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Spiritual Care Education of Health Care Professionals

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ABSTRACT

The nurses and health care professionals should have an active role in meeting the spiritual needs of patients in collaboration with the family and the chaplain. Literature criticizes the impaired holistic care as the spiritual dimension is often overlooked by the health care professionals. This could be due to feelings of incompetence due to lack of education on spiritual care, lack of inter-professional education (IPE), work overload, lack of time, different cultures, lack of attention to personal spirituality, ethical issues and unwillingness to deliver spiritual care.

Literature defines spiritual care as recognizing, respecting, meeting patients' spiritual needs, facilitating participation in religious rituals, communicating by listening and talking with clients, *being with* the patient by caring, supporting, showing empathy, promoting a sense of well-being by helping them to find meaning and purpose in their illness and overall life; and referring them to other professionals including the chaplain/pastor.

This paper outlines the systematic mode of intra-professional theoretical education on spiritual care and its integration into their clinical practice, supported by role-modeling. Examples will be given from the author's creative and innovative ways of teaching spiritual care to undergraduate and post-graduate students. The essence of spiritual care is *being* in *doing* whereby personal spirituality and therapeutic use of self contribute towards effective holistic care.

While taking into consideration the factors which may inhibit and enhance the delivery of spiritual care, recommendations are proposed to the education, management, clinicians and further research to ameliorate patient holistic care.

Keywords: spiritual care, holistic care, education, intra-professional students, health care professionals

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Introduction

The International Council of Nurses **(ICN) Code of Ethics** (2000 p.5) specifies the nurse's role of promoting 'an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected'. This is supported by the **Malta code of Ethics** for nurses and midwives (1997 p.3) stating that the nurse is to 'recognize and respect the uniqueness of every patient/client's biological, psychological, social and spiritual status and needs'. Since patients are attended by the diverse members of the multi-disciplinary team, these codes of ethics address also the holistic care of the health care professionals which contribute towards patients' safety. Examples of some heroes in nursing are given whereby their *being* in care generated signs of spirituality in their attempts to address patients' needs and their caring attitude instilled hope and healing.

Florence Nightingale (1860) proposed that the environment should do no harm to patients. In this paper, the environment is provided by the presence of the nurses and health care professionals, including the ward management personnel who attempt to deliver care holistically.

Patients' safety may be achieved by individualized spiritual care whereby care is given according to the patients' biological, psychological, social, cultural and spiritual needs (Baldacchino 2003).

Similarly, **Mary Seacole** (1805-1881) known by soldiers under her care in Crimean War, as 'Mother Seacole' because she nursed sick soldiers so kindly. Mary suffered from prejudice and racism as her mother was from the Caribbean island of Jamaica and her father was Scottish. However, courageously, Mary made her own way in the world, as a single woman and as a person of mixed race. Mary learned her nursing skills from her mother, who kept a boarding house for invalid soldiers. Mary mixed medicine with kindness. She is an admired role model to nurses and health caregivers.

Additionally, **Elisabeth Cadwa-ladyr** from Wales volunteered to nurse the sick soldiers in the Crimean War with Florence Nightingale in 1854. Strong willed Betsy did not like Florence Nightingale and was angry at being

assigned to mend old shirts and sort rotting linen instead of being allowed at the centre of action that is the Crimean peninsula. Therefore, Betsy left for the hospital at Balaclava and immediately set to work to treat the infested wounds of the soldiers. Also she was put in charge of the special diet kitchen and made sure that the soldiers had good food produced from the best ingredients. However, ill health forced her to return to Britain. Her biography says that Betsy was devoutly religious and the small Welsh Bible, given to her when she was young, remained her 'constant companion' and appeared to help her overcome the disappointments of her distorted plans in life and accept her situation in life. Betsy travelled widely around the world and also visited **Malta**, Greece and Egypt.

During the last twenty five years, care of patients has been criticized for neglecting the spiritual dimension in patient care (Baldacchino 2006; McSherry & Ross 2010). This may be due to various reasons such as, unwillingness to deliver spiritual care; lack of time, work overload, feelings of incompetence to deliver spiritual care and lack of education and lack of inter-professional education in the undergraduate and post-graduate curricula which generate omission of spiritual care (Baldacchino 2006, McSherry 1998, Ross 1994), secularization of the contemporary society and the medical model, the attention of which is the illness of the patient and its progress of cure, which overlooks the spiritual dimension in care, and fails to address religious needs and spiritual needs, and thus threatening holistic care.

Definition of Spirituality in illness

Spirituality is derived from the Latin word *spiritus*, *spirit*, the essential part of the person (Piles 1990) which "controls the mind and the mind controls the body" (Neuman 1995:48). Religion may shed light on the interpretation of this spirit. For example, as a Roman Catholic person, I relate this spirit to the spirit of God within me which gives me life day by day. Also, spirituality is 'the power within a person which motivates the person to find meaning, purpose and fulfilment in life, suffering and death and fosters hope to one's will to live' (Renetzky 1979, Golberg 1998). It infers that spirituality is the vital life force which unifies all aspects of the human being, including the religious component (Reed 1992, Baldacchino 2003, Neuman 2010).

However, spirituality goes beyond religious affiliation as it strives for inspirations, meaning and purpose in life, even in those who do not believe in any god (Narayansamy 1991, Baldacchino & Draper 2002).
Consequently, spirituality applies to both the believers and non-believers, including the presence of different cultural and religious beliefs.
Thus, a person who is in tune with this vital unifying life force of the spiritual dimension, a more balanced state of physical, mental and social well-being will result.

In order to understand patients' concealed holistic needs, let's try to put ourselves in the position of these clients seen in this video-clip.

Video clip: (4 mins 44 secs)
Captions of different patients ……

You might wonder then what spiritual care means! …… Just think about it! …….. What if **you**, or rather, what if **I** were to be one of the patients seen on the video clip? It could be reality to you and me!

What would it mean to you, if you were to receive a result of a metastasis after having procrastinated to seek medical advice? Oh, it's all my fault!
What if you were alone in the clinic, receiving information about the possible different treatments for your surgery and you were too shocked to understand all that information?
From total independence, a stroke might drive you to the opposite pathway of dependence in life! Then, who do you think would be able to take care of you in such a busy work oriented life?

We often take care of immigrants with different cultures. What if you were to live in the 1950s in Malta when bread winners, usually men, risked their freedom and travelled to some other countries for a better future for their family?

What if you are waiting outside the clinic for a result of a mammogram or a biopsy, and you are told, 'Please wait for the doctor to speak to you'! A diagnosis which will jeopardize your life, including the life of the ones around and their family!

In all these instances a person becomes a patient! What a difference! From independence to dependence; from a secure life to a life full of uncertainties! Thus, patient care needs also to address the spiritual distress and spiritual needs by the delivery of spiritual care not only by the chaplain but also by the various members of the multi-disciplinary team who may help patients to find meaning and purpose in their illness and life.

Definition of spiritual care

Spiritual care is part of the art of nursing and professional care (Giske 2012). Spiritual care is defined by the literature, as recognizing, respecting, meeting patients' spiritual needs, facilitating participation in religious rituals, communicating by listening and talking with clients, *being with* the patient by caring, supporting, showing empathy, promoting a sense of well-being by helping them to find meaning and purpose in their illness and overall life; and referring them to other professionals including the chaplain/pastors (Baldacchino 2006, Ross 1997, Piles 1991, Taylor et al 1994). The outcome of spiritual care was found to enable patients to count their blessings in life, achieve inner peace and explore coping strategies to overcome obstacles during illness and crisis situations (Baldacchino 2003, Kociszewksi 2003). Also, spiritual care may help patients to find a new equilibrium in faith by re-conceptualising the self as one who is known and loved by God in the context of their specific illness (Van Dover & Pfeiffer 2011).

The essence of spiritual care is ***being*** rather than simply ***doing*** (Halm et al. 2000, Tuck et al. 1997, Turner 1996); ***being*** in ***doing*** (Baldacchino 2010). Thus, therapeutic use of self is of utmost importance (Van Leeuwen &

Cusveller 2004). The role of the multidisciplinary team is to help patients find meaning in illness and purpose in life with a positive outlook to life and/or afterlife. Thus, spiritual care is not merely the delivery of care which matters, but it includes the ***heart and the spirit*** by which holistic care is given (Younger 1995, Bradshaw 1994, Piles 1990).

In order to address spiritual needs both in health and in illness, competences are needed to guide the education of the health care professionals.

Aim

The aim of this paper is to present modes of theoretical and clinical education on spiritual care of health care professionals and students; and outline the dimensions of spiritual leadership to sustain the learning process.

Competences in Spiritual Care

The Nursing and Midwifery Council (NMC) in the UK (2002), in line with the European Qualifications Framework (EQF) (2008) defines competence as 'the proven ability to use knowledge, skills and personal, social and /or methodological abilities in the work or study situations and in professional and personal development' (p.11) referred to as 'responsibility and autonomy' (EQF 2008 p.11).

Benner's Theory 'From Novice to Expert' (1982) defined nursing competency as the ability to perform a task with desirable outcomes under the ***varied*** circumstances of the real world. Benner placed competence in the middle of the continuum ranging from: novice to advanced beginner, to competent, to proficient, to expert. Competent practitioners are consciously able to plan their actions, but lack the flexibility and speed (Benner, 1984). The practitioner is described as 'tolerably good but less than expert' because when practitioners are considered competent, they would still have something more to achieve (Erau, 1994) for them to reach the level of proficiency and expertise (Benner, 1984). This is highly applicable to the education of health care professionals. While considering the characteristics of the students who are undertaking the nursing, medical and paramedical education programmes, who are young, with lack of personal life experiences and with minimum attention to spiritual issues in life, it is very

important not only to equip students with loads of ***information***, but also attention needs to be given to their personal ***formation*** as spiritual individuals, who find meaning and purpose in their profession, and to help them develop the necessary skills and attitudes across their education programmes in class and in the clinical practice. This process will contribute towards ***transformation*** into a professional health care *being* who becomes ***responsible*** and ***accountable*** for holistic patient care *including* the spiritual dimension of care.

Students and health care professionals need to achieve competence i.e. acquiring knowledge, skills and attitudes. Spiritual care competence is defined as an *active* ongoing process characterized by three interrelated elements which involve a growing awareness of one's value, developing an empathic understanding of the client's world view and the ability to implement individualized interventions appropriate to each client (Hodge, 2004a).

Research on competences in spiritual care is growing. An exploratory study in Malta which collected qualitative data from nurses, hospital and community chaplains and patients with heart attack (Baldacchino 2006) revealed the following seven *generic* competences:

1. Integrating the individual person within the role of the nurse as a professional;
2 Assisting the search for meaning of illness and acceptance of illness;
3. Maintaining trustful relationship with patients and family;
4. Communicating with patients, inter-disciplinary team and clinical/educational Organizations;
5. Delivering spiritual care by the four stages of the nursing process i.e. assessment, planning, implementation and evaluation;
6. Controlling ethical issues in care such as, confidentiality, data protection issues;
7. Delivering holistic care.

These findings supported the three core themes derived from an extensive literature review (Van Leeuwen & Cusvellar 2004) found *three core* domains of competences for spiritual care namely,

i) awareness and use of self;
ii) spiritual dimensions of the nursing process that is, (assessment, planning, implementation and evaluation of care); and
iii) assurance and quality expertise.

Research has shown that the strongest predictor for effective spiritual care is ***personal*** spirituality. *No one can give from what he/she does not possess*. This indicates the importance of maintaining the integrity between the individual person and the role of the health care professional to address and meet patients' needs holistically (Lundmark 2006). Therefore, the health care professional can both provide spiritual care and also can provide care spiritually (Miner-Williams 2006). Since, competence in professional practice incorporates knowledge, skills and attitudes with achievable outcomes (Sullivan 2000), additional to knowledge, the ***active*** presence of the health care professional, that is *being* in *doing*, not simply *doing*, is needed to meet patients' spiritual needs and to generate the holistic doing of spiritual care. Therefore, the therapeutic use of self could be very helpful as it may enhance a trustful helping relationship.

While awaiting patiently for the results of a PhD study on specific spiritual care competences to be achieved by the student nurses and midwives at the point of registration, which is conducted locally under the supervision of University of South Wales, by a Lecturer in Midwifery studies, so far research recommends that health care professionals should take an ***active*** role in meeting patients' spiritual needs and not simply referring them to a chaplain (Baldacchino 2006; Wright 1998; Taylor 1995). However, it is argued that when patients need help in their *theological* beliefs and conflicts, then the chaplain, an expert with Clinical Pastoral Education should deliver this kind of specialized spiritual care (Anandarajah &Hight 2001). Hence, the importance of considering the hospital chaplain/pastor as an important collaborator in the inter-disciplinary team (Van Leeuwen & Cusveller 2004, Baldacchino 2005) especially when prepared educationally for a chaplain's role (Cramer & Tenzek 2012).

The Nursing and Midwifery Council (2002) and the European Qualifications Framework (EQF) (2008) remind us about the responsibility of the health care professionals to acquire the necessary skills and ability to practise competently, safely and effectively (NMC 2002; EQF 2008). However, research shows the concern of the nurses and health care professionals who consider themselves as incompetent to deliver spiritual care (Narayanasamy 2006, Baldacchino 2003, Ross 1997).

Thus, an overview on the theoretical and practical education on spiritual care will be explained, derived from the literature review and also from my teaching experience in Malta and in various foreign universities.

Personal experiences of spiritual care

My first clinical experience as a staff nurse in ITU, gave me the opportunity to work with a real collegial team. I was very fortunate to understand exactly what it means to deliver patient-centred care.

By attending international conferences in my nursing professional life, I met various theorists such as, Verginia Henderson, who specified the role of the nurse in holistic care by emphasizing on communication with the patient and facilitation of religious rituals to worship God according to patient's own religious faith. Before departing, I remember Verginia telling me,

'Safe journey back home, keep a low profile, but give a high profile to the patient!! (*personal*:Verginia Henderson 1985)

Those words did guide my clinical practice and also my teaching and research where I tried to give priority to what the patient says as 'X'jaf min ma garrabx! (a Maltese proverb) : Experience teaches us'!

At the ICN conference in 2000 I met Nancy Roper who devised Roper's et al model of care, based on Henderson's model of care. Unfortunately, the religious activity was absorbed within the 'communication' activity of daily living, and thus its importance started to diminish along with the secularization of the contemporary society. I remember that we had some time with Nancy Roper and since I had started my PhD research on spirituality in illness and care, I drew her attention about the omission of spirituality in her model of care. Following agreement with this argument, she told me, *'Yes, you're right, we have just revised it!'* In fact, the revised version was then published in 2002. As an educator, Professor Nancy Roper told me assertively:

'The essence of nursing is You; yes You! Your communication with the patients and with their beliefs! See what they tell you, think about it and learn from it! You can make a difference in patient care!' (*personal*: Nancy Roper 2000)

An impressive statement! So we as health care professionals can make a *positive* difference or a *negative* difference with our knowledge, skills and attitudes!! This is a great responsibility! We didn't have much time to discuss with her the complexity of this statement! This statement, yes, it was and is still very complex, but it meant a lot to us! I remember we had long discussions about the issues of *giving and receiving;* health beliefs; religious beliefs; reflection on our behavior and practice; attending the patient during rituals, for example during delivery of 'Holy Communion' and the sacrament of the Sick; and learning through our own experiences and through clinical experience!

I repeat Roper's advice: *'....See what they (patients) tell you, think about it and learn from it! You can make a difference in patient care!'* (*personal:* Nancy Roper 2000)

When I used to work in ITU, I used to be impressed by some answers to my question, *How are you*? Like for example:

Heq, bezbizni wahda hija kif imiss! Kien haqqni! *He gave me a warning! I deserved it!*

Being naïve at that time, I used to reply: *U isa aghmel kuragg! / I beg you to encourage yourself!* Now that I have explored in research patients' experiences of spiritual distress and the meaning they give to their illness, I can now acknowledge the seriousness of that statement! So I confess that I was not in tune with the patient's spiritual experience at that time! So, additional to the life threatening illness, the patient was feeling that he was being punished from God! This *negative* experience will undoubtedly need professional spiritual care both from the chaplain and the health care professionals attending that individual patient.

Education on spiritual care / Modes of Clinical Education on spiritual care

a) Intra-professional and/or inter-professional Education on Spiritual Care.

Intra-professional education is when students from different levels of education in the same profession are taught together. For example, currently, at the Faculty of Health Sciences in Malta, final year students work in their

clinical placements with first year students under the same mentor in preparation for the formative and summative clinical assessment. Feedback from both the first and final year students is generally very satisfactory and the intra-professional clinical experience is considered as a rich learning opportunity. This experience supports project results in clinical simulation which support intra-professional nursing student education (Leonard, Shuhaibar, Chen 2010).

Inter-professional education (IPE) is also known as multi-professional education, common learning, shared learning, and interdisciplinary learning (Centre for the Advancement of Inter-professional Education 1997) (CAIPE). Therefore, inter-professional education refers to students from different professions learning FROM each other, WITH each other and ABOUT each other. The WHO-Study Group (2010) consisting of 30 education, practice and policy experts, issued the *WHO Framework for Action on Inter-professional Education and collaborative Practice.* The framework highlights:

- 'The current status of inter-professional collaboration around the world; identifies the mechanisms that shape successful collaborative teamwork; outlines a series of action items that policymakers can apply within their local health system; and
- Provides strategies and ideas that can help health policymakers implement the elements of inter-professional education and collaborative practice that will be most beneficial in their own jurisdiction' (WHO 2010).

The effectiveness of inter-professional education in enabling collaborative practice is still debatable. Some evidence was found by research on for example 'death and dying learning' (Mcllwaine, Scarlett, Venters, Ker 2007); and systematic reviews (Hammick, Freeth, Koppel, Reeves, Barr 2007); on the effectiveness in changing attitudes (Pollard & Miers 2008). However, more longitudinal research is needed to identify the possible effects on service quality and patients' and service users' experiences.

Inter-professional education was also implemented to teach different professions such as social workers and chaplains (Lennon-Dearing et al 2012) and also IPE was adopted on students from different professions such

as medicine, nursing, chaplaincy and social work (Ellman et al 2012). *Online* learning and interactive simulation modes of teaching were adopted. Educational programmes on spiritual and cultural aspects of palliative care and spiritual assessment demonstrated that concepts of spirituality and basics of spiritual assessment may be taught and learnt while students were found to develop an understanding and respect for the role of chaplains, social workers and physicians. Evaluation of these programmes suggests that this innovative inter-professional educational programmes may be transferable for use in other educational settings (Ellman et al 2012). Additional to the physical presence of students together in class, *on line forums* discussing and outlining the contribution of each discipline to spiritual care and holistic care of a patient case study may enhance understanding and appreciation of the precious contribution of each member of the interdisciplinary team to holistic care.

Some years ago in this hall, a forum was conducted to discuss the outcome of an inter-professional educational programme on holistic care of a patient with a stroke. Both online and interactive simulation were adopted. Unfortunately, the hospital chaplain was neither included as part of the inter-disciplinary forum panel and nor part of the audience to discuss holistic care. This indicates the persistent medical model of care which challenges us to commit ourselves to include the spiritual/religious dimension of patients' needs and care.

b) Areas Essential for learning spiritual care (Giske 2012)

A recent literature review identified 'four main areas as essential for learning spiritual care: (Giske 2012)

1. the importance of learning in *real-life* situations with repeated exposure to patients in the clinical placements supported by role modeling and mentorship;
2. use of pedagogical methods that assist students to understand, work with and reflect on patient's spirituality such as, reflective journals, written reflective accounts; writing care plans which include spiritual interventions; role plays to practice spiritual assessment including values, beliefs, and spiritual needs; group discussions on the relationship between religion, spirituality and health; analysis of case studies; reading literature and analyzing research on spirituality in illness and care;

3. to be aware of and overcome conditions inhibiting spiritual care learning such as, lack of knowledge about spirituality; uncertainty about the health care professional's role in spiritual care; unawareness about one's own spirituality; having a different faith from that of the patient; incompetence in addressing spiritual needs; lack of role models; lack of time and work overload ;
4. to evaluate students' spiritual care learning related to how students are prepared and how they are followed up after clinical studies by for example, post clinical-reflection sessions; sharing of stories with fellow students, teachers and chaplains; supporting their learning by literature and research on spiritual care; reflective exercises and debriefing sessions to enhance safety of students and safe patient care.

These are reflected in the ASSET Model for (Actioning Spirituality and Spiritual Care Education and Training) for teaching spiritual care. (Narayanasamy 1999)

The ASSET model incorporates a tripod of structure content, process of learning and outcome of education. Firstly, the *structure content* encompasses self-awareness, spirituality and spiritual dimensions of care. Secondly, the *process* of teaching and learning incorporates experiential learning related to value clarification, holism, a broad perspective of spirituality, the four stages of the nursing process and evaluation of teaching and learning. Thirdly, the *outcome* of education which is measured by value clarification, knowledge and competence in the delivery of spiritual care.

The foundation of this model lies on the importance of nurses' self-awareness about their ***personal*** spiritual beliefs, communication skills and assessment procedures. Spirituality in this model has a Judeo-Christian perspective. However, it is argued that the present era of displaced individuals and refugees with different religions demands inclusion of other religions. **Culture** and interdisciplinary teamwork including the chaplain play an important role in this model.

Culture may challenge both the students and the educator. Last year I was invited to teach at a University in Brazil– (PUC-PR). Following analysis of the definition of the concept of spirituality, a psychology student asked me,

'What has motivated you to tackle spirituality and spiritual care? Having a class of young students in a quite secularized class environment, I explained my personal spirituality, based on my Catholic religious background, my affiliation with the Society of Christian Education, and my clinical experience in ITU and also my clinical care of an Arabic patient in a British hospital whose prayers calmed him down post-operatively (*full explanation* in my book: Spiritual care: *Being* in *Doing*). At the end of the session, several students shared with me *privately* their religious and/or their spiritual experiences in life. Some of the students attended also the research group session because they wished to investigate spirituality in their research project.

Culture was again prominent in my teaching visit at the University of **Pardubice, Czech Republic.** It was interesting to note that a paramedic student asked me the same question! *'What motivated you to tackle spirituality and spiritual care?* Having referred to my research findings on Maltese patients' spiritual coping strategies, of which some were religious coping, students with an atheistic background asked me ***'Who is God?'*** What is the relationship between God's plans in life and 'destiny' and 'coincidence' in life? These profound questions generated a long discussion across the whole week.

Therefore, education of health care professionals should prepare students to:

a) Recognize and act on spiritual cues;
b) Build a trusting relationship and communicate respectfully and sensitively to patients to discover what is important to patients.

Education should focus on holistic patient care with attention to spiritual and existential themes throughout the nursing programme to help students integrate learning into the clinical practice (Giske & Cone 2012).

Research could also be a medium of learning to explore the real experiences of patients and a resource of learning. Thus, I tried to give the opportunity to patients to teach us from their own experiences by publishing my research and by encouraging and inviting students on research projects on spirituality. For example, nine students accepted the invitation to participate in a comparative research study between Malta and Norway under the supervision of Professor Mary Kalfoss, the Norway WHO

representative. Seven students explored the definition of spirituality; and how spirituality may contribute towards coping with illness. Another two students explored the nurses' perceptions about how spirituality at work may contribute towards patient care. Publication of these results in peer reviewed journals gave voice to patients and health care professionals to add further knowledge about the importance of spirituality and culture in care.

Integrating Theoretical learning on spiritual care into clinical practice

Literature review on how to develop a clinical learning culture emphasizes the importance of role model attitudes and behaviors of the health care professionals (Henderson 2011; Giske 2012). Role modeling in spiritual care is a concept which is still theoretical in nature because of various reasons, such as feelings of incompetence to deliver spiritual care and secularization of the contemporary society. Bradshaw (1997) argues that spiritual care may be 'caught rather than taught'. However, research shows that both are needed in the education on spiritual care. The clinical environment fosters integration of knowledge, clinical reasoning and formation of students (Benner & Sutphen 2007). Practice facilitates students' discovery of professional beliefs, values and attitudes and it assists them in integrating relevant knowledge and theories (Giske 2012 p.2)

Experiential learning and **voluntary work** could also be a resource of learning for health care professionals. As presented earlier on the inter-professional educational programmes, core study units and organization of short or long term voluntary activities facilitate students from various disciplines to learn together and share their learning experiences. Optional study units at the University of Malta are open to all students of the university. However, time-tables clash with other study units rendering limited mix of students.

Voluntary work may play an important role in students' learning in the form of community outreach. Voluntary work is acknowledged by the University of Malta Degree*Plus*. Thus, a study unit (2ECTS) on Spiritual Care for Health Caregivers (NUR3903) offers the students to do a minimum of five hours voluntary care in the community or accompanying patients on a pilgrimage such as, Lourdes in France. The experience of a group of nursing and midwifery students was impressive! It was a means of self

reflection with enhancement of altruism. They confirmed the principle of *giving and receiving* as they were impressed by the patients' religious faith to travel so far to a sacred place, with an outcome of empowerment to cope with their illness.

Voluntary work took also the format of health promotion activity to groups of adults, mostly older persons in the community. First, students deliver a 20 minute power-point presentation on for example, care of diabetes or hypertension and then answer their queries under my supervision or a parish nurse. The second part is asking the audience themselves to teach students by stating and interpreting proverbs or life principles of which spirituality was prominent. The third part is measuring their blood pressure on voluntary basis. Following the community outreach session, all students (average of 20 students) sit around and share their experiences using Gibb's Theory of Reflection. Then a reflective account is written on such an experience which is usually a very positive learning experience.

This experience may take the format of a small group of students paying a visit to a family who is taking care of a person with terminal illness at home or visiting a family whereby the older person/s in the house explain how they have coped in life and how they are currently coping at home, alone or with the support of their relatives, as informal caregivers and the support of the community services. Such a learning experience is usually interpreted by students as *'an experience which I will treasure for life'*.

These health promotion activities in the community are further extended to students' participation on an-hour weekly radio programme: *Il-Kuragg nofs il-Fejqan* (*Courage doubles the healing process*) on Radio Maria in Malta. Students deliver a teaching session on health promotion in my presence and respond to public queries on telephone and text messages. The feedback on students' performance is usually very positive.

The use of arts in identifying the spiritual dimension of the role of the nurse in holistic care:

Towards the end of the introductory study unit (NUR0118/NUR1116) for first year students on 'Foundations in Nursing', students were invited to

identify the spiritual dimension of the role of the nurse in holistic care by drawing their thoughts on a piece of white paper. A brief explanation was written at the back of the picture. This **arts exercise** helped them to analyse the complexity of the spiritual dimension in holistic care. After three years, i.e. at the end of their course programme, a focus group of 12 students was conducted explaining the differences they noticed between the perceived version and the observed real-life holistic care.

Experiential learning was conducted on first year students in their clinical placement with institutionalized older persons. Only few clients from each ward attend the activity centre, leaving the majority of older persons passive, sitting all day, waiting for their meals to be served and perhaps waiting for someone to visit and communicate with them. On paying a visit to these students under my link-mentorship, students were talking together while going through the residents' histories, which of course was a learning resource for them. However, students could not understand the possible boredom experienced by older persons every day, day in day out, until they experienced it themselves.

Permission was granted by the respective ward nursing officer and following students' consent, they were invited to experience an hour of **aloneness, segregated in a room alone for an hour.** Using Kolb's Theory of experiential learning and Gibb's Theory of reflective learning, each student stayed in a deserted room on the same ward, without having their mobile phone and without time orientation, no uniform watches, no clocks hanging in that room. During that hour, students were asked to reflect on their experience and write notes on a piece of paper. Boredom was experienced by the majority of students. They became frustrated as that hour was eternity for them. Few of them decided to write a sentence or two on that piece of paper and slept the rest of the time until the next student knocked on their door to replace her. Another two students could not cope and they left the room after about 20 minutes. Some of them passed the time reflecting on their life and praying. The common exclamation of students on coming out of that room was: *How boring! Poor them!* During the focus group discussion, this experience was applied to the older persons' aloneness all day long and confirmed the importance of communication and activity exercises to help them live with dignity. Thus transfer of knowledge appears

to be facilitated. A written reflective account of this critical experience was submitted as part of their clinical portfolio and followed up as deemed necessary.

The ability *to be present* is crucial to spiritual care. Availability, concentration at work and reflection allow the students to bear witness to patients' suffering and do something meaningfully about it *without getting immune* to the patient's suffering. Ability to listen to unspoken words accompanied by compassion and sensitivity is part of professional presence and spiritual care. Thus, connection and building rapport with patients are fundamental for spiritual care (Mitchel et al 2006; Giske 2012). Assignment of a mentor in the clinical environment helps to follow up students on a one-to-one basis (Newton et al 2012) to help students to identify spirituality as part of the fabric of everyday patient care. This demands also good collaboration between students, lecturers and clinical mentors for optimal learning outcome (Giske & Cone 2012).

Nurse and health care professional leaders play a key role in keeping holistic care a nursing focus and creating a good learning environment (Giske 2012 p.1)..

Creating a clinical environment conducive to learning spiritual care

Let us remember, that ***personal*** spirituality of the caregiver was found by research as the strongest predictor for perceiving ability to provide spiritual care (Pesut 2002; Meyer 2003; Mitchell et al 2006;) and to be sensitive to patients' cultural and spiritual needs in their holistic care (Narayanasamy 2006; Cortis 2004; Feldstein et al 2008). Thus, the importance for students to be helped to explore one' own spirituality as it allows students to be more sensitive to the spirituality of others (Giske 2012; Catanzaro & McMullen 2001; Lemmer 2002; Meyer 2003; Callister et al 2004; Rankin & Delashmutt 2006; Cone & Giske 2012; Giske & Cone 2012). Research shows that students reported discomfort with self-reflection but it provided them with access to their own growth (Giske 2012; Catanzaro & McMullen 2001). *No one can give from what he/she does not possess. The environment should do no harm to patients!* (Nightingale 1860).

Since the health care professionals form the major part of the clinical environment of patients, attention needs to be given to the spiritual dimension and the holistic perspective of the health care professionals at the workplace (Gupta et al 2013; Grant et al 2004). **Personal** spirituality refers to an attitude and/or a lifestyle of an individual which recognises his/her own spiritual dimension of one's life. When personal spirituality is acknowledged, team work will generate a peaceful environment with enhanced patient care, incorporating also the individual patients' spirituality in their care. Spirituality at work both in the clinical and the academic sectors, may help to motivate the health care professionals to search meaning and purpose in their work, understand the value of work and the personal belief system (Sadeghifar et al 2014). The education system both in the clinical and the faculty sectors need highly motivated educators who radiate happiness and peacefulness to others including the students, colleagues and patients (Fisher & Brumley 2007). To sustain such an environment conducive to learning and self-development, the managers need to link their personal life values and educators' values to the respective university values, which may eventually pass on these values to the students resulting in spiritual growth of both students and educators (Crossman, 2010; Neal, 2013).

Literature suggests that a successful learning environment is created through inspirational leadership, reflective management and creation of a positive partnership between the clinical setting and the educational organisation.

The spiritual leadership theory by (Fry 2003) was selected as a guide for such an inspirational leadership. This is based on an intrinsic motivation model and on characteristics such as, faith, hope and altruism which may generate homogeneous vision and values at the individual, team, and organizational levels. These values may eventually generate higher levels of commitment to holistic care (Fernando et al , 2009).

Fry identifies **seven** dimensions of **spiritual leadership** which may be applied to an environment conducive to learning which are *vision, altruistic love, hope/faith, membership, meaning/calling, organisational commitment and productivity.*

Vision*:* With the advancement of technology, patient care may be enhanced but at the same time health care professionals may be distracted from the actual holistic care of the person under their care. The vision looks to the future goal to be reached, which gives meaning to the organisation's aspirations, and fosters hope and faith (Fry et al 2011). Ideally, undergraduates and post graduate learners need to be grouped together and learn together in classrooms and clinical seminar rooms about holistic care of specific patients. Methods of education are consistently changing such as, the introduction of *on line* course programmes which may facilitate interdisciplinary education.

Altruism**:** is a set of values, of going beyond one's needs to give care to others, and ways of thinking that are morally right, and are shared by group members and taught to new members (Fry et al., 2011). These values may be taught theoretically but also by role models during patient care and communication with colleagues.

Hope/Faith**:** During this pathway of looking to the future**,** hope and faith in the ability of the educators and the students themselves may help actualisation of the set vision and goals to be achieved successfully in the proposed mission. The individuals' spiritual belief system may generate empowerment along this pathway.

Membership**:** The diversity of religious affiliations, spiritual beliefs, culture and social structures, demands efforts to try to understand each other and appreciate each others' strengths and tolerate each others' limitations with the intention to generate self-development and team work. This collegial process stems from the interactions and communication between the members of the multidisciplinary team and also the development of therapeutic relationship with the patient.

Meaning/Calling**:** Educators in the faculty and clinical placements identify the 'calling'/ vocational aspect, that is the sacredness of our profession, which may yield a transcendent experience, while becoming aware of the related empowerment to dedicate oneself to the care of others professionally. Eventually, educators may realise the worth of serving others, the wealth of making a difference in students' and patients' lives. Hopefully, through

reflection, educators may realise that while they are *giving to others*, they *are receiving*. Consequently, meaning and purpose in life is created along the pathway of learning from each other. Thus, the actual work environment is transformed into a workplace with a social meaning and value and not simply a job of people, or just seeking competence and knowledge (Pfeiffer, 2003).

***Organizational Commitment*:** The practice of altruism, safe belongingness, and a sense of meaning at work will contribute towards a healthy environment, enhanced collegiality, with less sick leave related to less stress, higher motivation and faithfulness to their individual 'calling'/vocation in their respective profession. Thus an environment with a culture based on values and altruism may generate role-models to teach spiritual care and feelings of peace and security at work.

Productivity: Productivity is interpreted as an intelligent process of implementing interventions based on research evidence, by creativity and innovations to achieve the set goals (Fry et al., 2011). Consistent reflection ***in*** and ***on*** action may lessen mistakes in care, one of which of course, is the neglect of the spiritual dimension in care.

These characteristics may foster learning by role models generated from an environment of cooperation, trust, commitment and effectiveness of collegial work (Mohammadi et al 2012). This environment may be inhibited by various factors such as, work overload, lack of time, incomplete staff complement, lack of job security (Khuwaja et al 2003), impaired personal spirituality and career motivation system. Research shows that while 20% of the factors of success depend on the staff members` efforts, 80% of success may depend on their motivation at work. Thus, job motivation creates a challenge for organizations who recruit staff members with low levels of motivation to their commitments (Torabi, 2007). Thus, motivation triggered by the individual's spirituality appears to be the most important factor for better performance (Al-Rfou & Trawneh, 2009) that contributes towards achievement of goals and focus on their commitments at work such as, to work collegially in the delivery of holistic care and education on holistic care.

Recommendations

1. Literature discusses spiritual care learning as part of a total curriculum programme emphasising on the clinical studies and ways of **facilitating reflection in practice** together with post-conferences as important in the students' learning process (Giske 2012). Thus, students need to be provided by 'teachable moments' (Johnston & Mohide 2009) by reflecting with students on patient care so that students can learn and approach new encounters with greater awareness and appropriate action (Giske 2012).

2. **Role modelling** by mentors and health care professionals is the best resource of learning for students. Thus continuous professional development is mandatory by reading literature and research, attending seminars, conferences, CPD courses on spiritual care in order to maintain high quality holistic care (Levison 2005, Handzo et al. 2004).

3. **Clinical studies** present students with diverse and rich opportunities to learn and grow in real-life situations (Catanzaro &McMullen 2001; Giske & Cone 2012).

4.Students tend to be *examination-oriented* so they prefer to study for their exams. Thus, examining clinical skills in spiritual care would identify the degree of acquisition of competence in spiritual care. Hopefully, the competency framework developed by my colleague Josephine Attard from Malta as part of her PhD studies will soon guide the education on spiritual care competences.

5. Students need to practice before they can fully understand the theoretical component. Thus role-modeling and mentorship in the clinical placements is of utmost importance to help them understand and implement spiritual care. Also, a good dialogue between clinical settings and educational organizations is needed to maximize learning opportunities for students (Henderson et al 2011).

6.The frequency of attending religious services and spiritual experiences were found to contribute towards the students' positive attitude towards spiritual care (Taylor et al 2008). Thus, further research is suggested to

identify the possible impact of personal characteristics, such as age, gender, personality traits, religious practices and life experiences;

7.Personal religiosity and spirituality of students, their mentors and health care professionals may foster a spiritual clinical environment (Giske 2012). Thus, *organization of spiritual retreats, prayer meetings for students and health care professionals* may be beneficial to both the caregiver and the recipient of their care. Recent data collection from health caregivers (4th February 2014) by the Diocese Pastoral Care Commission for Health Caregivers in Malta supports this search for the sacred dimension in the life of health caregivers.

8.Spiritual leadership is needed to develop a clinical environment conducive to learning spiritual care by facilitating holistic care and teamwork which fosters spirituality at the workplace.

9.Spirituality and spiritual care are complex concepts. Addressing spiritual distress and spiritual needs may involve various ethical issues, such as confidentiality in documenting certain aspects of spiritual assessment. Thus, support groups are needed for debriefing sessions to express feelings, biases and address ethical issues involved in spiritual care.

10.Further research to identify the most appropriate and effective approaches to teach spiritual care to students (Ross 2006), such as by *online* and interactive simulation by intra-professional and inter-professional educational programmes.

11.Awareness of the sacredness of our profession and clinical environment is needed.
Reflection: Jekk l-isptar huwa l-knisja, il-pazjent huwa t-tabernaklu:
'When comparing the hospital to a sanctuary, the patient is the tabernacle'
(Padre Pio : Saint Pio of Pietralcina)

12. A recent study which will soon be published in the Nurse Education Today (NET) confirmed that education on spiritual care was the strongest predictor to the nurses' and midwives' perceived competence in spiritual care.
Coming to this conference will give us a boost to be ***change agents***!

Let's think of the possible ultimate outcome of spiritual care:
'If you reform your *spiritual-self*, you will reform your *professional care*;
If you reform your *professional care*, you will reform your *holistic care*;
If you reform your *holistic care*, you will reform the world *spiritually'*.
(14th Dalai Lama: Adapted: 22nd May 2014)

Song: If we all give a little…..

Original Quotation: (Tenzin Gyatso, 14th Dalai Lama)
There is no need to reform the world because:
If you reform yourself, you will reform your family
If you reform your family, you will reform your nation;
If you reform your nation, you will reform the world. (Tenzin Gyatso, 14th Dalai Lama)

References

Anandarajah G. & Hight E. (2001) Spirituality and medical practice: Using the HOPE Questions as a practical tool for spiritual assessment. American Family Physician January 1 2001 http://findarticles.com/p/articlesmi_m32225/is_1_63/ai_68547568 (accessed on 24/08/2005)

Babler J.E. (1997) A comparison of spiritual care provided by hospice social workers, nurses, and spiritual care professionals. *The Hospice Journal* 12(4): 15-27.

Baldacchino D. (2007) Teaching on *The Spiritual Dimension In Care*: The Perceived Impact On Undergraduate Nursing Students. *Nursing Education Today. doi:10.1016/j.nedt.2007.09.002.*

Baldacchino D. *(in press)* Teaching on *The Spiritual Dimension In Care* To Pre-Registration Nursing Students: The Content And Teaching Methods. *Nursing Education Today doi:10.1016/j.nedt.2007.09.003..*

Baldacchino, D.R., 2006 Nursing competencies for spiritual care. Journal of Clinical Nursing 15, 885-896.

Baldacchino D. (2005) The nurse's role in spiritual care: A comparative study between perceptions of patients with first myocardial infarction and health carers in Malta. IN Beldean L., Zeitler U., Rogozea L. (editors) *Nursing Today*, Editura "Alma Mater" Romania pp. 137-146.

Baldacchino D. (2003) *Spirituality in Illness and Care*. Veritas Press, Malta.

Baldacchino D. (2002) Anxiety, Depression and spiritual coping strategies of Maltese patients with myocardial infarction. Unpublished Ph.D Thesis, University of Hull, Yorkshire, U.K.

Baldacchino D. and Draper P. (2001) Spiritual coping strategies: A review of the nursing research literature. *Journal of Advanced Nursing* 34 (6) 833 – 841.

Barnes, L.L., Plotnikoff, G.A., Fox K., Pendleton, S. (2000) Spirituality, Religion, and Paediatrics: Interesting Worlds of Healing. Paediatrics October 2000, http://www.looksmart.com/ Accessed on (16-09-2006).

Benner P. (1982) Issues in competency-based training. *Nursing Outlook* May, 303-309.

Benner P, Sutphen M (2007) Learning acrossthe professions: the clergy, a case in point. *Journal of Nursing Education* 46 (3) 103-108.

Boutell KA. & Bozett F.W. (1990) Nurses' Assessment of Patients' Spirituality : Continuing Education Implications. *The Journal of Continuing Education in Nursing* 21 (4) 172 – 176.

Bradshaw a. (2000) Competence and British nursing: a view from history *Journal of Clinical Nursing* 9, 321-329.

Bradshaw A. (1997) Teaching spiritual care to nurses: an alternative approach International. *Journal of Palliative Nursing* 3 (1), 51-57.

Bradshaw A. (1994) *Lighting the Lamp. The spiritual dimension of nursing care.* Scutari Press, Middlesex, England.

Brunt P.W. and Short D.S. (2005) Body, mind and spirit. What doctors need to know about the Scottish Health Department's Spirituality Initiative *Scottish Medical Journal* 50 (1) 3-4.

Burkhardt MA, Nagai – Jacobson MG (2002) *Spirituality. Living our connectedness.* Delmar Thomson Learning, Australia.

Burnard P. (1993) Giving spiritual care. *Journal of Community Nursing* 6 (10) 16-18.

Burnard P. (1991) A method of analyzing interview transcripts in qualitative research. *Nurse Education Today* 11, 461-466.

Bush, T., 1999. Journaling and the teaching of spirituality Nurse Education Today 19, 20-28.

Callister LC, Bond AE, Matsumura G, Mangum S (2004) Threading spirituality throughout nursing education. *Holistic Nursing Practice* 18 (3) 160-166.

Catanzaro AM, McMullen KA (2001) Increasing nursing students' spiritual sensitivity. *Nurse Educator* 26 (5) 221-226.

Centre for the Advancement of Inter-professional Education (CAIPE) (1997) *Interprofessional education – a definition.* London: CAIPE Bulletin 13, p.19.

Chan, C.L.W., Ng S.M., TH Ho, R., Chow, A.Y.M. (2006) East meets West: applying Eastern spirituality in clinical practice. *Journal of Clinical Nursing* 15, 822-832.

Chapman H. (1999) Some important limitations of competency-based education with respect to nurse education: an Australian perspective. *Nurse Education Today* 19, 129-135.

Clarke J. (2006) A discussion paper about 'meaning' in the nursing literature on spirituality: An interpretation of meaning as 'ultimate concern' using the work of Paul Tillich. *International Journal of Nursing Studies* 43, 915-921.

Conco D. (1995) Christian patients' views of spiritual care. *Western Journal of Nursing Research* 17(3): 266-276.

Cone PH & Giske T (2012) Teaching spiritual care – a grounded theory study among undergraduate nursing educators. *Journal of Clinical Nursing* doi: 10.1111/j.1365-2702. 2012.04203.x

Cornette K. (1997) For whenever I am weak, I am strong.....*International Journal of Palliative Nursing* 3(1): 6-13.

Cortis J.D. (2004) Meeting the needs of minority ethnic patients. *Journal of Advanced Nursing 48* (1): 51 – 58.

Courtney Sellers S. & Haag B.A. (1998) Spiritual nursing interventions. *Journal of Holistic Nursing,* 16 (3), 338 - 354.

Cramer EM, Tenzek KE (2012) The Chaplain profession from the employer perspective: An analysis of hospice chaplain Job Advertisements. *Journal of Health Care Chaplaincy* 18(3-4): 133-150.

Culliford L. (2003) Spirituality and clinical care. bmj.comCulliford 325(7378): 1434. file://A\Spirituality.htm (accessed on 14/01/03).

Cumming A. (1993) Clinical Spiritual Care. Patients' access to hospital chaplains. *Nursing Standard* December 14, 8 (13/14) : 30-31.

Daaleman, T.P., Cobb, A.K., Frey, B.B. (2001). Spirituality and well-being: an exploratory study of the patient perspective. *Social Science and Medicine 53,* 1503-1511.

De Bertodano, I. (2006). Faith in the NHS. The Tablet. 6th May, 6-7.
Ellis, C., 1987. Teaching spiritual care of patients. *Journal of Staff Development* 3 (1), 43-44.

Doyle D. (1992) Have we looked beyond the physical and psychosocial? *Journal of Pain and symptom management.* July 7 (5), 302-311.

Dossey L.K., Guzzetta C.E., Kolkmeier L.G.(1995) *Holistic Nursing.* 2nd Edition. Aspen Publishers, Inc., Maryland.

Dossy B.M. & Dossy L. (1998) Attending to Holistic Care. *Advanced Journal of Nursing* 98 (8) 35 – 38.

Dyess SM (2011) Faith: A concept analysis. *Journal of Advanced Nursing* 67 (12) 2723-2731.

Ellis, C. (1987). Teaching spiritual care of patients. *Journal of Staff Development* 3 (1), 43-44.

Ellman MS, Schulman-Green D, Blatt L, Asher S, Viveiros D, Clark J, Bia M (2012) Using online learning and interactive simulation to teach spiritual and cultural aspects of palliative care to inter-professional students. *Journal of Palliative Medicine* 15(11): 1240-1247.

Emblem J.D. and Halstead L. (1993) Spiritual needs and interventions: comparing the views of patients, nurses and chaplains. *Clinical Nurse Specialist* . 7(4): 175-181.

Emblen J.D. (1992) Religion and Spirituality defined according to current use in nursing literature. *Journal of Professional Nursing* 8 (1) : 41 - 47.

Fisher J.,& Brumley D. (2007). Nurses' and carers' spiritual wellbeing in the workplace. Australian Journal fo Advanced Nursing, Vol.25, No.4, 49 – 57.

Frankl V.E. (1973) *The Doctor and the Soul. From Psychotherapy to Logotherapy*. Vintage Books, New York.

Frankl V.E. (1966) Self - transcendence as a human phenomenon. *Journal of Humanistic Psychology* 6, 97 - 106.

Frankl V.E. (1962) *Man's search for meaning : an introduction to logotherapy.* Simmon and Schuster, New York.

Fraser D. (1996) Blessing in disguise? *Health Service Journal,* 11 July : 28 – 29.

Gilutz H., Bar-On D., Billing E., Rehnquist N. & Cristal N. (1991) The relationship between causal attribution and rehabilitation in patients after their first myocardial infarction. A cross cultural study. *European Heart Journal* 12, 883-888.

Giske T (2012) How undergraduate nursing students learn to care for patients spiritually in clinical studies – A review of literature. *Journal of Nursing Management* DOI: 10.1111/jonm.12019

Giske T & Cone PH (2012) Opening up to learning spiritual care of patients: A grounded theory study of nursing students. *Journal of Clinical Nursing* 21, 2006-2015.

Grant, D., O'Neil, K., & Stephens, L. (2004). Spirituality in the Workplace: New Empirical Directions in the Study of the Sacred. *Sociology of Religion*, 65 (3), 265-283

Greenstreet W.M. (1999) Teaching spirituality in nursing: a literature review. *Nurse Education Today* 19, 649-658.

Gouder A. (2002) Religious Affiliation in Malta and Gozo. Archbishop Curia, Malta.

Halm M.A., Myers R.N., Bennetts P. (2000) Providing spiritual care to cardiac patients: Assessment and implications for practice. Critical Care Nurse, 20 (4) 54-72.

Hall, J. (2006). Spirituality at the beginning of life. *Journal of Clinical Nursing* 15, 804-810.

Hammick M, Freeth D, Koppel I, Reeves S, Barr H (2007) A best evidence systematic review of inter-professional education: BEME Guide No 9. *Medical Teaching* 29(8): 735-751.

Hancock B. (2000) Are nursing theories holistic? *Nursing Standard* 14 (17) 37 –41.

Harrington A. (1995) Spiritual care; what does it mean to RNs? *Australian Journal of Advanced Nursing* 12 (4) 24-29.

Harris, E.E. (1993). *Atheism and Theism.* Humanities Press, New Jersey.

Henderson A, Briggs J, Schoonbeek S, Paterson K (2011) A framework to develop a clinical learning culture in health facilities: ideas from the literature. *International Nursing Review* 58 (2) 196-202.

Henderson V. (1969) *The nature of Nursing*. The MacMillan Company, New York.

Highfield, M.F., 1992. Spiritual health of oncology patients. Nurse and patient perspectives. Cancer Nursing 15(1), 1 - 8.

Hoffer D, Henshaw C, Mvududu N (2007) Enhancing the ability of nursing students to perform a spiritual assessment. *Nurse Educator* 32 (2) 66-72.

Hungelmann J.A., Kenkel-Rossi E., Klassen L. & Stollenwerk R.M. (1996) Focus on spiritual well-being: Harmonious interconnectedness of mind-body-spirit -Use of the JAREL Spiritual Well-Being scale. *Geriatric Nursing* November/December, 262-266.

Hoover, J. (2002). The personal and professional impact of undertaking an educational module on human caring. *Journal of Advanced Nursing* 37 (1), 79-86.

ICN-International Council for nurses (2000) *Code of Ethics for Nurses.* ICN, Geneva.

Jaarsma T., Kastermans M., Dassen T. & Philipsen H. (1995) Problems of cardiac patients in early recovery. *Journal of Advanced Nursing* 21, 21-27.

Johnson M., Bulechek G., Butcher H., Dochterman JM, Maas M., Moorhead S., Swanson E. *(Editors)* (2006) *NANDA, NOC, and NIC Linkages. Nursing Diagnosis, Outcomes and Interventions.* Mosby, Missouri.

Johnston C. & Mohide EA (2009) Addressing diversity in clinical nursing education: support for preceptors. *Nurse Education in Practice* 9 (5) 340-347.

Killough, W.B. (2005). Acknowledging spiritual dynamics during trauma care. Topics in Emergency Medicine. 27 (3), 183-185.

Kim A.K., Moser D.B., Garvin B.J., Riegel B.J., Doering L.V., Jadack R.A., McKinley S., Schueler A.L., Underman L., McErlean E. (2000) Differences between men and women in anxiety early after acute myocardial infarction. *American Journal of Critical Care* 9 (4) 245 –253.

Kirsh B (1996)A narrative approach to addressing spirituality in occupational therapy: Exploring personal meaning and purpose. Canadian Journal of Occupational Therapy. April 63 (1): 55 – 61.

Koenig H.G. (2002) Religion, congestive heart failure and chronic pulmonary disease. *Journal of Religion and Health* 41(3), 263-278.

Koeing H.G., Larson D.B. & Larson S.S. (2001a) *Handbook of Religion and Health.* Oxford University Press, New York.

Koeing H.G., Larson D.B. & Larson S.S. (2001b) Religion and coping with Serious Medical Illness. *The Annals of Pharmacotherapy*, March, 35, 352 - 359.

Koenig H.G., Pargament K.I. & Nielsen J. (1998) Religious coping and health status in medically ill hospitalized older adults. *The Journal of Nervous and Mental Disease* 186 (9) 513 - 521.

Kociszewski C. (2003) A Phenomenological pilot study of the nurses' experience providing spiritual care. *Journal of Holistic Nursing* 21 (2) June 131-148.

Lane D, Carroll D, Ring C, Gareth Beevers D and Lip GYH (2002) The prevalence and persistence of depression and anxiety following myocardial infarction. *British Journal of Health Psychology* 7, 11-21.

Lemmer C (2002) Teaching the spiritual dimension of nursing care: A survey of US baccalaureate nursing programs. *Journal of Nursing Education* 41 (11) 482-490.

Leonard B, Shuhaibar EL, Chen R (2010) Nursing student perceptions of intra-professional team education using high-fidelity simulation. *Journal of Nursing Education* 49(11): 628-631.

Lauterbach S.S. & Hentz Becker P. (1996) Caring for self: Becoming a self-reflective nurse. *Journal of Holistic Nursing Practice* 10 (2) 57-68.

Lundmark, M. (2006). Attitudes to spiritual care among nursing staff in a Swedish oncology clinic. *Journal of Clinical Nursing* 15, 863-874.

Matthews D. A. (1997) Religion and Spirituality in Primary Care. *Mind/Body Medicine* 2 (1) 9-19.

Mayou R.A., Gill D., Thompson D.R., Day A., Hicks N., Volmink J., Neil A. (2000) Depression and anxiety as predictors of outcome after myocardial infarction. *Psychosomatic Medicine* 62, 212-219.

Mcllwaine L, Scarlett V, Venters A, Ker JS (2007) The different levels of learning about dying and death: An evaluation of a personal, professional and interprofessional learning journey. *Medical Teaching* 29(6): 151-159.

McSherry W. & Ross L. (2002) Dilemmas of spiritual assessment: considerations for nursing practice. *Journal of Advanced Nursing* 38 (5), 479-488.

McSherry W. (2000) *Spirituality in nursing practice. An interactive approach.* Churchill Livingstone, London.

McSherry, W. (2006). The principal components model: a model for advancing spirituality and spiritual care within nursing and health care practice. *Journal of Clinical Nursing* 15, 905-917.

McSherry W. (1997) A descriptive survey of nurses' perceptions of spirituality care. Unpublished M.Phil Thesis. University of Hull, Yorkshire, U.K.

McSherry W. & Draper P. (1997) The Spiritual dimension: why the absence within nursing curricula? *Nurse Education Today* 17, 413 - 417.

McSherry W. (1996) Raising the spirits. *Nursing Times* 92 (3) 48-49.

Meraviglia M.G. (1999) Critical analysis of spirituality and its empirical indications. *Journal of Holistic Nursing*. 17, 18-33.

Miner-Williams, D. (2006). Putting a puzzle together: making spirituality meaningful for nursing using an evolving theoretical framework. *Journal of Clinical Nursing* 15, 811-821.

Mitchell DL, Bennett MJ, Manfrin-Leder L (2006) Spiritual development of nursing students: developing competence to provide spiritual care to patients at the end of life. *Journal of Nursing Education* 45 (9) 365-370.

Morrison R. (1990) Spiritual health care and the nurse. *Nursing Standard*, April 11, 4 (29) : 34 - 35.

Narayanasamy, A. (2006) The impact of empirical studies of spirituality and culture on nurse education. *Journal of Clinical Nursing* 15, 840-851.

Narayanasamy A. (2006) *Spiritual care and transcultural care research* Quay Books, Nottingham.

Narayanasamy A. (1999) ASSET: a model for actioning spirituality and spiritual care education and training in nursing. *Nurse Education Today* . 19: 274-285.

Narayanasamy, A., 1995. Spiritual care of chronically ill patients. Journal of Clinical Nursing 4, 397-398.

Narayanasamy A. (1993) Nurses' awareness and educational preparation in meeting their patients' spiritual needs. *Nurse Education Today* 13,196-201

Narayanasamy A. (1991) *Spiritual care: a resource guide*. Quay Publishing, Guildford.

Neuman B. (1995) *The Neuman System Model.* 3rd edition. Appleton and Lange - Norwalk.

Nightingale F. (1860) *Notes on Nursing: What is nursing and what is not.* Dover Publications Inc, New York.

Oldnal A. (1996) A critical analysis of nursing: meeting the spiritual needs of patients. *Journal of Advanced Nursing*, 23 : 138-144.

Oldnal A. (1995) Guest editorial : on the absence of spirituality in Nursing Theories and Models. *Journal of Advanced Nursing,* 21 : 417-418.

Orley J. (1994) Spiritual dimensions. *World Health*. 47th Year (2) March-April, 9.

Patterson E.F. (1998) The philosophy and physics of holistic health care: spiritual healing as a workable interpretation. *Journal of Advanced Nursing* 27, 287-293.

Pesut, B. (2002). The development of nursing students' spirituality and spiritual care-giving. *Nurse Education Today* 22, 128-135.

Picard C. (1997) Embodied soul: The focus for nursing praxis. *Journal of Holistic Nursing* 15 (1) 41-53.

Piles C.L. (1990) Providing spiritual care. *Nurse Educator* 15 (1) 36-41.

Polzer Casarez RL, Engebretson JC (2012) Ethical issues of incorporating spiritual care into clinical practice. *Journal of Clinical Practice* 21, 2099-2107.

Pollard KC, Miers ME (2008) From students to professionals: Results of a longitudinal study of attitudes to pre-qualifying collaborative learning and working in health and social care in the United Kingdom. *Journal of Interprofessional* Care 22(4): 399-416.

Reed P.G. (1998) A Holistic view of nursing concepts and theories in practice. *Journal of Holistic Nursing* 16 (4) 415 - 419.

Reed P.G. (1992) An emerging paradigm for the investigation of spirituality in nursing. *Research in Nursing and Health* 15, 349 - 357.

Reed P.G. (1987) Spirituality and Well-Being in Terminally Ill Hospitalised Adults. *Research in Nursing and Health* 10, 335-344.

Roebuck A., Furze G. and Thompson D.R. (2001) Health-related quality of life after myocardial infarction: an interview study. *Journal of Advanced Nursing* 34 (6) 787-794.

Rogers M.E. (1970) Man's developing culture. An introduction to the theoretical basis of nursing. F.A. Davis Company, Philadelphia.

Roper N., Logan W.W. and Tierney A.J. (2000) T*he Roper-Logan-Tierney Model of Nursing* . Churchill Livingstone, Edinburgh.

Ross, L., 2006. Spiritual care in nursing: an overview of the research to date. *Journal of Clinical Nursing* 15, 852-862.

Ross L. (1997) *Nurses' perceptions of spiritual care*. Avebury - Aldershot.

Ross L. (1996) Teaching spiritual care to nurses. *Nurse Education Today* 16, 38-43.

Ross L. (1995) The spiritual dimension: its importance to patients' health, well-being and quality of life and its implications for nursing practice. *International Journal of Nursing Studies* 33 (5) 457 - 468.

Ross L. (1994) Spiritual aspects of nursing. *Journal of Advanced Nursing* 19, 439-447.

Sadeghifar J, Bahadori M, Baldacchino D, Radaabadi M, Jafari M (2013) Relationship between Career Motivation and Perceived Spiritual Leadership in Health Professional Educators: A Correlational Study in Iran. *Global Journal of Health Science* 6 (2) : 1-10.

Steen Lauterbach, S., Hentz Becker, P. (1996). Caring for self: Becoming a self - reflective nurse. *Holistic Nursing Practice* 10 (2), 57 - 68.

Stern, J., James, S. (2006). Every person matters: enabling spirituality education for nurses. *Journal of Clinical Nursing* 15, 897-904.

Stevens Barnum B.J. (1994) *Nursing Theory : Analysis, Application and Evaluation.* J.B. Lippincott Company, London.

Stoter D. (1995) *Spiritual Aspect of Health Care*. Mosby, New York.

Sullivan, W.M., 2000. Medicine under threat: professionalism and professional identity Canadian Medical Association Journal March 7, 162 (5) 1-7, http://www.cmaj.ca/cgi/content/full/162/5/673 Accessed on (11/10/2005).

Swinton, J. (2006). Identity and resistance: why spiritual care needs 'enemies'. *Journal of Clinical Nursing* 15, 918-928.

Taylor EJ, Mamier I, Bahjri K, Petersen F (2008) Efficacy of a self-study program to teach spiritual care. *Journal of Clinical Nursing* 18 (8) 1131-1140.

Taylor E.J, Highfield M.F. & Amenta M. (1999) Predictors of oncology and hospice nurses' spiritual care perspectives and practices. *Applied Nursing Research* 12(1) 30-37.

Taylor B. (1995) Nursing as healing work. *Contemporary Nurse* 4 (3) 100-106.

Thornton L.A. (2001) Depression in post-acute myocardial infarction patients. *Journal of the American Academy of Nurse Practitioners* 13 (8) 364 – 367.

Tuck I, Pullen L and Lynn C (1997) Spiritual interventions provided by mental health nurses. *Western Journal of Nursing Research* 19 (3), 351-363).

Tuning Project (2005). Tuning educational structures in Europe http://tuning.unideusto.org/tuningeu/index.php?option=contentandtask=viewandid=29anditemid=52 (accessed on 10/11/2005).

Turner, P., 1996. Caring more, doing less. *Nursing Times*, August 21, 92 (34), 59 - 61.

Urden, L.D., Stacy, K.M., Lough, M.E., 2002 Thelan's Critical Care Nursing. 4th edn. Mosby Publishers, St. Louis.

Van Leeuwen, R., Tiesinga, L.J., Post, D., Jochemsen, H. (2006). Spiritual care: implications for nurses' professional responsibility. *Journal of Clinical Nursing* 15, 875-884.

Van Leeuwen R. & Cusveller B. (2004) Nursing competencies for spiritual care. *Journal of Advanced Nursing* 48 (3), 234-246.

Van Leeuwen R, Tiesinga LJ, Middel B, Post D, Jochemsen H (2008) The effectiveness of an educational programme for nursing students on developing competence in the provision of spiritual care. *Journal of Clinical Nursing* 17, 2768-2781.

Van Loon, A.M., 2005. Commentary on Fawcett T and Noble A (2004) The challenge of spiritual care in a multi-faith society experienced as a Christian nurse. Journal of Clinical Nursing 13, 136-142.

Walker A.C., Tan L., George S. (1995) Impact of culture on pain management: An Australian nursing perspective. *Holistic Nursing Practice* 9 (2) 48-57.

Walton J. (2002) Discovering meaning and purpose during recovery from an acute myocardial infarction. *Dimensions of Critical Care Nursing* 21 (1) 36 -43

Walton J. (1999) Spirituality of patients recovering from an acute myocardial infarction. *Journal of Holistic Nursing* 17 (1) 34 - 53.

Watson J. (1999) *Postmodern nursing and beyond.* Churchill Livingstone, London.

World Health Organisation (2007) *WHO Study Group on Framework for Action on Interprofessional Education and collaborative Practice.* *(*http://www.who.int/hrh/resources/framework_action/en/index.html). Geneva: WHO Press.

Widerquist J. & Davidhizar R. (1994) The ministry of nursing. *Journal of Advanced Nursing* 19, 647-652.

Widerquist J.G. (1992) The spirituality of Florence Nightingale. *Nursing Research* 41(1) 49 - 55.

Wright K.B. (1998) Professional, Ethical, and Legal Implications for Spiritual Care in Nursing. Image. *Journal of Nursing Scholarship,* First Quarter, 30 (1) : 81 - 83.

Yalom, I.D. (1980). Existential Psychotherapy. Harper Collins Publishers, New York.