Addressing the spiritual care needs of people near the end of life


**Abstract**

Spiritual care is increasingly being recognised as an essential component of healthcare practice. People with life-limiting illness and those who are recently bereaved are particularly likely to require this type of care. This article identifies some of the practical ways in which nurses can identify, support and assist people to meet their spiritual care needs.

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**Aims and intended learning outcomes**

The aim of this article is to help nurses adopt a practical approach to spirituality and spiritual care. It focuses on the role of nurses in helping patients and their families to deal with life-limiting illness and to meet their spiritual needs. After reading this article and completing the time out activities you should be able to:

- Define spirituality and spiritual care.
- Discuss the relationship between spirituality and health.
- Describe the potential spiritual effect of a diagnosis of life-limiting illness.
- Identify different ways of assessing a patient's spiritual care needs.
- List the principal communication skills required of the nurse providing spiritual care.
- Outline several examples of spiritual care interventions that might be performed by nurses.

**Introduction**

Spirituality and spiritual care have received increasing attention in the nursing and health-related literature over the past decade. Many journals now regularly publish articles on spirituality and spiritual care, and some deal exclusively with these topics. Many government documents relating to health and health care acknowledge the importance of the spiritual domain (Department of Health (DH) 2003, 2009a, 2009b). For the nurse, the study of spirituality and spiritual care opens up a number of exciting areas of learning and development, including the relationship...
between spirituality and health, the challenge of accurate and meaningful spiritual assessment and the potential for appropriate spiritual care to relieve suffering and improve quality of life.

Complete time out activity 3

Spiritual domain
Defining spirituality may be difficult, particularly because it is an aspect of human existence that it is experienced and interpreted differently by every individual. This difficulty is acknowledged by the DH (2009a): ‘Spirituality is difficult to define, as it can mean different things to different people, and its existence as a discrete phenomenon may be denied by some. In essence it is to do with making important connections which provide people with hope, purpose and comfort’. The European Association for Palliative Care (2010) established a taskforce on spiritual care within palliative care, and proposed a simple and practical definition: ‘Spirituality is the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or the sacred.’

The European Association for Palliative Care (2010) identified three distinct components of spirituality:

- Existential challenges, for example questions concerning identity, meaning, suffering, death, guilt and shame, reconciliation and forgiveness, freedom and responsibility, hope and despair, and love and joy.
- Value-based considerations and attitudes, including that which is most important for each person such as relations to oneself, family, friends, work, nature, art and culture, ethics and moral, and life itself.
- Religious considerations and foundations such as faith, beliefs and practices, and the relationship with god or ‘the ultimate’.

The Royal College of Nursing (RCN) (2011) provides a similar list of components, which includes hope and strength, trust, meaning and purpose, forgiveness, belief and faith in oneself and others (and for some this includes a belief in a deity or higher power), values, love and relationships, morality, creativity and self-expression. The RCN (2011) guidance points out that spirituality is a concept that extends far beyond religious beliefs and practices. This has been acknowledged by an overwhelming majority of respondents to an online survey of nurses conducted on behalf of the RCN in 2010 (McSherry and Jamieson 2011). However, for some people, spirituality is associated either wholly or partly with adherence to a certain faith tradition (Hawter 1995, Salman and Zoucha 2010, Thrane 2010). Indeed, some may regard illness almost exclusively within the context of religion and belief. In such cases, a working knowledge of the traditions, beliefs and practices of the major world religions is essential if nurses are to provide culturally appropriate care (Cioffi 2005, NHS Education for Scotland 2006). Furthermore, as the UK population becomes increasingly diverse in its beliefs and practices, the nursing workforce will need to be open and sensitive to that diversity.

For a significant proportion of the patient population, spirituality will not be associated with conventional religious adherence, but may be expressed (if it is expressed at all) in terms of a personal philosophy or a world view (Parkes and Gilbert 2011). These patients may not ‘fit in’ to the traditional categories that tend to be used, and risk having a spirituality imposed on them, which reflects either the dominant view in that particular society, or the attitudes and leanings of the staff caring for them. Neither of these approaches is acceptable (RCN 2011).

One of the greatest challenges of spiritual care is finding ways of identifying and addressing the spiritual needs of people in the absence of an identifiable religious framework or other value system (Creel and Tillman 2008). Often even the language used, laden with words that are symbolic of other traditions (for example, prayer, meditation, forgiveness, peace and transcendence) serves to alienate such people. As a result, a new language of spirituality may be needed, which recognises that not all individuals express their spirituality using conventional or readily identifiable terms (McSherry and Cash 2004). Inherent to this argument is the acceptance that the most useful concept of spirituality in health care may be one that is deliberately vague and flexible (Swinton and Pattison 2010).

Spirituality should always be regarded as unique to the individual. Even those who share the same religious tradition and come from similar cultural backgrounds may differ greatly in their spiritual wants and needs. Central to an individualised approach to spirituality is recognition of the intrinsic
identity, authentic self and unique relationships with others, the world and the infinite that characterise each patient (Edwards et al 2010). Nurses do not have to agree with, identify with or even understand a patient’s spirituality to provide effective spiritual care. This last assertion has led the author to challenge students in class with the rather unconventional statement that spirituality could be defined as ‘using things that don’t make sense to make sense of things’. **Complete time out activity 2**

The fact that healthcare professionals in general, and nurses in particular, seem to be taking a renewed interest in spirituality probably stems from a growing understanding of the potential role that spiritual wellbeing can play in determining overall health (Belcher and Griffiths 2005). Most models of health and wellbeing have at their core the concept that each individual consists of physical, psychological and spiritual components. Philosophical arguments continue about whether the spiritual should be seen as a component of the psychological, but such debate is beyond the remit of this article. However, health can be regarded as a state of wellbeing dependent on (and affecting) the state of the body, mind and spirit (Parkes and Gilbert 2011).

There is good evidence from the literature that spiritual health contributes to overall health and wellbeing (Narayanasamy 2007). For instance, retaining a sense of meaning in life has been identified as one of the factors enabling people with cancer to adapt to living with their disease successfully (Lethborg et al 2007). Religious beliefs and practices have also been shown to contribute to perceived health, even against a background of serious illness (Lin and Bauer-Wu 2003).

Spiritual wellbeing and the potential benefits of spiritual care (for both patients and caregivers) have perhaps been most intensively studied in people with advanced cancer (Boston and Mount 2006). However, studies have also shown that these are important considerations in other specialties, such as critical care nursing and the care of older people (Mowat 2005, Carpenter et al 2008).

Mental health is another area of practice where interest in spiritual care appears to be growing. Parkes and Gilbert (2011) reviewed the evidence for integrating spiritual care in mental health and concluded that ‘a service which fails to address a person’s animating or life-giving principle may be hitting a target but missing the point.’ Parkes and Gilbert (2011) recommended that spiritual care should be humane, ethical and effective, and that it should be incorporated into mental health services as a means of engaging with the whole person and their whole life situation.

**Spirituality and palliative care**

There is perhaps no other area of health care where spirituality takes on greater significance than in end of life care. The pioneers of hospice care, such as Dame Cicely Saunders, emphasised the importance of identifying and addressing spiritual needs and concepts such as total pain, and acknowledging the relevance of the spiritual domain to suffering and healing (Milligan and Potts 2009). Furthermore, the World Health Organization (2011) suggests that palliative care ‘integrates the psychological and spiritual aspects of patient care’.

Few people anticipate the effect of a terminal diagnosis on spiritual wellbeing. Some people may go through life without contemplating seriously the meaning or purpose of life. Similarly, there are individuals who may not anticipate the effect of a terminal diagnosis on spiritual wellbeing. When the individual realises that life is suddenly limited, any illusion of security that previously existed may be shattered. This is what Coyle (2004) refers to as the ‘existential slap’. Many people will be able to mobilise strategies that enable them to adapt to and cope with this new challenge to their wellbeing (Ando et al 2008). Indeed, for some people, that realisation of their own mortality can lead to positive outcomes, including personal growth and transformation (Wayman and Gaydos 2005, Arnold 2011). However, for others, the result can be acute existential despair, loss of spiritual integrity, loss of a sense of meaning and purpose in life and increased suffering (Narayanasamy 2007).

The spiritual ramifications of a diagnosis of life-limiting illness can be evident in the questions people ask healthcare professionals. Some of these questions are listed in Box 1. **Complete time out activity 3**

Questions such as these demonstrate that dying is, at least in part – and at least for some people – a spiritual encounter. It may be a time when a sense of self and inner peace are threatened fundamentally (Narayanasamy 2007). It may also be a time when spiritual reserves are diminished, leading to inability to cope and increased suffering (Wayman and Edwards et al 2010). Before reading further, think about your definition of the word spirituality. What does it mean to you, personally? You may or may not have a sense of a spirituality of your own, but you are likely to have some thoughts about what topics might fall into the spiritual domain. Make a list of as many as you can.

Would you know where to find out about the spiritual needs of a patient who belongs to a different religion to you? Download or obtain hard copies of some of the following resources: NHS Education for Scotland 2006, 2009, DH 2009a, 2009b. It is important to note that these only give broad generalisations about the different faith groups. They are not a substitute for an individualised approach.

Think about the questions that people ask when they are told or become aware that they have a life-limiting illness. Make a list of any questions that you have heard, and any others that you think might be asked. Reflect on why patients ask such questions when most are impossible to answer.
McSherry (2011) interviewed a group of hospice patients and identified three meta-themes within the coping strategies they employed. These were:
- Life review leading to reorganised life perspectives.
- Factors related to attitudes about death.
- Lifestyle changes, including living while dying and finding an acceptable and satisfying completion to life.

From this and other studies, it is apparent that dying and death are times when at least some patients will experience spiritual distress that may contribute to suffering and spiritual work – such as resolving spiritual issues and coming to terms with the personal reality of death. These will manifest as spiritual care needs. These needs are often difficult to ascertain. However, Galek et al (2005) have identified seven dimensions of spiritual need. These are listed in Box 2.

Patients are not alone in experiencing spiritual and existential distress associated with dying and end of life. Caregivers and others closely associated with the dying person may have similar experiences that translate into spiritual needs (Murray et al 2004, Buck and McMillan 2008). For example, an Australian study found that around 5% of active caregivers interviewed some time after their loved one had died would have found additional spiritual support helpful (Hegarty et al 2011).

It should not be assumed, however, that everyone with a life-limiting condition or terminal diagnosis (and those close to them) will have spiritual needs. Murray et al (2004) interviewed a group of people who were dying from either heart failure or lung cancer and concluded that spiritual issues were significant for many patients (and their carers) in these two groups in the last year of life. However, other studies have shown that the prevalence of spiritual or existential distress among people approaching the end of life can sometimes be relatively low. For example, one group of hospice patients rated spiritual needs as sixth most important out of seven identified domains of end of life need (Arnold 2011). However, such findings could be the result of the recording methods used, which in this case allocated items such as fear, letting go and dying to non-spiritual domains.

Even when existential concerns are present, existential distress may not automatically result. For example, Blinderman and Cherny (2005) interviewed members of a culturally diverse, Middle Eastern Jewish population with advanced cancer and found that patients were often able to draw on family support, their own coping strategies and their own belief systems to circumvent any spiritual distress they might otherwise have experienced. In other words, patients may be able to deal with the spiritual issues they face without relying on support from healthcare professionals. This last conclusion may explain why some patients report that they do not wish nurses to help them address their spiritual needs (Taylor 2006).

**Role of the nurse in spiritual care**

It is generally accepted that spiritual care is, at least partly, within the remit of the nurse (DH 2009a). According to the Nursing and Midwifery Council (2010), every nurse ‘in
partnership with the person, their carers and their families... should make... a holistic, person-centred and systematic assessment of physical, emotional, psychological, social, cultural and spiritual needs, including risk, and together... should develop... a comprehensive, personalised plan of nursing care. ‘The implication here is that spiritual assessment and spiritual care are integral to the role of the nurse.

Nurses themselves seem to be comfortable about the inclusion of spiritual assessment and spiritual care in their role, even if they are sometimes uncertain about having sufficient expertise or being able to overcome the barriers that may get in the way (Murray 2010). Milligan (2004) surveyed the opinions of 59 registered nurses undertaking post-registration education and found that more than two thirds agreed with the statement that ‘spiritual care is the responsibility of nurses’ either ‘very much’ or ‘quite a lot’. An online survey of RCN members in 2010 found that respondents had a broad and inclusive concept of spirituality, and the majority regarded spiritual care as a fundamental part of their role (McSherry and Jamieson 2011).

It should be remembered, however, that other groups also have a role to play in meeting individuals’ spiritual health needs. Guidelines produced by NHS Education for Scotland (2009) identify three distinct spiritual care roles. The first, that of routine spiritual care, is envisaged to be the responsibility of all NHS staff while the second, more complex spiritual care tasks, such as assessment and identification of need, and routine pastoral care, is to be taken on by spiritual champions, including some nurses. Chaplains and other counsellors fulfil the third role, providing complex spiritual and pastoral care. This model recognises the continuum of need that could exist for spiritual care, and helps to identify the boundaries that may define the roles of nurse and chaplain.

More complex collaborative models have also been proposed, reflecting the potential contributions of all members of the multidisciplinary team as well as family members, the community and patients themselves (Puchalski et al 2006). The role of family caregivers is potentially important, and there is evidence that they are sometimes well equipped to explore spiritual concerns with and administer spiritual care to their loved ones (Boston and Mount 2006). Finally, it is important to acknowledge that patients themselves often have remarkable potential for self-transcendence and healing in the spiritual domain (Arnold 2011).

Complete time out activity

Assessing spiritual need

Assessing the need of a particular individual for spiritual care is difficult, not least because the nature of spirituality will vary from individual to individual. There may also be challenges associated with a lack of shared vocabulary or a shared conceptual framework in which to explore need. Some patients may have no spiritual needs and this position should be respected. However, Vachon et al (2009) have identified 11 dimensions of end of life spirituality, which may inform the process of spiritual assessment in this patient group. These are listed in Box 3.

Recognising the various dimensions of end of life spirituality has enabled a number of spiritual assessment tools to be devised. However, sometimes the most simple of questions can be sufficient to open up discussions about spiritual matters. A doctor known to the author regularly followed up the usual ‘How are you?’ question to patients during the ward round with a supplementary question: ‘But how are you really?’ Patients almost always knew that this was an opportunity to explore deeper issues, but the question was always asked in a way that allowed patients to choose not to ‘go there’ if that was their wish. The literature contains numerous examples of other ‘gateway’ questions. For example, Speck (2003) suggested asking: ‘In the course of your life,

BOX 3

Dimensions of end of life spirituality

- Meaning and purpose in life.
- Self-transcendence.
- Transcendence with a higher being.
- Feelings of communion and mutuality.
- Beliefs and faith.
- Hope.
- Attitude towards death.
- Appreciation of life.
- Reflection on fundamental values.
- Developmental nature of spirituality.
- Conscious aspect.

(Vachon et al 2009)
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With all its ups and downs, have you found ways of making sense of the things that have happened to you? While Steinhauser et al (2006) recommended using a more direct question: ‘Are you at peace?’ Clearly, patients will vary in their reaction to such questions, and the nurse should choose carefully when deciding how best, when and even if to start a conversation on this sensitive topic.

A number of semi-formal spiritual assessment tools have been developed, and create the possibility of focused exploration of potentially complex spiritual needs. These tools generally consist of a series of questions which seek to address the main areas of spiritual concern for patients. The FICA Spiritual History Tool was developed by Christina Puchalski at the George Washington University in Washington DC. This tool focuses on four domains:

- **F** = faith and belief.
- **I** = importance.
- **C** = community.
- **A** = address in care.

It has been shown to be a feasible way of conducting spiritual assessment in an outpatient population in the United States (US) (Borneman et al 2010).

The similar HOPE approach to spiritual assessment is based on four concepts (Anandarajah and Hight 2001):

- **H** = sources of Hope, strength, comfort, meaning, peace, love and connection.
- **O** = the role of Organised religion for the patient.
- **P** = Personal spirituality and practices.
- **E** = Effects on medical care and end of life decisions.

This tool was developed primarily for doctors working in primary care settings.

Both tools were devised in the US and developed with a predominantly Judeo-Christian population in mind. Therefore translation to other settings and cultures may not necessarily be easy. Someone who is personally or culturally reticent about discussing spiritual matters, or someone who has no religious framework or vocabulary to use as a starting point for such discussions, may find the direct questioning associated with such tools intrusive or inappropriate. There is then the possibility that such people will fail to have their spiritual needs identified or addressed.

More complex, multidimensional tools have also been developed. These include the Spiritual Need Questionnaire (Büssing and Koenig 2010) and the Functional Assessment of Chronic Illness Therapy – Spiritual Well-being Scale (Ando et al 2008). Such instruments are demanding of time and labour intensive, and generally not well suited to the clinical setting. Instead, they are used mainly to generate outcome measurements of spiritual wellbeing for clinical trials and other research studies.

McSherry and Ross (2002) urged caution concerning the development and use of spiritual assessment tools because of multiple risks, including overburdening patients and nurses with unnecessary paperwork, uncovering issues that are then subsequently not dealt with and alienating certain groups through inappropriately worded questioning. They conclude that much work has still to be done to develop spiritual assessment tools that are evidence based and contribute to the provision of effective and appropriate spiritual care.

Nurses will often identify people in need of spiritual care, not by the use of questions or spiritual assessment tools, but by observation and subtle enquiry. For example, one participant in an unpublished study of hospice nurses’ experiences of spiritual care described what she looked for (Milligan 2000):

‘I think the common signs that I would be aware of when I am caring for somebody is that inability to sleep and not be rested. I know that people have insomnia for all sorts of different reasons, but I think in the front of my mind, probably working here, when I’m on night duty, that’s the kind of things that I would be looking for; people that are not sleeping; people who are awake until the sun rises, then they seem to be able to get to sleep; people who are fairly withdrawn, who find it difficult to articulate how they feel. People may be quite up front and say that they feel frightened, but they’re not sure what they’re frightened about. And for other people, I think it’s when it’s difficult to actually pinpoint what’s wrong; when people almost become so withdrawn and almost depressed, that they become irritable, and almost unresponsive, where they’ve sunken, kind of so deep into themselves, that they are so dominated by fear, so dominated by anxiety, that they can’t function as themselves anymore.’

Detailed and accurate assessment of an individual’s spiritual needs is important and should not be neglected. However, some of the most effective interventions begin with a nurse simply sensing the patient’s anguish. Guidance from NHS Education for Scotland (2009) on spiritual care matters states...
that: ‘Spiritual care begins with encouraging human contact in a compassionate relationship, and moves in whatever direction need requires.’

Complete time out activity

Effective communication is essential to foster a trusting nurse-patient relationship that allows individuals to share their spiritual needs. McSherry (2006) identified the following communication skills as particularly important:

- Attentive listening – focusing on what the person has to say without prejudice or distraction (verbal and non-verbal) and being comfortable with silence.
- Non-verbal communication – being aware of one’s own facial expressions, body language and other non-verbal cues, and being able to communicate compassion, honesty and sensitivity in an unforced way.
- Presence or giving time – being with the individual in a physical, psychological and spiritual sense.

**Spiritual interventions**

Some years ago, an American doctor who had advanced cancer wrote a pamphlet entitled ‘Don’t just do something, stand there’. In these words (which echo ideas from Zen Buddhist philosophy), he was exhorting nurses to spend less time ‘doing to’ and more time ‘being with’ dying patients. This is perhaps the first lesson that has to be learned about spiritual caregiving – that presence is important in itself. By his or her caring presence, the nurse identifies with the patient in his or her suffering and conveys convey dignity and respect. By his or her caring presence, the nurse identifies with the patient in his or her suffering and conveys dignity and respect.

Puchalski et al (2006) identified six distinct roles that the nurse might use in the spiritual care of a dying patient. These are:

- Building trusting relationships and conveying dignity and respect.
- Providing a supportive, peaceful environment.
- Changing goals of care and hope.
- Active listening, presence and attending.
- Spiritual care assessment.
- Collaborating with the interdisciplinary team.

The spiritual care competencies compiled by Marie Curie Cancer Care (2003) identify four levels of practice which are summarised in Box 4.

Such a framework has the advantage of identifying the knowledge required and the actions expected of any nurse practising at a particular level. It also enables a hierarchy of care to be provided, where increasingly complex skills and interventions are available to address increasingly complex needs.

In practice, however, much spiritual care is not provided in a structured way, but arises from nurses responding directly to immediate need. A study of the spiritual caregiving behaviours of hospice nurses found three main dimensions of practice: providing a therapeutic presence, sorting through spiritual issues as they arise and referring to religious or spiritual care ‘experts’ (Milligan 2000). Spiritual caregiving is not provided in a structured way, but arises from nurses responding directly to immediate need.

**BOX 4**

**Spiritual and religious care competency levels**

- **Level 1**
  - Basic skills of awareness, relationships and communication, and the ability to refer concerns to members of the multidisciplinary team.

- **Level 2**
  - Increased awareness of, identification of and response to spiritual and religious needs.

- **Level 3**
  - Assessment of spiritual and religious needs, development of a plan of care, and recognition of complex spiritual, religious and ethical issues.

- **Level 4**
  - Management of complex spiritual and religious needs, liaison with external resources and provision of training, support and education to others.

(Adapted from Marie Curie Cancer Care 2003)
also determined in practice by what patients want from those responsible for their care. There will be significant variation between individuals. However, a North American study found that the most common reported spiritual needs among patients were ‘for love and belonging’ and ‘to find meaning and purpose’ (Flannelly et al 2006). There is also evidence that patients prefer interventions that are ordinary and everyday, not particularly intimate and not overtly religious (Taylor and Mamier 2005).

Examples of spiritual care

It should be clear from the preceding discussion that there are numerous ways in which nurses can help patients and their loved ones to identify and address their spiritual needs. Some of these interventions will result from complex spiritual assessment and will be delivered in a carefully planned and structured manner. Others will happen spontaneously or will be provided on an informal basis. Indeed it is notable that many nurses are able to integrate spiritual care interventions with other duties. As a result, even simple tasks such as bathing the patient or settling him or her at night become opportunities for spiritual care (Milligan 2000).

Being present

Perhaps the most fundamental spiritual care intervention has already been mentioned, that of being present. Martins and Basto (2011) described a nursing accompaniment that is ‘interactional, dynamic, integral and systematic.’ It is not passive or casual, but deliberate and relentless. The potential benefits for patients include a sense of not being abandoned, of being valued and of being cared for (Ellenberg 2005, Puchalski et al 2006, Zikorus 2007).

Accompanying

For many people with life-limiting illness, the journey towards death is a lonely one. Few who have not been there before know the territory, and the final part of the journey will inevitably be made alone. However, for much of that journey, the nurse may be the patient’s closest companion. Accompanying the patient can create a sense of shared humanity. It can engender feelings of communion and community. The connections formed with a nurse or other professional may also give the patient courage to start reforming connections with oneself, with others and with sources of faith and peace which had been lost (Martins and Basto 2011, Edwards et al 2010).

Harmonising environment

Care environments can be dispiriting. Some spiritual comfort may be achieved through the modification of care environments to create opportunities for peace, quietness and contemplation (Narayanasamy 2007, Hathaway 2011). Access to light, music or nature may also be uplifting (Edwards et al 2010).

Managing the ‘scene’ at the very end of life is particularly important. Ideally, as much of the ‘paraphernalia’ of medical and technical care as possible should be removed to create a more ‘natural’, harmonious environment (Martins and Basto 2011). Family members can be encouraged to replace professionals in the ‘inner circle’ of care if they wish. Teaching them simple skills such as hand massage and basic mouth care, if permitted by local policy, will encourage a sense of purpose and intimacy. Such moments at the end of life are almost always remembered as meaningful and profound.

Encouraging reminiscence and life review

Death in modern Western society often takes place remote from life. There may be a physical separation, if death takes place in hospital or another unfamiliar setting. However, there may also be a personal separation, between the person who is dying and the person they once were. Being able to recover a sense of personhood, and being able to contemplate death in the context of a life lived have been found to be beneficial for some patients (Ando et al 2010). Family photographs can sometimes be used to elicit forgotten memories. Recalling a life that is about to be lost can be poignant and painful for all concerned, but recognising past successes may give a sense of achievement as well as contributing to the recovery of meaning (Lethborg et al 2007, McSherry 2011).

Assisting planning

Consciously preparing for death, usually centred on the patient planning his or her own funeral, requires considerable courage on the part of the dying person and great sensitivity on the part of the nurse. However, there is evidence that patients receive spiritual as well as practical benefits from carrying out such ‘death work’ (McSherry 2011). It is possible that patients can derive some sense of accomplishment from finding an acceptable
conclusion to their life. Also, the process by which decisions are reached may involve beneficial life review and completion of unfinished business.

**Signposting to others**

The examples provided here give insight into the many roles the nurse may have in supporting patients and families with spiritual needs near the end of life. More complex interventions such as spiritual counselling, addressing unresolved issues and enabling self-transcendence are likely to be carried out only by nurses with specific, advanced training in spiritual care. Usually, the nurse’s role in this context is to recognise, in conjunction with the interdisciplinary team, when the patient’s need exceeds his or her skills level, and to signpost the patient to appropriate specialist help. An awareness of the services that are available and an effective working relationship with the pastoral or spiritual care team will be invaluable.

**Conclusion**

This article has addressed the challenging and thought-provoking area of spiritual care near the end of life. It has explored some of the theoretical and ethical aspects of the topic, but has focused primarily on the practical ways that nurses can meet patients’ spiritual needs. For nurses, this type of work can be emotionally and spiritually challenging. However, there are also profound benefits. As nurses care for dying patients, they have an opportunity to learn about themselves, transforming experience into wisdom and experiencing healing as they seek to relieve the suffering of those in their care.

**References**


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