In My Opinion

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Nurses – to believe or not to believe, that is the question!

The nursing literature surrounding the spiritual needs of atheists and agnostics is sparse, and where mention is made, there is often brief reference to term definition rather than the recognition and subsequent discussion of spiritual needs (Govier, 2000). It may be argued that those writing on the subject of spiritual care in nursing, or practicing in any clinical setting, consider that those who profess atheism or agnosticism do not have any spiritual needs. This may be based on a prevalent attitude that the term spirituality may only be equated with those who claim belief in, or worship of, a higher being often referred to as God. What is interesting is that although many people profess a belief in a higher or transcendent being, they may be quite passive in their practice of this belief. However, the person who adopts the stance of either atheist or agnostic has usually considered the matter and then made a conscious and active decision whether to believe or not to believe.

The term atheism may be explained as an unequivocal denial of the potential existence of God, or a supreme being, whereas agnosticism may be viewed as a position where it remains impossible to prove or disprove the existence of God. Therefore, discussion is irrelevant and silence on the matter is the only wise position (Burnard, 1997). Atheism can take many forms, and it may be argued in the absolute sense whether there is such a position as true atheism. For example, even though a person may deny the traditionally taught concept of deity, they may substitute their worship of God or a supreme being through veneration of the environment, sporting pursuits or the arts. People may even joke that their particular pastime or interest is their religion or their God!

Carson (1989) views spirituality as having two dimensions. The vertical dimension consists of the person's transcendent relationship with a higher being, which may not always be defined by, or practiced within a formal religious organization. Conversely, the horizontal dimension develops the supreme belief experience by complementing it with personal beliefs and values, lifestyle choices, quality of life and interactions with self, others and the environment. It may be argued that a continuous relationship exists between the vertical and horizontal dimensions although the person's position along these planes may vary according to the influence of life span and situational factors. Within the framework of atheism or agnosticism, it may be contended that the horizontal dimension is the predominant area of concern as there is denial or indifference towards the vertical dimension. In complete contrast, nurses may suggest that for some individuals spiritual matters, however defined, are completely irrelevant!

The secular humanistic approach, which observes and practices a belief system in a world without the notion of a supreme being, may also fit into this idea of a predominant horizontal dimension of spirituality. The person has chosen, either consciously or unconsciously, values that become the supreme focus of life, around which their life is established. These supreme values motivate their lifestyle toward achievement of their goals, needs and aspirations. It would appear that this search for self-fulfillment encourages a person toward a spiritual quest for being on a humanistic plane only. Nevertheless, humanistic philosophy contends that all human beings need a framework of values, a philosophy of life, a religion or surrogate religion to live by.

Nurses may fall into any of the aforementioned categories and just because they don't subscribe to a belief in a higher being, does not mean that they, too, do not have spiritual needs or are unable to recognize these needs in the patients they care for. There is a danger that some nurses may believe that colleagues who take an atheistic or agnostic position are in some way less able to care. This is clearly not true when one considers the principled stance of the atheist or agnostic who, because there is no 'final judge' of what is right or wrong, must often mould their own morality and ultimately respond to the humanity in others.

In the clinical setting, there are situations in which the nurse may need to consider the beliefs of another. This usually occurs during the admission stage where the patient is often asked whether they have a religion. This question appears to presuppose that the person has a religion, or is a 'believer', and may be considered quite leading and presumptuous when posed. Nurses need to be cautious when dealing with the answer given from such a question as value judgements may result.

If nurses are believers, is there a danger that they might judge harshly the non-believer? Conversely, if they are non-believers, do they then dismiss the believer? In practice, neither of these extremes should be taken and nurses must realise that their belief or value system may not coincide with that of the patient and it is not their duty or role to persuade another of their beliefs. Occasionally, a spirit of religious proselytising may occur in clinical settings. If this does exist, it should be considered inappropriate. However, for some nurses a problem may occur if their religion demands that they attempt to win converts when the opportunities arise. A major issue exists if a nurse's profession then serves as a vehicle to place the nurse in the presence of those who may be converted. On the contrary, the nurse's religion may just dictate the way in which the function of nursing may be expressed, albeit with a religious spirit. The dominant issue appears to be, which takes precedence: nursing or religion? Patients and their families often find themselves in vulnerable positions from a physical, mental, emotional as well as a spiritual point of view. For any nurse to take advantage of this vulnerability by attempting to persuade another toward their religious values or beliefs, would be considered wholly unacceptable and unprofessional.

What is required is an attitude of acceptance and respect, regardless of the stance the patient adopts towards religious or spiritual affairs. This requirement follows the guidelines in the Code of Professional Conduct (UKCC, 1992) whereby nurses, midwives and health visitors, in the exercise of their professional accountability, take account of the 'customs, values and spiritual beliefs' of patients and clients. Of course, in order for members of the nursing profession to take account of these customs, values and spiritual beliefs, including atheistic and agnostic perspectives, it seems appropriate that they undergo some kind of educational preparation to enable them to perform this function rather than give cursory attention to this section of the professional code.

It is reassuring that nurse education programmes are recognising and increasingly introducing the concept of spiritual care. However, in doing so, the educational institutions and the nurses they educate, must also realise that those who claim to be non-believers have needs, which can be just as deep or even deeper than those who claim to be believers. Additionally, nurses must also recognise their own limitations when dealing with matters of a spiritual nature and refer to nursing colleagues skilled in these matters or individuals such as hospital chaplains or nominated patient representatives.

Significant life events, like serious trauma or illness, bring nurses into unplanned but inevitable encounters with patients. Within these relationships, fundamental spiritual issues often emerge whereby patients may question their very existence. These issues are not solely the domain of believers but extend to all people regardless of whether they choose to believe or not to believe – for nurses, that is the question!

References

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