JENNIFER CARTER AND MELISSA CAREY

7 Reawakening Spiritual Roots in Nursing Practice: Sacred Places and Sacred Spaces

ABSTRACT

Sacred spaces exist in-between the human experience of living and dying, yet these spaces are often forgotten within the Western biomedical health care paradigm where there is a long history of mind and body separation. However, a new trend is appearing which is akin to an awakening of a spiritual focus moving towards a partnership with clients and their families. This chapter explores the registered nurse's experience of caring for people towards the end of their lives. Through the nurses stories we explore the notion of the sacred spaces and places as people move from diagnosis to the end of their life journey. Findings from this exploration indicate that there is a need for nurses to initiate and encourage end of life conversations, which honour the sacred spaces and places of the dying. Thus raising awareness for the inclusion of spiritual concepts within the Western health care paradigm as advocates for the dying.

Introduction

This chapter invites the reader on a journey into the intimate sacred space between the living and the dying. This in-between space is usually reserved for nurses, carers, family, friends and the medical staff of the ill or aged. The dying space or the space where the human being takes their last breath is often secreted away from sight, particularly within Western nursing practice. Access to the sacred space between the living and the dying during these final moments of life is rarely shared. This chapter seeks to show a glimpse of the sacred space through the inclusion of personal anecdotes, which document the relationship between the dying patient and the nurse. Thus, beginning a conversation on the importance of sacred spaces and places

in contemporary nursing practice. Through our anecdotes we explore the impact that early spiritual intervention could make to the experience of the dying space for the person and their carer.

The authors of this chapter have a combined experience of over fifty years within the clinical and theoretical nursing practice in Australia. We are of Celtic-Māori heritage, which creates a juxtaposition between our cultural heritage and the contemporary practice environment of healthcare in Australia. Nursing practice has followed in the footsteps of the medical field that has led to the current hospital-centred and illness focused approach to dying (Kellehear 2014; Mazzotta 2016). Given that nurses are the largest body of health professionals (62 per cent) in Australia (Australian Nursing and Midwifery Federation, 2012) we are well positioned to advocate for a paradigm shift for the dying person in Western societies.

Spirituality and Nursing Practice

The spirit plays a part in the connection between the two worlds of life and death creating a sacred space (Koopsen and Young 2009). Nursing practice in Australia focuses on the biomedical model of health, which is incongruent with many non-Western interpretations of health and wellness. Within eastern and indigenous cultures an unbroken link joins the living and the dying. Dying is considered as continuum, a circle of life. Eastern cultural practices of health are inclusive of the metaphysical energy of the spirit, believing that there is a life force or unseen energy field, which surrounds all living things (Niska and Snyder 2006). The biomedical model of health is devoid of any of these practices in the Australian healthcare system, which is leaving emptiness in the space between the nurse and the dying person.

Many authors (Candy et al. 2012; Lepherd 2013; Sinclair, Pereira and Raffin 2006; Sessanna, Finnell and Jezewski 2007) agree that spirituality is metaphysical or a transcendental phenomenon so it is therefore difficult to define or capture spirituality as a single entity (Wynne 2013; Gijsberts et al. 2011; Dose et al. 2014). The original nursing philosophy was infused with

the concept of spirituality and sacredness, which is thought to be largely due to its early beginnings in religious institutions (Kellehear 2007). Many nursing theorists continue to include spirituality in their nursing theories. Jean Watson (1988) in her definition of the person clearly indicates that a person is both a physical and spiritual being:

> A person is both a physical being and a spiritual being, with an individual experience and existence. The person and the self are the same when the person is congruent with the real self. That occurs when there is harmony in mind body and soul of the person. (Watson 1988, 5)

To incorporate each person's individual cultural interpretation of spirituality it is imperative that a broad definition be used in nursing practice (Koenig 2008). The word spirituality includes many interpretations and is not bound to a doctrine of religiosity. According to the Oxford English Dictionary (2017) the word 'spirit' derives from the Latin word 'spiritus' meaning breath spirit, from *spirare* 'breathe' and words synonymous with spirit are often linked to our emotions such as energy, sparkle, vigour and happiness. Nursing definitions of spirituality clearly identify that spiritual concepts are separate from but inclusive of religion. The North American Nursing Diagnostic Association (NANDA) definition of spirituality is:

> To experience and integrate meaning and purpose in life through a person's connectedness with self, others, art, music, literature, nature, or a power greater than oneself, while at the same time, differentiating spirituality from religiosity but allowing inclusion of religiosity as an integral piece of an individual's spirituality. (Sessanna, Finnell and Jezewski 2007, 258)

Despite the nursing profession's clear holistic definition and understanding that a person requires harmony in mind, body and spirit and that spirituality can be separate from religion, it is well documented that there is very little spiritual care included within contemporary nursing practice (Koenig 2013; Wynne 2013; Gijsberts et al. 2011). Spiritual concepts have been identified as relating to words such as wellbeing, trust, peace, harmony, purpose, meaning and connectedness to others and a power greater than oneself (Gijsberts et al. 2011). Although spirituality is a core human value an interest in researching spirituality did not occur until the early 1990's

(van Manen 2014). Most instruments used in nursing research to measure spiritual concepts are quantitative in design and have a bias towards Judeo-Christian beliefs (Lowry 2012). The problem is also compounded by the fact that many nurses feel inadequate in giving spiritual care. This inadequacy is due to the lack of clarity surrounding spiritual issues in nursing practice (Wynne 2013).

Much of this spiritual neglect in client care can be attributed to nursing education, which has been largely driven by the curative focus of biomedical science (Mazzotta 2016) and which leaves spiritual concepts in nursing practice poorly addressed and implemented whilst caring for dying people (Cable-Williams and Wilson 2017; Robinson et al. 2014). This has resulted in a practice gap for nurses when they are confronted with end of life care. Nurses are often unable to recognize and care effectively at the end of life until death is imminent. It is increasingly difficult to recognize the sacredness of dying if spirituality needs are not included within patient care, yet studies have demonstrated that there is a significant link between supporting a client's spiritual needs and a reduction in unnecessary and invasive medical interventions at the end of life (Wynne 2013; Puchalski 2014).

Contrary to Western practices of health and illness, sacred spaces have long been recognized by the Australian Aboriginal and Torres Strait Islander peoples, who have a strong spiritual connection with the environment, the land and country links with family, community and the wider universe (Eckermann et al. 2006). Similarly, the notion of spirituality has always been included in the Australian Aboriginal people's definition of health. Aboriginal people's spirituality may include signs of the supernatural, such as the death of a bird, howling of dogs or black dreams which are said to bring bad news. Land has always been important to Aboriginal peoples for food, shelter and sense of place (Eckermann et al. 2006).

Current health practices in New Zealand are leading the way for the inclusion of spirituality at the end of life. Māori models of health are represented by an image in which spirituality is a necessary inclusion. The Whare Tapa Whā model [the four-sided house] (Durie 1985) compares the state of health to the four walls of a house: the family, spiritual, physical and thoughts and feelings. *Te Wheke* [the octopus] is another

symbol that defines family health (Pere 1991), where each tentacle of the octopus represents a dimension of health. These models of health that identify spirituality, the mind, physical wellbeing and family are important inclusions to Māori health. Prior to the introduction of Western medicine this was a seamless link. *Whānau* [family]-centred nursing is a Māori concept, in which it is extremely important to recognize the *tapu* or the sacred spiritual space held within the process of dying. The *tapu* is understood as a sacred state of not only the dying person but also all those who come into the space of the ill person. Knowing this, *karakia* [prayer] and *waiata* [song] will be done to strengthen the deceased *wairua* [spirit] (Moeke-Maxwell 2014).

To speak openly of death is the last taboo in Western societies (Koenig 2013; Kaminsky 2016). Compounding the problem is the medicalization of death, which has encouraged dying to be managed by professionals in a hospital or nursing home environment (Kellehear 2007). Therefore, the reality of death remains hidden until we have a direct personal experience. Historically the home or other culturally designated places were the space for the dying person. In Western society, most elderly citizens were dying at home as recently as 1945, with their families (Gawande 2014). The bodies of loved ones were washed, dressed and cared for as a rite of passage, until the outsourcing of the body to funeral directors (Kaminsky 2016). With the shift of dying moving out of the family home to acute care hospitals and nursing homes in the industrialized world came modern procedures and medical interventions, in many forms.

The hidden nature of death continues within a hospital environment (Marcella and Kelley 2015). When a person dies, it is not uncommon for nursing staff to quickly shut all doors and to pull closed all curtains that surround the living. In this way, nurses are obliged to hide death from other people who are ill. This social conditioning continues the story on hiding the reality of death. Many people in contemporary societies are not comfortable speaking openly about death. Indeed, death is often preceded by a long chronic illness. There are many interventions that can extend life and there are numerous people who are not sure exactly when they are dying (Gawande 2014). This end of life confusion can be seen in this first scenario (case study one) of a man who isn't quite sure if his life is ending.

Case Study One: Gary

Gary: Conversations at the deathbed

> *During a very busy morning on the medical ward there was an old bony, thin, and frail man gasping for breath, purple in colour, calling out as much as his breath would allow, pleading with me through his steely blue eyes, 'I'll be alright, won't I?' What do I say to him? No, I give you a day to live at the most? Surely, he knows on some level he just won't be all right? Or do I say, no you're dying, slowly without breath ... and this is the way it will be. You will struggle until you have no more breath or until I sedate you, which would you prefer? Well, I did the latter ... better for him I thought (and me ...). It was unbearable listening to his struggle, watching him trying to catch some air on the wind. I reassured Gary that he would be okay, as I attached the oxygen tubing to his face making his breathing easier. I asked if he wanted to see anyone. I knew that this was unlikely as he was elderly and came in alone to the hospital. I knew whether it meant life or death that I would ensure he was kept peaceful. Yet it still seems so wrong that we (as nurses) can't speak about death because the fear of death is so great that it is too difficult for people in our care to discuss.*
>
> *Through the western cultural sequestering nature of death people are afraid to speak openly and honestly about the end of their life, even at the moment when it is inevitable. I realised that in the moment of dying, it is too late to discuss unless the client has awareness that this is death, the fear of knowing that dying is imminent.*
>
> *Fear is powerful.* (Carter 2016)

Gary (in the scenario above) was seeking reassurance that he would be alright; it was unclear what was meant by 'alright'. Did he believe that his breathlessness he had suffered with for years would in some way be resolved? Had he realized that death was imminent or had it not yet entered his conscious awareness? It was not the time or space to discuss his death when he was clinging so strongly to the hope of living.

Cartesian Dualism and Medical Dominance

Western medicine and nursing practice have a history of separating the mind and body, focusing on the human body as a well-oiled machine, so the words sacred and spirituality are rarely considered within this paradigm

(Mazzotta 2016). The most likely outcome in a Western hospital environment is one of a production line, where treatment is driven by diagnosis, followed by the medical management of an acute episode of ill health, or a chronic illness, which leads towards the end of life. Biomedical scientific ideology relies heavily on objective and subjective measurement; if a concept is considered unmeasurable then its very existence is called into question (van Manen 2014). The metaphysical nature of spirituality renders it unable to be quantified and therefore the very notion of its existence and significance within the Western health care environment remains contentious. van Manen reiterates the importance of including spiritual concepts into care, believing that health care practitioners are suffering from 'Cartesian blindness'.

As a consequence of the biomedical model of health, the reality of death is pushed further from conscious awareness due to the separation of the spiritual from the physical nature of the body (Reinert and Koenig 2013). The language of death in Western societies is militant in its fight towards saving our bodies from the inevitable ending. We fight infections and diseases, and we wage a war on cancer while our bodies waste away. Euphemisms are unconsciously designed to shift the topic away from the reality of dying (Kaminsky 2016). Death or dying is often thought of as dirty words, called by many other names such as passed away, lost, gone and moved on (Gawande 2014; Kellehear 2007). Warner (2014, 65) writes of the current neglect of spirituality towards the end of life, describing it as an illness of the soul, that the medicalization of dying has left the Western world 'spiritually bankrupt' that dying in our modern age is harder than it needs to be. The medicalization of death and dying is incongruent with any other tradition of health and wellness and in fact is a relatively new concept within Western traditions (Germov 2014; Kellehear 2007; Gawande 2014).

Modern medicine has made dying a longer process; people no longer suffer from diseases that cause sudden death but are living longer with more complex health needs. Medications, operations and technological advancements in medical equipment that can sustain our lives increasing longevity, however, increasing our lifespan does not necessitate an improved quality of life (Kaminsky 2014; Gawande 2014; Kellehear 2007). Consider the recent case (case study two) of an elderly gentleman, admitted to hospital due to his frail state caused by old age. In most cases, by the time our bodies reach

ninety years the cardiovascular system starts to fail, which induces a state of disease within the whole body. This manifests as difficulty breathing, reduced circulation, thinning skin and reduced effectiveness of the digestive system causing poor nutrition amongst other conditions (Hillman 2017). The following case study took place on a medical ward when an elderly (ninety years old) frail patient was admitted for care.

Case Study Two: Peter

Peter: Understanding the quality of life at the end of life

> *Nurses on duty noticed on arrival to the ward that Peter had a leg ulcer that was not healing, due to his general frail condition. He could still move about, slowly managing to care for himself. However, the surgeon thought it best that he operated on the leg, giving him a skin graft to cover and heal the wound quicker. Unfortunately, this operation entailed a long time on bed rest, with his leg elevated and constricted by a bandage, holding the skin graft in position. Peter spent many weeks on intravenous antibiotics using a line that was inserted through his vein into the tip of the large vein that enters the heart. After weeks on complete bed rest the skin graft did not work. Furthermore, he had developed a large new wound beneath the bandage. This wound was so deep that his tendon was clearly visible. He once again went back to theatre. For Peter, this meant even longer periods of bed rest with intensive nursing care. The new wound did not heal, and he was bedridden, no longer able to care for himself until after approximately three months he died.* (Carter 2016)

Peter's story is only one of many that demonstrate the powerful force that false hope plays in the sanctity of life (Hillman 2017). Peter thought that his second operation would give him extra time to live independently, he did not understand the full consequences of further surgery. The following case study involves a young woman who was gravely ill. Elsie had been living with a terminal illness for many years, and was admitted into hospital for the last few months of her life. The hospital room was cold and sparse, white walls were empty of images, and medical equipment lined the head of the small bed.

Case Study Three: Elsie

Elsie: Awareness of being mortal

> *Elsie was focused on a graph in the pages of the book, I looked closely and noticed that it was a timeline of chronic illness and I asked Elsie to show me where she felt she was on the timeline. She took a deep breath and thought about the question for a minute and pointed to the graph in the book. She said, 'well, I've been down here', pointing to a large dip in the graph, 'but today I think I'm back up here.' Her finger placed clearly on the line that was heading towards health. I looked at her miserable bodily state and thought that she was back closer to the dip in the graph than the wiggly up-line in the book. I asked her if she had anything she needed to finish before her time ends. Until this moment in time she would never talk to the nursing staff about her illness or death. She shut us out completely. She tried to attend to her own care and stayed in her room behind closed doors. There was a sense of sadness and fear surrounding her. This was distressing, as we could not provide her with her dying wishes. However, through using her book on illness as a bridge, I had found a way to approach the subject of being mortal. She died within a week of this event.* (Carter 2016)

From this story, we can see that some people do think about their spiritual pathway during the end of their lives, and that even through the pervasive fear of dying and a reluctance to speak about death there are still opportunities for nurses and patients to collaborate and find peaceful resolutions.

Sacred Spaces in Western Cultures

A sacred space is understood to be a space that is infused with invisible energy such as prayer, chanting, extreme joy or grief as in birth or death. It is considered sacred because of the thinning of the veil that exists between the world of visible and the invisible (Silf 2014). Sacred space can be geographical and physical such as a temple or a space within your own felt experience. This sacred space is by its very nature infused with a powerful life force known as *wairua* [spirit] in New Zealand, or *chi* [life force] in

China or *prana* [breath; life giving force] in India (Koopsen and Young 2009). The ancient Celts just like all indigenous cultures knew and never doubted the two worlds of the seen and unseen. In fact, these two worlds were always interwoven, as in the Celtic knot, which is a symbol of interwoven threads that represent the timeless nature of the human spirit where there is no beginning and no ending; an uninterrupted cycle of life and death (Silf 2014).

Silf (2014, 112) describes this sacred space surrounding dying as a 'spiritual ozone' layer in which, through our own emotional experience we can break through this thin layer and reality can appear. Consider the case (case study four) of an elderly man who died quietly, peacefully and easefully one night on a palliative care hospital ward. His death was brushed aside because of the staff's busyness, and lack of insight into the sacred art of dying.

Case Study Four: Eric

Eric: Last days

Eric had a strong non-religious faith that sustained him throughout his life, and he knew that his death was close. He would ask us (nurses) not to worry about him. Although he found it difficult to move, he would often potter around in his room. Slowly over a couple of months Eric lost his mobility and was bedridden before his death. He was extremely peaceful in his last hours and the room was filled with the sacredness of death. The space in the room was palpable, and very quiet. As I walked in to prepare his body I quietly shut the door and stood for some time. It felt like I had shut the chaos of the rest of the ward out of the room and behind the closed door. Unfortunately, this sacredness was not recognized by others. This was evident by the way the staff reacted to his death. I asked the doctor if he could certify the body but he said he was too busy. I was dismayed at his response as it only takes a few minutes to sign a death certificate and it seemed the honourable thing to do for Eric. Likewise, the nurse in charge of the ward was too busy to speak to his grieving wife, who left the hospital. Two hours later his body was retrieved by the funeral home, and that was that. No ceremony, except the closing of the ward doors, and the curtains to hide his death from other clients. The undertakers

> *wheeled him out under a sheet through the back entrance. Another client was admitted to the empty room within minutes of Eric's death.* (Carter 2016)

Eric's death had transformed the space of the cold white hospital room into a place of reverence, where the space was filled with the sound of silence, and stillness. The nurses directly caring for Eric understood that his peaceful ending was a result of his strong spiritual connection with the afterlife, which he expressed before his death. However, for the rest of the staff on the ward it was just another thing to add to the busyness of the day.

Reawakening Spirituality in Nursing Practice

There is a slow movement away from the medicalization of nursing care towards client-centred care in Australia as a result of the Pew-Fetzer Task Force (Tresolini 1994–2000) on advancing psychosocial health education in the USA. This has allowed an awakening of a spiritual focus encouraging a partnership of discussion where authentic relationships between nurses and clients can be formed (Watson and Foster 2003). One goal for the inclusion of spiritual care within nursing practice is to invite people who are at the end of life to share their feelings on spirituality and to begin a conversation around spiritual health needs (Kellehear 2014). One of the most useful spirituality assessment tools currently available is the Faith, Importance, Community and Address in Care model (FICA) (Borneman 2011; Puchalski 2014).

The FICA Tool consists of open-ended questions that enable a dialogue around specific concepts of spiritual care, such as the community, love, trust and natural surroundings. The assessment is recommended to be carried out when the client is admitted to a health facility, or when they receive a terminal diagnosis, so that interventions can be targeted to meet their spiritual needs thereby allowing people to live full lives and increase their quality of life until death (Koenig 2013). Considering

the scenarios within this chapter, the application of the FICA tool in practice would have provided an opportunity to change the course of the end of life experience for each of these clients through providing a space for dialogue around the choices that people make regarding treatment options and outcomes. This type of intervention has the potential to lessen the forbidden nature of the dying conversation, enhancing the patient's understanding; however, it requires further investigation within the Australian health sector.

In Conclusion

Western health care has much to learn from indigenous approaches to health and wellbeing, particularly where care of the dying person is concerned. Spiritual care for the dying is a crucial component of nursing practice, however it requires the engagement of both the dying person and their nurses. Nurses are so close, emotionally and physically, to the dying person that they hold the key to enabling a sacred space and place for the dying. When people experience the end of their lives in the care of a nurse, a partnership is formed but it can only be informed when everyone within the partnership has opportunity and the language to discuss matters related to dying. The importance of increasing spiritual care within the nursing profession is extremely urgent. It is vital that a wider audience including health professionals understand the importance of spiritual literacy within contemporary practice environment. Whilst it is acknowledged that quantitative tools are not the best measure of the metaphysical concepts of sacredness and spirituality, the FICA Tool is a method of beginning the conversations on addressing the spiritual care of clients. It is time for Western nursing practice to give the sacredness of this space the acknowledgement it deserves, and to cherish these moments as a human transitioning, and a sacred place. This is especially urgent for nurses who can lead their profession into a paradigm shift that is inclusive of the client's spiritual needs.

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