

NURSES: 21ST CENTURY EVANGELISTS?

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Abstract: This article discusses the outcomes of a doctoral study into why nurses are asked to give spiritual care to patients. Tensions between bodily nursing care and spiritual care were explored in semi-structured interviews with eighteen experienced nurses. Interview materials were interpreted within feminist frameworks of caring and spiritualities as patriarchal constructions rooted in Christianities. Themes of nursing care described as spiritual demonstrated that body/spirit dualisms persisted despite secularisms. However, since spiritual care remained a confused and nebulous concept, how the addition of spiritual care by nurses will remedy the stresses and distressed described in the study is questioned.

Key Words: caring, feminist, gender, nurse, religious, spiritual, suffering

Introduction

The doctoral study investigated why nurse are asked to give spiritual care to patients by exploring the tensions between bodily care and spiritual care (Grosvenor 2005). Bradshaw (1994) argued that competent nursing was sufficient to meet patient need. Waugh/Ross (1992/1994) and a subsequent dominant discourse on spiritual care by nurses argued that nurses need to give spiritual care in addition to bodily nursing care. The studies by Bradshaw and Ross, together with feminist spiritualities and theologies, provided the theoretical framework for analysis and interpretation of material from semi-structured interviews with eighteen experienced practising nurses within central Scotland.

The meanings of spirit and spiritual care for nurses and nursing

Spirit and spiritual: what are they?

Whilst fifteen (83%) of the nurses in the study were not practising Christians, all had religious backgrounds and many of them described the spiritual as distinct in some way from the body. They believed in the existence of such a thing as 'spirit,' however defined. These included a religious spirit or soul and contemporary notions of spirit as 'self', 'essence', 'person', 'it' or something other than material bodily life. However, they did not think helping patients

with meaning, purpose and fulfilment was their role in spiritual care. Indeed, they actively recoiled from the idea. Apart from specific cultural/religious needs, which may be grounded in ethical and cultural practices, spiritual care by a nurse was seen in terms of caring about how a person feels regarding their illness, treatment, and impending loss of life; being with patients, especially in times of distress, and developing therapies such as therapeutic touch.

Time talk and teamwork

There are several interrelated factors in giving such care regardless of whether it is called 'spiritual', 'intimate personal', 'holistic' or given any other label. One is that time needs to be allocated for this area of care. It takes time to listen and time to respond thoughtfully. As many of the nurses indicated, lack of time meant they were already unable to attend adequately to existing bodily care needs. Significantly, when nurses told me about what they and patients valued about hospital chaplains it was that they were perceived as having the time to talk with the patients, whereas nurses were continually occupied with treatments and other practical care-giving. Time to talk with those patients who need or wish to do so was recognised as essential to care across all specialities. However, whilst such subjective or personal care should be included, it is important that it should not devalue or displace practical,

physical bodily nursing care. As Bradshaw (1994) argued, patients derive great comfort and peace of mind from competent compassionate nursing care.

Spiritual care by nurses as a gender issue

The frequency with which nurses agreed that patients need spiritual care, allied to their enthusiasm for it, belied a deeper, underlying dissatisfaction with their experiences of nursing. Although they all spoke positively of nursing people as patients, they frequently spoke negatively and sometimes, indeed, vehemently, against the systems and structures of care within which nursing was practised. These twin aspects of the nurses' experiences can be said to have gender aspects. This can be argued from two views. Firstly, that nursing care is gendered as women's work and secondly, that the nurses in the study had unconsciously absorbed the dualistic hierarchy of values where spiritual care was perceived as both superior and important

Gendered caring, patriarchy and spirit-mind/body dualisms

Gendered roles are described as socially constructed expectations of men and women associated with the biological categories *male* and *female* (Walby 1990). The social construction is said to be due to patriarchal power and authority of a master over his subjects, especially women, children and subordinate males, "*backed up by an appeal to the sacred*" (Turner 1996: 148). It is literally 'rule of the fathers', which both as a word and a socio-cultural force is said to have roots which are inextricably connected with Christian traditions (King 1997). The argument is that as God is male, males are also believed to have God-like powers that create a false consciousness of worshipping masculine values (Daly 1983). This results in androcentric or man-centred world-views, which are said to have developed out of dualisms of spirit/body. Carol Christ (1979) argued that women who are part of a culture dominated by patriarchal ideas and religion continue to be dominated by these values subconsciously, especially when under stress, even if they have consciously rejected these in favour of secularism or other belief systems. Pateman (1988) argued that patriarchal values become part of the cultural psyche as 'fraternal' patriarchy that permeates social, economic, political, ideological and psychological aspects of individual and social life. Masculine

domination of values is internalised so that people become 'docile bodies': whilst they appear to choose such values voluntarily they are, in fact, passively dominated into acceptance (Bordo 1990). Consequently, secularism does not necessarily liberate women, or others, from masculinist, patriarchal power and, indeed, it is argued that women continue to be psychologically dependent and subordinated to male authority and men because this is woven into the fabric of the culture (Hampson 1990 1996). This includes social constructions of caring and those who are carers, both in private and in public.

Caring work taken for granted in private and in public

Caring is said to be 'taken for granted,' or hidden, in social institutions such as marriage and the family where it is considered instinctive and therefore 'natural.' (Hochschild 1983, Sydie 1987). It is women as mothers, daughters, wives, grandmothers and friends (Lister 1997) who give everyday practical care of children, spouses, the sick and elderly. Such care is borne out of love and affection, duty and obligation (Graham 1984 Leonard & Speakman 1986), in addition to sustaining the physical, social 'kith and kin' and community fabric of life (Gerstel & Gallagher 2001).

Nursing as gendered caring work

Several nursing authors have linked hidden or invisible caring to gender. Lawler (1991) found nurses had no word(s) to describe their knowledge and experiences of caring for the intimate, physical needs of the body. Similarly, innermost care, as "emotional labour" (Smith 1992) or "intimacy" (Savage 1995) has been largely unarticulated in nursing. This raises very important questions. Why did the nurses call intimate or personal care nursing care 'spiritual'? I suggest this is because of the dominance of dualistic ways of thinking in Christianised societies, itself related to gender. This means that the material body and its various interrelated care needs are considered to be separate and even inferior to 'higher' care needs such as the spiritual/rational.

Not only was the real work of nursing care hidden, unexpressed, and even inexpressible - typified by remarks such as *how do you describe the care you just GIVE to the patient?* - it was further complicated because what was competent nursing care was now being called 'spiritual' care by my study participants. Whilst describing nursing care they con-

sidered to be spiritual, the essence of this care was competence, compassion and beneficence, given in a spirit of mutual humanity. Included were virtues of kindness, presence and being with patients in times of their distress, as well as technical abilities. Such virtues are already well-recognised characteristics of nursing (Bradshaw 1994, Campbell Gillett & Jones 2001, Tschudin 2003 et al). 'Spiritual' care was perceived as overcoming, or rebalancing, the constraints of bio-medical treatments identified by participants in the study. There was thus a mismatch between what experienced practising nurses considered spiritual care to be, and the type of spiritual care which the dominant authors, following Waugh/Ross (1992,1997) argue is imperative for nurses to learn.

But would providing additional spiritual care be a help to nurses, nursing or patients? From the evidence of the study I suggest it is not, for nurses need to be empowered to articulate the needs of patients, as well as their own needs for more humane relations. As one study participant said:

How badly we are looked after...that is why nursing staff after a time and after a fashion have very little of our own reserves left to then care for people, because nursing staff I have met have always come in with the best intentions...you start to tire, or burnout can they be expected to have loads of reserves to still do that, and that's when I do think washing the hair becomes a task, a proper task - I've got Mrs Jones to get up next...that's where you get the niceness in your job - and it's a crap job at the end of the day cos you know you are in a pokey wee room you know.

Conversely, however, as noted by Jantzen (1995), far from becoming assertive about their own and others' needs, the mark of a truly spiritual person is to be meek, submissive and humble, by saying prayers and reading Holy Scriptures as authoritative in life. These in turn produce a meek, calm, submissive person:

It is clear that while a person may use these daily readings as a basis for daily meditation may well find herself calmed and encouraged, it is unlikely that they will provoke her to think hard about the social cause of her stress, let alone about the ways in which the structures of capitalist society produce the stresses she feels. (Jantzen 1995, p.20)

In more contemporary mode, When (2002) wrote that the vogue to seek solace in crystals was anti-rational and anti-Enlightenment where searches for 'inner wisdom' were

...an expression of inner despair by people to improve their lives and [who] suspect that they are at the mercy of secretive impersonal forces [...] much the same function that Marx had attributed to religion – the heart of a heartless world, the opium of the people. Far better for the powerless to seek solace in crystals [...] and the myth of Abraham than in actually challenging [...] the social and economic systems. (When 2002, p.193)

Accepting that spiritual care is what patients or nurses need could be said to be continuing to submit to powerful hegemonic religious authority, whether this is traditional or contemporary dualism. It is a way of dealing with material problems that ultimately are only likely to achieve yet more silence about real life concerns. Such concerns require material action rather than passive spiritualising of the issues. What nurses seemed to me to indicate they want and need is time and resources to give whole person care, which includes the needs for understanding of the inner self or person, as well as the bodily needs for nourishment and other activities of living or dying. But personal care is not what those who argue for spiritual care by nurses have in mind. They view spiritual care as a further care category, seeing it as transcendental to bodily needs (Ross 1997 et al). This has as its root the ideas of spirit or soul developed in Christianities. One reason for this, I suggest, is the decline in church membership and parallel growth in alternative approaches, which includes individualistic, consumerist spiritualities, often loosely called 'New Age,' or contemporary alternatives to traditional religious beliefs and practices: spirituality has become the new religion in a secular age (Heelas 2005). This has the effect of diminishing the numbers with church connections that impacts on the work of religious ministers, including hospital chaplains. Coutts (2001), for instance, wrote that the growth of interest in spirituality in the domain of health is "*an exciting time for chaplains*" (p.1) which suggests that there is a correlation between the two factors I have just identified: namely, that if people do not have church affiliations before they are ill or dying, then those involved in giving them health care can encourage them to have spiritual care since, if this is included

in everyday nursing assessments it will become part and parcel of nursing care and patients, when weak and vulnerable, are highly likely to agree to it. This raises questions about professional boundaries, competencies, trust and ethics. On the other hand, it could mean that chaplains are excited because spirituality has become such a buzzword that nurses will be alert to 'inner' needs of patients. In such a scenario, nurses might well involve chaplains in patient care when otherwise they may be more inclined not to see spiritual need in secular patients.

But this begs the question of what spiritual care is in the first place. If 'spirit' is the breath, *ruah*, of Genesis myths of the Hebrew Bible or the contemporary electrical energy, which enlivens the material body, then it could be said that nurses by caring for the body in competent manner fulfil their professional requirement. If, however, there is an immortal substance soul or spirit, separable from the body and destined for life eternal in transcendental spiritual realms, however described, then it is questionable if such important and complex concerns could or should be within the competencies of a nurse.

Trust and ethical issues

If patients trust nurses to give them the care they believe is necessary for recovery or a peaceful death, they may feel it is normal to have spiritual care even if they would not normally believe in 'spirit' or 'spiritual' when strong and well. As Tschudin (2003) observed, when people are patients they are in vulnerable situations and as such are easily influenced by outside factors such as family and friends. A nurse has a great deal of power over patients since patients trust him or her. This is particularly so with weak and powerless patients, who may be elderly, demented, confused or dying. I argue that adding spiritual care as a specific category of care to everyday nursing practice would make it normative. If a nurse appeared with a clip-chart to ask about a patient's spiritual needs, in much the same way as she does about bodily needs and functions, and asked if the patient found God a help (Stoll 1979), as every person has a need for Him (Fawcett & Noble 2004), then this could create a power dynamic where patients believe that spirituality is important for recovery or dying. Nurses have a duty to ensure that this does not happen and that they do not impose their own beliefs or non-beliefs, on vulnerable patients, whilst at the same time ensuring that those patients

who wish spiritual or religious/cultural care do receive it (NMC 2004).

Suffering and grounding care by nurses

Suffering: meaning, medicine and management issues

Several nurses said that coping with their own feelings when faced with individuals who were ill and suffering had overwhelmed them to the extent that they could not face going to work. In addition, several spoke of unsympathetic or hostile management, as well as less than pleasant working environments, that resulted in them wishing to leave nursing. Given that those affected are often the most sensitive nurses, whom patients would wish to care for them, it seems to me that nebulous spiritual care will not meet nurses' needs for more humane relations with managers and work-place surroundings. Here, justice and emancipation issues come to the fore. The human heart of understanding and sympathy also needs to be developed and maintained. Nurses need support with facing suffering every day as many nurses in the study described.

Whilst the nurses recognised the importance of intimate personalised nursing care, particularly with dying people, they almost all identified distress to themselves and patients when they were prevented from giving the care they felt best qualified to do. *I felt robbed of the ability to practise*, said one participant.

Often this included 'simply' being with a patient to share their distress; ensuring they were comforted and adequately supported when a bad diagnosis was given. By 'being with' such patients, comforting them in their anxiety and distress, communicating painful diagnoses and treatments to them in the face of poor information and objectifying medical approaches, as well as in their specific nursing care competencies, nurses demonstrated that they know well enough what patients need. As one nurse said emphatically *I had the skills already*. However, these skills are subordinated to the demands/approaches of medicine, to the detriment of patient care and nursing satisfaction.

Allied to the idea of nurses doing 'being with' others who are suffering is that of human benevolence towards others. This teaching is at the heart of all hu-

man cultures and religions. The Chinese character for benevolence depicts, in a single brush stroke, out-stretched arms (Mace 1996). In Judeo-Christianities there is the central teaching of loving your neighbour as yourself and of God suffering with us, though in nursing and life this is grounded, or embodied, in human flesh, both in sufferer and nurse. Many of the nurses described spiritual care as being human, warm and comforting in the face of cold technical treatment environments, and this is how they understood spiritual care.

Conclusion

Why then should nurses give spiritual care to patients? I suggest that it may be because a minority of people whose beliefs in a transcendental spiritual God compel them to believe all people have spiritual needs. Such people would have nurses become the unwitting Christian evangelists of the twenty-first century.

Doyle (1996) said we should not interfere with people's spiritual needs, even supposing we, or they, knew what these were, since we may well do more harm than good. Those who want or need priests will seek them. Nurses, however, need to be able to practise the art and science of nursing. However whether that is a spiritual service of love to fellow humans, or a practice in need of loving attention from others, remains an interesting question. It is worth asking ourselves seriously, as did Doyle (1996):

...do we have as much right to involve ourselves with spiritual issues as we have with psychological and psycho-social suffering? (p. viii)

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