mankind is faster and vaster data processing. According to this perspective, then, the unfolding of technology is a process of natural evolution.

Perhaps, referring back to Emerson's (1847) words, it is man's destiny to weave a web that would give us the option to exercise amity or enmity over unprecedented distance. For most of us, technology is far from neutral. It shapes our choices; it directs our actions. We have a largely unexamined relationship with technology that consists to some degree of both fear and worship. "Awake" is how Buddha described his state of being. And it would serve us well to be "awake" to the consequences of technology, both good and bad. We should not shut our eyes, or close our ears, or silence a dialogue, or be seduced by technology. We must strive for a conscious awareness of technology, so we can evaluate the relevance of existing technologies with clarity and can build an appropriate relationship with technology. We must begin to nurture the power of technology instead of rejecting it or blindly embracing it. We can begin to anticipate the development of new technologies and debate the merits and the consequences in advance of the application of those technologies, and in doing so we will become less anxious about the future. In doing so, we will find a balance between technological advances and matters of the heart.

Weaving nursing's future

If, as Emerson (1847) says, we are "weaving a web," I thought searching the web for "weaving" would be a good idea, especially if I wanted to talk about weaving a tapestry for nursing's future. The experience was not what I expected. My thoughts of weaving stirred up images that were strictly high touch - an image of quilts and teddy bears with hand-woven ties, an image of the throw cover my mom gave Tom and me for an anniversary gift this year - a thick, woven, wooly fabric, soft as a lamb, and a deep verdant green. I thought about the woven bedspread that I have had since childhood. I imagined the wedding gift we received, loosely woven place mats with a little tag that said, "Hand woven in Prince Edward Island." I recalled the exhibit I visited last spring in Charlotte, NC - "Spirits of the Cloth" - which was comprised of contemporary African American wall hangings. My conception of weaving pertained to a handicraft - something created with the talented, agile, and magical fingers of a creative individual. Definitely high touch.

What did I find on the Internet? Examples of combining the traditional high touch weaving with high tech methods. Hand Jacquard weaving by Louise Lemieux Berube (2000) from Montreal. Her description of her work read as follows:

Ever since I first began exploring textiles, I have continuously worked to develop a specific approach that uses computers to combine my knowledge of textiles with my interest in abstract art and the theoretical principles of weaving structures as potential elements of creation...Via computer technology, I begin creating one of my woven images by digitalizing a photograph. The number of shades of grey in the scanned photograph is reduced, then each shade is replaced by a weaving structure. I then weave the image onto a Jacquard loom in my studio.

Another artist, Alicia Felberbaum (2000) explained her work like this:

For the past four years, the computer has replaced the loom as the essential equipment in my work. Like the loom before it, the computer has a central place in my studio. I see it as another form of weaving. As I started to work in this new medium, I realized that I was going to require a new set of skills if I were to become a digital crafts person. To be able to manipulate this new material to create a cohesive fabric, I needed to become skilled in the grammar of the computer. For me, the process was comparable to learning a new language, so that I could engage in visual conversations.

A final commentary by Barbara Layne, the artist of "Drawing Threads," added to my expanding view of weaving. Each week, digital drawings of textiles in the McCord Museum of Canadian History in Montreal will be made on a laptop computer. The drawings will be transported through the Internet to the UC Davis gallery, where they will be downloaded, printed, and mounted in the gallery. The project envisions how the museum will function in an electronic age.

Can we envision how nursing will function in the electronic age? I believe we can if we build that technological future around the central core of high touch. In the 1980s, Fritjov Capra (1982) identified his vision of nursing as a social force. He foresaw a new system of primary patient care:

being forcefully advocated today by nurses who find themselves at the forefront of the holistic health movement...These highly educated and motivated nurses will be best qualified to take on the responsibilities of health education, counseling and preventive health care (p.414).

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Gretta Styles (1989), a past dean of UCSF School of Nursing and a past president of ICN, affirms:

Our view of the social significance of nursing is based in large part on a clear conception of nursing - of its social value; of its past, present, and future accomplishments. In a word this means vision, a quality that is a source of inner direction and outward inspiration (p.124).

Ten years ago, my colleague, Kathy Oberle and I published an article that still remains one of my favourite publications (Davies & Oberle, 1990). We described a model of supportive care nursing. The work derived from my discussions with Alice Weinlick who then was in a clinical specialist role at the Cross Cancer Institute in Edmonton. One day, Alice expressed frustration with the weekly reports she had to complete. She noted that on the days when she felt as if she had done little of significance, she had lots of numbers to record - numbers of phone calls, consults, referrals. On the days when she felt she really made a difference in someone's life, she had few numbers to fill in. We decided to see if we could find an explanation. What resulted was a conceptualization of nursing, applicable not just to Alice, but, we have since learned, applicable to many nurses in many settings.

Nursing occurs in the context of valuing. Nurses connect with patients and family members, empower them to do what they can do for themselves, help them to find meaning in their situation, and "do for" patients when they cannot "do for" themselves. At the core of the model is preserving integrity of both the patient and the nurse. The personal and the professional selves are not isolated one from the other. As you can see, "doing for" is only one part of nursing care - it's the part that has to do with procedures, techniques, skills, and equipment. It's the part that focuses on procedures, method, and evidence-based practice. But it's important to remember that a nurse can "do for" patients without really connecting, empowering, or helping the patient find meaning. I am sure you have all started an IV, changed a colostomy bag, or administered medications without always connecting with the person who was on the other end of the procedure. In such situations, you may have given adequate and safe care, but you did not give optimal care. Unfortunately, this is the kind of care that is occurring more often in our health care system, due to too few nurses to do too many tasks. And, what happens when the "doing for" part of nursing takes front and centre stage? It's not a problem, I suppose, for nurses who believe that this is what nursing is all about. But, for those of us who believe that nursing is based in human interaction, in relationship, it's a major problem. We experience cognitive dissonance between what we believe nursing should be, and what it has become. How do we respond? We either leave nursing because we cannot reconcile the dissonance, or we stay and adopt the cultural mantra. We convince ourselves that what we are doing is really the best we can do; we are giving safe and adequate care, and that's all that matters. We become part of the system that we once criticized and vowed to improve for the benefit of the patients we cared for and about as

people, as persons. But there is another, more effective response. It's the one voiced by Hathaway (1943) when she said:

Then and there I invented this rule for myself to be applied to every decision I might have to make in the future. I would sort out all the arguments and see which belonged to fear and which to creativeness, and other things being equal, I would make the decision which had the larger number of creative reasons on its side. I think it must be a rule something like this that makes jonquils and crocuses come pushing through the cold mud.

And, that makes roses bloom after winter.

As we look for evidence for nursing practice, let us look not only at evidence for procedural interventions. Let us also focus on that part of nursing that is not easily measurable - in the same way that the beauty of a rose is not measurable, but rather symbolizes the immeasurable contributions of a gentle touch, a reassuring word, a consistent relationship over time, a genuine concern for the well-being of one's patients and colleagues, a belief that quality of life is sometimes more important than quantity. Let us call for an evidence base that shows that artful human contact has positive effects and supports health. Technology doesn't help people be human beings in different contexts, but if nursing helps the human element, then let us have more evidence of that. If we need evidence to make our case, then let's get the evidence. A First Nations elder, known for his ability to fish, was asked how it was that he could always catch so many more fish than anyone else. He answered simply, "I think like a fish." We must learn to think like a fish - think not as a nurse, but as the recipient of nursing care. Imagine not what you can do for patients, but what you would want from a nurse if you were the patient, if you were the family. Imagining what you would want from nurses - that's one way to broaden our vision.

Let us envision nursing as a voyage of discovery that lies not in seeing new vistas, but in seeing with the heart. Let us treasure moments of connection and inspiration. Let us remember that to find meaning is to see things differently. As gatherers and users of evidence, we are trained to be objective. But one cannot find meaning at a distance. Let us not depend only on rulers as our only way of knowing. Let us also incorporate the rose. In the familiar song by Seals and Croft:

Forever like the rose

I suppose that's the way to live

Strong and ever giving

Always living with a purpose and a goal

To blossom day to day...

Forever like the rose.

Let our vision of nursing incorporate service, not as a technique, but as a relationship between two human beings who bring their combined strength to the table. Let us not see ourselves as experts dealing with problems, but as weavers of relationships. Tapestries woven in service of our fellow human beings will reach out and beyond what we expect or know. Let that be the tapestry we weave. ★

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