CE 2.8 contact hours

By Elizabeth Johnston Taylor

Spiritual Care: EVANGELISM at the Bedside?

ABSTRACT: *News media stories about Christian nurses sharing religious beliefs with patients raise questions about ethical spiritual care and the appropriateness of sharing one's faith at the bedside. The purpose of this article is to explore the ethics of faith sharing in the context of Christian nursing and offer guidance for ethical spiritual care.*

KEY WORDS: *ethics, faith, nursing, spiritual care, religious beliefs*

In November, 2008, British registered nurse Caroline Petrie made a home visit to an elderly woman in Somerset, England. This was Caroline's first time meeting this patient. Caroline carefully completed the required wound care to the patient's lower extremities in 20 to 25 minutes. Before leaving, Caroline did what was natural and customary for her as a Christian: She asked the patient, "Would you like me to pray for you?" The patient declined the offer. Caroline respectfully did not push her offer and took her leave (Alderson, 2009; Wilkes, 2009). After Caroline left, the patient called Caroline's employer and reported that although the offer of prayer did not upset her, it could distress other patients. The employer, Britain's National Health Service (NHS) North Somerset Trust, immediately placed Caroline on leave.

This story received attention in the British press and continues to raise questions for nurses and healthcare organizations expected to support clients' spiritual health. After this public debate about the appropriateness of a nurse introducing religious beliefs or practices in clinical care, the North Somerset Trust released this statement:

> *It is acceptable to offer spiritual support as part of care when the patient asks for it. But for nurses, whose principal role is giving nursing care, the initiative lies with the patient and not with the nurse. Nurses like Caroline do not have to set aside their faith, but personal beliefs and practices should be secondary to the needs and beliefs of the patient and the requirements of professional practice. (Wilkes, 2009)*

The Trust later invited Caroline to return to work.

A similar case occurred at the Cape Cod Hospital in Massachusetts, hitting the press a few months later in early 2009. An American RN, Julie Peterson, was engaged in a conversation about religious beliefs with a dying patient she was discharging. She asked the patient if she could ask a personal question. After receiving "clear confirmation," she inquired about her beliefs in an afterlife. During this conversation, Peterson acknowledged that she responded to the patient's comment, "Christianity is narrow," with: "Yes, it is. If God were to be what the Bible represents then the access to him would be through repentance. Many other religions aren't so exclusive" (McCormick, 2009). The patient's

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family complained about Peterson's probing about afterlife beliefs, talk about "repentance" and so forth. The hospital discontinued Peterson's per diem contract.

We don't know exactly what transpired between these nurses and their patients and cannot (nor should we) judge what occurred. However, for the Christian nurse who takes Jesus' directive seriously to "Go everywhere and announce the Message of God's good news to one and all" (Mark 16:15, The Message), these stories create questions about the appropriateness of faith sharing at the bedside. Indeed, reading the next verse, "Whoever believes and is baptized is saved; whoever refuses to believe is damned" (verse 16) may create inner tension. How does the Christian nurse juxtapose an inner mandate to "preach the gospel" everywhere with a professional ethic for clinical practice that may caution or prevent such preaching? This raises an important question: Should spiritual care include Christians sharing their faith (i.e., "evangelism")? Might there be a possibility that the "good news" could be perceived as bad news when it is introduced by a nurse to a patient?

The purpose of this article is to explore the ethics of evangelism in the context of Christian nursing and offer guidance for ethical spiritual care. Jesus himself admonished the first Christian preachers (his disciples): "I am sending you out like sheep among wolves. Therefore be as shrewd as snakes and as innocent as doves" (Matthew 10:16, NIV). Jesus is recognizing in this

statement the need for extreme sensitivity and respectful gentleness; to be wise, speak the truth without being harmful; to be innocent and without falsity when witnessing about God's love. This advice is pertinent for Christian nurses who potentially can impose their beliefs on vulnerable patients.

ETHICAL FAITH SHARING

In a seminal discussion of the ethics of Christian evangelism, theologian Roger S. Greenway (1993) observed that "evangelism makes Christians vulnerable to a variety of charges ranging from spiritual arrogance and bigotry, to cultural and religious imperialism" (p. 147). Although this statement may frustrate an evangelistic Christian, it also encourages reflection on how sharing one's beliefs might be approached. Some Christian denominations have used healthcare as an entering wedge in communities to gain entrée so the gospel could be preached. Yet Greenway raised the question of whether healthcare or material assistance should be used as bait in a "bait-and-switch" tactic for evangelism, meaning something desirable is offered to get people's attention then a switch is made to reveal another (real) reason for bringing them in.

Responding to this need to consider the ethics of Christian faith sharing (indeed, to consider how the love exemplified by Jesus Christ can guide personal witnessing to God's love), Greenway proposed four principles for ethical faith sharing:

Reciprocity—maintaining a stance of mutual interest and equality. Reciprocity in faith sharing would mean allowing those listening (being evangelized) equal opportunity to share their ideas and win converts. For a nurse who has shared something about his or her religion with a patient, for example, it would mean allowing a patient to reciprocate and share his or her religious perspective.

Honesty—in not only the message, but in methods used. Evangelists should not use deception such as a bait-and-switch. For example, an evangelist trying to convert a person to religion X should forthrightly answer questions and explain not only the popular doctrines but also the difficult or embarrassing ones. For nurses involved in missionary work, are strategies misleadingly used to lure patients so that they can then be given religious instruction?

Humility—evangelizing without arrogance or condescension, otherwise such an approach would likely be self-serving, self-glorifying, and for personal gain. Helpful questions a Christian can ask during reflection include: What really is motivating my desire to share my religion? Is it ego (masked religiously as accomplishments for God)? Is it for some other personal gain, such as a reward or recognition at church? Is it a guilt-based desire to please God or earn salvation?

Respect for the person—appreciating that others are not objects to manipulate. Faith sharing must recognize that persons need freedom to make their choices. Evangelism that is coercive eradicates such freedom—and misrepresents God's love, which by nature allows humans freedom. (The story of how Jesus related to the rich young ruler illustrates this point well [Matthew 19:16-22]. Although it filled Jesus with sadness, he recognized this gentleman would reject a new understanding of salvation.) In a "Code of Ethics for Christian Witness," Doug Whallon (2005) offers eight points for ethical Christian witness. Whallon speaks of respecting the value of persons, elaborating "Respect for human integrity means no false advertising, no personal aggrandizement from successfully persuading others to follow Jesus, and no overly emotional appeals that minimize reason and evidence" (p. 17).

A dictionary definition of proselytize is "to try to persuade someone to change their religious or political beliefs or their way of living to your own" (Cambridge Advanced Learner's Dictionary, 2010). Many types of ideas, such as political opinions, scientific theories, diets, fashion, and so forth, can be proselytized. Advertisements try to convert consumers. Teachers try to instill new theories in students. Philosopher E. J. Thiessen (2006; 2011) has given considerable thought to the act of proselytizing, and cautioned that if proselytizing is to be done ethically, it should be done in a way that protects the dignity and worth of potential converts. Furthermore, if proselytization is done morally, it is actually an expression of care and respect for the other person (e.g., the proselytizer cares about others and wants to share with them what they have found helpful).

Proselytization is fundamentally about persuasion. Thiessen (2006) proposed a continuum of persuasion. At a gentle end of this continuum is education. While moving toward a more aggressive end of coercion, one passes through advisement and persuasion, as schematically illustrated in Table 1. Thiessen posited that *moral* proselytization is non-aggressive and noncoersive, whereas *immoral* proselytization is aggressive and coercive. Using this framing, sharing the Gospel in a manner that is void of coercion and non-aggressive would be moral. In contrast, using coercive, aggressive strategies (e.g., fear tactics, emotionalism, group pressure) would be immoral. These perspectives contrasting ethical and unethical faith sharing bring insight to Christian nurses about how the personal and professional should interact. Of course, for the Christian nurse, personal mandates received from God's Word—the Bible, and God's Spirit provide guidance as well.

Table 1.
THEISSEN'S (2006) CONTINUUM OF PERSUASION

WHAT IS "WITNESSING?"

How does the Christian nurse live life authentically at the bedside if that authenticity means the nurse witnesses of God's love? Before exploring guidelines for spiritual care that will allow for moral, ethical spiritual care, it is important to consider what preaching the Gospel or witnessing actually means. Theologians of different religious traditions and applying varying hermeneutic methods to interpret Scripture will make diverse conclusions, however common ground may be found in the following points:

Jesus never coerced individuals. His life, a model for the Christian nurse, exemplified authenticity, respect for self and others, and compassion for all. He was comfortable with not controlling others, with remaining tender in the presence of vulnerability, with being a servant-leader. Jesus was interested in the big picture of those to whom he offered healing. He was not just wanting people to start attending synagogue and asking them to keep all the *mitzvot* (Mosaic laws, religious rules). He yearned for a true conversion that was outside of current religious tradition. We have no record of how many baptisms occurred among those he "converted," and no indication of how religious most his followers became. Healing was a transformative experience that demonstrated the super power of a tender love—God's love.

Witnessing became the natural reaction to having been transformed by this love. Those who were healed by Jesus witnessed, they talked of Jesus' miracle in their lives. Those who saw the empty tomb witnessed to that sight. Those who saw the ascension of Jesus then witnessed to that event. Witnessing is a personal reaction to experiencing God.

Live peaceably and with integrity. In letters to early Christians, apostles urged believers (who knew they could be persecuted for their unique beliefs) to live peaceably with non-believers (Romans 12:18) and to earn others' respect by living life with integrity (1 Thessalonians 4:9-12). The Apostle Peter wrote: "Live such good lives among the pagans that, though they accuse you of doing wrong, they may see your good deeds and glorify God on the day he visits us" (1 Peter 2:12, NIV).

These observations may seem contradictory to biblical admonitions to go into all the world to preach the gospel and to apostolic examples of preaching energetically to thousands about Jesus' life, death, and resurrection. While further scriptural analysis is not the purpose of this article, these biblical accounts provide insight about what is Christian witness.

ETHICAL GUIDELINES

Given these biblical insights and contemporary perspectives on ethical evangelism, what can guide nurses who want to share their religious beliefs or practices with patients? A Christian ethicist Winslow and Christian nurse Wetje-Winslow (2007) offer the following guidelines for providing ethical spiritual care that help answer this question:

To give respectful care, seek to know client spiritual needs, resources, and preferences. Every nurse understands that appropriate care responds to an assessment of patient problems. Although recent discussions in nursing literature raise questions about implications of applying a nursing process approach to spiritual care (Sawatzky & Pesut, 2005), it is still unimaginable to support another's spiritual health without first having some knowledge of that person's spiritual perspective and perception of need. Mnemonics or acronyms and other strategies for spiritual assessment exist (Taylor, 2010), however, suffice it to say that such an assessment should match the circumstances.

Experts recommend that an admission interview allow for a simple assessment of (a) how important spirituality is to the patient and whether there are pressing spiritual concerns, and (b) what spiritual support the patient would want from the healthcare team (Taylor, 2002). Hodge (2006) suggested that a more in-depth assessment be considered only when: (a) such an assessment was important or relevant to the patient, (e.g., further assessment would not be appropriate if there were no verbal or non-verbal manifestation of spiritual concern); (b) if it respects patient autonomy (e.g., if the patient indicates a desire to be probed deeper and gives consent); (c) if the clinician is competent to conduct such an assessment (e.g., is culturally safe, aware of the impact of counter transference); and, (d) if such an assessment is relevant to patient health or healthcare to be delivered (e.g., if information is needed about how patient religious beliefs affect decisions about care).

NURSES MUST RECOGNIZE THAT EVERY CLIENT IS IN A VULNERABLE POSITION.

Follow client expressed wishes. Patients express their wishes in verbal and non-verbal ways. A patient who turns over in bed to face away from you when you broach spirituality may be communicating he does not want to go there with you. Likewise, a patient who answers questions about spirituality with extremely superficial or passive responses can be showing she does not want to disclose further. If a patient's response to a spiritual assessment question is vital to the healthcare that

is to be delivered, and she or he fails to consent to such assessment, the nurse can acknowledge the lack of response and clarify if that is the patient's intent.

Such a response is unlikely, however, if prior to such an assessment the nurse briefly states the rationale for the assessment. For example, "Your healthcare team knows that the beliefs and values people have, whether religious or not, influence the decisions they make about the care they want to get. Given this, it would help us if we could learn from you how your spiritual or religious views might affect your____decision now?" Or, "We know that people often cope with difficult times like this by finding comfort in their spiritual beliefs or practices. If there are any beliefs or practices that might have an impact on your health, it would be helpful for your healthcare providers to know."

Note that some aspects of nursing care considered to be spiritual care are implicitly consented to. For example, listening to a patient's life story, providing an empathic response to expressions of spiritual pain, encouraging meaningful reframing for tragedy (when the patient is ready for it), or respecting a request for a spiritual care expert, would not require consent. Yet if the nurse is eliciting this life story, probing about the meaning of tragedy, or wanting to initiate a referral, then obtaining some type of permission from the patient would constitute respectful care.

Do not prescribe your own spiritual beliefs or practices, or pressure a patient to relinquish theirs. The fundamental fact nurses must recognize is that every client is in a vulnerable position. The patient may be in acute distress, desperate to have any help, and clinging to anything that brings hope. Or even, if not in mental or physical distress, the client may sense a dependence on the nurse or obligation to conform or please the clinician. Every client is vulnerable; it is this vulnerability that makes proselytization a potentially coercive act.

Strive to know your own spirituality. A nurse's spiritual or religious beliefs—his or her worldview, assumptions about existence—will inevitably affect the way that nurse relates to a patient. For example, many Christian nurses believe there is an afterlife in heaven to which the dead may immediately go. A nurse who believes this may attempt to comfort the bereaved with statements like, "He's okay now, he's in heaven" or "She's up in heaven watching over you now." For some patients—even Christians, this is not what they believe about life after death. Such an attempt to comfort would be unhelpful; indeed, it could potentially be hurtful. Such an imposition of religious beliefs, however, can be checked if the nurse is able to recognize how these beliefs can come to the bedside. Thus, understanding one's religious beliefs and how they influence caring are requisite to ethical spiritual care.

Provide care that is consonant with your own integrity. Not only must the patient's religiosity (or lack thereof) be respected, neither should the nurse provide care that goes against her or his religious beliefs. While a nurse might argue that spiritual care that respects personal integrity means evangelizing, it is important to remember that ethical care also respects the patient's wishes. The dying atheist patient who has requested no religious discourse should have his wishes respected.

Against the backdrop of these ethical guidelines, let's consider some practical suggestions for spiritual care.

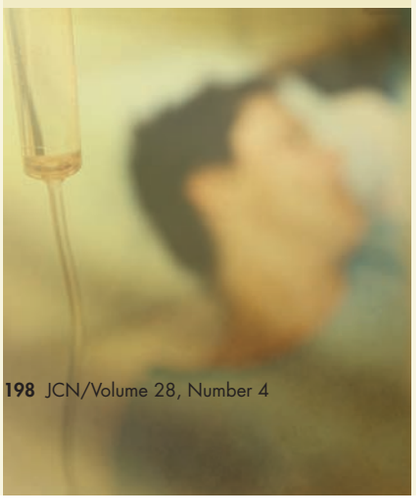
SUGGESTIONS FOR SPIRITUAL CARE

Spiritual care, defined by Sawatzky and Pesut (2005, p. 23), is "an intuitive, interpersonal, altruistic, and integrative expression that is contingent on the nurse's awareness of the transcendent dimension of life but that reflects the patient's reality…. [it] is an expression of self…'love, lived out in the relationship of care'" (quoting Brashaw, 1996, p. 43). Spiritual care is grounded in "love and dialogue" and may lead to interventions that "take direction" from patients' religiosity or spirituality. Spiritual care is not about measuring a spiritual titer, planning to fix spiritual pain, prescribing spiritual therapy, spiritual problem-solving, manipulating, controlling, or managing spiritual outcomes or health—or being a savior. With this in mind, consider the following suggestions for clinical contexts.

Create "sacred space." Trinity Western University Associate Professor of Nursing Sheryl Reimer Kirkham (personal communication, June, 2009) described the climate or environment which the nurse can create for spiritual nurture as "sacred space." Sacred space is not likely about humming hymns or playing soothing religious music during patient care, hanging pictures of Jesus or crucifixes in patient-care settings, or placing inspirational or prayer cards on food trays. Sacred space is created by the nurse who recognizes holiness in the acts of caring and by the nature of her or his presence introduces safety, respect, and compassion into the nurse-patient relationship. Such a relationship is void of judgment and effort to change the patient's religious beliefs. Creating sacred space requires advanced levels of presence and may be as simple as exchanging a knowing look or remaining silently with a patient.

Listen deeply. Listen with your head, heart, body, and soul. That is, hear what the patient is expressing intellectually by being attentive to facts and stories (head), by "hearing" the

THE NURSE WILL ALWAYS FOLLOW THE PATIENT'S LEAD — AND NOT PUSH, PROD, OR DRAG.



emotions behind the facts (heart), by tuning in to your own bodily responses (e.g., need to take a deep breath or sense of tension in your gut) to increase your awareness of what the speaker is feeling, and by being open to the holy in the encounter.

By listening deeply, you allow the patient to give voice to his or her inner experience. If necessary, respond with brief restatements, open questions, or reflections of his or her feelings to allow him or her to explore one's own spirituality. In doing so, the nurse encourages the patient to hear the self (and some would also say the Self [Inner Light, God]) who is speaking. By listening, the nurse offers the patient an opportunity to hear the interior movements, God-sent yearnings, or spiritual insight. (For more guidance on how to verbally respond to patients' expressions of spirituality, see Taylor, 2007.)

Follow the patient's lead. If the nurse has deeply listened, then she or he can follow a patient's cues about spiritual needs. Respond to the cutting edge of what is being said, to what is pivotal in what he or she is saying. For example, imagine that during a 10-minute conversation with a patient where she tells you about the different visitors she has had, she says, "I wish people from my church visited me, but they don't. I didn't join this church until last year, but I thought they were my second family. The minister is. . . .[and the patient could talk on for several minutes about her church]." What is this patient experiencing that is crying for attention? It is likely a sense of betrayal or abandonment by those whom she had previously thought of as being a social safety net. It may be that her church family represents God's family, and it may be an extension or reflection of what God's love is like. Thus, if a nurse responded with, "So what church do you attend?" this nurse would miss the pivotal point. Rather, a response that addresses the sense of betrayal or abandonment would more likely help the patient to gain insight into her experience. For example, "I'm wondering if you feel a bit like you've been betrayed," or, "Tell me more about what you expect (need) from a church family."

Experienced nurses may want to move a patient from point A to point B, assuming that point B is a place of greater spiritual wellness. But this is never the best response. For example, with a patient scenario like that above, a nurse might make a statement or ask a question to try to lead the patient to point B: "Are there other friends who visit who represent God to you?" (Of course, a less subtle form of response to get a patient from point A to B would seem pushy [e.g., "Don't you think that church family members aren't the only members of God's family?"].) Either way, the practice of chaplains (the experts in spiritual care) is to stay with a patient at point A. It is by staying with a patient at point A, that allows a patient to understand A and then move on to B. When the patient then moves to B, the clinician can accompany her there. Thus, the nurse will always follow the patient's lead—and not push, prod, or drag.

Use the patient's language. These interior movements are typically not couched in religious or overtly spiritual language. Instead, a patient may tell stories that reflect inner transformation or challenge. Patient spiritual concerns typically will be spoken using common parlance, embedded in discourse about family, work, and living with illness. Such comments that could reflect a deeper spiritual significance, for example, include: "What's the use?" "I hate being a burden." "I want to make things right." "Why?" "There's gotta be a reason." "I just need to stay positive!" Whatever the language used to convey a spiritual concern, the nurse can use this language in response, and thus avoid alienating or embarrassing patients. For example, if a patient states he is using his "faith" to cope with his illness, an appropriate follow up question would be, "How is your faith helping—or not helping, you to cope?" An inappropriate response would be one that replaces the word faith with Jesus, religion, or some other word that may not fit the patient's as yet unassessed experience. It is important for us religious nurses to recognize that we may use tradition specific language that may not fit the patient's spiritual lexicon. Terms such as "born again," "repentance," "salvation," and "righteousness" are loaded words for some patients. Their use would be unnecessary, and harm is avoided if the nurse observes such words are not in the patient's language.

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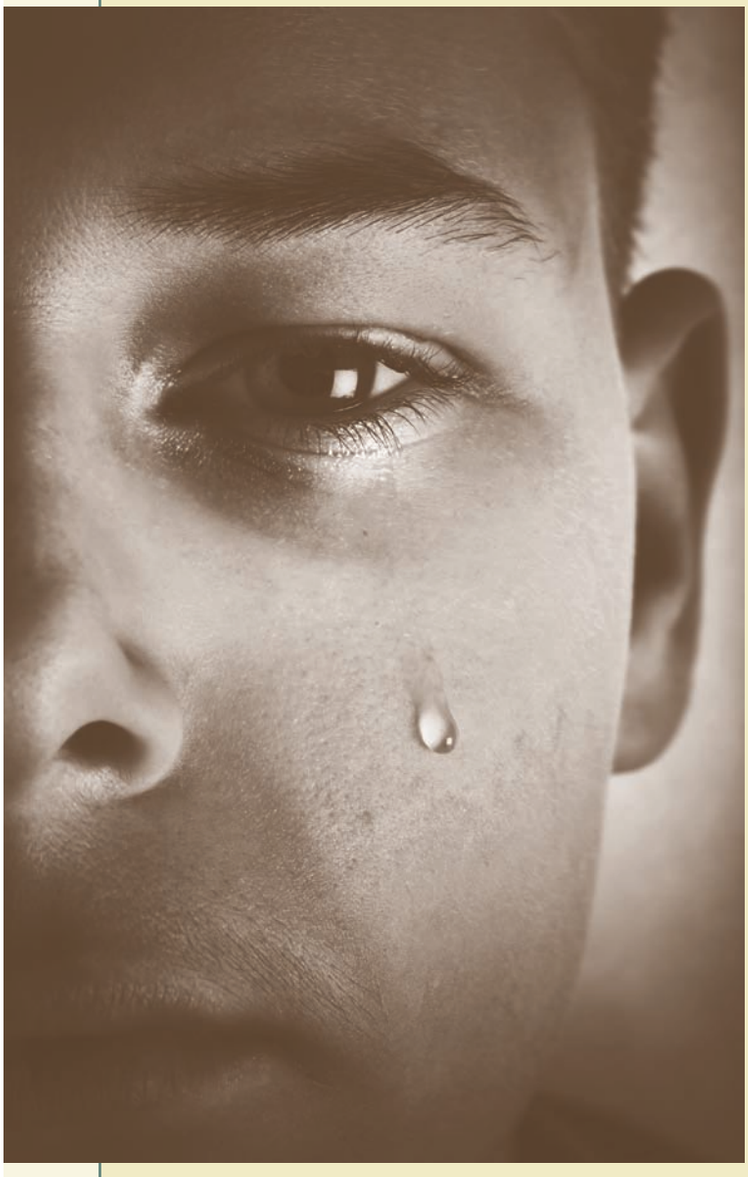
Understanding one's religious beliefs and how they influence caring are requisite to ethical spiritual care.

When appropriate, make a referral to a spiritual care expert. In community settings, the expert may be a spiritual director or clergy with whom the patient has an established relationship. In healthcare contexts, the expert is the trained chaplain. While there may be a cadre of volunteer chaplains at a hospital who have received a minimal amount of training, the experts include chaplains who have received substantial training during Clinical Pastoral Education. Depending on how deeply distressed the patient is,

A Spiritual Care Story



Recently I cared for a patient in his 30s who was brought in to our hospital for detoxification from drugs and alcohol. His nurse from the prior shift reported he had stayed in his room in the dark, in bed, and had not eaten anything all shift. She concluded, "Be careful with him, he's 'med seeking'"—a term staff use to describe patients they believe are inappropriately seeking prn medications, typically pain meds.

With that introduction I went to his room. Typically, we ask patients to come to a chair in the hallway to have their vital signs checked each shift. This time, I took equipment to the room thinking it would be good to go to him instead of making him come to me. As I entered his dark room he was lying on his side with his back to the door, but he stirred. I introduced myself and asked how he was feeling. He said, "Like hell."

I asked what that meant and he told me he was nauseous, having diarrhea, and his head was about to explode. I asked if I could check his blood pressure. He rolled over and extended his arm. His B/P and pulse were elevated and I observed tremors in his hands. I asked if he would like something for nausea and could I give him medication for his B/P and heart rate, explaining they were elevated and telling him the readings. He said, "Yeah, that would be nice. I haven't had anything all day." I explained his B/P and heart rate may not have been elevated earlier but were now and I would get him some medication.

Returning, I gave him the prn meds and asked if I could get him some ice chips. He said no. I asked if there was anything I could do to make him more comfortable. He quipped, "You're the first nurse who seems to give a damn."

I told him we were all concerned about him and that I was trying to help him through this difficult time.

He replied, "You have no idea how hard this is. I'm tired of it."

I told him he was right, I didn't know but wondered what he meant by that and he started talking. He would say something and I would acknowledge his words, sometimes reflecting back a question. He told me his family was steeped in drugs and alcohol, this was his fifth detox, and that when he got out he would "just go right back into it." I conceded how hard that must be and asked what kind of support he had. He indicated not much but with more probing he described a few places he could go where alcohol and drugs would not be flowing freely. He liked one of the local halfway houses and was hoping he could go there after discharge.

AS HE TALKED I NOTICED A TEAR ROLLING DOWN HIS CHEEK.

As we talked about support systems I asked if faith or spiritual things played a role in his life. To my surprise he said rather forcefully, "God doesn't give damn about me!" I asked him if he wanted to talk about that and he proceeded to tell me he had gone to church as a boy but had left "years ago." He figured God was done with him because he had quit church and "screwed" up so badly.

As he talked I noticed a tear rolling down his cheek. I asked if this was upsetting him and he wanted to stop. He indicated no and said talking about this was "good for his soul." Noting his faith background, I asked if he was familiar with the Bible and he said, "Yeah, maybe. Why?"

I told him that when I read the Bible, I was always surprised by the people God reached out to.

He said, "Like who?"

I mentioned King David who had a woman's husband killed because David got her pregnant (2 Samuel 11), and the Samaritan woman Jesus met who had had five husbands and was living with a man not her husband (John 4). I told my patient how Jesus revealed he was the Messiah to this messed up Samaritan woman and that she and her town believed in the Christ. We talked about the fact that even by today's standards, these were pretty bad things these two people had done.

Throughout the conversation he kept wiping away tears. I asked him several times if he didn't want to talk or wanted to rest and be alone. He kept saying no. After about five minutes of talking he said he wanted to read the story about the woman for himself. I offered to get him a Bible from the hospital chapel.

I gave him the Bible with bookmarks inserted at the two stories. I told him that from these stories it would seem God was in the business of helping "screwed up" people, that God had helped me after I had done some pretty bad things. He said he wanted to be alone now and I left. When I checked on him 30 minutes later he was sleeping.

Before the shift ended I asked if he wanted a list of places he could go to for spiritual support after discharge and told him if he didn't that was okay. He said yes, so I provided contact information for the Salvation Army, a church that offers twice weekly Bible studies for people struggling with addictions, and another church that runs support groups and Alcoholics Anonymous (AA) meetings. Because of our previous conversation and his faith background, I asked him if it would be okay if I prayed for him, not necessarily right there but just pray for him on my own. He said he'd like that but asked if I would I pray for him right now. I said a short prayer, asking God to help my new friend and show him he loved him.

I don't know if what happened that shift made a long-term difference in this man's life. I never saw him again after that evening. I do believe he felt cared for in those hours—by me, and I hope, by God. If this patient had indicated he didn't want to talk about spiritual things I would have backed off. I've had other patients tell me they don't believe in God or say they don't want to talk about "it" (spirituality) and I stop. But I note that if they want to talk to someone later I or another nurse would be happy to listen, and that we have a trained chaplain at the hospital.

I believe God sends Christian nurses to patients to listen, to offer support, to connect briefly, and in so doing be Christ's hands, feet, ears, and hopefully words to them. Sometimes when patients are open (and sometimes *they* ask), we talk or pray or share Scripture. Sometimes patients have a faith background, perhaps current or buried long ago. I believe in this situation, this man who had almost completely slipped away from faith, who was hurting spiritually, emotionally, and physically, was my patient for a reason. Perhaps I was his nurse that shift to help him realize God still cared about him.

—Leslie George, RN

the nurse may assist the chaplaincy department to identify whether a volunteer or expert chaplain should provide spiritual care.

Although many nurses may want to explore deep, inner spiritual concerns with patients, most of the time this is inappropriate. The nurse must recognize the limits of his or her role, responsibility, and training. A nurse is not a chaplain. With the superficial (at best) training in spiritual care nurses receive, nurses often are ill-prepared to care for deeply distressing spiritual pain. Furthermore, it is not the role of the nurse to delve into a patient's spiritual concerns unless this is necessary for providing healthcare or the patient requests it. Fowler (in Pesut, Fowler, Riemer-Kirkham, Taylor, & Sawatzky, 2009) recommends that most nurses are only prepared to address the public and semi-public layers of one's spirituality, while experts may address more intimate layers of spirituality.

Self-disclosure. Sometimes a patient asks a nurse about his or her spiritual or religious beliefs. For example, dying patients may ask their nurse about what they believe happens after death. Or victims of tragedy may ask, "Why would God allow this?" While such a question may confound a non-religious nurse, it is sometimes seen by the religious nurse as an invitation to share religious beliefs. The following suggestions allow a nurse to respond to such queries in a therapeutic manner (Taylor, 2007):

1. Assess why the patient is asking? Why now? Patients may want to know about their nurses' religiosity for various reasons. They may want to determine if it is safe to disclose a spiritual concern to the nurse. A nurse who has a similar religious orientation may be considered safe. Other patients may want to make the typically asymmetric nurse-patient relationship more symmetric; asking the nurse about this intimate aspect of the self potentially creates more balance and closeness in the relationship. Some patients, however, may genuinely desire answers for some of life's big questions. They may be interviewing those in their circle to find an answer that is satisfying. Thus, before responding to a patient's request for nurse religious self-disclosure, it is helpful to assess why the patient is asking. For example, "Before I answer, could we explore what this means to you?" or, "What brings you to ask this question now?"
2. Ask yourself whose needs are being met? Am I sharing my religious beliefs or practices because they will comfort me as I care for this patient? Am I sharing because I believe I will gain something from doing so? If the self-disclosure of religious beliefs or practices is meeting a nurse's need, then it is inappropriate.
3. Always follow up any religious self-disclosure with an open question or reflection that "returns the ball to the other person's court." For example, "I've just explained what I think. I wonder what is going on inside you now?" It is important to ascertain how your self-disclosure has impacted the patient, what questions he or she may now have, or if your self-disclosure has compromised the therapeutic relationship.

Table 2. Sharing Religious Beliefs in the Clinical Setting: Questions for Reflection (Taylor, in press)

Why do *I need* to share my beliefs?
What is the source of what I share? (my gut? Holy Spirit?)
Has God (vs. inner need) prompted me to share with this particular patient?
What might I be gaining from sharing?
Who saves? What role do humans play in helping God to save people?
Have I spoken the gospel by my actions so that I have earned the right to speak in words?
What is going on in conversations with patients that tends to make me become more controlling of the conversation? (Do I get more controlling when we venture near religious/spiritual/ethical/philosophical topics?)

4. Keep self-disclosure short and infrequent. Self-disclosure of religious beliefs should never become a sermon or Bible study. Make your answer brief. The focus is not to be on what the nurse has to share, but on what brings the patient to ask and what the patient's response to the nurse's self-disclosure is.

The accompanying sidebar *A Spiritual Care Story* describes a true patient encounter shared by a staff nurse. This experience offers insight on how the above suggestions for spiritual care might be implemented.

CONCLUSION

These suggestions for ethical, non-coercive spiritual care may leave some Christian nurses concerned about witnessing in the clinical setting, perhaps even believing the above ideas do not allow them to practice nursing in a way congruent with their personal faith. The questions offered in Table 2 can help nurses reflect on how their faith and work intersect. Indeed, regardless of a nurse's religious (or a-religious) worldview, the beliefs and values inherent in their worldview will affect the way the nurse provides care (Taylor, in press). What is vital, however, is for the nurse to understand how these beliefs and values can impact nursing care, so beliefs can be bracketed—held in check—so as to not coerce a vulnerable patient, or used effectively to support a patient who shares your beliefs or wants spiritual support. There also is need for serious theological and ethical study to help clinicians grow in our ability to discern between inclinations to evangelize driven by unrecognized inner needs, versus the leading of the Holy Spirit. Yet even as we continue to seek to understand how to follow God's leading in patient encounters, we can be guided in spiritual care by principles expressing God's non-coercive, freeing, love.

Christian nurses are not called to straighten out others' beliefs about God. Rather, "the glory of God is the human person fully alive" as the 2nd century Christian mystic Irenaeus of Lyons observed (FitzGerald, 2004). Or, as theologian Eugene Peterson (2010) wrote (quoting Cardinal Suhard):

> *To be a witness does not mean engaging in propaganda, nor even in stirring people up, but in being a living mystery. It means to live in such a way that one's life would not make sense if God did not exist. (p. 185)*

A Christian nurse infused with the love of God and inspired by the life of Jesus will undoubtedly bring this "fully aliveness" to the bedside.

Should spiritual care be Christian evangelism? No, if means inappropriately trying (even subtly) to persuade vulnerable patients to believe the same way as I do. Yes, if it means reflecting the compassion of Christ in the holy work of nursing—being the hands, feet, and care of Jesus.

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