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Fundamental or Foundational Obligation?

Problematizing the Ethical Call to Spiritual Care in Nursing

Barbara Pesut, PhD, RN

Spiritual nursing care is increasingly being cited in the nursing literature as a fundamental ethical obligation. This obligation is based upon the argument that nurses provide holistic care, spirituality is a universal dimension of the person, and so nurses should care for the spiritual dimension. However, the literature on the spiritual dimension in nursing illustrates widely differing foundational assumptions about this important aspect of care. The philosophic categories of humanism, theism, and monism can be used to illustrate the different understandings of the spiritual dimension, and the implications of these understandings for the competence of the nurse and the nature of the nurse-patient interaction in the context of spiritual care.
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UNTIL the last 2 decades, spiritual care was a vital, but somewhat invisible, aspect of nursing care. Typically, it occurred unobtrusively at the bedside between patients and nurses for whom spiritual or religious needs were particularly important. Certainly, it was not a prominent area of discussion or debate in the mainstream nursing literature. That has now changed. Spirituality and spiritual care have entered the mainstream, and the literature in this area has burgeoned. Wright's argument about the ethical responsibility of nurses to care for the spiritual needs of patients is now widely accepted.[1] Healthcare policy documents[2] and accreditation criteria[3] are recognizing the spiritual dimension of healthcare. Although some nurses responsible for delivering the care might not agree with such a mandate, or might feel uncomfortable implementing it, there is general consensus in the literature that it is an essential part of care. The argument for spiritual care generally goes as follows: the spiritual is a universal dimension of the person; healthcare disciplines have a responsibility to provide holistic care; therefore, healthcare workers have an ethical responsibility to provide spiritual care, the neglect of which would be neglecting a fundamental obligation.

One of the semantic transitions that facilitated this argument was the redefinition of religion and spirituality in the literature. Although traditionally religion and spirituality were indistinguishable, the conceptual separation between these 2 terms has been increasing. One of the seminal nursing articles to make this distinction was published by Lane in 1987.[4] In her article on the care of the human spirit, she identified 2 types of spiritual care, one characterized by specific beliefs of the nurse and the patient (ie, religious) and one characterized by more

From the Department of Nursing, Trinity Western University, Langley, British Columbia, Canada.

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Corresponding author: Barbara Pesut, PhD, RN, Department of Nursing, Trinity Western University, 7600 Glover Rd, Langley, British Columbia, Canada V2Y 1Y1 (e-mail: pesut@twu.ca).

universal needs such as connecting and transcending (ie, spiritual). This semantic separation of religious needs from spiritual needs spawned a number of other articles drawing the same distinction,[5–8] and indeed in almost all the literature, except that produced by certain theistic writers, this separation remains to varying degrees. Religion has been relegated to beliefs and institutional forms while spirituality is characterized by universal terms such as transcendence, connectedness, meaning, and energy.[9] McSherry and Cash[10] refer to this as the blanket approach to spirituality because it has the tendency to cover everything, but in doing so tends to suppress distinctions. Nevertheless, such a broadly inclusive approach allows one to argue that all individuals have spiritual needs that should be attended to in the context of healthcare.

However, are understandings of the spiritual and spiritual care really that homogenous in the literature? Does this universal, somewhat undifferentiated definition of spirituality mean that there is general agreement on the nature of the spiritual in the nursing literature? In a recently completed doctoral dissertation, the works of 9 nursing theorists who have written extensively on the spiritual in nursing were analyzed to answer this question.[11] Theorists studied were Ann Bradshaw, Judith Allen Shelly, Mary Elizabeth O'Brien, Elizabeth Johnston Taylor, Aru Narayanasamy, Margaret Burkhardt, Rosemary Parse, Jean Watson, and Barbara Barnum. The philosophic categories of theism, monism, and humanism were used to categorize and to critically reread this literature. This literature on the spiritual in nursing can be distinguished on 7 dimensions: the foundational assumption of the origin of the spiritual; the nature of persons; the nature and scope of nursing in relation to the spiritual; the characteristics of the nurse-patient interaction; how nurses become competent in spiritual care; how knowledge of the spiritual is acquired or constructed; and the relationship of the spiritual to ethics. Although there is some commonality in this literature, there is no universal consensus on the spiritual or spiritual care. This is not surprising given that the nature of the spiritual has intrigued philosophers for centuries. Which naturally leads to the question of what we are advocating for when we claim the ethical necessity of providing spiritual care?

Before nursing can make a claim about the ethical responsibility for spiritual care, a number of more foundational questions should be asked. What do nurses mean when they use the term spiritual care? Are nurses competent to provide spiritual care in the context of this understanding? What power relationships characterize the nurse-patient relationship in this approach, and are these appropriate given the nature of the spiritual? The philosophic categories of theism, monism, and humanism can be used to illustrate the potentially different approaches to the spiritual and spiritual care in nursing literature and the ethical implications of these approaches. However, first it is important to acknowledge some of the limitations of such a categorization. Categories while useful in helping to organize and understand different perspectives are by their very nature limited. Paul Tillich has made this point well:

> The establishment of types, however, is always a dubious enterprise. Types are logical ideals for the sake of a discerning understanding; they do not exist in time and space, and in reality we find only a mixture of types in every particular example. But it is not this fact alone which makes typologies questionable. It is above all the spatial character of typological thinking; types stand beside each other and seem to have no interrelation. They seem to be static, leaving the dynamics to the individual things, and the individual things, movements, situations, persons (e.g., each of us) resist the attempt to be subordinated to a definite type.[12(pp54,55)]

And so, although the philosophic categories of theism, monism, and humanism are used to represent the various perspectives, it is important to note that few theorists writing in this area would neatly fall into one category. Furthermore, there is both overlap between categories and diversity within categories. Some theorists blend elements of all 3 perspectives, and there is a great deal of

variability among theorists within a particular category.* Hence, rather than trying to essentialize theorists within a category, it is more important to understand the range of variability that occurs within this literature in general, as Thorne has advised in a recent editorial on the role of conceptualization in nursing: "I believe that our theoretical project ought to be motivated toward the goal of deeper reflection and expanded critical interpretation, not defining, constraining, or concretizing ideas."[13(p107)]

WHAT IS SPIRITUAL NURSING CARE?

At face value, the answer to this question might seem simple. Nurses identify the spiritual needs of their patients and seek to meet these needs. However, whether spirituality should be considered in terms of human needs[14] or whether intervention in the area of spirituality is appropriate[15] is a matter of debate. Furthermore, understandings of nursing intervention in the realm of the spiritual varies widely. This diversity is illustrated in a chapter by Simington in a recent Canadian textbook on nursing ethics.[16] Simington defined *spirituality* as the capacity to live fully and described the nursing role as one whereby nurses have an ethical responsibility to advocate for the removal of barriers to full living. Her exemplars of spiritual care included supporting a dying patient who chooses alternative rather than conventional treatment, allowing a dying mother to hold her baby, and listening to an elderly person's life review. The exemplars represent enabling patients to live their choices to the ultimate extent possible, a role that nurses have always fulfilled. However, there is another dimension to spiritual care that she addressed in the chapter, that of soul healing. "In addressing soul pain, we must be able to move beyond the boundaries of religion and culture, beyond the boundaries of our limiting filtering system. We must expand our paradigm, our consciousness."[16(p477)] Simington has advanced training in this area and describes a number of interventions such as visualization, guided imagery, and energy and dream work that she uses to help heal the souls of patients. When considering spiritual nursing interventions, there is a vast difference between simply advocating for patients' spiritual choices and actively intervening to heal patients' souls.† The categories of humanism, theism, and monism can be used to illustrate some of the differences in these understandings of spiritual care.

Probably the most familiar approach to spiritual care is that of humanism. Persons are viewed as multidimensional beings of which the spiritual is one dimension characterized by needs such as transcendence, connectedness, meaning, and purpose. Although belief in God may be part of an individual's spiritual dimension, no such belief is necessary. Spirituality is a universal human dimension, just as pertinent for atheists as for religious individuals.[17] The foundational assumption of such an approach is that individuals subjectively define what is spiritual for them. Spiritual care then seeks to uncover what is important to the patient in terms of spirituality and to address these concerns. Spiritual care within this understanding is often articulated through the nursing process. Nurses assess the spiritual needs of patients, formulate clinical diagnoses, and seek to intervene toward some goal such as spiritual well-being. This nursing process approach is common in the spiritual care literature.[18,19]

The theistic approach to spiritual care starts from the underlying assumption that the origin of the spiritual lies not in the

*This is actually an interesting characteristic of this literature. Some theorists blend worldviews freely while others argue that worldviews are logically incompatible. This debate is similar to one that has pervaded the nursing science discussion in other areas.

†For a more extensive discussion of the interventional role of the nurse, see Pesut and Sawatzky.[15]

individual but in God who is both the creator and the sustainer. Humankind has been created to live in a covenantal relationship with God, and ultimately health and well-being are found in the context of this relationship. As a response to the goodness of God, humans seek to be good to one another. Nursing then is considered vocational service to humankind, and ultimately to God.

> The nurse's service to her [sic] fellow man, from this theological perspective, is a privilege in which the tasks of washing, feeding, dressing, toileting and cleaning away excreta are of no less value than the highly technical procedures, for they are sanctified and consecrated because they preserve the person and personhood of the sick individual as the creature of the covenant.[20(p304)]

Spiritual care, rather than being an intervention for a particular dimension, is an ethic and motivation of care that pervades all aspects of care.

The monistic approach to spiritual care may be less familiar, but one that is gaining in popularity and influence. Monism assumes that the universe consists of one unified substance.[21] For nursing theorists writing from this perspective, this unified substance is often characterized as energy. Humans are part of an indivisible, universal consciousness that transcends space and time. Well-being and health are often framed in terms of ascending into a higher consciousness or human becoming. For example, Watson, citing her article with Smith,[22] provided the following assumption as the basis for caring science:

> [Caring science] makes explicit an expanding unitary, energetic world-view with a relational human caring ethic and ontology as its starting point; once energy is incorporated into a unitary caring science perspective we can affirm a deep relational ethic, spirit, and science that transcends all duality. As this thinking evolves, we open to the infinite, which invites the sacred to return to our professions and science.[23(p28)]

Spiritual care from this perspective emphasizes attention to that which transcends the physical restrictions of space and time. Interventions may include the energy-based forms of healing such as Therapeutic Touch, Healing Touch, or Reiki Therapy.

So, what are nurses agreeing to when claiming to have an ethical responsibility for spiritual care? From the humanistic perspective, it is an interventional approach to care for spiritual needs; however, the individual would define these needs. From the theistic perspective, it is an ethic and motivation for care rooted in an understanding of a sovereign, relational God. From the monistic perspective, it entails attention to the universal consciousness whereby nurses facilitate growth and healing through that consciousness. What this demonstrates is how intricately related spiritual claims are to claims about the ontology of nursing, particularly those claims that suggest that the ontology of the discipline is found in shared understandings of what it means to be human.[24,25] Many of nursing's philosophic claims related to the meta-paradigm concepts of environment, persons, nursing, and health are claims about the nature of reality, and hence traditionally have been the concern of spiritual and religious discourse. How then should nursing be considering these claims? Is it useful to adopt a single worldview and to create normative claims for nursing around that perspective?

I argue that to adopt any single view would fail to do justice to the needs of the diverse society that nursing serves. There is an inherent ethical tension between constructing claims in hopes of unifying the discipline of nursing and ensuring that nursing worldviews adequately represent the views of patients. There has been a tendency in the spiritual care literature to construct a spiritual discourse that represents a preferred vision for the evolution of the profession, a vision that may not always be congruent with what research has suggested patients want from nurses in the area of spiritual care.[26] The perpetual temptation of nursing will be to adopt a normative disciplinary discourse as it relates to the nature of the spiritual to serve disciplinary ends, particularly during a time when nursing continues to struggle to define its ontology. The discourse of the spiritual can easily be co-opted to

provide a sense of disciplinary meaning and cohesion. However, nurses have a foundational ethical responsibility to ensure that spiritual care is constructed in such a way that precedence is given to preserving the dignity and choices of patients to maintain their own diverse worldviews in the context of healthcare.

ARE NURSES COMPETENT TO PROVIDE SPIRITUAL CARE?

If nursing adopts the ethical mandate to care for the spiritual needs of patients, then a critical consideration is whether nurses are competent to assume this role. One can appreciate from the previous discussion of the various views of spiritual care that competence might look quite different from these perspectives. From the humanistic perspective, spiritual care can be taught much the same way that other dimensions of care are taught. Nurses are not required to have any particular spiritual belief to become competent in this aspect of care, only an underlying understanding and sensitivity to this dimension. An example of this approach is Narayanasamy's[27] ASSET model for teaching spiritual care. In this model, students are taught basic understandings of spirituality, undergo self-awareness training, and are introduced to spiritual care using the nursing process. Students use structured assessment guides, clinical diagnoses, goals, interventions, and evaluative criteria. An assumption of this perspective is that all nurses should be able to learn spiritual care, regardless of personal spirituality or beliefs.

With the theistic emphasis on spiritual care as an ethic and motivation for care, the character of the nurse becomes central to competence. How nurses engage on a moral and interpersonal level with patients becomes more important than learning to assess and intervene spiritually. Generally, the more mature nurses become in their spirituality, the more effective they will be with patients. Bradshaw[28] has argued that the ability to provide spiritual care must be caught rather than taught. Students learn to provide spiritual care by having this ethic of care modeled by their instructors. It is not necessary for the nurse to embrace theistic assumptions to provide this type of ethical care because the principles remain true whether the source of these principles is acknowledged or not.[20] Competence is also gained through an understanding of the theological principles that inform the meta-paradigm concepts of nursing, health, humans, and the environment. Although Bradshaw[20] emphasized the sharing of love rather than the giving of doctrine in her approach, other theistic writers have emphasized the importance of sharing their faith in the context of care. For example, Shelly and Miller encouraged practitioners to learn practical theology, which included "knowing how to share their faith, how to pray with patients and read Scripture appropriately, how to listen to the Spirit as well as the patient."[29(p253)] From the theistic perspective, competence is based upon applying theological concepts in an ethic of care.

The monistic preparation is similar to the theistic approach in that it is based upon a foundational way of viewing the world (eg, unitary or energy), and the development of the nurse within this worldview is central. Parse[30] has proposed a curriculum plan through which nurses are prepared within the human becoming school of thought. This curriculum seeks to ensure that nurses are well rooted in the philosophic principles that form their unitary understandings of humanity. If the proposed interventions include an emphasis on soul as opposed to body work, Barnum[31] has suggested that nurses should be in an advanced state of spiritual preparation. Energy-based interventions such as Therapeutic Touch, Healing Touch, or Reiki Therapy have not traditionally been within the scope of nursing practice and so achieving competence is potentially problematic. Few nursing education programs offer standard curriculum in energy-based forms of healing. Many of these therapies have roots in ancient societies where the roles of the priest and the healer were often combined[32,33] and where these

individuals received extensive spiritual preparation for their healing role. This linking of the sacred and the healing roles means that we must consider what basis we would use for determining what constitutes an appropriate spiritual journey, both for ourselves and our patients.

So, how practitioners are prepared for spiritual care will depend upon understandings of what this care entails. From a humanistic approach, spiritual care can be taught like other aspects of the nursing curriculum. From a theistic approach, spiritual care is modeled as an ethic and service of care. Theological knowledge informs foundational understandings of nursing's meta-paradigm concepts. From a monistic approach, the nurse should be well established in the philosophy or worldview that informs the approach. This illustrates how potentially problematic competence is in the area of spiritual care. What is so intriguing about this literature is how quickly nurses have adopted the call to spiritual care with relatively little consideration of competence. Although competency is being considered in the theoretical literature,[34,35] preliminary research suggests that nursing education programs in general provide insufficient preparation[36,37] and that many nurses feel inadequately prepared to provide spiritual care.[38] In other areas of practice, nurses have traditionally been highly conscientious about competence. Why would nurses be so willing to pick up an aspect of care for which there is so little preparation? Part of the answer to this question may lie in the need for nurses to recover a sense of meaning in their work. Watson[23] has suggested that nursing as a profession is broken and that its survival is at risk. Carson and Koenig[39] have suggested that the profit-making emphasis in healthcare has resulted in a diminished sense of meaning and purpose for healthcare workers. An emphasis on the spiritual, both for nurses and patients, provides some promise for recovery of that meaning.

There is general consensus in the spiritual care literature that the more spiritually mature the nurse is, the more effective he or she will be in this aspect of care. But what occurs in nursing education to promote spiritual maturity? The development of spiritual maturity is recognized within all faith traditions to be a long and arduous process, requiring both devotion and discipline. Indeed, the oversimplification of the spiritual development process seems a particular challenge. Its dimensions were recently exemplified for me in a nursing journal advertisement, in which the components of a 3-year course on integrative energy healing for nurses were promised within a compressed format of four $4\frac{1}{2}$-day retreats. It leads one to wonder whether therapies that have roots in ancient spiritual healing traditions should be taught in a fast-tracked, condensed format. Clearly, competence in these spiritual aspects of care extends beyond the traditional realm of nursing action, and as such requires more careful consideration. Nursing cannot claim an ethical responsibility to spiritual care without clearly delineating what that care entails and then ensuring that every nurse receives adequate preparation to fulfill that responsibility.

WHAT POWER RELATIONS CHARACTERIZE THE NURSE-PATIENT ENCOUNTER DURING SPIRITUAL CARE?

The final question for consideration is what power relations characterize the nurse-patient encounter during spiritual care, and are these appropriate given the nature of the spiritual? Although understandings of the spiritual vary widely, Smith in his book *The Concept of the Spiritual: An Essay in First Philosophy* suggests that "spirit is, by consensus, an invisible suprapersonal reality that decisively affects the perceptions, intentions and actions of persons."[40(p44)] By implication, the spiritual is a force or power that produces an effect. Recognizing this, it is important to consider how nurses use this power within the context of the nurse-patient relationship, and to what end.

The use of the nursing process is common within the humanistic approach. Care

begins with an assessment of the patient's spirituality. Assessment tools vary with some being oriented toward what has traditionally been considered religious indicators[41] and others oriented toward more existential indicators.[19] Patient self-evaluation is fundamental to most assessments, although the nurse is also expected to observe behavioral cues such as restlessness or anxiety, which might indicate spiritual distress. The patient subjectively evaluates his or her spiritual state, but there are also objective criteria that characterize spiritual well-being. For example, Narayanasamy has stated that "the person who has attained spiritual integrity demonstrates this through a reality-based tranquility or peace, or through the development of meaningful, purposeful behavior, and a restored sense of integrity."[19(p1144)] This statement suggests that there is some objective spiritual reality by which the nurse can make a judgment about the patient's spiritual state. But, what if the patient does not evaluate his or her spiritual state in terms of tranquility or purposeful behavior? For many patients, the work of the spirit is dynamic and mysterious, not something that can necessarily be understood or explained. Indeed, within many faith traditions it is common to experience "dark nights of the soul" where spiritual growth is characterized by less positive emotions. For the nurse to assess and make judgments in this area may be perceived as both intrusive and objectifying.[15]

The theistic theorists generally take a service rather than an interventional approach toward spiritual care. Theoretically, this approach should attenuate some of the issues of power in the relationship. However, how this unfolds depends upon how nurses view their role in the context of the relationship, particularly as it relates to the goal of proselytizing or converting someone to a particular doctrinal position. For example, Bradshaw[20] has clearly stated that patients must be free from ideological pressure from the nurse. The nurse-patient relationship in her work has been characterized by mutuality, partnership, and authenticity, and the nurse's role as one of unself-conscious service. In contrast, Shelly and Miller[29] have taken a more evangelical approach in their writings on spiritual care. From their perspective, nurses have a moral responsibility to share the good news of their faith with patients, even though this may not be particularly comfortable for patients. The patient experience in the context of these contrasting understandings of spiritual care could be quite different. Using potentially vulnerable times to influence patients toward particular doctrinal understandings of spirituality is ethically problematic.

However, introducing energy-based forms of healing, which are characteristic of some of the monistic approaches, may be just as ethically problematic. This risk is particularly high if nurses do not realize that for some patients these therapies are not value neutral. Those from certain theistic traditions may consider the energy-based therapies as spiritually unhealthy.[29] Practitioners may fail to realize that in introducing these therapies without ensuring they are congruent with the patient's worldviews they are potentially introducing a spiritually harmful treatment.

Michel Foucault revealed how power, and in particular our discourses of power, tend to create subjects.[21] Nursing's discourse around the spiritual in nursing care has this same potential to create subjects and to influence the power dynamics that occur in the nurse-patient relationship. Nurses can view patients as subjects who need to be influenced toward some particular spiritual endpoint, or nurses can view patients within a perspective of mutuality, acknowledging that many patients bring significant spiritual expertise and capacity. As nurses hold a position of trust with potentially vulnerable patients, it is vital to question where our care might be experienced as spiritual coercion. Berlinger[42] has outlined key questions that physicians should consider in the context of spiritual care, questions that should be asked by all healthcare workers. Do healthcare workers have the right to condemn spiritual practices they consider unhealthy? Should healthcare workers be promoting spiritual practices that they consider

healthy? Where do healthcare workers introduce their own dogmas into care? Careful consideration of these questions will help to reveal the areas where our spiritual discourses may be creating unhealthy relations of power.

CONCLUSION

In light of the various understandings of the spiritual and spiritual care, nurses need to be cautious about uncritically picking up the ethical call to spiritual care. Differing understandings of the spiritual and spiritual care have important implications for nurse competence and for the experience of patients in the context of that care. The tendency to adopt a generic perspective of spirituality that fails to maintain distinctives must be replaced by a deeper engagement with various worldview understandings of the spiritual, worldviews that represent how patients negotiate the spiritual and religious meanings of their health and illness experiences. Careful consideration needs to be made of how the spiritual discourse is creating nurses and patients as subjects. Does it foster a sense of mutuality, recognizing that both nurses and patients may bring spiritual maturity and resources to the encounter? Or, does it place nurses in a position of expertise that potentially exacerbates the position of vulnerability that patients encounter all too often in healthcare? Nurses must critically consider their ability to provide competent care within the diverse perspectives. It is not enough to claim that we have an ethical responsibility to provide spiritual care and then to consider competence post hoc. Before nursing can adopt the responsibility of spiritual care as a fundamental ethical obligation, questions about the foundational nature of spiritual care, what constitutes competence, and how that care is languaged in terms of relationships of power need to be reflected on more deeply. It is paradoxical in this discourse that those who seem to hold the deepest understanding of, and reverence for, the power of the spiritual are perhaps the least likely to assume that nursing could and should feel competent to intervene on its behalf.

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