Nursing: A Healing Ministry

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Abstract

Nursing is a profession that involves caring for people from all different backgrounds, cultures, ethnicities, races, and religions. The world is full of unique individuals. One unifying factor for all people is that everyone has needs. In nursing, most of the care needs are physical and psychosocial needs. However, each person has spiritual needs. Nurses are expected to provide holistic care to their patients; thus the spiritual matters cannot be divorced from the physical and psychosocial ones. Since patients do need spiritual care, nurses have a unique opportunity to minister to these individuals. Nurses are also placed in a position that allows them to minister to the family and friends of their patients. Currently, some concerns focus on how nurses should care for spiritual needs. There have also been some suggestions made toward improving spiritual care. This thesis will explore why nursing should be a ministry and how to minister best to patients.

Nursing: A Healing Ministry

Nursing

The profession. The nursing profession encompasses the care of individuals who need medical attention for a variety of reasons. Many are physical; some are psychosocial. No matter what the reason that the patient has sought care, the nurse has the duty to treat the whole patient. Nursing takes on a holistic view of people. The whole person, including the body, mind and spirit, must be provided care (McSherry, 2006). The whole is greater than the sum of all the parts. Treating, or neglecting to treat, one part will affect the other parts (Pedrao & Beresin, 2009).

Nursing is "the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities and populations" (Laabs, 2008, p. 227). The role of the nurse is to protect and promote health. The ultimate goal is to prevent illness and injury. When that cannot be done, the nurse cares for the patient with the goal of returning the patient to health (Laabs, 2008).

Health has been defined as "wholeness, a unity and harmony of body, mind and spirit" (Miner-Williams, 2006, p. 817). According to this definition of health, a patient could have physical wellness and still not have health. Thus, the role of the nurse includes the care of the mind and spirit (Miner-Williams, 2006). When surveyed, the majority of nurses stated that they believe that they should provide spiritual care to their patients (Pedrao & Beresin, 2009). They see this as part of the holistic perspective of the nursing profession. Many nurses believe that the spirit is an integral part of the whole

patient; they see the need to assess the spiritual status of the patient and intervene when necessary (Pedrao & Beresin, 2009).

The background. Over the years, and through many social changes, the profession of nursing has parted from what it was at one time. Many individuals fail to realize that nursing has spiritual, even religious, roots. The early Christian Church was one of first organizations responsible for caring for the helpless and the ill (Laabs, 2008). This, in part, stemmed from the belief that spiritual matters were responsible for illness and the results of illness. This was a commonly held view before science and reason claimed authority as the correct way of thinking (Miner & Williams, 2006).

Florence Nightingale said that

> Nursing is an art: and if it is to be made an art, it requires an exclusive devotion as hard a preparation, [*sic*] as any painter's or sculptor's work; for what is the having to do with dead canvas or dead marble, compared with having to do with the living body, the temple of God's spirit? It is one of the Fine Arts: I had almost said, the finest of Fine Arts (Gullo, 1998, p. 10).

Nightingale understood and viewed the body as the temple in which God’s spirit dwells here on earth. This is especially significant for those of Christian faith. Nurses are not just caring for a body, but a living person who has value in the eyes of others and in the eyes of God (Gullo, 1998).

Bertha Harmer (1925) said that

> Nursing is rooted in the needs of humanity and is founded on the ideal of service. It’s object is not only to cure the sick and heal the wounded but to bring health and ease,

> rest and comfort to mind and body, to shelter, nourish and protect and to minister to all those who are helpless or handicapped, young, aged or immature (p. 3).

Many believe that nursing is a service and a vital part of nursing care is ministry. Nurses need to remember that they are servants; their profession calls them to serve others in the community (Laabs, 2008). Christ has also called everyone to serve others as He did. He did not come to be served, but to serve (Matthew 20:28, New International Version).

Spiritual Care

Evangelizing. Evangelizing is different from ministering to a patient, which any nurse, no matter his/her religious background, can do. Therefore, nurses who do not consider themselves Christians will not be involved with evangelism. Christians are commanded to share their faith with everyone. This command is known as the Great Commission. Evangelism specifically relates to Christ's command to His followers to teach others to obey His commands (Matthew 28:19-20, New International Version). Christ has also charged His followers to care for the sick. Christ told His followers that they are to care for those in need, and when they do these things, they are doing them for Christ (Matthew 25:39-41, New International Version). He also sent His followers out, telling them to heal the sick, raise the dead, cleanse those with leprosy, and drive out demons. Since Christ has freely given to those who follow Him, they should, in turn, give freely to others (Matthew 10:7-9, New International Version). This again ties into the act of serving – serving others and serving Christ. Nurses who are Christians are in a unique position to care for others and to share Christ's love with them.

Ministering. Ministering to patients is simply the act of showing love to them. Any nurse can show love and compassion to patients, and thus provide spiritual care.

Christians are commanded by their faith to love others. Christ said that the first and greatest commandment is to love the Lord. The second greatest commandment is to love your neighbor as yourself (Matthew 22:36-39, New International Version). Christians are supposed to love others no matter what their background or current situation and no matter the differences that lie between them. Nurses are expected, by their profession, to show love and compassion to everyone. Nurses have interactions with all kinds of people from all different backgrounds. Each person is different and unique. The nurse must be careful to avoid being judgmental of the patient or the situation the patient is experiencing. The nurse must also avoid imposing personal biases on the patient (Henery, 2003).

All patients need spiritual care. The spirit is the non-physical part of the body, the person within the patient (Miner-Williams, 2006). All patients have this element; to be human is to be spiritual (Pesut et. al., 2008). The components of the spiritual side of individuals include connectedness to a higher being, others, nature and/or self, meaning in life, transcendence, values and beliefs, and energy and emotions (Miner-Williams, 2006). Some patients that nurses encounter will claim that they do not believe in any sort of religion or supernatural being. These patients still have spiritual needs. Christian nurses specifically can still show the love of Christ to this patient and show compassion to this patient (McSherry, 2006).

Spirituality versus religion. Spirituality and religion are not synonymous or interchangeable, though many use the terms as though they are (Clarke, 2008). Spirituality has been defined as the part of the human being that is seeking significance in life (Pedrao & Bereson, 2009). It has also been called an individualized journey

characterized by experiential descriptors like meaning, purpose, transcendence, connectedness and energy (Pesut et. al., 2008). Religion is a systematic institution that is based on practices and a doctrine shared by a group (Pedrao & Beresin, 2009). It is characterized by institutionalized beliefs and rituals. It may be a subset of spirituality and culture (Pesut et. al., 2008). Nurses must remember that, though a patient may not be religious, this does not mean that he does not want spiritual care. Likewise, a non-religious patient may greatly desire spiritual care (Taylor & Mamier, 2005).

Spirituality

Spiritual crisis. Most patients are weak and fearful. They are usually being seen by a nurse because they are experiencing an illness or other medical crisis. This can leave the patient extremely vulnerable. Many patients are worried about the possibility of death or disability. Nurses will encounter these facts of life in one facet or another no matter where they decide to work. They need to remember that these topics are viewed and treated differently by different groups and cultures (Holloway, 2006).

The conditions that bring patients to seek medical care can often leave them facing spiritual crisis as well (Agrimson & Taft, 2009). It often accompanies illness, depression, potential death and grief. A spiritual crisis usually leads the patient to question his faith or to search for meaning in life. At this point the nurse is uniquely positioned to assist the patient. The actions of the nurse can aid the patient in journeying through the crisis and finding a meaningful purpose in his/her life (Holloway, 2006).

Spirituality and outcomes. Another important reason for implementing spiritual care is that patients with spiritual backgrounds have been shown to have better outcomes. These patients have hope and have found purposes for their lives (Baldacchino, 2006).

They also have well adjusted coping mechanisms and are proficient at adapting these mechanisms to the situations at hand (McSherry, 2006). Comfort, hopefulness and reduced anxiety are more helpful elements that accompany persons with a strong spiritual background. Since spirituality has such positive influence for patients, it only follows that care for spirit matters is of great importance (Miner-Williams, 2006).

Parts of a whole. Since the body is an integrated whole, if one part is ill, it can cause other parts or the whole to be ill. This means that spiritual issues can affect the physical and emotional health of the individual. Spiritual struggles have been associated with suicide, stress, depression, Post Traumatic Stress Disorder, anxiety and guilt (Agrimson & Taft, 2009). The Bible speaks about a person who hid his sins. It says "when I kept silent, my bones wasted away through my groaning all day long. For day and night your hand was heavy upon me; my strength was sapped as in the heat of summer" (Psalm 32:3-4, New International Version). This sounds similar to depression. The weight that comes with guilt can have physical effects. However, verse 5 says "I acknowledge my sin unto you, and did not cover up my iniquity. I said, 'I will confess my transgressions unto the Lord' and you forgave the guilt of my sin" (Psalm 32:5, New International Version). Once the spiritual problems have been attended to and the burden of guilt is lifted, physical and emotional problems such a depression will often resolve.

In the Bible, Christians of the early church were healing individuals in the communities in which they preached. In some cases, the words for healing and for salvation are the same word. One such passage says,

> It is by the name of Jesus Christ of Nazareth, whom you crucified but whom God raised from the dead, that this man stands before you healed. He is "the stone you

> builders rejected, which has become the capstone." Salvation is found in no one else, for there is no other name under heaven given to men by which we must be saved. (Acts 4:10-12, New International Version).

In this case, the words for salvation, which can be equated with spiritual health, and the word for healed, meaning physical health, are the same words in both the Greek and Hebrew languages (Strong, 2001). This is an example of how complete health depends on all the parts of the person being health, including the spirit.

Spiritual problems and illness. Some patients may believe that physical illness or deformity is a form of punishment for spiritual problems (Baldacchino, 2006). Patients with this view may begin looking for what is wrong with their lives that could have caused this illness. However, illness is not always the result of sin. There is a story of a man who had been blind since birth. Christ's followers approached Him and asked if the man's or his parents' sins had caused him to be blind. Christ's reply was "neither this man, nor his parents sinned, but this happened so that the work of God might be displayed in his life" (John 9:3, New International Version). This illness was not a punishment. The point of this illness was for people to learn and grow and for the glory of God. This can be reassuring to patients if they believe they have done something to deserve punishment.

The way people think can affect their physical health. If people are thinking negatively, then they are more likely to fall into depression. Negative or guilty thoughts can accompany actions that go against one's beliefs and values. When a patient's behaviors align with his beliefs and values, the patient will have spiritual well-being. If they are not aligning, the patient will have spiritual distress (Miner-Williams, 2006). The

Bible urges people to think about things that are noble, right, pure, lovely, admirable, excellent and praiseworthy (Philippians 4:8, New International Version). If a patient is focusing his/her thoughts on these categories, he/she will be less likely to experience illness generated by depression and like afflictions.

Spiritual needs. In taking a holistic approach toward medicine, the spiritual needs of the person must be considered. The spirit is part of the person. If any part of the person is not well, or goes uncared for, then the whole person is unwell. This spiritual element is even recognized by science as integral to humanity (Baldacchino, 2006). Especially when the subject of mortality is approached, even atheists will admit that spiritual matters have meaning for them (Holloway, 2006).

The public is beginning to realize the importance of spiritual matters and providing spiritual care. Nurses have been mandated by professional organizations, such as the Joint Commission on Accreditation of Healthcare Organizations, to incorporate spiritual assessments and interventions into their care (Miner-Williams, 2006). In one study, 94% of patients stated that they regard spiritual health as equal to physical health in importance (King & Bushwick, 1994). It has also been shown that atheists have a spiritual component to their lives. This spiritual component is just not connected with a higher being (Miner-Williams, 2006).

Patients do need spiritual care. Patients faced with illness are usually in crisis. They are concerned for their lives. The illness, especially if it is serious, can cause the patient to reevaluate his life. The patient begins to reflect and look for the meaning in his life and the purpose in living. In doing this, patients can find hope and a will to live and overcome their illness. Patients who have a strong spiritual component to their lives have

increased recovery and survival rates. They also have a more positive outlook on the future. Some patients who do have a spiritual component to their lives may vent anger towards God or see their illness as a punishment from God. These patients need spiritual support from the nurses and may want to meet with a chaplain or other clergy (Baldacchino, 2006).

Science versus spirituality. Many people look to science, specifically medicine, for the answers to their healthcare problems. When it comes to spiritual issues, this may present an obstacle since science often leads to doubt (Henery, 2003). It is based on theories that can be tested and shown to have the same result much of the time. However, at any time, new evidence may be presented, and, once it is shown to be reliable, the theory will be altered accordingly (Hussey, 2009). This ever changing nature of science means that there is nothing to trust (Henery, 2003).

This leaves nurses in an interesting position. They are mandated to care for patients' spiritual needs, while immersed in a scientific environment. This provides a unique opportunity for nurses to reconcile spirituality, and even faith, with science (Henery, 2003). The two need not be separate. For instance, the Christian faith supports a spirituality that is based on a connectedness with God. It holds that God is the creator of the universe and everything in it, including science. Also, He governs everything within the universe (Genesis 1:1, New International Version).

Providing Spiritual Care

Building a relationship. Ministering to patients is not a simple or trivial task. Being able to minister to patients takes skills, some that are gained as a nurse. Spiritual matters are often personal for people. Patients may be skeptical about talking about

spiritual matters. The nurses must build rapport with their patients and earn their trust. This means that the nurses must be trustworthy and must grant personal time with their patients. The nurse needs to remember that each patient is an individual and needs individualized care. If the patient believes that the nurse cares about him/her personally, he/she will trust the nurse more (McSherry, 2006).

Nurses need to build relationships with their patients. They need to remember that each patient is different. The nurse must avoid offering generic spiritual care. For instance, though a nurse may have two patients from a similar, or even the same, cultural and religious background, the patients may decide to practice that religion and express their faith differently (McSherry, Cash & Ross, 2004). The nurse needs to show interest in the patient. If the patient feels that the nurse is genuinely interested, he/she will be more likely discuss spiritual issues with nurse. This will allow the nurse to build a personal relationship with him/her and thus provide spiritual support (Baldacchino, 2006).

Nurses need to remember that they are servants (Laabs, 2008). Part of being a servant involves having a servant's attitude. The attitudes of the nurses make a difference for their patients. An attitude of genuine interest, acceptance and respect will be comforting to the patient. This will build a relationship with the patient and will make spiritual care go more smoothly (Miner-Williams, 2006).

Being prepared. The nurses need to be open with the patients and need to be ready to provide spiritual care at any time. Many nurses feel that the initial interview is not the best time for an in-depth spiritual assessment. Thus the nurse needs to create an environment that will make the patient comfortable. The nurses need to be prepared for

the patient to share information at anytime (Leeuwen, Tiesinga, Post & Jochemsen, 2006). The nurses also need to be discerning enough to recognize when the patient does not want to discuss the topic. The nurses need to watch for verbal and non-verbal cues on whether or not the patient is ready and willing to address spiritual matters (Miner-Williams, 2006).

Taking time. Nurses need to take time with their patients. This will build the trusting relationship and allow the patient opportunities to show or express spiritual distress. The nurse should approach the topic in private since it is such a personal matter. If the topic is broached in a public arena the patient may become defensive and unwilling to share (Leeuwen, et. al., 2006). Nurses also need to understand that spiritual care is related to being, as opposed to doing. What matters the most is not the tasks that the nurse can complete, but just being present for the patient (Baldacchino, 2006). Nurses also need to provide care spiritually. They can do this by being present, listening, respecting and supporting values and beliefs and giving of themselves. This can take place along with and during other tasks that the nurse needs to complete such as a bed bath or a dressing change (Miner-Williams, 2006).

Supporting patients who have beliefs that differ from, and that may even go against, the beliefs of nurses can make providing care difficult at times. At these times especially, nurses must be sure to be aware of their personal biases and not allow them to interfere with their care. Nurses also need to be sensitive to cultural issues that may arise as they work with patients from different backgrounds (Miner-Williams, 2006).

Nurses need not participate in any actions with patients that go against their beliefs. However, nurses should attempt to accommodate the wishes and desires of the

patients as much as safety and hospital policy with allow. Nurse can arrange to have special foods brought in by family members, to have certain religious individuals come in to visit the patient or to accommodate special rites and rituals if hospital policy allows. The nurse can arrange for the means for these activities to take place without having to participate with them (Holloway, 2006).

Patient desires. Nurses need to take time to find out what sort of spiritual care the patient desires to receive. Some patients may not wish to receive spiritual care, at least not in a direct form such as discussing spiritual matters. When surveyed, most patients wanted a nurse to care and show respect to the patient. They wanted the nurse to respect their religious beliefs, to help them feel hopeful and to listen when they wanted to talk. They also wanted the nurse to treat their religious articles with respect. The patients stated that they did not want the nurse to try to explore spiritual issues with them, to offer to pray with them, to ask about a relationship with God or to help them explore the meaning or purpose for life. If the patients were interested in prayer, they wanted the nurse to pray for them in private, not with them. The results of this study indicate that patients do not, in general, want religious care, but spiritual care (Taylor & Mamier, 2005). It seems clear that patients prefer being, rather than doing.

Presencing is an important part of ministering to patients that they appreciate and desire. This involves being present—with the patient rather than doing tasks. Being available sends a sincere message of care and concern. Touch is also a useful tool in showing care for patients. Touch can send a strong nonverbal message of empathy and support. Nurses need to be cautious with this intervention. They need to assess the cultural background of the patient and ensure that this is an acceptable measure. Some

cultures value their personal space, and see touch as extremely intimate or inappropriate. In these cases, nurses should avoid using touch (Benner, 2001).

Nurses' spiritual backgrounds. Research has shown that nurses with spiritual backgrounds pay more attention to spiritual needs. They notice the spiritual needs of the patients and take measures to meet those needs (Baldacchino, 2006). The spiritual health of the nurses affects the care that they provide (Wong, Lee & Lee, 2008). Nurses who understand spirituality and who have experienced spiritual development will not avoid the patients who need spiritual care, or offer them simple clichés (Miner-Williams, 2006).

A study showed that patients preferred the care of older, more experienced nurses for spiritual care. They felt as though the more experienced nurses offered more and higher quality spiritual care than the younger nurses did (Miner-Williams, 2006). This could be attributed to the experience that nurses gain in their practice. As nurses work with patients, they begin to notice patterns and correlations among situations and outcomes. This can be applied to their practice of physical medicine, as well as how they care for their patients spiritually. The longer nurses practice, the more adept they become at noticing the spiritual needs of patients. They also learn the best ways to approach these situations and what interventions produce the best outcomes (Benner, 2001).

Team effort. Ministering to patients also needs to be an inter/intra-disciplinary effort. Chaplains, social workers, nurses, doctors, psychologists and other staff are responsible for attending to the patients' spiritual needs (McSherry, 2006). The nurse, however, is in a unique position to take on this responsibility since he/she has the most patient contact (Wong, et. al., 2008). William Osler, said "the trained nurse has become one of the great blessings of humanity, taking a place beside the physician and the priest"

(Carey, 2007, p. 52). The nurse cares for the healthcare issues and for spiritual issues at the same time.

Using the Nursing Process

Ministering to patients can be based on the nursing process. The nurse needs to assess the spiritual status of the patient. There are assessment tools available to do this. These tools include the Carpenito Spiritual Distress Indicator tool, JAREL (Journees Audiovisuelles Rurales et Environnementales de Lema) spiritual-well being scale and the Howden Spiritual assessment scale. However, these are limited and structured assessments. The nurse could also encourage the patient to discuss his spiritual status and to give his opinion on his spiritual health. The nurse and the patient may together diagnose, or identify the spiritual problem; however the nurse may have to identify the problem on his/her own if the patient is not ready to discuss spiritual problems. Next, the nurse must plan interventions. The nurse may include the patient on this and the patient may even request certain interventions such as referrals to clergy or the observance of spiritual rites and rituals. The nurse should accommodate this as much as possible based on policies of the facility and safety issues for the patient and others involved. Once the plans have been made, they must be implemented. After implementation, the results need to be evaluated and changes to the plan of care made accordingly (Baldacchino, 2006).

Assessment. The initial step in the nursing process is to assess the patient (Ackley & Ladwig, 2008). Nurses need to assess their patients' spiritual backgrounds and spiritual statuses (McSherry, 2006). Most interview assessments include questions about religious affiliations. The nurse can use this as a spring board for discussing deeper spiritual matters (Tanyi, 2006). The nurse needs to watch for cues from the patient to tell him/her

whether the patient is ready and/or comfortable with discussing spiritual issues. Cues may be subtle statements in conversations, physical evidence such as the presence of a religious article, the ways in which the patient interacts with his/her visitors or blatantly obvious statements of readiness and need (Miner-Williams, 2006). The nurse needs to assess whether the patient is ready for this topic. It may take time before the patient is comfortable enough with the nurse to discuss this, or he/she may never feel comfortable enough to talk about it (Taylor & Mamier, 2005).

Ideals and parts of life that are of value and give meaning to the patient should be assessed as well. Knowing about these situations will help nurses to see what parts of care are causing the patient distress. It will also help the nurses provide interventions tailored to the patient (Miner-Williams, 2006). Nurses need to assess how the patients' spiritual beliefs and practices relate to health care. This will direct the nurse in providing care spiritually for the patient. Nurses should also identify how the patient perceives that the nurses should support and care for his beliefs and values. Providing spiritual care that the patient does not want may make the patient feel defensive or may fail to support the patient which in turn can cause more problems, both physical and spiritual as a result of the added stress (Taylor & Mamier, 2005).

Diagnosis. The next step in the nursing process is to diagnose the patient. Nurses do not make medical diagnoses as physicians and nurse practitioners. Nurses diagnose an issue that is related to a medical diagnosis that the patient currently has. This must be an issue, or potential issue, that nurses are able to treat. There is a list of possible diagnoses from the North American Nursing Diagnosis Association. The most common diagnosis pertaining to spiritual matters is Spiritual Distress. There is also Risk for Spiritual

Distress and Readiness for Enhanced Spiritual Well-Being (Ackley & Ladwig, 2008). While these seem like negative conditions, the nurse should keep in mind that the patient may also need help expressing and coping with eustress, or good stress, such as a celebrated birth (Taylor & Mamier, 2005).

Planning. Once the nurse has made a diagnosis, she must then plan interventions that will assist the patient in correcting the problem (Ackely & Ladwig, 2008). In one study, patients were asked what sort of interventions they wanted from their nurses. Some wanted the nurse to suggest that the patient seek help, give an educational brochure, inform the patient of local resources, discuss an issue in depth or make a referral. Other patients said that they would prefer that the nurse refer them to a spiritual expert, use different types and methods of care, actively listen, facilitate and validate the patient's feelings and thoughts, accept the patient, have a non-judgmental attitude, instill hope, and clarify values and experiences. This is not an exhaustive list of possible interventions. Each patient is unique and so two patients may have different interventions to meet their spiritual needs. The nurse must be discerning in what care and how much care the patients want to receive (Taylor & Mamier, 2005).

Implementation. The next step in the nursing process is to implement the interventions the nurse has planned (Ackley & Ladwig, 2008). Researchers have questioned whether or not nurses should take this step. Some believe that nurses are not qualified to intervene and that it presents an ethical dilemma. They base this on the fact that nurses are not chaplains or clergy, thus they are not *experts* in the field. This means that they would not be qualified to make diagnoses and implement treatments. They refer to the story of Job to support their point. They explain that Job's friends attempted to tell

him that he was experiencing his illnesses and other losses in his life because he had sin in his life; they believed he was being punished by God. However, they were not clergy, so they were not experts (Pesut & Sawatzky, 2006). However, Job's friends were wrong about the source of his afflictions. Job's afflictions turned out to be from God for the reasons of testing him and to glorify God.

However, Christians are qualified to be *experts* at this topic. Therefore, Christian nurses are qualified to minister to their patients. Christ gave His followers the power over devils and the power to cure diseases (Luke 9:1, New International Version). In the Great Commission, Christ gives His followers the authority to teach, counsel, and disciple people throughout the world (Matthew 28:19-20, New International Version). Therefore, nurses who are Christians, have the *expertise* to assess and support their patients in spiritual matters as they pertain to the Christian faith. However, nurses should be cautious not to discriminate or impose personal biases on patients. Also, nurses should not coerce their patients to agree with their beliefs. The nurse can provide information and show Christ's love, but the patient must make the decision willingly (Pesut & Sawatzky, 2006).

Evaluation. The final step in the nursing process is evaluation (Ackley & Ladwig, 2008). Without evaluation, there is no way to know if the interventions were successful. Evaluation needs to be an ongoing process. If at any time the nurse sees that the interventions are not being successful, or that different or more interventions are necessary, the plan of care can be altered accordingly (Pedrao & Beresin, 2009). Many of the nurses who do employ spiritual care fail to evaluate the care they are providing. This only hurts the nurses' practice, as they are unable to see if their care is effective (Baldacchino, 2006).

Ministering to Patients' Support Systems

Part of the profession. Part of the nursing profession is offering care to the support system of the patient as well as the patient. This may include the patient's immediate family, extend family, friends, and others within his/her community. Nurses are expected to care for individual patients, for families, for communities and for whole populations (Laabs, 2008). Research has shown that the family does need and desire care. In one study, researchers assessed the level of spiritual care desired by patients and their families. Data from the patients indicated that they desired for nurses to provide spiritual care during their hospital stay. There was no statistical difference between the desire for nurse-provided spiritual care between the patients and patients' families. This indicates that the families believe they are in need of care as well, specifically spiritual care. The important difference between the patients' wishes and the wishes of the families is that the patients desired indirect care, with little questioning or discussion of spiritual issues. The families did desire direct care and open discussion of spiritual issues with the nurse (Taylor & Mamier, 2005).

Family as the patient. In palliative care settings especially, the family and other members of the support system may become patients themselves. The medical team is providing comfort measures for the patient and the family that is grieving. The nurse can help the family through this grieving process by offering spiritual care. They may experience spiritual distress with the patient or as a result of the patient's current situation (Taylor & Mamier, 2005). The patient's support system can experience a spiritual crisis just as the patient himself/herself. This is usually related to grieving for the illness or death of the patient (Agrimson & Taft, 2009).

Family desires. When caring for the family, the nurse needs to have discernment in how much spiritual care to offer and when to offer it. The patient's thoughts and wishes on the topic many not necessarily reflect those of his family. For instance, most patients want their nurses to pray with them in private if they want prayer at all. However, this study also showed that 56% of families wanted to pray with the nurse. So the nurse must assess the family, and their receptiveness to her and her provision of spiritual care (Taylor & Mamier, 2005).

Along with discerning whether or not the family desires spiritual care, when it is desired and how much, the nurse should also use judgment in deciding what type of interventions to utilize. Just as with patients, individual families are unique. Different families will require different interventions to meet their needs. Some interventions that are most accepted and seem helpful to the family include being available, respect, prayer, and non-nursing support. As with the patient, this is a service of being rather than doing. In expanding upon these interventions, along with having the nurse be available and present, the family also wanted the nurse to provide comfort, companionship, conversation and consolation (Taylor & Mamier, 2005).

Current Needs for Improvement in Spiritual Nursing Care

Education. One of the problems currently facing nurses as they try to minister to their patients is the lack of education. Nurses are not taught how to approach spiritual matters with patients and how to plan and implement interventions. If nurses believe that interventions are needed, they usually feel that the responsibility should be passed on to clergy. Nurses have stated that they feel the need for more education in preparation for

becoming a Registered Nurse. They also feel that some continuing education for nurses should be focused on approaching and dealing with spiritual matters (Wong et. al., 2008).

Many nurses feel as though their coursework in preparation for their degrees left them feeling untrained and inadequate in dealing with spiritual matters. Bachelor's prepared nurses believe that approaching and caring for spiritual issues should be included in their undergraduate coursework (Baldacchino, 2006). The results of one survey showed that 67% of nurses reported that they did not receive any professional training for dealing with spiritual matters in their undergraduate coursework. The same survey also questioned Master's prepared nurses and 93% of them reported that they did not receive any training on spiritual matters in their graduate studies. The lack of education on the topic only presents a barrier for offering spiritual care. The nurses feel as though they should provide spiritual care but they are unsure on how to do that (Pedrao & Beresin, 2009). The nurses are also unsure about the care itself. They feel the drive to care for the spiritual component of their patients, but they do not know how their patients feel about this. They do not know what kinds of interventions the patients want (Taylor & Mamier, 2005).

Many nurses do not understand how and when to make use of chaplains and other religious officials. They are unsure of when they should make referrals and if their patients want such referrals to be made. A number of nurses feel that they should provide spiritual care but admit that the Chaplain usually ends up being the ultimate care giver in this area (Pedrao & Beresin, 2009). Nurses need to be trained so that they learn to recognize when they are incapable of handling a spiritual situation and a referral is needed (Miner-Williams, 2006). While nurses should provide spiritual care, the

responsibility for patient care lies with the medical team as a whole. This means that it is right, and even necessary, to make referrals to other members of the healthcare team, including chaplains. Nurses just need to take caution to ensure that they do not make use of the opportunity to make a referral to avoid providing complete holistic care themselves (McSherry, 2006).

Caring for the spirit is often overlooked by nurses. Many who do take spiritual needs into account will pass the responsibility on to clergy or other religious leaders who the nurses see as experts in these matters. If the patient does not express a faith or desire of spiritual care, the nurse may overlook the matter completely. However, even those who claim to have no faith, need spiritual care, especially when they are faced with the stressors and challenges that accompany a medical crisis (McSherry, 2006). Nurses need to be taught the difference between religion and spirituality. They need to understand that the two are not synonymous, as explained above (Miner-Williams, 2006).

Some professionals suggest that nurses be offered continuing education that covers addressing spiritual care. One study revealed that 87% of nurses report having received no education or training on spiritual care other than in their nursing courses that they took in preparation for obtaining their license (Pedrao & Beresin, 2009). Offering continuing education would provide an opportunity for nurses to obtain training, even if their preparation coursework did not offer it (Holloway, 2006). There is also a gap between having all of the information and skills, and integrating them. Even when nurses are taught what spirituality is, they do not know how to apply their knowledge in practice (Miner-Williams, 2006). Providing continuing education on spiritual care would give nurses the opportunity to be in practice and see the issues that they are confronting with

their patients, and then seek guidance on integrating appropriate care from their instructors (Holloway, 2006).

Nurses feel as though they do not understand how to integrate spiritual care into their practice. This is a result of the lack of education and other perceived obstacles. But training in this topic would allow for instruction in overcoming those obstacles (Pedrao & Beresin, 2009). The medical field is reluctant to incorporate spirituality into the care of patients (Miner-Williams, 2006). This places further obstacles before nurses who see a need for providing spiritual care. Overall, this leads to a wide variation in the frequency and type of care provided for spiritual matters, and makes the care itself rare (Taylor & Mamier, 2005).

Cultural competencies. Having cultural competency is necessary for nurses in providing any type of care, especially spiritual care. Nurses need to be sensitive to other cultures. They should recognize different cultures and the fact that these cultures have their own beliefs and values. They also need to understand that there can be variations on these belief systems within the culture itself. Each culture handles illness and death in a different way. Nurses should do their best to support patients and family members in expressing their feelings and coping with illness and/or death according to their cultural norms (Holloway, 2006).

Since there are variations, even within cultures and communities, and possibly even families, the nurse needs to approach each patient as an individual. Nurses can use information about the culture and background of their patients as a guideline for planning their care. But they should remember that individuals have a unique way of expressing and observing their own culture (McSherry, 2006). Nurses need to be aware of the

diversity that exists even within small groups who share a cultural or religious common ground (Hussey, 2009).

Knowing that these differences exist, nurses should help their patients and their patients' families to observe cultural and religious rites and practices. This will not always be possible due to hospital policy issues or safety concerns. However, nurses should make an effort to accommodate patients and their families as much as possible (McSherry, 2006). Determining what rites and practices the patients want to observe, and helping them to observe them, requires sensitive skills. Nurses need to be familiar with the cultural groups in their area so that they are prepared to deal with common observance. They should also develop assessment and interview skills that are culturally sensitive and allow the nurse to learn how to assist the patient in taking care of himself/herself spiritually (Holloway, 2006).

Sensitivity. When providing spiritual care and ministering to patients, nurses need to exhibit sensitivity. Nurses should remember that patients may have religious beliefs that differ from their own. It is unlikely that a nurse will be paired with a patient who has the same beliefs system. Even if the nurse and patient do not agree, the nurse should still support the patient in his belief system. The nurse must afford each patient unbiased care (Hussey, 2009).

Patients are vulnerable, both physically and emotionally, thus they can be more easily influenced by those caring for them when they are ill. Nurses hold a special place of authority over the patient as a caregiver and educator on health matters. The nurse must take care to avoid abusing this authority. He/she must see the responsibility that comes with this authority— a responsibility to care for the entire person, but to not coerce

the person or force views onto the person (Pesut & Sawatzky, 2006). But since these patients are weak and vulnerable, they need guidance and support. The nurse should use cultural competencies and get to know the patient and attempt to provide for any rites and rituals the patient wishes to observe. Nurses may not agree with these practices, but they must remember that they are caring for their patients and they must be sensitive to the needs and desires of them (Holloway, 2006).

Nurses need to take extra caution when dealing with patients from differing religious backgrounds. Nurses have a fiduciary relationship with their patients, who are vulnerable. Nurses should not take advantage of this by coercing their patients to agree with their religious beliefs. Nurses must care for and support their patients' beliefs regardless of the patients' backgrounds (McSherry, 2006). These rules are handed down to nurses by the authority of the law. No one can discriminate based on religious and/or spiritual background and no one can coerce or force someone else to agree with him/her. This is also a matter of ethics and not taking advantage of that fiduciary relationship (Henery, 2003). However, nurses need not be involved to the point that they violate their personal beliefs. The Bible directs Christians to obey authorities: "everyone must submit himself to the governing authorities, for there is no authority except that which God has established. The authorities that exist have been established by God" (Romans 13:1, New International Version). This means that Christian nurses are commanded by their faith to obey these laws as well. Nurses should be cautious to avoid coercion.

Comfort. Nurses should be comfortable with spirituality. This means being comfortable with discussing the topic, implementing care and being comfortable with their personal spirituality. Assessments are a critical part of providing care. The nurse

cannot know what interventions are needed without looking at what the problems are and what the patient needs. Thus, the nurse needs to be comfortable with his/her assessment style. Nurses also need to understand their own spirituality. This will make the nurse more comfortable with spirituality and providing spiritual care. It will also make the nurse more sensitive towards and aware of the spiritual needs of the patients. The care that the nurses provide has also been shown to be of higher quality if the nurse is comfortable with spiritual topics and his/her spirituality (Miner-Williams, 2006).

Nurse spiritual well-being. Nurses may also become spiritually drained from ministering to their patients. In these times, the nurses need to remember that they have to lean on God and He will refill or renew them. “All this is for you benefit, so that the grace that is reaching more and more people may cause thanksgiving to overflow to the glory of God. Therefore we do not lose heart. Though outwardly we are wasting away, yet inwardly we are being renewed day by day” (2 Corinthians 4:15-16, New International Version). Nurses need to be sure to take care of themselves spiritually. This includes renewal and refreshment as well as maintaining spiritual well-being. As stated for patients, when the behaviors and actions align with the values and beliefs, the individual will have spiritual well-being (Miner-Williams, 2006). If the nurses do not ensure that they are spiritually healthy, they will not recognize spiritual problems in their patients, nor will they be able to provide competent, quality spiritual care (Baldacchino, 2006).

Conclusion

Nurses, especially Christian nurses, are servants by profession and by faith (Laabs, 2008). Holistic care of the patient is the ultimate goal for the nurse. This includes

caring for the spiritual part of the patient (McSherry, 2006). Spiritual care is a vital part of nursing care, for, if the patient does not have spiritual well-being, the patient cannot have health (Miner-Williams, 2006). Nurses can follow the nursing process as a guideline for providing spiritual care (Baldacchino, 2006). Nurses need to use careful judgment when deciding how much spiritual care to provide, when to provide it, and what interventions to use (Taylor & Mamier, 2005). Cultural competence and sensitivity are indispensible when providing culturally competent care (Holloway, 2006). Many professionals, nurses included, believe that more training is needed in both preparation coursework and continuing education (Wong et. al., 2008). To provide quality and proficient holistic nursing care, nurses must care for and minister to the spirit of the patient.

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