Nursing's Mission: Spiritual Dimensions of Health Care

Rosemary Donley
ESSAYS

NURSING'S MISSION: SPIRITUAL DIMENSIONS OF HEALTH CARE*

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Any discussion about nursing's mission and the spiritual dimensions of health care must be placed within the context of medical specialization and the high technology health care system which developed in first-world countries after the Second World War.

The American health care system is blemished by concerns about quality of care,1 inadequate measurement of care outcomes,2 a serious nursing shortage,3 limited public accountability of health professionals,4 escalating costs,5 and significant loss of trust.6 What factors contributed to the erosion of nursing and, perhaps, of the health care system itself? The growth of

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1. It is not possible to read a contemporary publication on health care without encountering concern with quality. See generally Haffner, Jonas & Pollack, Regulating the Quality of Patient Care, in Hospital Quality Assurance: Risk Management Program Evaluation 3 (J. Pena, B. Rosen, A. Haffner & D. Light eds. 1984); Maraldo, The Nineties: A Decade in Search of Meaning, 11 Nursing & Health Care 10 (1990).

2. Institute of Medicine, Effective Initiatives: Setting Priorities for Clinical Conditions (Washington, D.C., 1989).


medical specialization and the infusion of large amounts of federal money into the health care system need to be examined in this analysis. The passage of the Medicare law supported medical and hospital insurance for persons over sixty-five and provided funds for hospital construction. Medicare stimulated advances in medical and informational technology because its fee-for-service payment system encouraged the use of tests, procedures, and treatment itself. During the mid-sixties, the federal government also increased its support for the education of doctors, nurses, and allied health workers. Medical education was redirected to produce physician-scientists and specialists. Nurse educators adopted the baccalaureate degree in nursing as the credential for entry into professional nursing practice and developed master's-level clinical specialist training in common medical specialties. By the seventies, hospitals were modern temples of science where highly specialized, scientific medicine was practiced. In the eighties, business interests joined, and perhaps competed, with scientific and medical interests. The medical-industrial complex which evolved had as its goals the creation of the perfectly healthy person and the making of money. Today, people expect that their diseased organs will be replaced and that disability and death will be postponed. Physicians, administrators, investors, and the federal government are preoccupied with the "bottom line."

During this period of rapid change, the so-called non-profit hospitals lost their quasi-religious character. Scientific medicine brought with it the values of technical rationality. Hospital administrators and doctors, supported by sophisticated, computerized data bases, demanded information which could be quantified and models of treatment which could be scientifically evaluated. Doctors acted like scientists, businessmen, or entrepreneurs. Nurses were also co-opted by the glamour and power of high technology nursing. As some of the art and most of the mystery of healing were lost, it became clear to nurses, and to others who worked in hospitals, that they were part of a technical money-making system, not a "sacred system." High technology medicine, the insatiable demand for more and better technology, and cost-containment have made health care uneven in quality, less human, and very expensive.

Other social forces have contributed to the loss of traditional values. The

10. Andreoli, supra note 8, at 66.
11. See generally E. GINZBERG, AMERICAN MEDICINE: THE POWER SHIFT (1985); P. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982); Donley & Flaherty,
women's movement had a particular impact in hospitals, where the division between the powerful (board members, administrators, and physicians) and the relatively powerless (nurses and support personnel) also coincided with the division between men and women. The failure of the current system is most frequently attributed to problems of access and limited funding.

Because the crisis in health care is one of meaning and values, spirituality and the nursing mission will be examined from the viewpoint of a suffering person. This viewpoint is consistent with traditional nursing values. Joyce Travelbee suggests that concern for those who suffer is at the core of the nursing ethic because "the professional nurse practitioner assists an individual, family, or community to prevent or cope with the experience of illness and suffering and, if necessary, to find meaning in these experiences." 12

Some researchers report that nurses with spiritual values helped patients give spiritual meaning to their suffering. 13 Others find evidence of failure to care for suffering persons, exemplified in negative descriptions of avoidance, emotional distancing, and the development of a "character armor." 14 The spiritual dimensions of nurse-patient relationships are important at a time when the medical and nursing professions and the health care system itself emphasize material and technical values. Many Americans live longer because of better nutrition, a higher economic standard of living, earlier diagnoses of illnesses, and access to better, less invasive treatments. 15 However, the American lifestyle does not, in itself, prepare persons to face loss, sickness, disability, and death. Recombinant technologies, organ transplants, "miracle" drugs, and the skill of physicians and nurses postpone, but do not eliminate, death. Actually, the application of high technology medicine may intensify suffering and contribute to the burden of illness. Technology has also led to a form of clinical submission to an imperative that abdicates deci-

13. See J. FICHTER, RELIGION AND PAIN 55 (1981); Soeken & Carson, Study Measures Nurses' Attitudes About Providing Spiritual Care, HEALTH PROGRESS, Apr. 1986, at 52; M. Mathai, Spirituality in Relation to Nurses' Perceptions of Their Own Coping Strategies When Patients Are Perceived to Be Suffering (Apr. 21, 1980) (EdD. dissertation available in Catholic University of America School of Nursing Library and Teachers College, Columbia University).
sionmaking and choice. Because of this abuse of technology, many older persons end their days in intensive care units, alone, surrounded by life-supporting and -sustaining machines. Persons have new ways to die. Doctor John Hansen-Flaschen suggests that we have re-created a primitive ritual, a mamba, where persons die slowly and with great torture.

Pope John Paul II noted in his apostolic letter, The Christian Meaning of Human Suffering, that suffering is a subjective experience. Eric Cassell commented that persons who experience suffering, exemplified in pain, perceive this suffering to be "a threat to their continued existence—not merely to their lives, but to their integrity as persons." Because suffering can be dehumanizing, care givers must be aware of the need to counsel those forces which, when left unchecked, diminish the spirit.

I. APPROACHES TO SUFFERING WITHIN THE CHRISTIAN TRADITION

Within the context of the modern health care system, an understanding of the spiritual dimension of the nurse's role with suffering persons will be examined. Three distinct understandings of suffering exist within the Christian tradition. They are (i) compassionate accompaniment or being with the suffering person, (ii) giving an interpretation to the responses and causes of suffering, and (iii) acting to alleviate suffering and its causes. Each of these approaches was evident in Pope John Paul II's address to the participants at an international conference on AIDS held in Rome, November 1989, where he said, "Do not feel that you are alone, the Church is with you; the effort to give meaning to your suffering is a precious call; at your side . . . are the scientists who are struggling to subdue and contain this serious disease."

The first spiritual response is compassionate accompaniment. Because some knowledge of the suffering person is necessary before interpretation or mediation can occur, philosophers and theologians rely on illness narratives drawn from literature or case studies. Although the work of nursing...
Nursing's Mission brings its members into direct contact with human suffering, presence does not ensure compassion. The spiritual response to the problem of suffering requires the “other” to enter into the reality of suffering so that a sense of communion and solidarity with the sufferer develops. In the Christian tradition, this response of sensitive accompaniment is called compassion. The compassionate person need not offer meaning or alleviation. Rather, the “other” offers a quiet sharing of the experience and helps the person to sustain the burden of suffering. There are Catholic chaplains and nurses who continue to be committed to the basic Christian task of simply accompanying those suffering in pain. They are motivated by the belief that, through their presence, the suffering person may experience the presence of the Lord from whom nothing can separate us:

Who shall separate us from the love of Christ? Shall tribulation, or distress, or persecution, or famine . . . ? . . . No, in all these things we are more than conquerors through him who loved us. For I am sure that neither death, nor life, nor angels, nor principalities, nor things present, nor things to come, nor powers, nor height, nor depth, nor anything else in all creation, will be able to separate us from the love of God in Christ Jesus our Lord.23

To search for a meaning of personal and communal suffering is a second type of spiritual response. Questions arise about why a particular person suffers, why a particular suffering must be endured, or why suffering occurs at a specific time. There are several dimensions in this quest for meaning. Religious and philosophical reflections focus on “suffering” while the nursing and medical professions speak of “pain.” The relation between the two terms calls for some explanation. Pain, a human response to injury, is expressed physically, especially in the face. The philosopher Ludwig Wittgenstein wrote that grief is personified in the face.24 Suffering, on the other hand, exists as an inner condition of the person. “Pain” must be understood as a clinical manifestation of the mysterious inner reality called suffering. Doctor E.L. Edelstein’s interpretive analysis, paraphrased by substituting the word “suffering” for the word “pain,” reads as follows in this abstract of his speech before the International Bat Sheva Seminar on Pain Mechanisms and Therapy:

[W]e find a sequence from the stoic interpretation of [suffering] as pure illusion, to the Christian positive attitude toward [suffering] as a charisma of purification, to its metaphysical elation to the symbol of virtue with Novalis and Nietzsche down to its profane devaluation and depletion of any sense as a “malum” as such in

western society at present. Nowadays [suffering] is considered by people as a superfluous nuisance.25

Sacred Scripture also provides different levels of meaning for suffering. It is perceived as punishment, mystery, and redemption. In the Deuteronomic tradition, which is echoed by Job’s friends in a book named after him, suffering is punishment for sin.26 In this framework, familiar questions arise: Who is being punished?; Why is this person being punished?; Does guilt lie with the suffering person, with his ancestors, or with the community? When Job searched for the meaning of his plight, he argued with this teaching and insisted upon his innocence.27 God’s response to Job’s cries places the meaning of human suffering in the realm of mystery. The image of the suffering servant in second Isaiah comes closest to the Christian belief that suffering is redemptive—that is, a person who suffers for the good of the community shares in the redemptive sufferings of Christ.28 Dr. Eric Cassell, reflecting this interpretation, said: “In some theologies, suffering has been seen as bringing one closer to God. This ‘function’ of suffering is at once its glorification and its relief.”29 When suffering is endowed with the glorious role of bringing a person closer to God, the person experiences relief even when suffering itself remains.30

Another ancient tradition suggests that suffering is instructive, that a person will learn by suffering, and that suffering will bring about a reordering of personal values.31 In the nineteenth century, it was commonly held that suffering was integral to the healing process and essential to recovery.32

The third, and perhaps most dramatic expression of a Christian response to suffering, is action to remove the suffering itself. Passive endurance is not a Christian response. The New Testament records the active engagement of Jesus with persons who are blind, lame, and diseased. There is ample evidence that Catholic hospitals, physicians, and nurses are committed to the task of removing suffering and its causes, using all of the resources that modern medical technology provides. The “para-technological” movement is

29. Cassell, supra note 19, at 641.
also directed at the removal of suffering, as reflected in the revival of healing ministries and the charismatic movement.33 However, when a Christian response is reduced exclusively to action to remove suffering, there is a profound loss. Kenneth Vaux, working from within the Protestant tradition, has noted how Christians can become completely preoccupied with the removal of suffering and forget the meaning of suffering reflected in the sources of their tradition:

The Protestant patient in the hospital wants to get rid of pain by whatever means. "Cut it out," "blot it out," and "tranquilize it away" express this mentality. The piles of valium consumed each year in the industrialized culture created in the Puritan ethos attest to the great distance we have come from Calvin.34

We need to ask ourselves whether, within the Catholic tradition, there has not been a similar fascination with technological removal of suffering and its causes at the cost of exploring its meaning. The search for meaning need not compete with efforts to remove suffering. Persons who suffer should be enabled to find meaning in suffering through the assistance of health care professionals, like nurses, who can offer words that define the experience of suffering. This journey of spiritual accompaniment must be reincorporated into the process of physical healing.

True consistency may be achieved only with the removal of the social and political structures that lie at the root of much human suffering. Such action is a necessary extension of the commitment to remove suffering and its causes. Support for human life in all its dimensions is the most conspicuous and organized religious effort, under Roman Catholic auspices, of this kind in the United States.35 But just as technical intervention is incomplete without a spiritual vision, so too, political action is incomplete without the integration of a total spiritual response. Nurses need to be with people who suffer, to give meaning to the reality of suffering, and, in so far as possible, to remove suffering and its causes. Herein lies the spiritual dimensions of health care.

What happens to the efficacy of the Christian tradition when human effort, even heroic human effort, fails, when suffering cannot be overcome, or when structures which support violence, repression, and ignorance are sustained? In the Christian tradition, suffering is made tolerable by compas-

33. Fichter, supra note 13, at 50-51.
34. K. Vaux, Health and Medicine in the Reformed Tradition: Promise, Providence, and Care 54 (1984). Interestingly, the author traces this phenomenon to "Calvinist serenity" or "complacency in the face of suffering." Id.
sion, by prayer, by acceptance, by words that give meaning to what seems to have no meaning, by the realization that there is no shame in suffering, and by the transformational belief that suffering can bring about good for the person who suffers and for others.

II. APPROACHES TO SUFFERING WITHIN THE NURSING TRADITION

Nursing’s response to suffering persons runs parallel to the religious tradition: accompaniment, meaning-giving, and action. Presence at the bedside, a traditional value, is expressed by words as bedside nurse or “hands-on” nursing. There are literary, artistic, and historic accounts of nurses sitting with, and quietly comforting, suffering persons. Early literature depicts nursing as a calling. Nurses who see nursing as a vocation are comfortable in the realm of the spirit. Perhaps the image that best captures the metaphor of “presence” is the Angel of Mercy. Patient-centered norms have been institutionalized in staffing patterns as nurse-patient ratios and, more recently, as modes of delivery of nursing services: primary care, nurse-managed care, and primary nursing. Although concern has been expressed that the nursing shortage may create more obstacles to nurses’ being present to patients, the larger problem in acute care hospitals is that presence can be mistaken for passivity because modern health care includes such an array of interventions. Application of high technology can therefore diminish compassionate presence. Consequently, there is a need to examine (and reemphasize) the therapeutic and spiritual value of presence with all patients, even those with treatable illnesses.

The nursing profession has also been concerned with understanding and explaining the human experience of illness and suffering. Though authors who interpret the illness experience are familiar, recently, through the work of Madeleine Leininger, Jean Watson, and Patricia Benner, there has


37. See Woolley, Shortage Fallout, 3 J. PROF. NURSING 75 (1987).

38. See Allan & Hall, Challenging the Focus on Technology: A Critique of the Medical Model in a Changing Health Care System, 10 ADVANCED NURSING SCI. 22, 22 (urging nurses to reject the hyper-technical focus of the “medical model” of health care in favor of “ecological” and “process orientations” that support “nursing’s concern with health and quality of life”).

39. See Collins, When the Profit Motive Threatens Patient Care, 74 RN 74, 74-75 (1988).


been a rediscovery of caring as a framework for practice. Concern with de-
personalized care led the Commonwealth-Picker Foundation to study pa-
tients recently discharged from acute care hospitals. These persons and their
families were asked to report experiences around nine domains: education, com-
munication, emotional support, involvement of families, management of pain, physical care, preparation for discharge, respect for preferences, and
financial counseling. The goal of this research was to remind professional
care givers what patients and their families considered important and mean-
ingful, so that care delivery systems and professional behavior could be more
oriented to patients and their families.

Contemporary professional literature explains the problem of suffering
within the physiological and psychological parameters of disease and life sit-
uations. Intervention flows from these explanations. Pain must be man-
aged. Anxiety must be overcome or repressed with drugs. Hurtful
relationships are fixed or dissolved. Nursing literature and curricula, reflect-
ing the values of scientific medicine, generally overlook spirituality in dis-
cussing illness and its treatment. One nursing critique identifies spiritual
distress. In reviewing the periodic nursing literature from 1985 to 1990,
163 articles appeared under the heading of “spirituality.” Many of these
articles were authored by the same persons or appeared in The Journal of
Christian Nursing. Nurses who work on cancer services, with persons with
AIDS, or with the aged also write about the spiritual dimensions of their
practices. In these situations, high technology has less to offer these pa-
tients, their families, and nurses. Pamela Reed’s research with dying pa-
tients supports other findings that terminally ill persons do have spiritual
needs and concerns. Nurses concerned with holistic practice, mind-body-
spirit relationships, and transcendental meditation give import to the spiri-

43. Commonwealth-Picker Foundation Conference, Managing the Quality of Patient-Cen-
44. See Burnard, Spiritual Distress and the Nursing Response: Theoretical Considerations
and Counselling Skills, 12 J. ADVANCED NURSING 377 (1987).
45. See Wheeler, Shattuck Lecture—Healing and Heroism, 322 NEW ENG. J. MED. 1540,
1546; see also FICHTER, supra note 13, at 72-73.
46. Champagne, Spiritual Distress, in NURSING DIAGNOSIS AND INTERVENTION: PLAN-
NING FOR PATIENT CARE 954, 956 (G. McFarland & E. McFarlane eds. 1989).
47. See, e.g., Brooke, The Spiritual Well-Being of the Elderly, 8 GERIATRIC NURSE 194
(1987); Granstrom, Spiritual Nursing Care for Oncology Patients, 7 TOPICS CLINICAL NURS-
ING 39 (1985); Sodestrom & Martinson, Patients’ Spiritual Coping Strategies: A Study of Nurse
48. Reed, Spirituality and Well-Being in Terminally Ill Hospitalized Adults, 10 RES.
NURSING & HEALTH 335, 335 (1987) (confirming that terminally ill hospitalized adults pos-
sessed a greater “spiritual perspective” than non-terminally ill hospitalized adults).
tual in their practice.49 There is some evidence that a positive mental outlook, feelings of hope, and the experience of being loved and valued results in improved well-being.50 In an interesting report of the effects of psychosocial treatment (support groups for one year and self-hypnosis to reduce pain), researchers have shown that patients with metastatic breast cancer, whose medical therapy was supported by these interventions, lived, on average, nearly eighteen months longer than a similar group of patients who were treated only with a medical regimen.51 When reported in the mainstream literature, these findings were disconcerting because they did not fit the accepted paradigm. H. Brownell Wheeler discussed the phenomenon as follows:

[M]odern physicians are uncertain how to adjust to data that suggest that a wife's love and support can apparently reduce her husband's risk of angina pectoris, even in the presence of high risk factors for heart disease. We tend to dismiss sporadic cancer cures that appear to have been based on faith. We do not know what to make of a study in which the survival of patients with metastatic breast cancer was increased more than three times by self-hypnosis and weekly participation in an ongoing support group. Any new chemotherapeutic drug that tripled the survival of patients with incurable cancer would cause great excitement, but we do not know quite how to handle the fact that kindness, emotional support, and optimism have quantitative therapeutic activity.52

The establishment of departments of pastoral ministry within hospitals may also explain some of the inattention to spiritual concerns within the nursing and medical professions in the United States. Concern with science has led doctors and nurses to give up their roles as healers and spiritual counselors and to minister to the body with little attention to the spirit. The absence of systematic educational and literary attention to the spiritual dimensions of nursing practice contributes further to the loss of spiritual values within the profession.53

How would care of suffering persons be different if spiritual values were appreciated in contemporary nursing practice? Most of us know persons

49. Labun, Spiritual Care: An Element in Nursing Care Planning, 13 J. ADVANCED NURSING 314, 319 (1988).
52. Wheeler, supra note 45, at 1546.
who trace positive changes in the direction of their lives after near-fatal accidents or experiences with suffering. Usually these positive outcomes are brought about by compassionate persons who lighten the burden of suffering and offer a positive reinterpretation of the experience. Patients would receive more humane care if compassion and spiritual support amplified physiological and psychological remedies.

The reintroduction of spiritual values into the education and practice of nursing would go a long way toward restoring respect for certain categories of patients: the poor, persons of different races or cultures, confused, older people, persons ill with certain diseases like AIDS, or persons addicted to drugs or patterns of violence. These persons are often blamed for their illnesses or shunned because of age, race, cultural differences, or behavior. The spiritual dimensions of practice also provide a sense of worth, meaning, and comfort to nurses themselves. Embracing these spiritual values can serve as an antidote to a sense of powerlessness and alienation often called "professional burn out."

Compassionate presence, meaning-giving, and the alleviation of suffering have been presented as a paradigm for nurses' spiritual mission. Perhaps the ordering that makes most sense in our highly technical environment is an integration of action to remove suffering and its causes with compassionate presence and meaning-giving. Concern for the spiritual needs of ill persons fosters respect for human life and contributes an element of humaneness so painfully absent in "high tech" clinical environments. If nursing reclaimed its spiritual mission, abandoned in the quest for science and specialization, action to relieve suffering would transcend concerns with race, culture, disease, or the ability to pay for care. Concern with spiritual elements of care brings greater meaning to the work of nursing and a sense of participation in the realm of mystery and grace. When nurses, acting compassionately to alleviate suffering, also search with their patients for a spiritual meaning for the experience, there will be a rebuilding of trust in professional relationships. This restoration will have a positive effect on patients, nurses, and on the health care system itself.