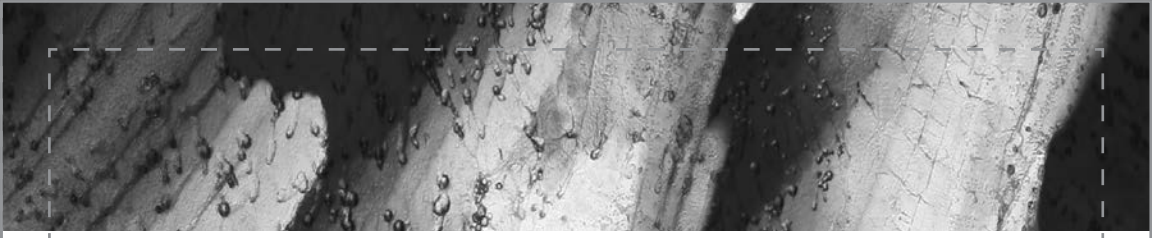

CHAPTER 5

The Nurse–Patient Relationship: A Caring Ministry

"Therefore, since it is by God's mercy that we are engaged in the ministry, we do not lose heart."

2 Corinthians 4:1

"When I do nursing, when I care for someone who is sick, I have a real feeling that I'm ministering to that person; that I am doing ministry. That goes back to the idea that the gospel tells us, as Christians, to care for the sick and that when we care for them we care for the Lord. Nursing is definitely a ministry".

Megan, Nurse Practitioner in Community Health

The Nurse–Patient Relationship

For centuries, the nurse–patient relationship has been unique and individualized. Both patient and nurse bring into the partnership a multiplicity of personal life variables, including such factors as demographics (age, gender, marital status, ethnicity, religion, and socioeconomic status), family history, illness experience, and spiritual orientation. All of the characteristics associated with these variables may affect how the nurse–patient relationship is played out during the course of an interaction. Recent literature has also begun to explore, in more specificity, the topic of professional boundaries related to the nurse–patient relationship (Griffith, 2013), focusing especially on such issues as: the nurse's power and the patient's vulnerability (Benbow, 2013, p. 30); trust in nurse–patient relationships (Dinc & Gastmans, 2013); person-centered practice (Deveney, 2014); communication (Reblin, Otis-Green, Ellington, & Clayton, 2014); and spirituality and the nurse's penchant for innate compassion (Wright & Newberger,

2012). Any or all of these variables, as well as sociodemographic characteristics, may impact the nurse–patient relationship.

The research data in this chapter poignantly describe the ministerial dimension of the nurse–patient relationship as identified by a cadre of practicing nurses. The nurses' own words are employed to label concepts in a paradigm of interaction that reveals the nurse as an anonymous minister. In this ministerial role the nurse enters into a sacred covenant of caring for the sick.

Spirituality and the Nurse

In discussing nurses' spiritual needs, Philip Burnard (1988) posed a number of questions that may help a nursing practitioner explore his or her own spirituality in relation to caregiving. These questions focus on such topics as understanding the term *spiritual*, religious education, the importance of spirituality to the nurse, feelings about spiritual beliefs different from one's own, the potential for changing personal spiritual beliefs, feelings regarding talking about spiritual beliefs with other nurses, and the perception of how one's own spiritual beliefs affect patient care (p. 36). For seasoned nurses, these questions may have been well explored in the course of their own faith development; for the newer clinician, exploring spiritual beliefs can be a valuable and growth-producing faith experience. Ultimately, responses to Burnard's questions may have an important impact on the nurse–patient ministerial relationship. Writing on the subject of a nurse's spirituality in 1912, distinguished nurse educator Isabel Hampton Robb asserted that indeed "the nurse's work is a ministry; it should represent a consecrated service, performed in the spirit of Christ, who made Himself of no account but went about doing good. The woman who fails to bring this spirit into her nursing misses the pearl of greatest value that is to be found in it" (1912, p. 38). Nursing's spiritual dimension has been described as including the fact that attention to the "spirit should be regarded as an important part of spiritual care" (Myers, 2009, p. 22); that there should be "a systematic provision of spiritual care to patients" (Dunn, 2008, p. 4); that the concept of spiritual care should be included in nursing fundamentals textbooks (Pesut, 2008); and that nurses have a duty to facilitate the meeting of patients' spiritual and/or religious needs (Ledger, 2005).

In a 2010 literature review exploring the integration of spirituality into nursing practice, Tiew and Creedy identified five themes that impact spiritual care: these include "a lack of shared understanding of spirituality, lack of emphasis on spirituality in nursing education, attitudes, organizational and cultural factors, and individuality" (p. 15). Among these authors' recommendations following the review was the notion that "more research is required to develop a better understanding of how nurses perceive spirituality and the types of difficulties or barriers they face integrating spirituality into practice" (p. 19). A paper in *Nursing Ethics* addresses one of the themes identified by Tiew and Creedy, that of a lack of emphasis on spirituality education. Annette Becker (2009) asserts that "despite the evidence in college students indicating a hunger for spiritual insight and spirituality's application in health care, there continues to be a guardedness within the academy toward the inclusion of curricula that address spirituality" (p. 697). Becker offers a model for teaching spirituality and health that contains four guidelines: "approach teaching spirituality as any other 'difficult topic'";

"develop . . . a pragmatic course including learning activities that engage depth of learning"; "create and sustain a secure environment of learning"; and "be a trustworthy citizen of the college community" (p. 703).

In line with Becker's concept of creating activities that promote learning, one nurse author suggests that "creative modalities offer nurses a new perspective on how to care for patients" in an article entitled "Creativity and Spirituality in Nursing: Implementing Art in Healing" (Lane, 2005, p. 122). Dr. Mary Lane focuses on the accomplishment of healing using such arts as music, painting, and sculpture (p. 122). Other authors who link the concepts of spirituality with healing include: Glen McCabe (2008), who suggests the integration of body, mind, and spirit with traditional healing practices in psychotherapy; Dr. Jane Hart, of the Center for Spirituality and Healing at the University of Minnesota, which offers programs based on an integrative healing model (2010, p. 50); and Pipe, Hansen, Hentz, and Hartsell, who describe a program of spirituality and healing using "Watson's Theory of Human Caring (as) the framework guiding the project" (2010, p. 47).

Tyler and Raynor remind nurses that "there has been consistent use of spiritual practices to address health concerns by individuals for thousands of years" (2006, p. 63); they note further that "incorporating spiritual care into practice is an integral dimension of holistic care that is the crux of nursing practice in the 21st century" (p. 63). Research employing focus groups, including patients, nurses, and hospital chaplains, showed that spirituality "played various roles in patients' lives during their illness" (van Leeuwen, Tiesinga, Jochemsen, & Post, 2007, p. 482), and myriad investigations have revealed that "spirituality is a fundamental quality that contributes to health and wellness" (Shores, 2010, p. 8).

Although the author's interviews with practicing nurses described in the following pages did address the nurses' own spiritual needs, only a modest amount of data was elicited on the topic. Nurses who participated in the study were clearly more interested in talking about the spiritual concerns and needs of their patients, how they had attempted to meet these, and how they might better practice spiritual care in the future. Nursing has historically been a discipline of service to others; the concern with one's personal well-being, spiritual or otherwise, was secondary to meeting the needs of the ill. The study nurses who did speak about their own spirituality, however, described the importance of such religious activities as prayer and Scripture reading in providing support for their practice.

Ellie, a pediatric oncology nurse practitioner who had worked with terminally ill children for more than 15 years, explained the significance of her personal spirituality:

> In this job, in this work I do with little ones, some of them are so, so sick. It hurts a lot to watch them get sicker and sicker; they are so brave, some of them. And the parents! It can get to you. Some days you just want to run away and say "no more!" I can't keep doing this job. You want to forget that babies are dying. . . . I truly do believe it's my faith in God, in the Lord Jesus, that holds me up. I try to pray every morning while I'm getting myself together for work. And when I can steal a few minutes I read some Scripture or something like Henri Nouwen; I love his books. And my church, they're a big, big support. I guess I could say that it is the spiritual that keeps me in oncology nursing.

The Nurse: The Anonymous Minister

In addition to the nurse's personal spirituality, a number of other factors are relevant to the spiritual dimension of nurse–patient interactions, including the nurse's comfort level in discussing spiritual issues with patients, the degree of spiritual support provided in the care setting (i.e., support for both patients' and caregivers' spiritual needs), and the emphasis or lack of emphasis on providing spiritual care to patients in the course of professional nursing education. "Ministry denotes service and servanthood," asserts nurse educator Do-rhen Angking (2012). Although "the notion of nursing as a service has been de-emphasized, mainly due to the vigorous efforts to raise nursing to the realms of science as a profession," Angking points out that "for many nurses, especially Christian nurses, nursing is indeed the ministry they are called to by Christ" (p. 59). In order to explore, empirically, these questions and issues regarding spirituality and the covenantal nurse–patient relationship, the author conducted focused interviews with 66 contemporary nurses employed in two East Coast metropolitan areas, soliciting individual experiences, attitudes, and behaviors regarding the relationship between spirituality and nursing practice. The nursing cadre was purposely chosen to include a broad range of experience and education. The 6 men and 60 women comprising the population of nurses reported the following religious affiliations: 39 Roman Catholics; 25 Protestants (4 Baptists, 3 born-again Christians, 2 Methodists, 2 Episcopalians, 2 Presbyterians, 1 Lutheran, 1 "Christian," and 10 persons who described themselves broadly as "Protestant"); 1 Jewish nurse; and 1 nurse who reported having no religious affiliation.

Two members of the group were licensed practical nurses, five were diploma registered nurses, and one had an associate in arts nursing degree. Eleven individuals had baccalaureate degrees in nursing, 25 had master's in nursing degrees, 14 had doctorates in nursing science, and 8 were registered nurses with doctorates in the biologic or behavioral sciences.

The largest subgroup of 38 nurses identified a history of 16 to 25 years of nursing experience; 19 had been nurses for 26 to 40 years; and only 9 had practiced nursing for less than 15 years. Thirty-three percent of the group described their specialty area as medical–surgical nursing. Seven nurses worked in the area of psychiatric–mental health, and seven worked in pediatrics. Five critical care nurses and five cardiovascular nurses were included in the group; there was one oncology nurse, as well as three hospice and five gerontologic nurses. Three nurses worked in the area of maternal–child health, and two each represented the areas of community health, emergency room, and operating room nursing. Three of the study nurses worked with the mentally retarded/developmentally disabled, and three worked in home health-care nursing; one of the latter group of nurses was primarily involved with the health care of homeless persons.

Sixteen of the study nurses were employed at military health-care facilities; 10 were faculty members in schools of nursing. Ten nurses were employed by medical centers, 7 by research institutions, 12 by private religiously affiliated hospitals, 3 by hospice facilities, 7 by city-run health-care facilities, and 1 nurse worked for an HMO. More than half of the group were identified as working in the area of nursing practice; 10 were nurse educators, 10 were nurse administrators, and 4 were employed as nurse researchers.

Interviews with the nursing group explored experiences and attitudes associated with nursing and spirituality, focusing on such topics as nurse–patient interactions related to patients' spiritual needs and/or spiritual care, the nurse's personal spirituality and/or spiritual needs, spiritual support provided in the health-care setting, and the inclusion or lack of inclusion of spiritual concepts in the nurse's educational program. Discussions were tape-recorded to preserve the nurses' attitudes, perceptions, and experiences in their own words. Confidentiality was assured to the nurses participating in the interviews; wherever naming is warranted, pseudonyms are used.

Tape-recorded interviews were transcribed and content analyzed to identify dominant themes related to nursing and spirituality. A multiplicity of concepts emerged associated with such broad areas as nurses' attitudes toward spirituality and spiritual care, the identification of patients' spiritual needs, nursing behaviors regarding the spiritual care of patients, and nurses' perceptions of their roles in ministering to patients' spiritual needs. All dominant themes and related concepts are derived from the practicing nurses' own words.*

Study Findings

Ultimately, an overall construct describing the association between spirituality and the nurse–patient relationship emerged from analysis of the interview data and was labeled "The Nurse: The Anonymous Minister."

This construct, which identifies the nurse's frequently unrecognized role in spiritual ministry, consists of three dominant themes: A Sacred Calling, Nonverbalized Theology, and Nursing Liturgy. Each theme incorporates six key concepts reflective of the category's content and orientation (see **TABLE 5.1**).

A Sacred Calling

The first concept of the empirically derived construct, The Nurse: The Anonymous Minister, is reflected in a dominant theme derived from the nurses' interviews and labeled A Sacred Calling. This theme relates to a perceived professional nursing role in ministering to the spiritual needs of patients. A majority of the nurse practitioners, educators, administrators, and researchers interviewed described nursing as being a vocation or calling, reflecting a spiritual element incorporated within their profession.

*The nurses who participated in the Nursing and Spirituality interviews were identified through informal sampling. The author requested key nurses, in the various types of health-care facilities described, to approach members of their staff who might be willing to meet and discuss the topic of spirituality. No criteria regarding the nurses' religious affiliations were specified. As demonstrated in the demographic profile, 64 of the overall group of 66 nurses who agreed to participate in the project identified themselves as Christian. Thus, many of the themes and concepts relating to spirituality and the nurse–patient relationship presented in this chapter are undergirded by Christian theology and spirituality. It is expected, however, that the reader affiliated with another religious tradition will be able to appreciate the universal themes of love, caring, compassion, and ministry to those in need.

TABLE 5.1 The Nurse: The Anonymous Minister

A Sacred Calling	Nonverbalized Theology	Nursing Liturgy
A Send of Mission	United in Suffering	Healing Rituals
Messenger of Good Faith	Proddings of the Holy Spirit	Experiencing the Divine
The Almost Sacred	The Day the Lord has Made	Touching the Core
Touching the Hand of God	Crying for More	Being Present
Sensing the Vibrations	Needing Ventilation	Midwifing the Dying
A Healing Ministry	Praying a Lot	Privileged Moments

Peg, a master's-prepared psychiatric–mental health nurse with 8 years of experience in the field, observed:

> When I was 16 I felt a "calling" to be a nurse; it's like a sacred calling. Over time you develop a devotion. I can't imagine doing anything else.

And Catherine, a doctorally prepared medical–surgical practitioner with 25 years of experience, perceived nursing as a calling from early on in her education:

> I went to school because I felt called to be a nurse. I see nursing as a spiritual vocation. It's much more than work; I find it a way of serving.

The term *vocation*, which is derived from the Latin word *vocare*, "to call," has been identified as a key theme "in both Hebrew and Christian scriptures" (O'Connell, 1993). "[V]ocation is central to understanding the relationship between Divine initiative and human response" (O'Connell, 1993, p. 1009). The concept of vocation is broadly understood as defining an individual's felt call to a particular ministry or work. In theological terminology the word *vocation* generally refers to "a Divine call to undertake a particular activity or embrace a particular 'stage of life' on behalf of God or the community" (Holland, 1990, p. 1087).

One of the younger study discussants, Amy, a 24-year-old baccalaureate-prepared nurse with 1 year of experience in the pediatric intensive care unit, asserted that although it had been a real "challenge" to master the health-care technology used in the care of critically ill children, it was the spiritual dimension of nursing that appealed to her: "When the day comes that I don't minister spiritually to that child or the family, then I need to get out. This is why I felt called to go into nursing; I don't just want to be a technician."

Supportive of envisioning nursing as a vocation, also, is the recent resurgence of interest among nurse researchers and educators in the relationship of moral belief

to the practice of nursing. Ray (1994) observed that nurse theorist Jean Watson "illuminated caring as the moral ideal in nursing where protection, preservation, and enhancement of human dignity are the mandates for the nurse" (p. 106).

The theme of vocation, or a sacred calling, may be further explained in terms of six key concepts derived from the data elicited in the Nursing and Spirituality discussions. These include A Sense of Mission, Messengers of Good Faith, The Almost Sacred, Touching the Hand of God, Sensing the Vibrations, and A Healing Ministry.

A Sense of Mission

A number of nurses described their perceptions of and experiences with spiritual care in terms of a call to mission or ministry. For Christians, all are called to ministry as pointed out in the New Testament:

> Then the king will say to those at his right hand, "Come you that are blessed by my Father, inherit the kingdom prepared for you from the foundation of the world; for I was hungry and you gave me food, I was thirsty and you gave me something to drink, I was a stranger and you welcomed me, I was naked and you gave me clothing, I was sick and you took care of me, I was in prison and you visited me . . . I tell you, just as you did it to one of the least of these . . . you did it to me. (Matthew 25:34–36; 40)

Although several terms are used to indicate the concept of ministry in the New Testament, interestingly, one used at least 20 times is the word *therapeu*, which means "to care for," "attend," "serve," "treat," especially by a physician, hence, "to heal" (Rademacher, 1991, pp. 39–40). Rademacher pointed out as well that "since the Jews, unlike some of the Greeks, did not divide the person into body and soul, we must assume the word describes a holistic healing of the total person" (p. 40). Most practicing nurses used the terms *ministry* and *mission* interchangeably; they also linked the concept of holistic nursing assessment and nursing care with a sense of ministering to the "whole" person, which they perceived as including the patient's spiritual needs.

Sarah, a baccalaureate-prepared nurse with 12 years of experience in hospice care and pediatric oncology, explained that, although she did need to work for financial reasons, she would not have chosen nursing if it were not for the ministry aspect, "I feel a real 'sense of mission' in nursing. It's a spiritual ministry. If I didn't feel that, I wouldn't be here." She added:

> I really depend on God to direct me. Every morning I try to spend some time in prayer and reading Bible verses to give myself strength. I try, when I have time off, to be alone and have a sense of God's presence. I know that I can't heal the children, but to just be there, that helps, and I pray that Jesus will work through me, to use my hands to in some way comfort or do the right thing for the patients.

A doctorally prepared pediatric nurse educator with 14 years of experience in practice described a strong sense of congruence between nursing and ministry:

> My nursing is my service to God. I believe that this is what I am supposed to be doing; this is my ministry. For me nursing and spirituality are intertwined.

> I deal with people in their hour of greatest need; whether it's rocking a dying child or helping to support a family. People need more than physical care; they need love and acceptance. And this is when your mission, your ministry, can be a healing presence.

Paula, a master's-prepared medical–surgical nurse, perceived ministry as a key role in nursing practice:

> We are ministering when we sit and counsel with patients; you are ministering to them when you are talking spiritual beliefs. This is part of our mission; we nurses wear so many different hats. We go from teacher, to being ministers, to doing the technical things of our trade like catheters and IVs. But the ministry part is a special gift; it is central to caring and to nursing.

And Martha, a critical care nurse, described how she learned the importance of spiritual ministry to those living with HIV/AIDS:

> I've found that ministering to [people with HIV], to be open, to listen to them, has led to some very humbling experiences for me, and [they] have also been some of my most rewarding experiences. Once I learned that it was OK to cry with the patients; to scream with them. It was OK to just sit there and say nothing because I just didn't know what to say. I learned to just sit there and hold their hand; they will let you know if they want to talk. They don't want anything a lot of times. All they want is a touch or just to know that you are there; they don't want anything else.

Finally, Shannon, in describing her ministry to intensive care unit (ICU) patients, spoke about her approach to critical care, which included a reluctance to impose her personal faith beliefs on patients:

> I try to figure out where a patient or their family is in terms of spirituality, and if there are needs there and they don't know how to bring it up. So, when something good comes up in a conversation, I'll say something like, "Well, you really have been blessed, haven't you?" And about 98 percent of the time that gives them the permission to let me know about their spirituality. I discovered that this way I can get to their spiritual side without being real threatening; it's just a word choice. . . . I've always been real sensitive to the fact that I have no right to impose my faith on anybody else, but to give folks a chance to articulate their own. If they're not clear on what they believe, sometimes just talking it out with a caring listener puts those issues in perspective. . . . There have been a number of times when folks have asked for a prayer after a conversation like that.

In sum, the spiritual mission of nursing might well be encapsulated in the challenge of Brother Roger of Taizé (1991) who asked, "Who will give the best of their creative gifts so that suffering throughout the world may be alleviated, in places where there is sickness, or hunger, or appalling housing conditions?" (p. 13). Brother Roger advised, "Perhaps you could place these Gospel words on the wall of your home; they come straight from the heart of Christ: 'Whatever you do to the least of my brothers and sisters, you are doing to me,' Matthew 25:40" (p. 13).

Messengers of Good Faith

A baccalaureate-prepared pediatric oncology nurse, Maria, described her perceived nursing vocation as related to the comments of a priest–chaplain at her hospital orientation. Maria explained:

> In our orientation Fr. O'Connor told us that we were "messengers of good faith." I really feel that is right but don't always see it happening on the units. The advanced technology has taken us somewhat away from the patients. But this is the kind of nurse I want to be, a nurse with a sense of vocation, of "good faith." . . . The spirituality, the strength of these children and their families amazes me; going through chemo and all that really affects their lives. I, being Catholic, attribute that strength to God. I need to support them with my faith.

Anna, a long-term hospice nurse, also spoke about the importance of spiritually supporting patients and families without imposing one's own beliefs:

> The idea of spiritual care is particularly important in the hospice setting. The spiritual component is just as important to hospice personnel as the physical component is. At every team meeting the spirituality of the patients is discussed; it is very holistic. . . . But we can't just go in and force our spirituality or our belief system on any patient. We need to meet patients wherever they are.

In their roles as messengers of good faith, nurses walk "among the hurting" attempting to "heal" and to "comfort"; they need to proclaim the love of God for His people. In her deeply moving book, *May I Have This Dance?*, Joyce Rupp (1992) reminded us that "[t]he Spirit of God dances among us, calls us to appreciate and enjoy life, and invites us to participate in the Divine Song that makes melody in the heart of all of creation" (p. 95).

No one is ignored; no one is excluded from the call to loving participation in the "Divine Song."

The Almost Sacred

The term *sacred* is defined variously as relating to "the service or worship of a deity"; "a thing worthy of religious veneration, or Holy"; or "something associated with religion or the religious" (*Merriam-Webster's Seventh New Collegiate Dictionary*, 1976, p. 757). A number of practicing nurses who shared spiritual thoughts or experiences used the word *sacred* in relating to some dimension of their interaction with patients. This is exemplified in the comments of Anne Marie and Karen.

A master's-prepared psychiatric–mental health nurse presently working at a research institution, Anne Marie noted that her choice of nursing had been strongly motivated by an "idealistic desire to help people." She reported:

> I considered other careers along the way but nursing gives you an opportunity to make a difference in people's lives. In nursing you deal with the "almost sacred." I know that sounds like strong words but nursing almost touches on the religious. Our work with patients is a real gift. The deep experiences and talks I have had with patients are the closest thing to a spiritual experience.

> These are the times when you make these deeper connections with people that are spiritual; that is Christ within. Although you don't always recognize it or define it as God's presence within. I have been personally touched by those times.

And Karen, a doctorally prepared medical–surgical nurse, spoke about her approach to patient spiritual care as being a sacred trust:

> I try to look and see if there is a way that patients are signaling me that they need spiritual support. I look to see if maybe they have a Bible laying out and if they're in pain or not sleeping, and I say, "I see you have your Bible here; is there a favorite passage you'd like me to read?" I might also ask, "What kinds of things are important to you?" to see if they might want to go to church or to talk to a chaplain.
>
> I know that my calling as a Christian is to share the Gospel, the good news of Christ; this is a sacred trust. But also, the patient is a captive there and I struggle with getting the balance of "OK, how much am I injecting my values?" So that's why I look for clues to see what's important in their lives; so if it's meditation or listening to music, or whatever, I can pick up on that but if they do mention something to do with the Lord then I can either talk about Scripture or call a chaplain without hitting the person over the head with denominational religion. . . . We have to separate religion and spirituality. Religion is a lot different from spirituality and may be tied up with a lot of rules and prejudices and judgments, but spirituality is about how God reaches out to us and how we respond to that.

Frequently, practicing nurses noted that, although they might not be affiliated with the same religious denomination as a patient, there was, nevertheless, a common sense of spirituality to which they could relate. This provided a starting point from which the nurse could then assess the patient's spiritual needs or concerns.

Touching the Hand of God

The sacredness of a nurse's spiritual ministry was recognized clearly in instances of care for those facing life-threatening illness. In discussing ministry to the terminally ill, Niklas and Stefanics (1975) admitted that this may represent a time when the patient, faced with the reality of his or her own mortality, is open to the presence and the love of God. They suggested that the one ministering actually "walks with the dying person through the valley of the shadow of death" (p. 115). Thus, ministers need to be secure in their own relationship with God and in the understanding of their role in spiritual care.

Christian, a doctorally prepared nurse with 18 years of experience in hospice care, which had recently included a significant amount of care for those with HIV or AIDS, related his nursing vocation to work in the area of death and dying:

> In nursing we have many opportunities to minister but we sometimes miss the opportunity to do this. But when facing death you really face the concept of spirituality, your own and your patients'. AIDS patients really articulate their spirituality in their coping. When you work with people who are dying, you touch the hand of God. . . . Spirituality is an area of nursing that would provide a really wonderful expanded role; for me, [spirituality] is primary.

Peg, a master's-prepared medical–surgical nurse with more than 20 years of experience, also described such a perception of closeness to God in caring for seriously ill patients:

> I remember working with some really critically ill patients, and really sensing the presence of God and their spiritual closeness. And especially at night when the hospital is quieter and more lonely, I felt that they [the patients] just wanted me to be there and to understand what they were going through. They may have only a few days to live but I could hold their hand and give them that presence of God's love and caring.

Sensing the Vibrations

Joyce, a master's-prepared nursing administrator with approximately 24 years of experience in medical–surgical and intensive care nursing, understood the concept of nursing as a sacred calling. She commented, "Spirituality, for me, is to allow both nurses and patients to self-actualize; to love, that is what brings about healing. That is what makes nursing, caring." Joyce observed that when she entered a nursing unit, she considered that part of her role as a clinical nursing administrator was in sensing the vibrations:

> When I walk on a ward, I can sense the vibrations, whether there's a lot of sickness, whether there's a lot of anxiety, a "darkness," and I think that those vibrations are part of spirituality. And I think that the more we love the more we send out our own vibrations of peace and we can lower the anxiety. As we love people we can bring them light; we can make them feel "lighter" and happier. I think that nurses need to do this to their stressful environments, to promote a wholesome, healthy, healing environment. . . . We are all connected in God.

A Healing Ministry

Jesus taught about the concept of ministry through His example of preaching, teaching, and especially of healing the ill and infirm. McGonigle (1993) pointed out that "Jesus sealed the truth of His ministry by the total gift of Himself for the Salvation of all those whom He came to serve" (p. 658). Many Christian health caregivers feel most appropriate in envisioning their work as a spiritual ministry when they relate their activities to Jesus' healing ministry.

This is well exemplified in the comments of Emily, a master's-prepared critical care nurse with 15 years of experience:

> Nurses, I believe, minister to patients, just as I believe that certified clergy do, as Christ did in his healing ministry. I look at the person in totality, the holistic approach. Sometimes it's just by being there, by listening. We talk about God and the love of God, and that He looks at the whole person, not just the last things you did. I have had many patients ask me to pray with them. . . . Nursing is a calling, a healing ministry. You can read and study but it has to be something that is within you, something you are called to do spiritually. . . . Especially in working with dying or critically ill patients you call on your spirituality. Sometimes if someone is suffering a lot you even pray that they will die but it's OK because of faith in God. We say,

> "I see an angel on the foot of the bed." . . . "Growing up" in critical care you can become focused on the technology but you need to go beyond that. You can cry with the family; I have cried with so many patients and families.

Finally, Emily observed that there was a "definite need for staff nurses to 'marry-up' with chaplains and begin to talk about their spiritual experiences."

The comments from the Spirituality and Nursing study group represent only a few selected examples of the nurses' perceptions of their chosen profession as representing a sacred calling. As observed earlier, virtually all of the group members viewed some dimension of vocation or spiritual ministry as integral to their profession. Although this perception might be articulated through different concepts or anecdotes, the essential theme of nursing as a sacred calling pervaded the discussions.

Nonverbalized Theology

The second concept supporting the construct of the nurse as anonymous minister is described as Nonverbalized Theology. Repeatedly, discussions revealed individual nurses' "God-relationships" and "God-understanding" as being supported by such practices as the reading of Scripture, attendance at formal religious worship services, and personal prayer and meditation. None of the group, however, reported having formally studied theology, although several nurses suggested that it was something they had thought about and might consider doing in the future.

For Christians, theology is the study of "Divinely revealed religious truths. Its theme is the being and nature of God and His creatures and the whole complex of the Divine dispensation from the fall of Adam to the Redemption through Christ" (Livingstone, 1990, p. 509). Gerald O'Collins (1981), in his classic text *Fundamental Theology,* noted that the common understanding of the theological discipline is "faith seeking understanding" (p. 5). Although O'Collins accepted that we must come to the study of theology from a position of personal faith, he posited that the discipline "can help believers to describe, explain, interpret, and account for their faith" (p. 10). O'Collins added, "[Christians] know that they believe in the God revealed in Jesus Christ. Theology makes it easier or even possible to say just what it is they believe. With this help they can state their faith to both themselves and others" (p. 11).

Most of the nurses interviewed were articulate in describing their own faith beliefs, especially in terms of the Christian admonition to care for brothers and sisters in need. Many, however, admitted that they generally did not spend a lot of time speaking or consciously thinking about the dimension of spiritual ministry incorporated into their nursing practice; it was simply considered part of the caring activity central to the profession.

The concept of Nonverbalized Theology was suggested by Paula, a doctorally prepared medical–surgical nurse administrator with 22 years of experience. Paula asserted that nurses "minister" spiritually throughout their professional careers, although the underlying theology may never be verbalized:

> Ministry is not a discreet function; a separate task. It is embedded in the careful giving of the meds, the wiping of the brow, the asking of the right questions, the acknowledgment of the patients' humanness, and what they are experiencing in their sickness. I can be there, to be a person of the love of God. You want to alleviate suffering, convey hope, bring love. It is in giving your care in a caring way; but there is no theology being verbalized; it's a

nonverbalized theology. It's in our nursing that we recognize the spiritual side of ourselves and others.

Judith, a doctorally prepared cardiovascular nurse, supported the position:

> I believe that nurses have been doing, and still do, spiritual care a whole lot but we just haven't called it that. . . . Before we didn't verbalize our theology or spirituality but now at least we have an official "nursing diagnosis" for "spiritual distress." I think that gives us a big opening for spiritual assessment of our patients. . . .
>
> Nursing is a ministry but you don't have to speak Scriptures every time you see a patient. When you do spiritual care it can be like Jesus; He just didn't go in and do teaching; He went in and took care of the needs of people first. He fed them and healed them. So when you go in to a patient, take care of their physical needs before you do spiritual care; I believe that nursing is a combination between the art of caring and science. . . . We need to be sensitive. You can turn somebody off by coming on too strong; but you never turn them off by loving them. You always draw them to the Lord; by letting His love flow through you to them. That is the "Cup of Cold Water"; "you did it unto me."

Peter, a master's-prepared psychiatric–mental health nurse with 25 years of experience, also envisioned the concept of Nonverbalized Theology as supporting his clinical nursing practice:

> We are oriented to look at patients holistically, as having a biological, psychological, and spiritual dimension. So, if you're dealing holistically with a patient, and if your underlying theology is that man is made in the image and likeness of God, and you have the perspective of an Incarnational theology, then this is how you approach the patient, even if not on a conscious or verbal level. I am an instrument through which God is present to this person, and in this person is the suffering, or the joyful, Christ. Christ is always present to the other person through you and you encounter Christ in that patient. So even if this theology is not always spoken, or conscious in your mind, but is your underlying theology, then, in holistic nursing, you are relating to the patient's spiritual needs as well as his physiological and psychological; you can't compartmentalize man.

In content analyzing the discussion data, six key concepts articulated by the nurses were identified as being reflective of the overall theme of Nonverbalized Theology: United in Suffering, Proddings of the Holy Spirit, The Day the Lord Has Made, Crying for More, Needing Ventilation, and Praying a Lot.

United in Suffering

Frequently during the discussions, nurse practitioners movingly demonstrated a nonverbalized theological concept of community by revealing a deep sense of empathy with and understanding of their patients' pain. Without sharing specific details, some of the nurses reported that personal experiences of pain and suffering had helped them become more sensitive caregivers; their interpretation was that having "been there" helped them better identify, at least broadly, with the concerns and anxieties of

their patients. This is supported by Henri Nouwen's concept of the wounded healer, which he explained this way: "Making one's own wounds a source of healing . . . does not call for a sharing of superficial personal pains but a constant willingness to see one's own pain and suffering as rising from the depth of the human condition which all men share" (1979, p. 88).

Sharon, a doctorally prepared gerontologic nurse with 19 years of experience, observed:

> The older I get, the more confident I feel in sharing spiritual issues with my patients; we are all united in suffering, all children of God. I may not talk about my own pain, my own theology, a lot but I feel comfortable praying with my patients or assisting with a person's rituals. I understand where they're coming from if they're hurting. At this point in my career I am secure in my spirituality. . . . Some nurses are afraid of saying the wrong thing. I think it is a fear of confronting their own spirituality in dealing with patients. . . . Spirituality is that sense of community where God is most, through the presence of other people; Grace in our lives comes through other people.

The concept that we are all united in suffering is well reflected in 1 Corinthians 12:12–26:

> As a body is one though it has many parts, and all the parts of the body though many, are one body, so also Christ. For in one Spirit we were all baptized into one body, whether Jews or Greeks, slaves or free persons, and we were all given to drink of one Spirit; . . . The eye cannot say to the hand, "I do not need you," nor again the head to the feet, "I do not need you." Indeed the parts of the body that seem to be weaker are all the more necessary, and those parts of the body that we consider less honorable, we surround with greater honor and our less presentable parts are treated with great propriety. . . . But God has so constructed the body . . . that the parts may have the same concern for one another. If one part suffers, all the parts suffer with it.

Proddings of the Holy Spirit

In Christian theology the Holy Spirit is understood as "the Third Person of the Trinity, distinct from, but consubstantial, co-equal and co-eternal with the Father and the Son, and in the fullest sense God" (Livingstone, 1990, p. 245). Farrelly (1993) suggested that in the early Church the "dynamism of Christian life" was ascribed to the Holy Spirit as the vehicle of God's love given to His people (p. 496). In John's Gospel, the "personal character" of the Holy Spirit is demonstrated. "'I will ask the Father and He will give you another advocate to be with you always, the Spirit of Truth'; John 14:16–17" (Farrelly, 1993, p. 499). A number of the nurse respondents spoke of the importance of the Holy Spirit's guidance in their work with patients, staff, or students. Maggie, a nursing administrator for over 11 years, who described herself as a Southern Baptist and born-again Christian, noted that, although she would never impose her spirituality on a patient, she was "comfortable discussing her own beliefs," if this seemed warranted. Maggie believed that there was definitely a "spiritual care" role for nurses "if you take the time to go a little deeper." She advised that the nurse has to observe and listen carefully to what a patient may be seeking, prior to any spiritual intervention, however. Her suggestion was, "Be attuned to the proddings of the Holy

Spirit." Maggie reported, "I have prayed with patients. The times I have felt good about a spiritual interaction [with a patient], I knew I was ministering."

Maggie described a specific instance in which she recognized the guidance of the Holy Spirit in her nursing ministry:

> I was working with a mom whose little girl was having some diagnostic tests and they didn't know what was going on and she was really worried. And when they were getting ready to transfer her, the mom came to me and said, "Are you a Christian?" And I said, "Yes, I am," and she said, "I thought you were. And I wanted you to know that you were an answer to prayer; because I prayed for a guardian angel during this hospital experience, because we didn't know what was going on and you were there for me, from the first day to the last.

Maggie concluded, "In those types of experiences I give credit to God; to the Holy Spirit. It was not me; I was just His instrument."

In commenting on the characterization of the Holy Spirit in St. John's Gospel, the ecumenical community of the Brothers of Taizé (Taizé Community, 1992) explained that we are not expected to actually see or experience the Spirit who dwells in us. "What is asked . . . is that we believe in the Holy Spirit, that we trust in Him, that we abandon ourselves to Him. Far from being another demand made on us, this call to faith sets us free" (p. 75).

The Day the Lord Has Made

Several nurses spoke of their gratitude for the spiritual ministry involved in their nursing practice. They saw it as a gift from God to whom they now gave thanks, as directed in Psalm 118:

> Give thanks to the Lord for He is good; His mercy endures forever. . . . The Lord is with me; He is my helper. . . . The Lord is my strength and my song. . . . This is the day the Lord has made; let us rejoice and be glad in it.

Margaret, a practical nurse with 16 years of experience who worked more recently with HIV and AIDS patients, asserted strongly:

> I may not discuss religion a lot but I couldn't do this work without my faith. I ask God to help me and then I can be calm. Prayer is important to me and seeing God in the smallest of things; in the miracles of flowers and birds. To deal with AIDS I have to do this. . . . I am so grateful to God for all that He has given me. I look at the trees in the morning and say, "this is the day the Lord has made." That's what will get you through.

Evelyn, an LPN with extensive experience working with mentally and physically challenged adults, also described her perception that each day was a day to give thanks for serving the Lord. "There is no separation of my day-to-day nursing and my spirituality. I live with it 24 hours a day; prayer in the morning, prayer at night. Each day is a gift of God. I'm not always conscious of it. I think it's like living prayer. It's all the time." Evelyn related her conscious awareness of the spiritual dimension of nursing to when she did hands-on care:

> I don't get to do as much "hands on" as I would like but when I do it's such a gift. I'm so grateful. There is something so holy. You say, "This person is

completely dependent upon my hands and my compassion to be cared for." It's seeing Christ there.

Crying for More

Repeatedly, nurses' comments reflected their perceptions of patients' spiritual hunger for God, their need for spiritual care and healing, even if not articulated in theological terminology. In his classic book *Reaching Out* (1975), Henri Nouwen observed that increased sophistication of the healing professions has resulted in depersonalizing the "interpersonal aspects" of the work (p. 92). Caregivers often are forced, by the demands of their jobs, to "keep some emotional distance to prevent over-involvement with . . . patients" (p. 73). Thus, Nouwen advised that "the healer has to keep striving for a spirituality . . . by which the space can be created in which healer and patient can reach out to each other as fellow travelers sharing the same broken human condition" (p. 93).

Anna, a doctorally prepared nurse educator who has worked with students in the clinical medical–surgical area for more than 28 years, expressed concern about patients' spiritual needs not being met:

> People have psychological and emotional needs, but deep down they have real spiritual needs; they are crying for more. . . . I think it's a real gap in our nursing practice; we get so caught up with the technology, there's no time for theology. There are times in life, especially when you're ill, when you really need spiritual support. . . . I try to get the students to see the whole person. They often don't get to that; especially the values, beliefs, religion. If we're going to look at the whole person, you have to include spirituality.

In the preface to her classic spiritual allegory *Hinds' Feet on High Places*, Hannah Hurnard (1975) reminded us that, as the Song of Songs expresses, there is in each human heart a cry for more, a desire for a deeper union with God. "He has made us for Himself, and our hearts can never know rest and perfect satisfaction until they find it in Him" (p. 11).

Needing Ventilation

Related to the concept of patients' spiritual "cry for more," is that of a need to verbalize spiritual and theological concerns and anxieties in the presence of a caring and supportive listener. Allowing a patient to tell his or her story was a concept that emerged frequently in discussions. Emotional pain, often long held at arm's length, may emerge vividly when the physiologic component of one's persona has been wounded. Defenses may be at an all-time low; this is a time when important healing can begin. Nouwen (1992) asserted that old wounds can only be healed by allowing them out of the dark corners of "forgetfulness." Caregivers must "offer the space in which the wounding memories of the past can be reached and brought back into the light without fear" (p. 23).

Karen, an ICU nurse with 30 years of experience, spoke at length about her intensive care unit patients' need to talk about their old anxieties and fears, especially related to the topics of illness and death. She recounted that when physicians suggest the administration of tranquilizing medication to calm patient anxieties, she reminds the staff that the patients "need ventilation, not sedation!" Karen, as ICU head nurse,

directs her staff nurses to "sit down and hold their patients' hands: Be open to listen; it's a humbling and rewarding experience." Karen advises, "It's OK to say nothing!" And she encourages the staff to do continual assessments of their patients' spiritual needs. She also teaches that "It's OK to cry with patients; crying is not a weakness. This may validate the patient's legitimacy in ventilating anxiety through tears."

During periods of illness or physical debilitation, a patient's latent emotional stresses may surface, generating responses such as anxiety and feelings of loneliness and alienation. It is important, as demonstrated by the nurses' anecdotes, that these stress responses be ventilated.

Praying a Lot

Prayer is as unique as the individual who prays. Whether one's prayer is of petition, adoration, reparation, or thanksgiving, both the form and the content may vary greatly. A few generalizations about prayer, however, can be offered.

The term *prayer* means "a petition or request": "Although the word may be used to mean a petition made to anyone at all, its customary use is . . . more particular, made to God or some holy person reigning with God" (Wright, 1993, p. 764). Some methods of prayer identified by Jesuit John Wright (1993) include "vocal prayer," which employs a specific word formula; "mental prayer," which is more of a conversation with God; "discursive prayer," which is led by one's reason; "affective prayer," in which love, joy, or other emotions may predominate; "meditation," in which one considers different aspects of God's activity; "contemplation," which involves a "simple gazing" lovingly upon God; "centering prayer," in which one contemplates God at the center of one's being; "mystical prayer," which is led by God's grace; and finally, "private" and "communal prayer," the latter consisting of a group of worshippers praying together (pp. 773–775).

In relation to the theme of Nonverbalized Theology, the majority of practicing nurses admitted that prayer, in some form, was an important part of their lives. Mark, a baccalaureate-prepared 8-year nursing veteran working with HIV/AIDS patients, reported that his personal faith was critical to his nursing practice:

> I have strong faith. I truly believe that God puts you where He wants you. God tests us as Christians and as nurses. You become friends with your patients; it hurts to lose them. I pray a lot; I can't do what I do without a lot of prayer. . . . Some AIDS patients feel guilty and not worthy of healing; they are afraid that God won't hear their prayers. I tell them that God does not punish illness. I tell them to pray.

And a long-term critical care nurse spoke about prayer in the midst of technology:

> Critical care nurses have to deal with a lot of technology; but the beauty of technology is that after a while it becomes so rote that you can do it without thinking. Once you've got the moves down, I think it is quite possible for you, in the midst of a "Code," while you are pulling up drugs, to pray for that patient, to pray for whoever is making the decisions, to pray for the families who have to cope with whatever happens.

Although most of the nurses interviewed admitted that they did not often speak about theology or spirituality with nursing colleagues, it was definitely an underlying theme related to their practice. Frequently, at the end of the discussions, nurses offered

such comments as, "At first, I didn't think I had much to say, but I really enjoyed talking about these spiritual things"; or "I do give spiritual care but I don't often take the time to think about it, or talk about it." The latter seems an excellent reflection of the overall theme of Nonverbalized Theology.

Nursing Liturgy

The third and final concept supporting the research-derived construct of the nurse as an anonymous minister is labeled Nursing Liturgy. Anecdotes describing creative nursing behaviors involving worship related to spiritual care of patients and families abound in the transcripts of the Spirituality and Nursing discussions. The term *liturgy* is broadly understood as relating to rites or rituals associated with public worship; the word *liturgy* is derived from the Greek, *leitourgia*, meaning "the work of the people" (*The Liturgy Documents*, 1991, p. xiv). In its early pre-Christian use, the term was understood to mean any public activities undertaken to promote communal well-being (Collins, 1990, p. 592). Christian usage focused the word's meaning on "the public worship of the Church" (p. 592).

Nursing Liturgy is conceptualized here as consisting of communal, worship-related, spiritual care activities carried out by nurses in the context of their professional practice. In its broadest meaning, the term *communal* may include worshipful interactions of the nurse–patient dyad only; that is, a nurse and patient praying together. The latter activity constitutes liturgy, for, as noted in Scripture, "Wherever two or three come together in My Name, I am there among them" (Matthew 18:20). Key concepts reflective of the Nursing Liturgy theme include Healing Rituals, Experiencing the Divine, Touching the Core, Being Present, Midwifing the Dying, and Privileged Moments.

Healing Rituals

The term *ritual* is derived from the Latin word *ritus*, meaning "structure." "Ritual is understood as a social, symbolic process which has the potential for communicating, creating, criticizing, and even transforming meaning" (Kelleher, 1990, p. 906). Madigan (1993) noted that "Religious rituals, like social rituals, are intended to be formative and expressive of personal and communal identity" (p. 832). Madigan asserted that, essentially, "Religious rituals are symbolic actions that unify the doer with the sacred" (p. 832).

In relating instances of what they perceived to be "spiritual care," many nurses described poignant worship-associated "rituals" that provided healing to both patients and caregivers; several discussants labeled these "graced moments."

Cathy, a pediatric nurse clinician with 15 years of experience, much of it in the area of pediatric critical care, told a touching story of the "liturgy" that she and two other staff members created to mark the passing of an anencephalic newborn.

> The baby, a "preemie," had lived for a couple of weeks, but there were so many congenital anomalies that there was no hope; so the family signed the papers to terminate life support. The parents just couldn't be there, though, so we decided to plan something. It was a very young neonatologist, it was really hard on him, and myself, and the peds ICU head nurse. We came into the NICU [neonatal intensive care unit] at about 5 am on a Saturday, when there weren't a lot of staff around. We took the baby into a separate little

> isolation room and discontinued the vent and the IVs, all the life support systems. And then we prayed and we sang hymns and we just held her and loved her until she died. It was her special ritual to go to God, and we shared it with her; that baby gave a lot to us, too.

Julia, a master's-prepared nurse educator with 22 years of experience in medical–surgical and ICU nursing, described a nursing ritual she had created for her students on completion of their clinical experience:

> At the end of the semester I wanted to do something special for the students, to acknowledge their gifts and their talents in caring for patients. It was to provide some type of rite of passage that they were finished with their clinical. I called it an "anointing of the hands"; it was a "blessing with oil." I would explain that oil is healing and say something specific to each student about her gifts as I rubbed the oil on her hands. As I was massaging the oil into the palms of their hands, I would describe their giftedness and their talents in terms of who they were. I would bless them in the name of the Lord. After I had been with them for 15 weeks, I could make the prayer specific to each one. It was acknowledging the sacredness within them. Some students would cry.

Megan, a doctorally prepared nursing administrator with 27 years of experience in hospital care, described what she labeled a "para-liturgical" service, during which she also conducted an "anointing of the hands." In this liturgy she anointed and blessed with oil the hands of her hospital's medical interns at their closing assembly of the year. Megan prayed over each young physician as she did the anointing. She reported that many were close to tears during the experience.

The symbol of anointing has always had a special place in the care of the sick. Oil is used sacramentally as a sign of healing and provides comfort for those who are ill and their loved ones. The concept of anointing the sick is found repeatedly in Scripture, for example, Mark 6:13. "And they cast out many demons, and anointed with oil many that were sick and healed them." Cunningham (1990) suggested that any "anointing" of a person may result in "a change in the person physically [health, strength, fertility] or in the relationship one has with the community" (p. 21).

Several of the nurse educators teaching in schools of nursing reported that they began their classes with a ritual of prayer or spiritual meditation. Frequently these rituals were nondenominational in order to include all of the students present. One nursing faculty member explained, "At the beginning of each class I give about a 2-minute spiritual reflection. One day, when we started into some questions about an exam without doing it, the students stopped me and said, 'Aren't we going to pray today?'"

Experiencing the Divine

The majority of practicing nurses indicated having at some time experienced God through interactions with their patients. For some the experience was conscious and ongoing; for others "critical incidents" highlighted a sense of experiencing the divine in a patient. This varied to some degree according to age and nursing experience, with more than a few nurses explaining that the longer they practiced their profession, the more "tuned in" they became to the presence of God within; this occurred in regard to both themselves and their patients. One nurse observed, "I feel like this kind of

caring, this kind of experiencing and caring for God in your patients, is like going to church; it's a worship experience."

Julia, with her 22 years of experience in nursing practice, commented, "Nurses are always involved in spiritual care but they don't talk about it; they don't put a label on it" (as reflected in the theme Nonverbalized Theology). She went on to identify some nursing encounters that she perceived as reflecting spiritual experiences in nurse–patient interactions:

> I remember the first time that I ever experienced the divine in another person, in the woundedness of an individual. It just happened. It was an unattractive little old man who was drooling and unable to feed himself. His name was Tom. He seemed repulsive to me. He wasn't pleasant to look at and couldn't even respond to you. But I was caring for him and all of a sudden I thought, "Oh, this is what is meant by Christ within. Christ is present within this man who I initially saw as repulsive." . . . This was a graced moment for me. It was like a quiet kind of awakening; it was parallel to a faith experience!

Touching the Core

As a dimension of the dominant theme of Nursing Liturgy, several nurses spoke about the unique nature of the relationships developed in providing spiritual care for those who are ill. This was true whether the interactions consisted of formal spiritually oriented rites or rituals or more informal types of behaviors, such as praying with patients or discussing spiritual needs or concerns. Repeatedly the concept of depth in nurse–patient interactions related to spirituality emerged from discussion data; nurses spoke of the special opportunity to relate to patients intimately at a time when they are particularly open and vulnerable. This was perceived as a rewarding experience for the caregiver as well as for the patient.

Kinast (1990) asserted that in spiritual ministry to the sick "the deepest and richest human experiences are those which are shared between persons" (p. 9); that is, those in which the minister is able to touch the heart of another person.

Barbara, a doctorally prepared nurse educator with 23 years of experience in the area of pediatrics, commented that "Nursing is much more important than what you are doing [technically] to people; healing takes place just by being with people, by touching their spirituality. A gift to us as nurses is to be able to touch the core of someone."

Barbara's concept of touching the (spiritual) core, or holy place, of another is supported by a description of ministry to those living with HIV infection, in which a caregiver labeled his patient interactions "holy places we share when we have time together" (O'Brien, 1992, p. 99). The caregiver continued, "There is an incredible sweetness in being with these persons [with HIV], even when they are very ill and death is imminent; it gives one the incredible sense of 'holding a sacredness'" (O'Brien, p. 99).

Being Present

Barbara also spoke about the concept of being present, which she perceived as "integral to the spirituality of the nurse–patient relationship." Barbara described being present as the idea of "listening with a loving heart." She affirmed, "I don't know how you can relate to somebody, to be with them in their loneliness, without that dimension."

Holst (1992) highlighted the loneliness of being ill in his discussion of the hospital as "paradox." Although, he noted, privacy is rare, "there can be an eerie loneliness in the midst of all those human contacts" (p. 6). This is, in part, related to the fact that, although advanced technology is devoted to carefully monitoring disease, the person experiencing the disease may be neglected. Technology, Holst (1992) observed, makes us "more preoccupied with the heart as a pump, than with the heart as the seat of emotions" (p. 7).

This paradox is also addressed by James Nelson (1976) who asserted that fundamental to a patient's healing process is the presence of caring persons in the health-care facility. "Caring," Nelson added, "is an active attitude which genuinely conveys to the other person that he or she really does matter. It is different from wanting to care for another in the sense of making that person dependent on us. Rather it involves a profound respect for the otherness of the other" (p. 63). To take the concepts of presence and caring a step further, Henri Nouwen (1991) observed that the basis of caring ministry, the point at which ministry and spirituality touch each other, is compassion (p. 33). "Compassion," Nouwen continued, "is hard because it requires the inner disposition to go with others to the place where they are weak, vulnerable, lonely and broken" (p. 34). This, he added, is not our natural response to suffering; we generally either desire to flee from it or to find a "quick cure" (p. 34). In so doing, however, Nouwen argued "we ignore our greatest gift, which is our ability to enter into solidarity with those who suffer" (p. 34).

Many other project participants highlighted the importance of being present to patients in their suffering.

Pat, a baccalaureate-prepared critical care nurse with 3 years of experience, observed that in providing spiritual care "You have to have intuition beyond the psychological. We're the ones right there at the bedside. You can be the facilitator, find out what the patient and family need spiritually, just by being present."

Kathryn, a master's-prepared psychiatric–mental health nursing administrator with more than 30 years of experience in nursing, noted that "Taking care of the sick is a ministry in and of itself. The idea of ministering and really being present to people helps me to see them as whole individuals, and my own spirituality leads me to see the individual through the eyes of Christ."

And, Diane, a master's-prepared operating room nurse with 19 years of experience, described her conceptualization of being present to her OR patients by praying for them during surgery. "Especially when open-heart surgery patients are in the OR, on the 'Pump,' and we are literally touching their hearts; that's the time when I especially pray for that patient." Diane added, "I serve God through being present for my patients."

Midwifing the Dying

In his article "Religious Approaches to Dying," Anglican Father David Head (1994) reminded us that "Death is integrated as a concept into religious belief systems, and also the religious belief systems integrate death and life" (p. 306). For many "religious" people the beliefs surrounding death "may be comforting" (p. 305). Their tenets often include such concepts as "the transitory nature of the state of death" and "entry into an unknown mystery that is congruent to human experience" (p. 305).

In ministering to a dying person, the caregiver must understand not only the patients' beliefs and feelings about death, but his or her own as well. Niklas and Stefanics (1975) pointed out that if a caregiver is "not in tune with his feelings [about

death], they become a weapon or a barrier preventing the dying person and his family from expressing their feelings, or cause him to lack appreciation of the feelings that are being expressed" (p. 114).

Although a number of nurses spoke about the importance of being present to their patients and their families during the death and dying experience, two actually described themselves as being like midwives helping their patients to be "born into a new life." One was Jan, a master's-prepared medical–surgical clinician with 21 years of nursing experience, a significant portion of which involved working with terminally ill patients. She observed, "I help patients to 'cross-over' in the last few days. Part of our job is being like midwives in assisting people in getting to that next state, to their new life in God. We are not only nurses and spiritual caregivers, we are family."

And Sarah, a peds oncology nurse with extensive experience in dealing with death and dying among children, related a special midwifing experience:

> I just got a letter at Christmastime from a family of a little boy who died about 5 years ago. And it was such a precious experience for me; how I bonded with him and with the family. When he was dying we picked him up and we held him and prayed with him and sang to him, and I felt like a midwife; that was really a gift. Being a midwife; it was like helping him to be born into eternal life. You feel so humbled and so privileged just being a part of it.

Sherrie, a master's-prepared critical care nurse with 15 years of experience, described her privileged experience in working with a family whose baby died shortly after birth:

> This was a gift for me and I hope I helped the family. We spent a lot of time with [the baby] in the 3 days before she died. We dressed her and held her and sang to her. I told the family, "We are all God's angels and some of us He wants back with Him sooner." . . . God had a special role for that baby. In the 3 days' time this baby gave and received more love than you will ever know. . . . It's a gift to us to be with anyone who is so close to being with God, to be with them in this special time of transition from this life to a new life.

Privileged Moments

As noted earlier, gratitude for the opportunity for spiritual encounters with patients emerged frequently as a theme in the Nursing and Spirituality discussions. Our nurse project participants reported a multiplicity of privileged moments related to spiritual care interactions with patients. A number of these are evident in the comments and anecdotes already presented. Especially touching are those related by Mary, Daniel, and Sarah.

Mary, a master's-prepared community health nurse with approximately 16 years of experience, most of it in hospice care, described her perception of spiritual care:

> Nurses should never force their spiritual beliefs on patients. . . . Just sitting with a patient, especially one who is dying, I think that is very much spiritual care. . . . Being a hospice nurse is so humbling; it's such a privilege. As hospice nurses, people really take us into their hearts. We have the opportunity to be with people during that time of life transition. We are connecting with

the very depth of a person who is facing death. And when they actually pass on, that is a very privileged moment to share with them.

Daniel, a 25-year nursing veteran, also spoke about the privilege of working with patients close to death:

> I have always felt so privileged to work with patients in the final chapter of their lives on earth because it is such a rewarding experience. It is the tremendous privilege of being there. You try to do things that the patient is comfortable with. I remember especially the time I was caring for Mark; he was terminal with AIDS and he wanted me to take him upstairs to the bathroom. So I got him up there and then I thought, "Now, how can I get him back down?"; getting him up had been challenging enough! And I just said, "Well, Mark, I think the best thing is if you just get on my back." And I carried him that way, and it was really a privileged moment, like a mystical experience, I guess. It was like carrying Christ, a really powerful experience. . . . In situations like this you see yourself as merely an instrument through which God's love is present in the life of the suffering person. It's a mystery to us but it's through grace that I am here and can do what needs to be done in order to make God's love and compassion present to this person in his time of need. . . . We don't usually think of this consciously but there are times when it raises our consciousness, to be used by God, like when I carried Mark down the stairs.

Finally, Sarah related a poignant story that she described as a special and privileged moment with one of her small oncology patients:

> Timmy was very disfigured with basal cell sarcoma and he hated to have his blood drawn. He usually screamed and his mom cried, so I'd started praying when I drew it; we prayed together. And so one day we prayed, and I got right in and got the blood, and Timmy was very happy. And it was the first time he had really made a connection with me. So he came into the utility room with me to help label the tubes, and he picked one up to put on the label and dropped it; and it shattered all over the floor. And I thought, "Oh God, how could you have let this happen after we all prayed?" But when I talked to the doctor he said that we could do without the blood that day. But Timmy felt really bad, and as a result, I spent a lot of time with him, and when they went to leave, I went over and hugged and kissed him; that was the first time that we really had connected like that. Since that time Timmy, when he comes in, always runs up and we hug and kiss. And, I realized that God was really working in our lives that day, except maybe not in the way I expected; that hug was much more important than the blood getting drawn. When God reveals something like that to you it is a very privileged moment.

The Mysticism of Everyday Nursing

The comments of Mary, Daniel, and Sarah, like those of other nursing practitioners reported in the previous pages, exemplify a concept identified by theologian Karl

Rahner as the "mysticism of everyday life." Rahner contended that "the human person is 'homo mysticus'—one who experiences God because of an orientation to God rooted in the way God has made human nature" (Egan, 1989, p. 8). In Rahner's mind "everyone is at least an anonymous mystic" (p. 8). Egan observed that for Karl Rahner nothing about day-to-day life was "profane": "Wherever there is radical self-forgetting for the sake of the other . . . surrender to the mystery that embraces all life, there is . . . the mysticism of everyday life" (p. 8). Rahner's concept might appropriately be translated to read: the mysticism of everyday nursing.

Throughout this chapter members of the professional nursing community have, through their anecdotes and reflections, demonstrated themselves to be not only "anonymous ministers" but also "anonymous mystics." This is evidenced by the many reports of tender care and compassion provided for patients. Although contemporary nurses, whether practitioners, educators, administrators, or researchers, generally do not consciously think of themselves as either mystics or ministers, the data, as exemplified in their attitudes and behaviors, warrant the use of both labels. These findings indeed explain why at least one author has called nursing "the finest art" (Donahue, 1985), why nurse authors Joanne Widerquist and Ruth Davidhizar have described nursing as "ministry" (1994), and why mysticism and ministry may truly be considered integral dimensions of everyday nursing.

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