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# Update - June 2004

Loma Linda University Center for Christian Bioethics

*LOMA LINDA UNIVERSITY CENTER FOR CHRISTIAN BIOETHICS*

# Update

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## Examining the Ethics of Praying With Patients

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> He said are you a religious man do you kneel down
> in forest groves and let yourself ask for help
> when you come to a waterfall
> mist blowing against your face and arms
> do you stop and ask for understanding at those
> moments
> I said not yet but I intend to start today.
>
> *Raymond Carver*[1]

These lines from Raymond Carver's poem are a reminder to us all. People who face a health crisis may turn to prayer for comfort, even if this has not been a typical part of their daily lifestyle. Some patients may desire prayer as part of their health care. Nurses who choose to provide spiritual nurturing must think carefully about the appropriateness of prayer in professional service.

Faith-based health-care institutions have long emphasized the importance of tending to the spiritual needs of patients. And praying with patients has traditionally been an expected part of care in such facilities. In recent years, the importance of spirituality in health care has also gained broad acceptance in the general culture. Researchers interested in the health-related effects of spirituality have generated a burgeoning literature, with numerous reports of empirical evidence for the positive benefits of practices like prayer and meditation.[2–4] Members of most faith traditions, whether patients or caregivers, probably did not need such evidence to convince them that prayer is a valuable part of their lives, but the rise of research in spirituality and health, with its accompanying professional conferences, seminars, journals, and academic coursework, has created a synergy with faith-based health care in which the importance of prayer for patients is gaining renewed emphasis.[5,6]

Prayer, as an intervention with patients, fits within the broader spectrum of spiritual care. From the inception of nursing as a practice discipline, nurses have been attuned to the spiritual needs of patients.[7] A review of current nursing theories shows that spirituality and spiritual care are considered concepts of central importance in the practice of nursing (eg, Neuman, Newman, Parse, Watson).[7–9] Scholars within the discipline of nursing are continuing to delineate the concept of spirituality and to describe methods by which nurses can provide appropriate spiritual care, including prayer, for their patients.[7,8,10] Building on nursing's rich heritage, we will focus on one aspect of spiritual care, that of prayer, in this article. Our purpose is to consider a set of normative principles that may guide nurses in their deci-

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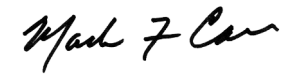
# Editorial

One of the finest pleasures in my professional life is being involved in the education of intelligent young people here at Loma Linda University. Our master's degree program in biomedical and clinical ethics draws students from a wide range of backgrounds and interests. This year we are proud to proclaim the accomplishments of Marco Artiano, Anika Ball, and Grace Oei who graduated on June13th. In this issue you will see pictures of Marco, Anika, and Grace and read a bit more about them.

We feature two articles here, one from Stephen Post and one from Betty Wehtje Winslow and Gerald R. Winslow. The Winslows co-authored this piece that examines the ethics of praying with patients, particularly as it relates to nursing practice. The huge increase of studies and literature in the area of spirituality and patient care may well affect the practice of nursing more than that of physicians. The Winslows address the topic of nurses praying with patients, with special attention toward respect for the patient and the integrity of the nurse. They offer five guidelines to help nurses gauge the appropriateness and manner in which they pray for and with patients. The Winslows have a long and distinguished history of publication in the area of nursing and nursing ethics, and we are privileged to be able to print their article. Furthermore, their involvement in the academic community of LLU is of incalculable value. We particularly salute the work of Gerald as he steps down from fulfilling the role of dean of the Faculty of Religion here at LLU. While he will continue to be involved in our academic and professional community, we will miss him in the capacity of dean.

Dr. Post's article recounts some of the issues he shared with us here at Loma Linda University while speaking for our Jack W. Provonsha lectureship. As many of you know, the Provonsha lectureship is held in the evening during our yearly national conference. Dr. Post spoke for the conference as well, which turned out to be an extremely successful conference. We were pleased to join the School of Public Health in sponsoring their annual "Healthy People" conference. A little more than 400 people attended; the largest conference we have helped sponsor here at LLU. Participants came from ten countries around the world. In fact, Dr. Joyce Hopp, distinguished emeritus professor and former dean of the School of Allied Health Professions said of the conference, "I have been to every Healthy People conference since they started more than 25 years ago and this one is the best." Thirty different speakers addressed topics on spirituality and health, culture in health care, and the health of children. We are so pleased to have been involved with the School of Public Health (SPH) in this effort and we applaud the vision of Dean Patricia Johnston, of the SPH for bringing us together. The untiring work and professional skill of Dianne Butler, the director of distance and continuing professional education for the SPH, is largely responsible for the success of the conference!



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sions about prayer with patients.

As the interest to include prayer in patient care seems to increase, the need for ethical reflection is pressing.[2,3,5,7,10–15] Attention to the vulnerability of patients and the variety of religious and spiritual backgrounds they may bring to the clinical setting should raise some important ethical questions. Because nursing has a well-established tradition of attending to patients' spiritual needs and resources as an expected part of the nursing assessment,[7,10] querying a patient about his or her spiritual preferences is already deemed to be an appropriate professional responsibility. So the ethical questions are not about whether or not good nursing care should include consideration of patients' spiritual or religious values, including beliefs about prayer. Rather, the ethical questions focus on whether and how to include prayer in ways that are respectful of patients in the clinical setting. For example, if prayer is believed to be genuinely beneficial, should nurses go beyond offering to pray with patients and urge patients to engage in prayer? If patients are given the option of prayer with a nurse, will those who reject prayer be likely to wonder how this will affect the rest of their care? What about patients whose religious practices differ greatly from those of their nurse? Can nurses, with integrity, participate in forms of prayer that are contrary to their own belief systems? Finally, what should be done with patients' requests for prayer if the nurse does not believe in prayer at all?

These and a host of related questions give rise to the central inquiry of this article: What, if any, are the ethical responsibilities of nurses who are attuned to patients' spiritual resources and who care for the spiritual needs of those who may benefit from prayer? Answers to this question, we suggest, can be sought under two broad categories: respectful care of the patient and the essential integrity of the nurse. Under these rubrics, we set forth a series of five guidelines we believe comport well with our culture's current understanding of ethics and with nursing's self-understanding of its professional responsibilities.

Our discussion will be facilitated by clarification of some of the central concepts. The first is prayer. According to Shelly and Fish, "Prayer is an intimate conversation between a person and God."[11] This simple definition is probably effective in our culture for the vast majority of patients who believe in prayer. But there are also reasons to add nuance to this concept of prayer. Some, for example, may be uncomfortable with reference to God. They may prefer expressions such as Higher Power, the Absolute, the Sacred Source, the Holy, the Great Spirit, or some other way of designating the one to whom prayer is addressed. For others, conversation may not be part of prayer. Poloma, who has offered a four-fold typology of prayer, identifies one type as meditative, in which the one who prays takes "the stance of a listener" waiting for God to speak.[12] And within the prevalent faith traditions in our culture, common forms of prayer include invocation, praise, thanksgiving, petition, and benediction. For the purpose of this article, we define prayer as being in communion with God . But we keep in mind the many different ways of typifying prayer because these differences can become ethically important.

Two other concepts require clarification: religion and spirituality. It has become common to distinguish religious beliefs and practices from spirituality. Many people now say that they are spiritual but not religious, though it is uncommon to hear someone say that he or she is religious but not spiritual. The reasons for this are likely complex and an analysis of them is beyond our present scope. For our discussion, it is sufficient to note that the concept of religion is generally associated with the teachings and rituals of various faith traditions. In a richly multicultural and religiously diverse society, there seems to be more comfort in talking about spirituality than in discussing religiosity—the latter frequently being linked with arguments and strife. Spirituality, on the other hand, is often viewed as a universal human trait that arises from the human need for hope and meaning.[7] For definitional purposes, we accept the common distinctions between religiosity and spirituality. By religion we mean the convictions and characteristic practices of a community of faith. By spirituality we mean the human quest for ultimate meaning, purpose, and hope. It is worth noting that, for the vast majority of persons in our culture, a strong connection exists between spirituality and religion. The sacred texts, the shared religious symbols, and the rituals of a particular faith tradition generally shape spiritual practices, including prayer. True, people may be deeply spiritual with little or no tie to a religious tradition. Some spiritual people may even be hostile to organized religion. And some apparently religious people may not be particularly spiritual. Nevertheless, paying attention to the complex relationship between religion and spirituality can be ethically significant, as we hope to show.

### Give respectful care to patients

A relationship of trust with the patient, as well as his or her family, is the essential ethical characteristic of all good nursing care.[16] Vulnerable because of their illnesses, patients count on the trustworthy care of their nurses. Trust is established when a nurse makes a commitment to seek the patient's well-being and protect the patient from harm. Trust is lost when considerations other than the patient's well-being are allowed to take priority. Trust may be undermined, for example, if the goal of profits for shareholders supersedes the goal of quality patient care or when institutional understaffing causes patients to wait for essential nursing care such as immediate relief of pain.

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Nurses must respect the patient as a person and accept that patients arrive with their own distinctive values and life plans. These may be radically different from the caregiver's values. Attempting to give care, without this recognition of distinctive values, risks giving disrespectful care. Genuinely respectful care, on the other hand, begins with an openness to learn about the needs and resources of the patient as a whole person. In the memorable expression of Cohen and her colleagues, health-care professionals "are constrained to treat patients as whole persons—for those are the only kind there are."[13]

Among the health-care professions, nursing has distinguished itself by emphasizing the care of the patients' whole being, including attention to patients' spirituality. As noted, many of the leading nursing models give major attention to the spiritual core of the patient, making it central to nursing care.[8,9,14] Learning to do this in a way that is genuinely open to the distinctive characteristics of each patient is fundamental to providing respectful care.

*Understanding spiritual needs.* The question of prayer in the clinical setting provides a useful test for respectful care. If prayer is as beneficial for patients as many of the empirical studies seem to indicate,[2,3,5,12] and if trustworthy nurses are seeking to do the best for their patients' well-being, it would seem that the value of praying with patients should be given serious consideration. But the question remains: How may nurses approach the possibility of prayer for patients in a respectful manner? The answer lies in learning more about the patient's spiritual needs, resources, and preferences. This observation leads to the first ethical guideline:

1. *In order to provide spiritually respectful care, nurses should seek a basic understanding of patients' spiritual needs, resources, and preferences.*

Just as it would be inappropriate to give physical care without an understanding of the patient's diagnosis and the goals of treatment, it would be inappropriate to proceed with spiritual care that is inattentive to the patient's beliefs. In the past, it was not uncommon for professional and institutional barriers to be established against health professionals asking patients about their faith.[13] A review of nursing literature indicates that conceptual clarity regarding spirituality needs further work and that issues of spiritual care continue to occupy the thoughts of nursing scholars.[8,17–19] Recent evidence that spirituality can be significant in patients' recovery from illness and that most patients want to include spirituality in their health care has changed the cultural environment for all health-care professionals.[20]

This development has been accompanied by a variety of proposed approaches to obtaining a patient's spiritual history.[7,10] The method developed by Puchalski is an example that has gained wide acceptance.[21] She proposes that patients be asked the following four questions:

1. Do you consider yourself spiritual or religious?
2. How important are these beliefs to you, and do they influence how you care for yourself?
3. Do you belong to a spiritual community?
4. How might health care providers address any needs in this area?

It is unlikely that everyone will agree that these are the best questions for obtaining a patient's spiritual history. However, regardless of the specific approach, nurses need to address at least two basic questions: What are the patient's spiritual needs and resources? And how will this impact the patient's care? There are many ways to script the specific questions that will help patients offer whatever information they choose to share. We can imagine a nurse saying, "I know that spiritual faith is important to some people when they need health care. Is there anything you want to tell me about your spiritual practices that might be helpful in your care?" Skillful nurses will find sensitive approaches to help patients disclose what they want their caregivers to know. Evidence from a number of studies shows that the majority of our society welcomes questions about their spiritual preferences from their health-care professionals.[6,21]

An adequate assessment of a patient's spiritual strengths, needs, resources, and preferences will often include some knowledge of his or her religious tradition. O'Brien states: "In order to engage in the assessment of spiritual needs and the provision of spiritual care for patients whose personal spirituality is intimately interwoven with religious beliefs and practices, the nurse should have some basic knowledge about the traditions of the major world religions."[14]

This norm may seem daunting for many nurses. After all, how much knowledge of "the major world religions" are most nurses likely to acquire? And how much would be enough? But in practical terms, O'Brien's prescription may not be too difficult to follow. The salient aspects of the faith traditions that most nurses are likely to encounter are not overwhelmingly difficult to know. Because the distribution of the members of various faith communities varies significantly throughout society, nurses in one region are likely to need a somewhat different bank of knowledge about religious traditions from nurses in another region. Fortunately, most nurses will have access to chaplains and local leaders of the various faith communities, who can serve as trustworthy sources of information about relevant religious beliefs and practices.

If a patient expresses a desire for prayer, some elementary knowledge of the patient's religious background should be

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helpful. In contrast, failure to have at least a minimal knowledge about the patient's religious heritage could contribute to the provision of less than fully respectful care. Thus the following caution:

> If you decide to engage in prayer for a patient, think of your action as meeting a spiritual need, not a religious one. Most religious beliefs share the common denominator of prayer, so don't worry if your religion differs from your patient's.[22]

This reassures nurses that they should not shrink from praying with patients just because they may not have a thorough understanding of their patients' religious tradition. And such reassurance is probably helpful. Still, the reason for caution is that religious beliefs can lead to very different understandings about the meaning, purpose, and form of prayer. Respectful caring begins with the nurse's attempt to understand how a patient's religious tradition, if there is one, might influence the way spiritual care, including prayer, is most effectively offered.

Patients typically bring many spiritual strengths and resources to the clinical setting. Puchalski's suggested questions for a spiritual history illustrate attention to such assets by asking about the importance of a patient's beliefs and membership in a "spiritual community."[21] Attention to the patient's spiritual resources, as well as needs, may open greater opportunity for genuine spiritual cooperation. Knowing that a patient wants the services of a particular spiritual leader or that the patient draws strength from a distinctive spiritual practice can be significant in the provision of respectful care. Skillful caregivers are also open to the remarkable potential of learning from their patients, who often have much to teach, especially in the realm of the spiritual.

In the process of securing a basic understanding of the patient's spiritual needs, resources, and preferences, a nurse is likely to have acquired information about the patient's attitude toward prayer. Murray suggests, "If you've done a complete spiritual assessment as part of your nursing history, you can probably judge whether your patient finds prayer comforting."[22] While this may often be the case, the introduction of prayer in the clinical setting is sufficiently sensitive to require the patient's consent. As O'Conner states, "A nurse always asks permission of the patient before introducing prayer."[10] Prayer may be considered part of respectful care only when permission is explicitly given.

*Pray only with permission.* The fundamental reason for seeking explicit permission for prayer is respect for the patient's autonomy, which is a central feature of respectful care and also leads to the statement of our second guideline:

> *2. Respectful care requires nurses to follow patient's expressed wishes regarding prayer with them.*

The last century saw a remarkable shift in health care's attention to the patient's autonomy. While the case can be made that seeking the patient's permission for treatment has long been our cultural norm, it was not until the 1970s, with documents such as the American Hospital Association's Patients' Bill of Rights and a spate of court decisions based on the requirement of informed consent, that patient autonomy arose as a dominant value in health care. Some may argue that we have gone too far in this direction, but there appears to be no turning back from the requirement that competent patients must be told the alternatives for treatment and asked what they will permit. Pellegrino, who has criticized too much reliance in health-care ethics on a narrow view of patient autonomy, nevertheless offers these strong words: "To ignore, override, repudiate, or ridicule the patient's values is to assault the patient's very humanity. This affront aggravates the disintegration of the person already there as a result of illness."[23]

> *"There appears to be no turning back from the requirement that competent patients must be told the alternatives for treatment"*

Another critic of an overreliance on patient autonomy concludes, "[T]he responsibility of the health-care provider is not so much to respect decisions, although that is surely the case, but to create an environment and a treatment plan that empowers the decision on the basis of the patient's values."[24] The point, well taken, is that nurses and other health-care professionals should not rely on the momentary expression of a patient who may be nearly a total stranger and whose ability to express his or her authentically held values may be impaired in many obvious or subtle ways. The goal of respect for the patient's autonomy is, to borrow Thomasma's word, to "empower" the patient to express the values he or she holds, and to understand autonomy as one feature of the patient's integrity or wholeness.[24] Obviously it takes time to understand

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enough about patient's underlying values and also what might be troubling them so their stated preferences on a particular matter can be located within the context of their larger integrity. This can be particularly true for something as deeply personal as prayer. As Shelly and Fish remind us, "If we do not have a fairly clear understanding of what is bothering the patient, we are not yet ready to pray."[11]

The importance of the patient's autonomy raises the additional question about whether the nurse should ask about prayer, suggest prayer, or simply wait for the patient to make a request. Some have urged considerable caution not just about prayer but all spiritual beliefs and practices. According to the authors of a prominent article, "It would…be disrespectful and not beneficial or supportive of autonomy to encourage patients to 'get' religious or spiritual beliefs if they do not have them."[21] This normative statement makes sense if what is proscribed is foisting religious beliefs or practices on patients. But this justifiable caution should not prevent caregivers from finding gentle ways to ask patients about their spiritual preferences.

*Spiritual practices must be voluntary.* Many patients may not be assertive enough to initiate prayer with nurses. If a major part of respecting autonomy is creating an environment in which it is safe and comfortable for patients to express their wishes, then it seems best for caregivers to ask.

But asking is not the same as prescribing. A gentle "Would you find it helpful if I prayed with you?" is different from "I think we should pray about this." And the difference is ethically weighty. This observation leads to our third guideline:

> *3. Nurses should not prescribe spiritual practices or urge patients to adopt religious beliefs, nor should nurses pressure patients to relinquish their spiritual beliefs or practices.*

For nurses who adhere strongly to a particular religious tradition or who have found great personal comfort in certain spiritual practices, the first part of this guideline may seem overly restrictive. However, respectful care requires nurses to refrain from using the clinical setting or their professional authority to promote religion or particular spiritual practices. It is sufficient to be attuned to the patient's already established spirituality. The clinical setting is not the place for proselytizing, and nurses' professional role does not include such activity.

Religion and spirituality issues become more contentious in terms of whether patients should be urged to relinquish beliefs or practices their caregivers consider detrimental to their health or health care. Post and his colleagues say that "we distinguish prayer as an alternative or substitute therapy from prayer as an adjunct to conventional medical therapy, and we strongly discourage the former."[21] The authors suggest that prayer, when it is complementary to established health care modalities is permissible, but prayer in lieu of health care should be strongly discouraged. For example, the cancer patient who refuses surgery or chemotherapy in favor of prayer challenges the established practices of empirically based health care. The complexity of this issue takes us beyond the scope of this article. It must suffice to say that respectful care should be attentive to widely divergent views about the relation of prayer to conventional health care. Nurses may often facilitate the communication that helps patients and their various caregivers understand and appreciate each other's convictions.

> *"What should nurses do if they believe that their patients' religious convictions may be harmful to their health?"*

Subtler still are the spiritual beliefs people hold that may be detrimental to their health, even though these do not interfere with conventional health care. Given the current enthusiasm for the positive health benefits of spirituality, it may be difficult to imagine that some spiritual beliefs can be harmful to one's health. However, Pargament finds evidence that patients' spiritual beliefs may be either helpful or harmful depending on the nature of those beliefs.[25–27] In his words, "religious methods of coping are neither always positive nor always negative."[25] He finds that some forms of religious coping are associated with greater distress and poorer patient outcomes. And he believes that a more comprehensive understanding of the relationship between spirituality and health requires that we study both the functional and the dysfunctional aspects of religious coping.

What should nurses do if they believe that their patients' religious convictions or spiritual practices may be harmful to their health or disruptive of their health care? The third guideline prescribes that nurses refrain from pressuring their patients to relinquish their spiritual beliefs or practices. Our culture has gradually come to the consensus that we should not force mentally competent adults to receive health care they find spiritually unacceptable, even if health-care professionals are convinced that failure to receive such care will lead to death. Hospitals are not prisons, and health-care professionals are not

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wardens or officers with the authority to coerce people to accept health care.

Still, none of this means that nurses should do nothing if they believe a patient's health may be in jeopardy because of his or her religious convictions. In some cases, the assistance of a spiritual care leader who is acceptable to the patient may be helpful. It is not uncommon to discover that members of a particular faith community may benefit from a deeper understanding of their own religious tradition. As Cohen and her coauthors observe: "Some patients, misunderstanding the tradition of their religious community, choose in idiosyncratic ways that could cause them injury."[13] Of course, it is not the proper role of the nurse to provide specialized spiritual assistance in such cases. But securing the help of an acceptable religious leader can sometimes have a salutary effect. Hospital chaplains and other specialists in spiritual care may also be able to assist patients in the exploration of the patients' belief systems in ways that may reduce dissonance or dysfunctional forms of coping. But, if not, then it is not the place of health care to force patients to yield their religious convictions. Health-care professionals "are not free," as Cohen says, "to coerce patients to change their informed religious convictions or to manipulate events in ways that conflict with those convictions."[13]

Whether or not patients have an interest in spiritual care, the obligation to provide respectful care remains. No patient should ever wonder if his or her nurse will provide less respectful care because their beliefs are different from their nurse's. Patients who trust their nurses will understand that their health care will not be in jeopardy because they have differing religious or spiritual practices—or because they have none.

While many other guidelines for patient care could be listed, these three provide basic illustrations of the normative meaning of respectful care. We turn now to the integrity of nurses and other caregivers who desire to care spiritually for their patients.

## Preserving personal and professional integrity

An essential ingredient in relationships of trust is the virtue of integrity. The ethical ideal of integrity is to be a whole person who has sincerity of purpose. Pellegrino links the concept of integrity to human wholeness in this way: "By the integrity of a person we mean the right ordering of the parts of the whole, the balance and harmony between the various dimensions of human existence necessary for the well-functioning of the whole human organism."[23] Viewed in this light, integrity is much more than honesty or trustworthiness. These are features of integrity, but integrity is the unity of all dimensions of a person's life so that he or she can function as whole person. Duplicity and insincerity are symptoms of loss of integrity. Underlying these symptoms is the failure to develop personal wholeness. This is why Pellegrino can add; "To violate integrity is to violate our whole being as humans."[23]

*Appreciate your own convictions.* Central to the pursuit of personal integrity is the examination of one's own convictions and values, including beliefs about what ultimately gives meaning to human life. A life of integrity is marked by actions that match well-considered beliefs. If spirituality may properly be defined as a quest for ultimate meaning, as we have done, then the development of integrity is linked to spirituality, because both have to do with the core of our personhood. As we observed at the outset, spirituality may be religious, or it may not be. Either way, spirituality is what secures meaning at the center of a person's life. This is why meaninglessness threatens integrity, or personal wholeness. The connection between spirituality and integrity leads to our fourth guideline:

> *4. Nurses who care for the spiritual needs of patients should seek to understand their own spirituality.*

Comprehension of one's own spirituality, including spiritual weaknesses, opens the way for respectful caring for another's spiritual needs. To quote Taylor, "The nurse's awareness of his or her sense of the spiritual…has a profound influence on the ability to provide effective spiritual care."[7] Spiritual self-awareness can be especially important when a patient asks for prayer. Nurses need an appreciation of their own convictions about the meaning and value of prayer if they are to be authentically present for the patient who requests prayer. Counsel given by two authors regarding prayer for clients in psychological therapy may also be appropriate for nursing:

> In the most unethical manner, therapists not guided by the principle of exploring and understanding their own beliefs, values, and needs might lead prayer in a manner which is unfamiliar and uncomfortable to the client, praying for the assumed needs of the client as well as a few of their own.[28]

*Spiritual care requires integrity.* A nurse's honest understanding of his or her own beliefs about prayer, including an assessment of his or her doubts or unresolved questions, can help ensure that the nurse is effectively attentive to the spiritual needs of the patient who wants prayer. These reflections on the relationship of integrity to spiritual care lead to the fifth guideline:

> *5. A nurse's participation in prayer with patients should be consonant with the nurse's integrity.*

There is no place in a trusting relationship or in the delivery

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of respectful care for inauthentic prayer. Elsewhere we have argued that it is sometimes possible to negotiate ethical compromises in ways that preserve integrity. This is often necessary in a culture where people with vastly different ethical visions live and work together and must find some middle way to resolve their differences. But we also recognize the boundaries of this strategy: "The limits of compromise are reached when we are so certain that a particular course of action is right or wrong that to compromise on that point would be to lose what is central to our sense of ourselves as moral agents."[29] Feigning participation in prayer would be a clear example of such disintegrating action.

There are, of course, a number of potentially effective strategies for nurses who are not comfortable praying with their patients. An obvious one is to request the services of a chaplain or a spiritual care specialist of the patient's own choosing. There may also be other nurses who could conveniently pray with the patient. Nurses who would not be at ease offering a prayer, may still choose to remain silently present as the patient prays. Creative exercise of integrity may find other useful approaches. A nurse who does not find prayer personally meaningful may still be supportive of patients who choose to pray.

For nurses who can, with integrity, join their patients in prayer there remain questions about possible differences in understanding the meaning of prayer or in sharing the form of prayer. Here, we would encourage sensitivity to the patient's needs and customs and flexibility in the nurse's participation. Prayer in the clinical setting is, after all, for the benefit of the patient. And it should be no breach of integrity for most nurses who believe in prayer to adapt to the expectations of their patients who desire prayer. In keeping with our first two guidelines, meeting the patients' spiritual needs will require careful attention to their spiritual beliefs and customs and to their permission. For example, believers in the major monotheistic religions pray to an all-powerful God. But the ways in which they address God may vary significantly. Some basic knowledge of these differences and a willingness to adapt to the spiritual needs of the patient may result in more respectful care without loss of the nurse's integrity.

Another important aspect of a nurse's integrity is the harmony between one's personal convictions and one's professional and social roles. We have taken the stance that prayer for patients is commensurate with the role of health-care professionals. Not all are in complete agreement with this. For example, Post and his colleagues have argued that, when physicians encounter patients' requests for prayer, the requests should be referred to chaplains or other spiritual leaders if possible.[21] Whether they would hold the same true for nurses is not clear. Our own sense of nurses' professional integrity leads us to conclude that nurses who believe in prayer should be willing to participate in prayer with their patients who ask for it. Nursing has generally been characterized by an inclusion of spiritual care at the center of the profession's identity. Prayer can be an important feature of the professional provision of spiritual care.

## Conclusion

In an era that has featured technologically sophisticated medical interventions, patients still desire spiritually nurturing care. Nurses should be prepared to offer care not only for physical needs but also for the needs of the human spirit in search of meaning. Prayer may be a helpful part of this care for many patients. Guided by ethical reflection, nurses who believe in prayer may pray with patients who request it. The guidelines we have presented are offered as illustrations of what respectful care requires and may be helpful in the lifelong quest for integrity. ■

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# Agape and the Deeply Forgetful

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We all feel at least a slight anxiety about dementia because it assaults the autobiographical narratives that constitute the very story of our lives. Are there hints of a deeper purpose underlying the universe even in such deep forgetfulness, both for those afflicted and those who care?

St. Augustine's sense of total awe at human memory rings out from the tenth book of his *Confessions*:

> All this goes on inside me, in the vast cloisters of my memory. In it are the sky, the earth, and the sea, ready at my summons, together with everything that I have ever perceived in them by my senses, except the things which I have forgotten. In it I meet myself as well. I remember myself and what I have done, when and where I did it, and the state of my mind at the time (x, 8).

Augustine set in motion a current of deep reflection on memory that carries forward in the works of Bergson, Proust, Chekhov, Dostoevsky, and others. He even believed that we are saved by memory. Despite all the false pursuits of happiness in possessions or accomplishments, our original human nature remains restless and on some level seeks true happiness in God. Our memories do

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not contain God; they do contain an all-important "still faint glow of light" that is nothing other than a memory, however dim, of a state of truer happiness (x, 23).

An estimated 90 percent of Americans with a diagnosis of dementia pray. They are thrown back onto whatever faith they have in the loving and beneficent purposes underlying the universe. They are shaken existentially, and must begin a final phase of their journey in remarkable spiritual courage. Empirical studies show this, and we see powerful case examples in such documents as President Ronald Reagan's 1994 "Letter to the American People," which is profoundly theological.

Rev. Robert Davis' *My Journey into Alzheimer's Disease* is an autobiographical account of living with the diagnosis and initial decline of Alzheimer's (1989). As Davis "mourned the loss of old abilities," he nevertheless could draw on his faith: "I choose to take things moment by moment, thankful for everything that I have, instead of raging wildly at the things that I have lost" (p. 57). A sense of attentive divine love sustained him, as did the love of his wife.

Throughout the course of progressive dementia, litanies, prayers, and hymns often have a deep emotional significance. Perhaps more contemplative and spiritual capacities are elevated as the capacity for technical (means to ends) rationality fades. Demented people continue to benefit from rituals that connect them with their spirituality. It is my belief that divine love never abandons the deeply forgetful, which is to say that it never abandons anyone, and is therefore truly unlimited.

I recall an old Catholic man with advanced dementia who could not speak unless a rosary was placed in his hand and someone started to recite the words of the Hail Mary. Then, surprisingly, he would go through the entire rosary on his own, verbalizing each prayer in order. The fragmentation of selfhood resulting from the deterioration of cognition requires spiritual mending. Is it possible that people with dementia might be spiritually enriched, even as they dwell within the depths of despair?

After returning from a national speaking tour for Alzheimer's families in late December 2000, I received the following e-mail from the daughter of a man recently deceased:

Hello Dear Friends:

As many of you know, my father has been suffering from Alzheimer's disease for the past 4.5 years. It has been a long and often very hard road for him, for my mom, and for me too. However, as of 7 p.m. last night, my father no longer has to struggle with the disease that robbed him of every part of his being, except one. He never once stopped recognizing my mom and never, ever stopped reaching out to her and wanting to give her a kiss. No matter how many parts of his personality were lost, no matter how many hospital visits full of needles and catheters, no matter how many diapers, he always retained his kind, gentle sweetness and his European manners as a gentleman. In the end, things went very quickly for him. He simply closed his eyes and closed his mouth, indicating no more food or water.

In this case, love constituted resurrection. Persons with dementia are not so different from the rest of us: they need to be loved, to feel good about themselves, to be respected, to be stimulated emotionally and relationally, to feel secure, to be included in activities, and to find moments of delight in the abundance of natural beauty. *They reveal these universal human needs to us who have forgotten them.* It is love that allows community and family caregivers to be buoyant in this darkness, preserving personhood and quality of lives.

A culture of dementia brings to light the emotional and relational aspects of those afflicted. There is the assertion of will or desire, usually in the form of dissent despite various coaxings. There is the ability to express a range of emotions, including positive ones. There is initiation of social contact (for instance, a person with dementia has a small toy dog that he treasures and places before another person). There is affectional warmth (for instance, a woman wanders back and forth in the facility without much socializing, but when people say hello to her she gives them a kiss on the cheek and continues her wandering). There is a remarkable appreciation for pet dogs and plants, which has resulted in sections of most nursing homes implementing the so-called "Eden Alternative" of a naturalistic environment with friendly animals. Individual memory fails, but quality of life in community remains a moral and practical goal. The loss of memory is similar to the loss of a leg, which can be replaced by a prosthesis. The family, the nursing home, and the church become prosthetics, supplying the remedy for a deficiency.

How can this be translated into practical reality? Caregivers should talk to everyone, even the most cognitively disabled, calling them by name and expecting a response. They may be surprised with a response. Speak with a warm and calm tone of voice. Have a joyful facial expression that affirms the other. Use pictures, music, verse, hymns, sacred scripture, poetry, meaningful symbols, and short simple prayers. Bend down to make eye contact, talking with them rather than around them. Empathically validate the feelings of the deeply forgetful, and do not feel obliged to reorient them into our reality.

A decade ago, I met Barbara McCurry in Charlottesville. Her father had passed away from Alzheimer's. She wrote me the following in a letter:

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*Agape and the Deeply Forgetful, continued…*

Looking back over the years, we feel we did some things well, some things not so well. We realize times were often difficult. However, there were good times too, seeing his face light up when we walked into the room, seeing his smile, watching him laugh, seeing him enjoying music or some other activity, receiving those big hugs, watching him sleep so peacefully after hours of restlessness, hearing him say 'I love you too!' or when he was no longer able to speak seeing the love in his eyes as he squeezed your hand so tightly! Yes, these and other memories are cherished. We're so thankful we were able to help him during his journey. All who knew him will remember his wonderful smile and Christian integrity. We've been told by many how he positively touched their lives in spite of, and even during his illness. We're convinced an Alzheimer's patient feels and yes, even comprehends, far more than we realize. Personally, we feel they never lose their need to be loved. Thank you and God bless you.

Barbara and her husband express what most family caregivers eventually do that there is still goodness in the lives of the deeply forgetful and this is worth our affirmation. And as is usually the case for family caregivers, spirituality is the dominant means of maintaining purpose.

The fitting response to the increasing incidence of dementia in our aging society is to enlarge our sense of human worth to counter an exclusionary emphasis on rationality, self-reliance, productivity, and "language advantage." We make too much of these things. Here the heritage of Stoic rationalism requires the leavening of Judeo-Christianity. The great Stoic philosophers achieved much for universal human moral standing by emphasizing the spark of reason (*logos*) in us all. Yet this is an arrogant view because it makes the worth of a human being entirely dependent on rationality, and then gives too much power to the reasonable.

Reinhold Niebuhr wrote, "since the divine principle is reason, the logic of Stoicism tends to include only the intelligent in the divine community. An aristocratic condescension, therefore, corrupts Stoic universalism" (1956, p. 53). Equal regard under the love of God, coupled with the remaining emotional, relational, and symbolic-expressive aspects of persons with advanced dementia, lead us to reject the hypercognitive assertion *cogito sum*, "I think, therefore I am," and replace it with the less arrogant notion, "I feel and relate, and above all, under God, I am." Theologian David Keck writes of his mother, who was diagnosed with Alzheimer's in 1990. He describes how she would chime in with hymns sung at services in the Yale chapel, and find emotional peace in the environment of worship (1996). Stripped of productivity, independence, and cognitive powers, she could "do" little but never lost her "being." In witnessing a beloved mother's decline, a son is reminded of those worshipful purposes that are most essential and most meaningful.

### An early life memory

Persons with cognitive disabilities need the sense of safety and peace that love creates; this universal need must be met in the context of dying. The first principle of care for such persons is to provide attention and tenderness in love, thereby revealing to them their value. As a culture of care, we must set aside the distorted position that a person's worth, dignity, and status as a human being depend entirely on their cognitive capacities. I prefer an "I-Thou" view of personhood that takes into account the emotional, symbolic, and even spiritual capacities of the person. Insofar as we live in a culture that is dominated by heightened expectations of rationalism, clarity of mind, and productivity, such expectations are internalized by persons with a diagnosis of early dementia and contribute to their despair. Our common purpose, however, must be to care for the deeply forgetful, and to see them as half full rather than as half empty. They are neither "shells" nor "husks" nor are they entirely "gone." They remain part of our shared humanity. Our purpose with them must be clear, lest we succumb to the banality of evil.

I prefer the way we treated my grandmother. I remember her lying in her nursing home bed. People did not use the word "Alzheimer's" back then, but that is what it probably was. Entering the nursing home, with all of its odors and senility, was shocking for a while. But grandmother had a warmth about her that was palpable. She offered dad and me peanuts—forgetting that she had already sucked away the candy coatings from these once pristine M&M's. We ate no peanuts. We did read stories and poetry to her, and helped with feeding. She smiled at the sound of our voices, and that mattered. ■

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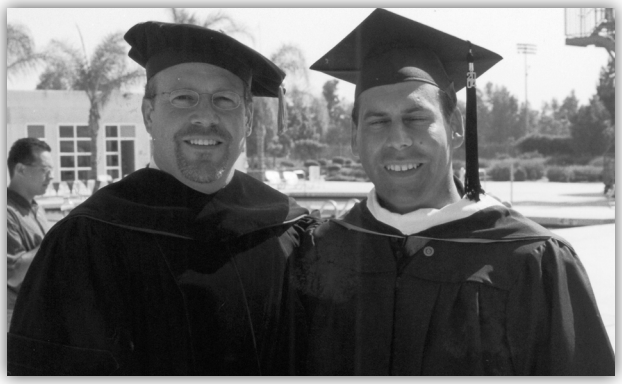
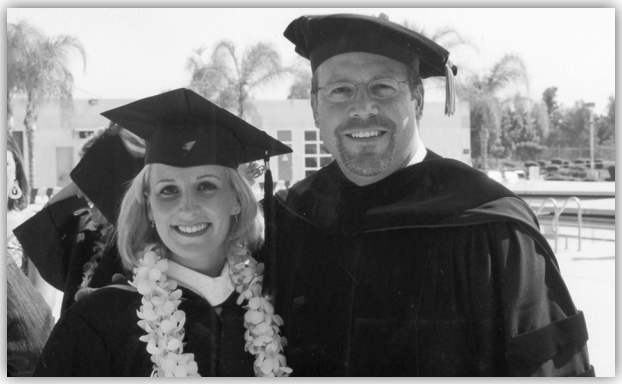
# *Congratulations to this year's clinical ethics graduates*



*Marco Artiano* (right) has a long and intense interest in medicine and ministry. The lines between ministry, medicine, and ethics are purposely held vague in Marco's life. His involvement in our program has been a means toward making a whole out of the often disparate elements of modern medical care. Marco will continue to shape his career in health care while pursuing further degrees in medicine and philosophy. He has a particular interest in the manner with which Albert Schweitzer blended ministry, medicine, and ethics in his reverence for life. We wish Marco well on his journey.



*Anika Ball* (left) came to my office some four years ago wondering if I thought she might be a feasible candidate for our MA in biomedical and clinical ethics. With an undergraduate degree from Walla Walla College and a dental hygiene degree from Loma Linda University she had become successful in her local dental hygiene practice. But she longed for an additional educational challenge in a field that she could integrate with her practice. The MA in bioethics seemed just the right fit. She was right on target! She has already distinguished herself as a scholar in the field of dental ethics by winning the Fifth Annual Dental Law and Ethics Student Award and having a paper published in the *Journal of the American College of Dentists.* Not one to rest on her laurels, Anika is now pondering what specific area of education she wishes to pursue next. No doubt she will continue to be a stellar student and professional.

*Grace Oei* (left) is one of a select number of individuals who manage to get both medical and masters degrees while studying here at Loma Linda University. Our combined degree program with the School of Medicine is one of the most rigorous and fulfilling degree programs available here. Grace has finished the program in fine fashion. I have a specific memory of Grace in my course in theological ethics. Her background and continuing interest in Seventh-day Adventist theology and practice will surely shape her medical practice. Both church and society are better off with Grace Oei working as a caring and compassionate physician!

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