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Journeying with Morrie: challenging notions of professional delivery of spiritual care at the end of life

Jacqueline H Watts
The Open University, UK

ABSTRACT

The spiritual welfare of dying people has in recent years moved from the domain of religion to become the concern of health care professionals, particularly as part of the ideal of holism that underpins palliative care. Professional delivery of spiritual care incorporates the features of assessment, control and treatment which may involve varying degrees of intrusion into the patient's deeply personal inner self. Using a case study approach, this article explores meanings of spirituality and understandings of what is meant by the term 'spiritual care'. It argues that biographical and community approaches to spiritual care of dying people may be more congruent with the concept of the 'whole person' because this support is rooted in an intimate contextual knowledge of the dying person by the caregiver. This challenges the dominant discourses of professional expertise to embrace informal personal and collective competence in this important aspect of end of life care.

Keywords: *community; dying; palliative care; spirituality; spiritual care*

Introduction
This article discusses the concept and practice of spiritual care in relation to those who are dying. It adopts a case study approach to explore meanings of spirituality and different types of spiritual needs in light of an increasing emphasis on the 'expert' delivery of spiritual care by the helping professions (for example, nursing, social work and counselling). The first section considers a broad literature that seeks to uncover what the term spirituality means and reveals that there is no consensus on its conceptual clarity. The next section explores spiritual care as active and applied, drawing mainly on the nursing canon that has influenced debate on this topic with its dominant focus on professional practice, particularly with respect to patients at the end of life. This will be followed by narrative that introduces Morrie to give the reader a sense of his life and his dying and my role within both. The last two parts of the article will draw together key elements of the case study to suggest that the biographical components of spiritual care may mean that, for some, this can only be successfully provided by those who have intimate and longstanding connections to the dying person. This essentially relational and ontologically based perception of spiritual care may present challenges to health care professionals whose relationship with their patients is inevitably instrumental and institutionally directed by virtue of the 'sick predicament' of the patient, placing them, as professionals, in an only brief and transitory spiritual stakeholder role (Wright, 2004).

Meanings of spirituality
Spirituality has been the subject of much debate about its definition and now has a vast taxonomy in the literature with a conceptual range that includes its distinction from religion (Rumbold, 2002) and its place at the core of individual lived experience as an underpinning feature of personhood (Moore and Purton, 2006). Because attempts at definition have failed to capture an essence that can be agreed to have universal application we are left with the sense that the concept is complex and inherently subjective, dependent on context for both meaning and relevance. This contextual approach to exploring meanings of spirituality is a relatively recent phenomenon that Robinson (2008) argues is a feature of the post-modern age where the cult of the individual has replaced the mantra of collectivism. Particular expressions of collectivism are to be found within formal religious practice that many have held to be synonymous with spirituality. This synergy has been widely challenged by contemporary theorists who contend that, although religion is an empirical spirituality, religion and spirituality are separate and independent dimensions of many cultures (see, for example, Mitchell et al, 2008). The importance of religion in respect of spiritual meaning, however, continues to be significant for many and this, therefore, provides an appropriate starting point for this discussion.

Across time and cultures spirituality has been allied to religion, particularly formal institutionalised religion with its emphasis on theist and doctrinal principles that can be understood as orthodoxy (Cobb, 2001). Robinson (2008: 50) sees religion as 'a system of faith and practice expressing a particular spirituality'; this system, he argues, is predicated on the features of community and corporate awareness of the ultimate *other* or God. Within a religious framework, although spirituality will find individual interpretation, its meaning is revealed and renewed through the narrative of the community. Because of its group structures, religion tends to be prescriptive maintaining collective congruence and sense of spiritual belonging that transcends everyday material or sensory experience. Acts of meditation or worship are spiritual

practices that 'bind' members of faith communities where the position of 'self' is less important than the cohesion of the group.

In recent years, with the widespread decline in adherence to formal religion, particularly in many countries in the West, alternative, mainly secular meanings of spirituality have found prominence in the literature. Some writers have mapped a matrix of conceptual possibilities with Cobb (2001), for example, providing a useful model of the spirituality conceptual landscape that includes philosophy, the soul, the sacred, psyche, personhood, psychology, sociology and theology. He argues that whatever form they may take it is 'ultimate values' that are at the core of spirituality because it is these values that are fundamental in framing the world of the individual.

This 'fundamental' attribute receives much comment in the wider spirituality literature, as does the claim to universality with, for example, McSherry (2000: 27) arguing that spirituality is a 'universal concept relevant to all individuals'. Zohar and Marshall (2001: 4) argue that human beings are defined by a universal longing to find meaning and value in what they do and experience, whilst Clarkson (2002: 2) develops this to claim that 'human beings will die (and do die) from loss of meaning more violently than from hunger, illness or deprivation'. Clarkson's (2002) reference to loss of meaning involves a sense of 'alienated dying', with individuals increasingly alienated from one another and the world, dissatisfied with materialism and feeling disconnected from a greater whole to invoke a sense of inner loneliness. With the developing emphasis in the West on secular and individually based forms of spirituality, the loss of community (that is a core feature of religion as discussed above) may be a significant component of the loneliness and spiritual isolation identified by Clarkson (2002).

In recent years some writers have directed their attention to the ways in which the search for universal meaning can be conceptualised as applied spirituality, particularly within education and health care (Robinson, 2008). A number of scholars working in these areas ascribe the search for universal meaning to an innate physiological-biological foundation (Buttery and Robertson, 2005; McSherry, 2006) with some making claims for the benefits of incorporating spirituality within mental health programmes (Pargament et al, 2005; Swinton, 2001) to enhance well being. For older people, a sense of identity and understanding of a person's place and status in the world appear to constitute key components of spirituality (Thompson, 2007) and this may have practice and policy implications in respect of effective long term care and social support provided to increasing numbers of the very elderly in many countries in the West.

The nursing canon has been particularly influential in this area and has made a major contribution to understandings of spirituality in the context of health. For example, McSherry and Cash (2004), writing in the nursing tradition, present a taxonomy of meaning of spirituality across a continuum with religious and theist ideals at one extreme, and secular, humanistic and existential elements at the other. They conclude that nursing is constructing an overarching 'blanket' definition of spirituality to accommodate what they see as the increasingly diverse human and spiritual needs of those in their care. Writing earlier on this theme, Walter (2002) focuses on health care's developing interest in the spiritual, drawing attention to the human and the emotional as a contrast to institutionalised systems that are driven by financial

rationality and medicalisation. The heightened emphasis on the individual and the subjective within Walter's critique, points to a broadly liberal and interpretive spirituality that is culturally inscribed but not theistically bound, with this model responsive to the trend towards secularisation and its application in a range of care settings (Heelas et al, 2005).

The literature suggests that at the end of life meanings of spirituality come into sharper focus, both for the dying person and their caregivers. Kellehear (2000) has developed a tripartite multidimensional model of spiritual needs for those in the dying phase and this has been useful in helping to clarify categories of spiritual needs and domains of experience, some of which have particular relevance to the case study below. He identifies situational needs (purpose, hope, affirmation, mutuality, connectedness and social presence); moral and biographical needs (peace and reconciliation, reunion, prayer, forgiveness and closure); religious needs (religious reconciliation, divine forgiveness, religious rites, clerical support, religious literature and discussion). These dimensions have instrumental value in developing understanding of different forms of spirituality together with the possible ways of addressing different spiritual needs. Another facet to the spiritual dimension of human experience is 'inter-connectedness'. Thorne (2005: 6) explains that 'spiritual is commonly used by those who wish to affirm their belief in an overarching reality which points to the inter-connectedness of the created order and to a perception of the human being as essentially mysterious and not ultimately definable in biological, psychological or sociological terms'.

Drawing these threads together from the literature, spirituality is emerging largely as a concept devoid of religion, an instrument to enhance personal well being, and a tool with which to improve or maintain health and quality of life (Sinclair et al, 2006). The search for new forms of spiritual meaning in Western societies is based on a rejection of both the materialism of science and of the commodification of society (Howarth, 2007: 100). This search also derives from widespread disenchantment with the collectivist and prescriptive structures of established religions. The increasingly positive evaluation of spirituality above formal adherence to religion appears to be linked to the valuing of personal experience, relationships and secular as well as faith belief systems that afford empowerment and transcendence. The possibility for spirituality to be privileged above and beyond the confines of institutionalised religious practice, particularly in the wealthy mature societies of the West where the threat of early death from disease and poverty has been almost completely eradicated, has resulted in an authentication of its value at the core of humanity. The fluidity of the spiritual domain that can include dimensions of 'self', others, higher beings and the cosmos as well as the activities of being, finding meaning, connecting and transcending points to both its inherent plurality and subjectivity.

This leads to the suggestion that spirituality can be whatever we want it to be though, as McSherry (2006) points out, this will be determined by cultural, social and faith influences resulting in highly individual and unique perceptions. An individual's self-identification as 'spiritual' and/or 'religious' depends on their definition of both 'spirituality' and 'religion' with the latter increasingly associated with institutionally driven practices that have been challenged by post-modern liberal aestheticism. Thus, new and different 'communities of spirituality' that challenge the old formal orders of prescription are beginning to emerge; operating outside religious orthodoxies, these

can be a pathway to what Klass (2006: 297) terms as 'solace'. A deregulated spirituality finds authority in the individual rather than in any 'ultimate' truth or doctrinal prescription (Cobb, 2001). This opens up a plethora of possibilities for care professionals who see their role as one of providing spiritual, as well as physical and practical, support, with the reduction, if not elimination, of suffering, as a key objective.

What is spiritual care?
Given that the spiritual is no longer the sole prerogative of religion, the responsibility for the spiritual well being of individuals, particularly at times of illness, crisis and loss, is increasingly seen as a shared concern with professions such as nursing, social work, counselling and psychotherapy. With the assumption that spirituality is a fundamental dimension of the human person and of human experience, these professions are now emphasising spirituality as an essential element in their practice, with the nursing profession leading discussion of 'best practice' in this area (Dyson et al, 1997; McSherry, 2006; Tanyi, 2002). The application of theory to practice, however, appears to be fragmented, not least because meanings of spirituality and how these might inform the delivery of spiritual care remain a contested area (Peberdy, 2000). This notwithstanding, all components of care have increasingly become associated with the discourse of 'patient-centredness', aimed at respecting autonomy and individual choice (Wright, 2004), acknowledging that 'one size does not fit all'. In pursuit of high quality personalised spiritual care, Stoll (1979) documents the way in which nurses have in the past been advised to construct a spiritual history of their patients by questioning them about their understanding of 'god', hope and the significance to them of faith practices. The idea that spiritual values can be neatly and conveniently identified, categorised and responded to in ways similar to those of disease diagnosis and treatment, is now acknowledged as problematic, although vestiges of this can still be traced within the 'audit culture' that now dominates UK health care delivery (Peberdy, 2000).

The model of patient-centred care has in particular been incorporated within the professional discourse of specialist palliative care practice that has its roots within the hospice movement (Wright, 2004; Randall and Downie, 2006). The philosophy of palliative care involves care of the 'whole' person that includes responsibility for practical, psychosocial and spiritual problems as well as the treatment of physical symptoms. This involves a multi-professional approach that implies that the aspects of the dying process can be compartmentalised into a discrete set of problems, issues and symptoms (Sinclair, 2007: 53). This 'whole person' model is connected to the concept of 'total pain' that emerged early in the development of specialist palliative care and refers to 'the patient's entire experience of distress resulting from terminal illness' (Randall and Downie, 2006: 150) and their facing loss of the future (Wright, 2004: 224). This has physical, emotional and psychological effects.

Palliative care philosophy places the spiritual dimension of care as central to the holding together of physical, social and psychological aspects of well being and argues for interventionist spiritual care plans to operate in parallel with other care plans to reduce suffering. Inclusive models of spiritual care that resonate with concepts of holism and the values of acceptance and non-judgmental compassion are widely discussed within palliative care literature (see, for example, Clark and Seymour, 1999; Wright, 2004) recognising that patients are drawn from pluralistic

cultural backgrounds. The actual 'doing' of spiritual care, either by health professionals or by informal caregivers, is the subject of widespread comment in the literature and discussion of a range of approaches now follows.

Drawing on a broad understanding of spirituality as the 'valuing of the non-material aspects of life', Twycross (2003: 38) offers insight into what spiritual care at the end of life might mean, outlining a range of appropriate interventions and behaviours. He suggests that affirmation and acceptance of the person in a non-judgmental way together with achieving forgiveness and reconciliation, as a form of completion, are core components of spiritual care of the dying. Open communication and a sense of 'being there' are also important but it is the activities of giving time and listening that he suggests are ultimately crucial. In his critique he identifies 'depersonalisation' rather than death as the ultimate tragedy of life. Key features of 'depersonalisation', he argues, are dying in an alien space, denial of appropriate spiritual nourishment and dying with no hope. Hockey (2002: 52) theorises the affirmation of self-identity in terms of acknowledging 'how we have become', as a key biographical spiritual resource that can counter institutional depersonalisation at the end of life.

Kellehear (2005) incorporates this concept of 'depersonalisation' within his model of community care of the dying that is rooted within a public health discourse that positions the dying person as citizen rather than patient. This conceptual shift, he argues, is significant in developing alternative approaches to offering spiritual and other support to the dying. It focuses attention away from specialist professional end of life/palliative care giving towards a radically different model that is centred on communities of living rather than on communities or sites of professional caring where patients can be seen to be 'in some sort of custodial relationship with a health care provider' (Kellehear, 2005: 47). Whilst palliative care focuses on the whole person as individual, within Kellehear's community model, the emphasis is on the whole person as an individual within his or her community. It sees the whole person in full social context in relation to their family, their work, their community involvement and their spiritual beliefs, whatever form these may take.

At the centre of this alternative approach is the development of non-professional social caring capital that involves friends, family and other kinds of support outside kin relations. The tools of this kind of support include that of story telling that honours individual and community legacies with 'reflecting back processes' (Kellehear, 2005: 63) instrumental in maintaining the important spiritual activities of 'reminding' and 'remembering'. A second tool is that of communication that recognises and privileges reciprocity with the expectation that dying people will contribute to the spiritual well being of caregivers and not just be recipients of this type of support. This community capacity building may challenge the occupational capacity building that underpins the careers of palliative care professionals, giving rise to conceptual and practical tensions. Although Kellehear's vision of community support for the dying requires further refinement and development in respect of its application, it does offer new ways of thinking about the delivery of all kinds of care within informal and non-professional networks and has relevance for this discussion.

Issues of biography and inherited history that contribute to Kellehear's (2005) communitarian model, directly challenge a culture of 'depersonalisation' within health care. They also bring to the fore questions about how realistic it is to expect

professionals to enter the whole life discourse of the dying person, given the constraints of time and pressure on services that operate within a highly managed system of healthcare such as we have in the UK (Randall and Downie, 2006: 154). From the patient's perspective, how is it possible to convey the complexity, richness and diversity of a whole life in small snapshots of rushed time and are these highly personal disclosures, made to professional strangers, of benefit to dying people? Most palliative care literature on this topic assumes that they are. Woods (2007: 66) makes the important and related point that palliative care philosophy does not seem to discriminate between a need and a capacity to benefit, resulting in palliative care practitioners feeling obliged to address this element of care for all their patients. Even in hospices, where the patient/staff ratio is higher than in most other care settings, time is still often at a premium for staff, making communication a lower priority than many would wish it to be.

Against this backdrop, from the patients' perspective, the themes of achievement, joy, disappointment, guilt, loss and fear may be deeply held, interwoven and even unsayable, especially as part of the hurried professional encounter. The ideal that this mix of feelings which contribute to psychosocial distress that itself can be effectively 'treated' by professionals as they attend the spiritual care needs of the dying, Randall and Downie (2006) suggest, is unrealistic and can lead to a form of 'harassment by questioning in the name of compassion' (Randall and Downie, 2006: 153). The pressure on patients to 'disclose' rather than share concerns as part of the patient/professional relationship can result in patients making deeply personal revelations, feeling unable to dissent from this exchange often because it is part of a wider package of care that is wanted and appreciated. Some of these concerns are developed in the discussion below that is centred on the case study of Morrie, whose dying and eventual death in September 2006 taught me much about suffering and how we tend our souls.

Morrie: a case study of hope
In 1939, when Morrie was twelve years old he said goodbye to his parents and younger sister, Rachel, in the Austrian city of Baden close to Vienna as he set off to be one of the thousands of children to form the Kindertransport. This train to freedom brought him to England and the start of a new life free from persecution and terror. Eventually he settled in a suburb of east London along with many resettled Jews. His wife, Lily, is also Austrian and she and her family managed to leave Austria earlier. Together they raised a family with two daughters and one son. The younger daughter became my lifelong friend and I was seen as Morrie and Lily's third daughter. Morrie built up a successful small business trading sausage skins and the family was moderately prosperous with Morrie always declaring his love for Britain and the British people for rescuing him and so many like him. The death of his parents and beloved sister, Rachel, in Auschwitz lived in his consciousness every day and it was the name of Rachel that was on his lips as he was dying.

Early in 2006, after a lifetime of uninterrupted good health, Morrie began to complain of terrible back pain that would not respond to treatment. In March that year, after several consultations he was diagnosed with multiple myeloma, a cancer of the bone marrow that is treatable but not curable. Morrie's response at the age of seventy-seven, was 'all we get is three score years and ten and anything else is a bonus', his way of beginning the relinquishing of self (Jenkins, 2002: 127). Though sad Morrie

was stoic but, above all, he was ready for the final journey. Chemotherapy was ineffective and he deteriorated rapidly with most of his remaining time spent in a general hospital. The family was stunned and his wife and son unaccepting and often hysterical. One Sunday at the hospital with us all by Morrie's bedside discussion turned to issues of visiting, caring and what Morrie saw as his transition. At Morrie's request it was agreed that I would make the journey with him with a commitment to visit most days and other family members coming less frequently and only briefly. Morrie was especially keen that his wife visited rarely and got on with her life that was centred on looking after grandchildren, Israeli country dancing and the local holocaust group. Although spatially set apart at this time, they remained emotionally well connected throughout Morrie's prolonged stay in hospital.

Accompanying Morrie on his journey into death was a privilege and one of the happiest times of my life. His son asked me to write down anything I thought the family might like to share and I kept a few very brief diary notes. These jottings have helped me revisit the journey Morrie and I made together, travelling through a landscape of death unfamiliar to either of us through a biographical landscape well known to us both, with only he completing the last part of the journey. The many hours I spent with him, listening, talking, in silence holding his hand, feeding him and giving him his mouth rinse could, given the discussion in the literature, be conceptualised as spiritual care but not in a professionalised sense as the discussion that follows will demonstrate.

Knowing me and my history - that's what matters

Spiritual care for Morrie appeared to be biographical and highly relational bound up with his history, that being known, understood and shared. For him the meaning of his life and his death was underpinned by a stream of connectedness and familiarity especially familiarity with the circumstances, people, work, interests and pleasures that had made up his life. The dual themes of survival and achievement were thread throughout Morrie's living and dying and voicing significant elements of these with someone who knew what they would be, as a form of intimate care taking of the past, without the need for explanation, gave them a powerful simplicity. During one visit I can recall arriving and finding Morrie agitated. He explained that the ward sister had earlier that day sat with him to talk through how he was feeling. His response to me was: 'she doesn't know me and I don't want to explain'. For him the energy of narrating his story to a stranger, albeit a kind and well-meaning stranger, did not seem worthwhile, not then at that stage. Although he did not recount the detail, I was told that he similarly rejected the attempts of a member of the hospital Macmillan team who had been asked to 'minister to' Morrie. He did not want the intrusion that he saw as part of a battery of assessments and interventions.

For the greater part my visits were spent undertaking the work of mutual reminiscence and identification (Jenkins, 2002) across a whole range of topics – holidays, my parents, celebrations, family upsets and important milestones. Much of our remembering began with phrases like 'what about the time when…..' and often we laughed, we laughed so much though it was clear that, for Morrie, laughing was physically exhausting even if spiritually enriching. Sometimes, however, we cried and his spoken memory of the service held at the local synagogue to honour my mother (herself a holocaust survivor and one of the righteous gentiles) left us both sobbing

and him holding my hand very tightly. It was his turn to offer me spiritual solace. Perhaps the most poignant topic for Morrie was that of reunion with, for him, the prospect of being reunited with his parents and Rachel a source of comfort and the reality of his future. Once he spoke about Rachel's lovely dark hair that I had seen in the few photos he had managed to keep and one in particular framed in the sitting room. I told him how I had always loved that photo and I could see in his tears that he treasured my fondness for the photo and that together we could picture his beloved sister. This meant everything to him, I know.

Talk of reunion with his birth family recurred, but this did not have eschatological or religious significance because Morrie was a cultural and 'community' Jew and his faith was only meaningful in relation to maintaining a sense of Jewish identity alongside which social and faith rituals coalesce to sustain continuity of the group. At no time did he ask for the Rabbi. His spirituality did not embrace institutionalised religious Jewishness; neither did he seek solace from the possibility of divine forgiveness and, in this respect, was estranged from orthodox doctrinal teachings that he saw as serving the interests of clerics rather than those of 'ordinary' Jews.

Discussion
The critical feature of spiritual care in this case study is the spiritual support provided by someone close to the dying person who has shared in his life and has the intimate knowledge of him as a wholly living man rather than a dying man. Drawing on Kellehear's (2000) model discussed above, Morrie's spiritual needs were predominantly situational and biographical and were met through connection with someone who knew him and understood and shared the nuances of his life that obviated the need for explanation or clarification. This intimacy of knowing through shared memory (Paver, 2002) is what professional spiritual care cannot provide because those involved have only recent and partial connection with the patient who has experienced the traumatic biographical disruption that life-threatening illness initiates (Bury, 1982). Professionals, in this context, meet the person 'too late' once they have embarked on their 'illness career' (Strauss, 1994) and, although they may act with a caring instrumentalism, they are not emotionally 'invited in' or 'chosen' by the dying person. This is difficult terrain because many who are dying, even those with close and loving families, may not feel able to draw on emotional spiritual support from them because it is too painful. Or too time consuming and too emotionally draining. The role of the professional who is compassionate, therefore, may be the compromise (and I would argue a second best) alternative. But not for Morrie, to him being known in the context of his inherited history was everything.

The potential for a more appropriately individual and congruent approach to spiritual care giving has contributed to Walter's (2002) questioning of the assumption by palliative care professionals that they are equipped to, and should, take responsibility for the spiritual needs of the terminally ill. Exploring the social context of palliative care practice, Walter (2002) argues that there may need to be a better cultural/philosophical/religious fit between caregiver and care receiver than palliative care philosophy acknowledges. The case study discussed herein (and it would be surprising if there were not other similar examples) extends Walter's (2002) questioning to argue that an essentially personal biographical approach to meeting the spiritual and existential needs of the dying may be more meaningful than even the most sensitive and 'best matched' professional approaches. This would obviate the

need for professional caregivers and health care workers to see this type of care as part of their core responsibility.

The widely held assumption or expectation that professional, expert or skilled 'others' can perform this role more successfully arises from the prevailing discourses of specialist training, particularly as a function of the professionalisation and 'qualification premium' within a whole range of occupations both within and beyond medicine and health care. This powerful discourse serves to disenfranchise and devalue the efforts of individuals acting outside formal professional frameworks of accountability and audit. It may also discourage the development of an extended caregiver network (Case, 2006).

The notion of a biographical response to spiritual care needs of the dying enacted through them talking with someone close and familiar, rather than with health professionals, has parallels with Walter's (1996) model of grief. This model links bereavement to biography, specifically support for the bereaved by the sharing of memories with those who knew the deceased rather than from professional grief counsellors. The biographical imperative of this grief model is driven by the need to make sense of self, relationships and loss in a continuing shared narrative. This has relevance for the spiritual nurturance of the dying proposed above that is rooted in a deep mutual empathic recognition that cannot be transposed into the patient/professional exchange as part of skilled and well intentioned but routinised practice (Randall and Downie, 2006: 154).

The ability to listen, by giving one's whole attention, is clearly important and has been emphasised in the palliative care literature, but what are health professionals listening for in particular? How can they understand or engage with mere fragments of past biography separate from contexts and personalities, in light of only recent association with the patient? The ability to fit the narrative pieces together to cohere as authentic reflection and reconnect people to stories of their past derives from knowing about one another's lives that functions as a form of mutual attachment. This is only truly possible in the context of longstanding valued relationships. The dying patient's relationship with a professional caregiver is generally brief and not one of reciprocity, that Kellehear (2002: 169) argues is likely to be enacted in a clinical, acute care style because of the emphasis on crises, problems and professional territory. Furthermore, the idea that the end of one's life is a separate episode isolated from the rest of one's life is inconsistent with the mantra of meaning making as a core feature of spirituality, and runs counter to the evidence presented herein. Woods (2007: 161) goes further to argue that 'our dying may be as worthwhile as any other aspect of our lives'; if this is the case, then valuing a person's dying in the context of whole life achievements is consistent with both a biographical and community approach to spiritual care. Thus, if, as Erricker and Erricker (2001) contend, the spiritual life is a community life that offers opportunities for belonging, then spiritual care cannot be solely a function of discrete professional practice. This resonates with Kellehear's (2005: 61) public health approach to end of life care giving and his contention that 'a self-conscious community is a help-conscious community'.

Finally, the idea that spiritual needs can be 'measured' in the service of a culture of audit and professionalism to demonstrate that practitioners are fully professional, can be understood as a form of 'depersonalisation' (Twycross, 2003) and raises ethical

concerns (Woods, 2007). Kellehear (2002: 175) articulates these concerns as the philosophical schism between the primacy of the social self and professional expertise that aims to dispense spiritual care as part of a problem-solving approach. This finds particular expression in the discourses of skills acquisition and in-service training. In contrast, the primacy for the dying person to be fully known in whole context by someone close and emotionally attached has been shown above to challenge the orthodoxy of the delivery of professional spiritual care, that at best can only achieve partial engagement with the inner lives of those it seeks to support, with some dying people unable to recognise its relevance, authenticity or value.

Person and place names have been changed to protect confidentiality

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Jacqueline H Watts

Jacqueline Watts is lecturer and staff tutor in the Faculty of Health and Social Care at the Open University and chairs the University's undergraduate Death and Dying course. Her research interests include feminist theory, gendered labour markets, qualitative research methodologies, death and dying education and user experience of a range of palliative day care services. Her work has been published in a number of journals including *Qualitative Research*, *Work Employment and Society*, *Feminism & Psychology, Open Learning, Teaching in Higher Education* and *Medical Sociology Online.* She is a contributor to two forthcoming edited collections to be published by Sage Publications in November 2008 - *Death and Dying: a Reader* and *Making Sense of Death, Dying and Bereavement: an Anthology.*