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IMPACT OF NURSING MODELS IN A PROFESSIONAL ENVIRONMENT: LINKING SPIRITUAL END-OF-LIFE CARE TO NURSING THEORY

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Abstract

Spiritual facilitation is a method in which the nurse provides spiritual intervention to assist in resolution of end-of-life (EOL) issues, supported by nursing conceptual models, and promoting positive client and family outcomes. The proposed approach of spiritual facilitation, intervention, nursing education and conceptual models of nursing are all intimately related. Research validates the need for basic education regarding nurses' ability to provide spiritual intervention in relation to end-of-life care issues and describe the pertinent concerns that nurses identify as barriers to providing EOL care (W. McSherry, 1998; and B. Ferrell, R. Virani, M. Grant, P. Coyne, and G. Uman, 2000).

Introduction

Spirituality is a concept that defines the intrinsic awareness of one's soul or spirit and is sensed within each person, apart from the beliefs of others. Spirituality is transcendence over the physical body in becoming authentic. Spiritual awarenesses suggest that a person's consciousness is capable of extending beyond what is considered physical reality in order to develop a sense of meaning and purpose to human life.

The American healthcare system has recognized the value of treating patients using a holistic approach. Holism is defined as treating the client and/or family as a whole that includes the body, mind and the spirit. The holistic approach to patient care reflects a shift from a problem-centered delivery system to a client-centered system that views the client and/or the family in totality. This shift in the focus of the provision of healthcare services created an awareness address not only the physical and emotional elements of the client, but the spiritual needs as well.

The Joint Commission of Accreditation for Healthcare Organization (JCAHO) sets standards by which nursing bases all practice to in order to provide quality, outcomes-oriented client/patient care. JCAHO has identified spiritual care as one of their standards of care. The North American Nursing Diagnosis Association (NANDA) has identified spiritual distress as a nursing diagnosis that will fulfill the criteria set forth by the standard. Spiritual distress is "the state in which an individual or group is experiencing a disturbance in the belief or value system that provides strength, hope, and meaning to life" (Carpenito, 1995, p. 886).

JCAHO responded to the trend of holistic care by instituting quality standards that specified what needs are to be included in a spiritual assessment. The assessment should at minimum include

1. Who or what provides the patient with strength and hope?
2. Does the patient use prayer in their life?
3. How does the patient express his/her spirituality?
4. How does the patient describe his/her philosophy of life?
5. What type of spiritual support does the patient desire?
6. What is the name of the patient's clergy, minister, chaplain, pastor or rabbi?
7. What does suffering mean to the patient?
8. What does dying mean to the patient?
9. What are the patient's spiritual goals?
10. Is there a role of church/synagogue in the patient's life?
11. How does your faith help the patient cope with illness?
12. How does the patient keep going day after day?
13. What helps the patient get through this health experience?
14. How has illness affected the patient and her family. (JCAHO, July 31, 2001)

This paper will examine the following considerations as they relate to the concept of spiritual facilitation and the need for formal training at the basic nursing school level. They are: (1) the role of the nurse providing spiritual facilitation as a nursing intervention and its relevance to nursing and healthcare (2) the identification of three nursing models that support the concept of spiritual facilitation and the need for formalized training at the basic nursing education level that will provide a framework for the application of spiritual intervention (3) the implications for nursing based on conceptual models of nursing practice and (4) the benefits of utilizing a variety of nursing perspectives.

The intention of the following paper is to identify nursing theories and conceptual frameworks that support the concept of spiritual facilitation in nursing practice and develop theory-driven strategies that will provide the impetus for nursing education to adopt spiritual facilitation as a recognized nursing intervention.

The Role of the nurse in spiritual care

Palliative and EOL issues are being investigated by leading researchers and scholars. The Open Society Institute formed project Death in America (PDIA) in 1996 as "a response to issues surrounding assisted suicide, the shift toward managed care and the overall attitudes of Americans who celebrate life and youth and ignore the needs of the dying" (PDIA newsletter, 1996).

This national project is funded by several notable organizations that include the AARP Andrus Fund, the Rockefeller Family Office, the Robert Wood Johnson Foundation and the Open Society. Members of the project determined fund specific areas of interest. These have included

1. the use of alternative and complementary medicines and techniques,

2. personal and spiritual meaning of life after death,

3. caregiver's burdens

4. attitudes toward euthanasia

5. patient preferences for care and

6. economic burdens (PDIA Newsletter, 1996).]

Of particular interest is the focus on the effectiveness with which healthcare professionals care for the dying patient (PDIA, 1996). One study (Ferrell, et al., 2000) surveyed oncology nurses on four major areas of EOL care

1. common dilemmas experienced by nurses in EOL care,

2. most common barriers perceived by nurses in EOL care,

3. how nurses rate the effectiveness of EOL care and EOL education and

4. nurses' beliefs and practices regarding assisted suicide and euthanasia (Ferrell, et al., 2000, p. 447)].

The study found that attention to spiritual needs and bereavement were rated *least effective* at 18% (n=2,333). Other items of interest:

1. 58% of those nurses surveyed stated that the issues of 'grief/bereavement' were *not adequately taught*.

2.'ethical issues of EOL care' at 56% *not adequately taught*,

3.'care of patients at time of death' at 52% *not adequately taught*

4.'communication with patients/families at EOL' at 52% *not adequately taught*.

5.'importance of EOL care to basic nursing education' 90% *very important*" (Ferrell, et al., 2000, p.450).

The need for nurses to provide spiritual care, particularly at end-of-life, requires an understanding of the concept of spiritual care and the ability to provide effective, therapeutic

interventions grounded in evidence-based practice. Working with the dying client is extremely demanding, but it can also be an emotionally enriching experience for the nurse. Not every nurse on a hospital unit can be intimately involved with every dying client and family members. However, the hope is that at least one nurse will be available to the client, to the client deal with pain, grief, anger, and whatever else is needed in this experience of death.

In spiritual interventions, albeit is important to differentiate between spirituality and religiosity. Spirituality refers to a universal concept of a connection with a Supreme Being. Religiosity refers to membership in and adherence to the practices of a particular faith, tradition or sect. Spiritual facilitation is defined as the process of assisting in the progress of a person's awareness of the multidimensional self and allows for the creation of one's higher sense of Self irrespective of religious beliefs or practices.

The nurse needs to be attuned to the client's verbal and nonverbal behavior that may reflect their feelings and thoughts toward God. These may be expressed, for instance, as feelings of anger, abandonment, or just as a pleading for God to hasten their death. Regardless, all expressions related to spirituality deserve assessment and direct intervention.

The family member roles relative to the dying person also require assessment by the nurse. The absence or presence of a support system can make an enormous difference in the client's ability to cope with death.

Wilifred McSherry (1998) performed a study in the United Kingdom (UK) that focused on five aspects of the nurse's perception of spirituality in the care of patients and/or their families. They are:

1. Discovering and exploring nurses' understanding of and attitudes toward spirituality and spiritual care,

2. Identifying whether the spiritual needs of patients are being recognized by both qualified and unqualified nurses,

3. Whether qualified nurses feel that they are able to meet patients' spiritual needs,

4.Whether qualified nurses feel that they receive sufficient education and training to enable them to meet patients' spiritual needs effectively, and

5. Associations that may exist between religion and nurses' understanding of spirituality and the provision of spiritual care.

Five hundred and fifty- nine nurses responded to a five-part questionnaire. "Only 39.9 % of the nurses surveyed felt that they were able to meet the spiritual needs of their patients while 52.8 % of the nurses surveyed stated that they had not received any educational preparation, either pre or post nursing registration, about the spiritual dimension." Data from this study correlate closely with the findings of the Ferrell, et al. (2000) study.

Ferrell, et al. (2000) conclude, "Major reform in EOL care obviously is needed, as echoed by many recent studies and efforts...To ensure that patients experience a peaceful death will require major educational approaches, policy reform and consumer demand." If a nurse is expected to provide positive spiritual intervention as a response to spiritual distress, it is imperative that nursing education in spirituality must be a standard component of the basic nursing curriculum. Formal education invites the nursing students to expand their consciousness and awareness regarding aspects of spiritual intervention and their own

personal feelings about spirituality, in order to enhance their effectiveness in dealing with client spiritual issues.

Clinical examples

As an RN who is currently practicing spiritual end-of-life care in a private setting, I can attest to the importance of understanding the concepts of spirituality and acceptance as they relate to the impact a nurse can make while assisting the patient and family to realize their own intrinsic awarenesses about life, death, and life after death. If the nurse and patient are afforded time in which to build a positive, mutually purposeful interaction, the results can be nothing short of incredible. It is important to note, however, that time should not be identified as a barrier to providing effective spiritual end-of-life care. Even brief interventions can have enormous impact. The following is an example of spiritual facilitation, as an intervention, and how the interaction impacts the lives of the patient, family and the nurse.

"Selima" was born and reared in Egypt, is Muslim and practices the Islamic faith. She is eighty-five years old and is cared for by her unmarried fifty-year old daughter. Upon recommendation from a family friend, I was contracted to provide spiritual care for the patient as a result of her deteriorating health following a mild cerebral vascular accident in June of 2000. She presented initially with mild deficits in speech, and mild right-sided weakness.

As her speech began to improve, Selima began to verbalize her fears of dying. At the onset of our nurse-patient relationship, I had nurtured trust and acceptance as the premise for all of our interactions. I began by simply telling her that I would always be honest with her. Keeping her updated on changes in her medical regimen and the rationale for the changes was critical in maintaining a level of trust. I reinforced the awarenesses she made regarding her physical potential to regain independence and helped her to begin a process of acceptance of the reality of her altered and still changing physical condition.

She told me on one occasion that she was afraid to die because when she returned in death to Paradise (heaven) that meant she would "see" her father, who had died when she was only 13 years old. This caused her great anxiety because as a child, he was emotionally abusive toward her. She feared that upon "seeing" him again, he would be the same abusive, authoritarian father.

An important goal, as a nurse, is to try to alleviate the fear of dying. While the journey to the afterlife is truly an unknown, I attempted to alleviate her fear by explaining that when the soul leaves the body at the time of death, so does the soul relinquish negativity. While this cannot be scientifically proven, the goal was to assist my patient in achieving a peaceful death when death arrived. This verbal interaction was a way to reframe her conception of her father into a loving spirit and thereby relieve her anxiety. I assisted her to visualize him as a loving, kind spirit who would be there for her at her time of death and assist in bringing her to Allah. The patient now expresses comfort in knowing that her journey to Allah will be made with her father and others that have gone on before her.

Yet another example of acceptance of the patient's experience in preparing to die came following the death of her dear friend of over 50 years. The patient's daughter was informed of her mother's best friend's death and asked if I could relay the news. I gently told Selima of Jane's death and remained at her side while she cried. Soon afterward, she began to tell me of the "visits" she received from Jane. Selima reported that Jane would come to her while she was sleeping. Remaining non-judgmental, I encouraged her to share the experience with me. She said that Jane would appear with her arms open and ask Selima to come with her. She said they "walked up the stairs" and would sit and talk. She described the area where they sit

as calming and happy. I sense these positive feelings and images will assist her journey to Allah at the time of her death. Again, while this is subjective in nature, I accepted and validated her detailing of the event and encouraged her to verbalize these experiences whenever she was ready to do so. This open acceptance of her experience added to her foundation for a spiritually and emotionally peaceful death.

Selima and her daughter have begun to plan for her funeral and Selima is making her wishes known. She has been able to do this due to the openness that she feels in talking about her own death. There are no “hush-hush” conversations about dying.

Her fear of leaving her daughter alone was also an issue. The approach that was used to allay that fear was for the daughter and patient to make a “soul agreement” that entailed each of them deciding when, where and how the patient’s spirit would make herself known to the daughter after she dies. Again, the purpose is to reduce the anxiety, allay fear and encourage verbalization of concerns. So, by reflection and reframing the patient has been given the opportunity to view her death as an experience that will be filled with love, protection and peace. And, whatever physical symptoms occur at the time of her death, she can be gently reminded of the joyful connection she has made with her spirit.

These are but a few examples of how spiritual facilitation enhances the outcome of the death experience. Remember, though, that whether it is if but a moment you have to connect on a spiritual level with your patient or several moments, the result can be transforming for all who are involved in preparing for the dying process.

Approaches to clinical-related concern suggested by three nursing conceptual models

Conceptual models are sets of relatively abstract and general concepts that examine the phenomena of central interest to a discipline and the propositions between two or more concepts. Concepts are abstract images that are generally not observable in the real world. Nursing conceptual models provide a distinctive frame of reference for practice, a coherent way of conceptualizing events that pertain to the nursing profession and structures and rationales for the scholarly and practical activities of its adherents.

Clinical issues must be connected to conceptual models of nursing. This substantiates the clinical issue as valid to the practice of nursing.

Jacqueline Fawcett (2000) provides a comprehensive text analysis of nursing theory, conceptual frameworks and nursing models.Excerpts from this text are utilized in order to recognize the efficacy of spiritual facilitation in the practice of nursing. Fawcett suggests that the systems category of knowledge identifies actual and potential problems in the function of systems and delineates intervention strategies that maximize efficient and effective system operation; change is of secondary importance.Fawcett highlights three nursing models that relate to the concept of spiritual facilitation are Neuman’s Systems model, Rogers Science of the Unitary Human Being and King’s General Systems Framework. Each offers a unique perspective on these issues, based on empirical observations.

Betty Neuman's Systems Model

Neuman's system model identifies the metaparadigm concepts of person, environment, health and nursing from the following unique perspective:

1. Concept of person - "relates to client/client systems, interacting variables, central core, flexible lines of defense, normal lines of defense and lines of resistance. The client/client system encompasses the components of the individual, the family, community and social issues, all which are relevant to nursing."

2. Concept of environment - "the internal environment consists of all forces or interactive influences internal to or contained solely within the boundaries of the defined client/client system. The external environment consists of all forces or interaction external or outside the defined client or client/client system."

3. Concept of health - "the concept of health is equated with optimal system stability, that is, the best possible wellness state at any given time."

4. Concept of nursing - "prevention as intervention noted at three levels 1. primary .2. secondary and 3. tertiary" (Neuman, 1995b, pp. 21, 22, 28-29).

The client/client system component of Neuman's model focuses on the relationship between the client and the caregiver/nurse, taking into account perceptions of the caregiver and how those perceptions impact the client. These perceptions are observed as lines of defense and resistance.

For example, if the nurse (consciously or unconsciously) perceives dilemmas and barriers to providing effective EOL care, they will be experienced as stressors. If one or more stressors are present for any length of time, the stressor will impact the nurses' flexible line of defense and the normal line of defense will be penetrated. This can lead to ineffective reaction to the stressor. For instance, a nurse might have a client who verbalizes the need to talk about spiritual concerns. If the nurse is uncomfortable in dealing with those issues, the natural response may be either to avoid the client as much as possible, or relegate the responsibility to a chaplain or minister. This may not be appropriate for the client especially if the client has negative feelings connected to religious practice.

Neuman's model integrates and reflects characteristics of the systems category of nursing knowledge. This category includes open and closed systems. The open system "maintains itself in a continuous inflow and outflow, a building up and breaking down of components" whereas the closed system " is considered to be isolated from its environment" (Fawcett, 2000, p. 13).

Neuman implies that stress and conflict that are the forces that alter the client/client system structure through interrelating variables, both from the internal and external environment.

Problems with Neuman's systems model

Logical congruence is "intellectual process that involves judging the congruence of the model author's espoused philosophical claims with the content of the model. It requires judgments regarding congruence of the world view (s) and category (s) of nursing knowledge reflected by the model." In other words, do the philosophical claims of the author reflect the content of the model (Fawcett, 2000, p. 67). Neuman's conceptual model "not only reflects the reciprocal world view but also elements of the reaction world view so it is not considered completely logically congruent" (Fawcett, 2000, p. 213).

The reciprocal interaction world view of Neuman's theory observes that "human beings are active, and interactions with client and environment are reciprocal, both the client and the environment may be positively or negatively affected by each other" (Neuman, 1995b, p.11).

Neuman fails to refine the concepts of created environment and the spiritual variable that contain elements of the reaction world view. Neuman attempts to refine the concept of created environment by stating "that although the created environment is functionally at the unconscious level, it exchanges energy with and encompasses the internal and external environments, making it congruent with the open system concept...of the Neuman System Model." However, the "emphasis is on the unconscious reflects a mechanistic, psychoanalytic orientation to the concept" and "the author of the model does not sanction structural changes which alter its basic intent, meaning, and purpose" (Fawcett, 2000, pp. 212-213).

The spiritual variable also contains a similar flaw, primarily surrounding terminology and usage of descriptive verbiage. For instance, in the following statement by Neuman, "The client/client system cam move from complete awareness of [the spiritual] variable's presence and potential, or even denial of it, to a consciously and highly developed spiritual understanding that supports client optimal wellness; that is, the spirit controls the mind, and the mind consciously or unconsciously controls the body." (Neuman, 1995b, p. 29). Fawcett (2000, p. 216) observes, "the flaw is found in Neuman's use of the mechanistic, psychoanalytical terms denial, consciously, and unconsciously, in the same sentence as the more organismic terms awareness."

Rogers' Science of the Unitary Human Being

RogersMartha Rogers focuses on "the unitary, irreducible human being and their environment" She claims that the Science of Unitary Human Beings "is not of the same order as the other conceptual models, nor does it derive from the same world view. The Science of Unitary Human Beings does not deal with health problems, but rather is concerned with the evolution of change in the direction of wherever the human beings think they are going" (Rogers, 1987c

Instead of the more widely accepted Reaction and Reciprocal conceptual world-views, Roger's concepts were founded within the simultaneous world-view. The reaction world-view sees human beings as only responding to environmental change in a linear manner. As life events occur, the human responds in order to maintain stability. Therefore, change in behavior is directly correlated to cause and effect.

In the reciprocal world-view, humans are viewed as holistic beings who are irreducible, with each part element participating in the whole. The human being has a reciprocal interactive relationship between Self and the environment that reflects change only as a means of survival.

However, the simultaneous world-view, held by Rogers, states that the Unitary Human Being is in a constant state of change that results in the formation of patterns of behavior. The interaction between the human being and the environment is a rhythmic, continuous and unpredictable phenomenon that serves as the direction for patterning the Self into a complex, organized unitary human being. (Fawcett, 2000, p.11).

Rogers' Science of Unitary Human Beings identifies the metaparadigm concepts of person, environment, health and nursing:

1. Person - “an open system in continuous process with the open system that is environment. Nursing views the person as an irreducible, indivisible, pandimensional whole. The person is a sentient (having the power of perception by the senses), thoughtful being able to participate creatively in change.”

2. Environment - “an irreducible, pandimensional energy field identified by patterns and manifesting characteristics different from those of the parts. Each environmental field is specific to its human field and both are involved in a continuous, mutual process.”

3. Health -“ Rogers does not have a formal definition of health, but describes wellness as the absence of disease and major illness.” Rogers also states that “Health and illness are manifestations of pattern and are considered to denote behaviors that are of high and low value.”

4. Nursing - “a learned profession that is both art and science. Nursing is a humanistic science dedicated to compassionate concern for maintaining and promoting health, preventing illness, and caring for and rehabilitating the sick and disabled” (Rogers, 1992b. p. 28)).

Of particular interest regarding spirituality is Rogers’ metaparadigm concepts of person, environment and energy fields. According to Rogers, energy fields are “fundamental units of the living and non-living that signify the dynamic nature of the field in which the field is in continuous motion and is infinite.” “Both human beings and their environments are conceptualized as energy fields with boundaries that do not end at the physical body. Rogers (1986, p. 5) states: ”...human and environmental fields are infinite and integral with one another.”

Homeodynamics is a metaparadigm concept of person and environment, defined as the similarity in energy manifestation. This concept encompasses three dimensions that illustrate the dynamics of spiritual facilitation. They are:

1.Resonancy - the principle that “denotes continuous change from lower to higher frequency wave patterns in humans and environmental energy fields. Humans are received as wave patterns and a variety of life rhythms that can be compared to wave patterns such as the sleep-wake, hormone levels, and fluctuating emotional states. Changes occur to patterns from lower to higher frequency patterns - slower, faster, and then continuous motion. Experiments from research studies have reported a greater sense of timelessness and relaxation where guided imagery was utilized” (Rogers, 1990a, p. 8). Increased awareness and a sense of relaxation prepare the client for the next phase of the spiritual facilitation process, which is the attunement of the higher sense of Self.

2.Helicy - “denotes continuous, innovative, unpredictable, increasing diversity of human and environmental field patterns. It is an ordering of man’s evolutionary emergence. Humans do not regress but become increasingly diverse and complex, much as a spiraling process of change. Humans are never static” (Rogers, 1990a, p. 8). Helicy is the dimension that best describes the recognition of the higher sense within the multidimensional self.

3.Integrality - the principle that “denotes continuous mutual human field and environmental field processes. Integrality explains the essential relationships between the human and environmental field relationship. These relationships are continuous with nature and human environment and is said to be a mutual relationship” (Rogers, 1990a, p. 8).). The nurse/client relationship exemplifies this dynamic. The nurse becomes the facilitator of empowerment for the client by altering their environment.

The dimensions of integrality, resonancy, and helicy provide a conceptual framework for a definition of spiritual facilitation, stated as: “the result of mutual interactions between two human energy fields (integrality/facilitation) that can be defined as an increased change from a

lower to higher frequency (resonancy/awareness) as distinguished by the continuous, innovative, unpredictable, increasing diversity of human field patterns (helicy/ higher sense of self)."

While Rogers (1986, p.5) dismisses "causality as invalid," due to the concept of open systems there is an interesting parallel between Roger's concepts of helicy, resonancy and integrality and Einstein's conjecture that "the energy of a photon is proportional to its frequency." In the 1920's, the French physicist, Louis de Broglie (1921), introduced the wave/particle concept into physics with a "brilliant prediction that particles of matter possess wave properties and act as though they were composed of propagating waves." The wave/particle duality employs the notion that an entity simultaneously possesses localized (particle) and distributed (wave) properties.

How does this simplified explanation of wave/particle duality pertain to Roger's concept of helicy, resonancy and integrality? The nurse is identified as the generator of particles of energy, and enters into an interaction with a client (integrality) for the purpose of spiritual facilitation. The client may experience emotional barriers such as fear, anxiety, and guilt that block the increased flow of energy (particles) from the nurse, resulting in the client's inability to accept incoming positive energy from the nurse or the client's environment. The nurse will remove barriers (fear, anxiety, guilt), utilizing a non-threatening, non-judgmental approach that allows the flow of energy to increase from nurse to client (resonancy) resulting in an increased awareness in the client. Lastly, the nurse removes all barriers and the increased flow of energy (particles) results in the formation of waves of energy instead of individual particles, thereby impacting the client (receptor of waves) in terms of realization of the higher sense of self (helicy).

An example of this phenomenon came from my personal experience with Patty, a close friend who was admitted to an ICU with an unknown medical diagnosis and remained unconscious for five weeks. The physicians were unable to identify the cause of her illness. She remained comatose for the entire period she was hospitalized, with the exception of one extraordinary time. I had telephoned "Tom," her husband, and asked him to meet me at the hospital to visit with Patty. He agreed, and together we made the long walk up to the unit. On the way, I asked him if he would be okay with me telling Patty that she could "let go.."

Tom and I had talked about what she would have wanted regarding quality of life and the prospects for a meaningful recovery from this event. After a brief moment he turned to me and said it would "be alright."

Upon entering her ICU room, Tom stood on one side of her bed and I positioned myself on the other side of her bed. She was not responding to verbal or physical stimuli. I sat down next to her and took her hand in mine. Silently, I prayed that I would be a channel of energy for her as I gave her permission to "let go." I spoke to her in hushed tones, telling her that there was nothing to fear. I called upon her angels for comfort, constantly reassuring her. Suddenly, she opened her eyes and grabbed my arm. For an instant, I was shocked. As she continued to stare into my eyes and not release her grip on my arm, I began to "walk" her through the fear I saw in her eyes. After some time had passed, her eyelids grew heavy and she released my arm. I continued to stroke her face and promise her safety in her journey home.

When I finally looked up, Tom was staring in amazement. We left the unit in silence. At 4:34 the next morning, my dear friend died, silently – and. I was sure, unafraid. Since that time Tom has kept in contact with me and still makes the comment that "our (Patty and my own) souls touched" that day. For me, this experience verifies the power of energy [and spirit] that can be exchanged under varying situations and circumstances.

Relating practice to Rogers' theory
Formal preparation for spiritual EOL care can be accomplished within basic nurses' training by the integrality of energy between educator and student in order to develop an awareness or resonancy of the process of spiritual facilitation. This awareness, in turn, enables the nurse to realize the impact of providing a therapeutic milieu in which the client can openly express thoughts, fears, and concerns surrounding death. This relates to the dimension of helicy in Rogers' conceptual model.

Barrett (1986) derived a middle range theory of power - "The Theory of Knowing Participation in Change - from the principle of helicy. Barrett defines power as "the capacity to participate knowingly in the nature of change characterizing the continuous repatterning of the human and environmental fields. Knowing is being aware of what one is choosing to do, feeling free to do it, and doing it intentionally. Awareness and freedom to act intentionally guide participation in choices and involvement in creating changes.

Logical congruence of Rogers' Science of Unitary Human Beings
Rogers' theory is logically congruent with the reciprocal world view. This is particularly evident in Rogers' concept of the reciprocal interaction between human energy fields and environmental energy fields. Fawcett (2000, p. 377) states, "There is no evidence of logical incompatibility in the content of the Science of Unitary Human Beings. The content of the Rogerian conceptual system flows directly from Rogers' philosophical claims, and the distinctive view of the person and the environment is carried throughout all components of the Rogerian conceptual system. The characteristics of systems and development models that are reflected in the content of the Science of Unitary Human Beings are addressed in a logically congruent manner."

With regards to the developmental category of knowledge, change is a major focus not only in Rogers' conceptual model, but also is a major focus as a process towards expected positive client outcomes as a result of effective spiritual intervention. As nurses are given the opportunity to assimilate wisdom outside the traditional realm of nursing knowledge, the horizons for personal and professional growth expand.

King's General Systems Framework
King's Framework provides yet another interesting perspective on spiritual facilitation and the lack of adequate nursing education in EOL care. In 1964, Imogene King voiced her concerns that "an existing 'anti-theoretical bias' had resulted in 'nursing theory-based' on practical techniques - the 'how' rather than the 'why.' King deliberately set out to develop a conceptual framework of reference for nursing as a precursor to a theory that would explicate the 'why' of nursing actions" (King, I. M., 1964, pp. 394-403).

King questioned the scope of nursing practice, current goals of nursing, alternatives in nursing situations, the essence of nursing, how nurses are educated and the nursing process. King formulated a nursing process model that was based on an "interaction-transaction" model for assessing client problems, developming interventions, determining goals and evaluating the outcomes of the identified goals (King, 1981, p. 62). Based on these, King developed philosophical claims, assumptions about open systems, human beings, nurse-client interactions; beliefs and propositions about nursing.

Each metaparadigm concept is reflected in King's General Systems Framework. They are:

1. Concept of person

a. Personal System - “Perception, Self, Growth and Development, Body Image, Time, Personal Space and Learning” (King, 1981, pp. 9-10, 24, 30-33, 36, 44) and (King, 1986a, p. 24).

b. Interpersonal System - “Interaction, Communication, Transaction, Role, Stress and Coping” ” (King, 1976, p. 54).

c. Social System - “Organization, Authority, Power, Status, Decision Making and Control” (King, 1981, p. 115).

2. Concept of environment - “unidimensional concepts of Internal and External environment.” (King, 1981)

3. Concept of Health - “unidimensional concepts of ‘health and illness (King, 1981, p. 5).”

4. Concept of Nursing - “unidimensional concepts of action, reaction, interaction process” (King, 1981, p. 2)

There are several interesting aspects of King’s General Systems Framework that lend entirely to the approach of spiritual facilitation and the concern of inadequate nursing education regarding spiritual EOL care. The first is the concept of perception as it relates to King’s Personal System. “Perception is a process of organizing, interpreting, and transforming information from sense data and memory. It is a process of human interactions with the environment. It gives meaning to one’s experience, represents one’s image of reality, and influences one’s behavior.” (King, 1981, p. 24).

A notable element in providing spiritual facilitation is the ability of the nurse to effectively [invite the client to examine past life experiences in relation to current life events (e.g. the approach of the client’s death) through the process of reflective thinking. Clients may be hindered or blocked by unfinished business from the past that keeps them from acknowledging and accepting the reality of their mortality and the appreciation of their own personal value as a human being.

Reflective thinking enables the client to discover patterns of relationships that require resolution. The relationships may have been person to person or person to event. Resolution may be needed due to a variety of reasons, such as issues of guilt or remorse for the client’s past behavior; unresolved anger over a situation in which the client may not have had any control; and fears of God based on religious perception. Reflective thinking allows the client to change their perception of self; approaching death and life after death as the result of acceptance and acknowledgment of self, others and life. This process has the potential to be empowering for the client especially as death approaches and feelings of powerlessness prevail.

Not only is the concept of perception empowering for the client, it also allows the nurse to assume an accepting, nonjudgmental approach to interacting with the client. In Western culture, death is generally not dealt with openly. Terminal illness is spoken of in hushed tones, advance funeral arrangements are often neglected, friends and even family members of a terminally ill person may become detached due to the inability to cope with or face the inevitable loss. Nurses are included in this population and while the profession exudes an air of non-judgment and acceptance of all human conditions, the reality is that most nurses feel uncomfortable and unprepared to care for the dying client on a deeper, more spiritual level.

Why is death so difficult for us to face? Is it that Western culture perceives death as an event to be feared ? If there is truth within the context of this question, then the answer to changing the perception of death within nursing practice lies within the ability of nurse educators to expand the students' insight and foster development of skills, awarenesses, values, knowledge and goals related to caring for the dying client on a spiritual level.

King's concept of person - interaction, as it relates to the Interpersonal System - is particularly relevant to utilizing the spiritual approach with the dying client."

King's non-relational proposition associated with Interaction states, "Interactions can reveal how one person thinks and feels about another person, how each perceives the other and what the other does to him, what his expectations are of the other, and how each reacts to the actions of the other." (King, 1981, p. 85).

This perspective is significant and relevant to the concept of spiritual facilitation in that, communication is enhanced between client and nurse when the client perceives the nurse as being willing to accept and validate the client's own feelings surrounding death.

Logical congruence of King's General Systems Framework
King's General Systems Framework is generally logically congruent. King's conceptual framework reflects the 'reciprocal interaction world- view' primarily due to the description used to illustrate the process of interaction. There remains an element of confusion surrounding usage of certain operational terms, such as action and reaction. Those terms suggest that the reaction world-view may be more appropriate. However, King translated those terms into the process of interaction that demonstrates the "dynamic sequence of verbal and nonverbal behaviors that are goal directed in which both individuals participate" (King, 1981).

The General Systems Framework reflects the characteristics of both the systems and interaction categories of nursing knowledge. Logical congruence is maintained, however due to King's use of an open systems approach that coincided with the perspective of active participation of individuals in human interactions. The characteristics of the interaction approach represent the dimensions of the concepts Personal System, Interpersonal System and Social System (Fawcett, 2000, p. 128).

Using nursing models
A nursing conceptual models can guide nursing practice by identifying a global approach to practice that can allow for a variety of creative, innovative methods of solving nursing problems. Nursing conceptual models provide "explanations of the relationships between the human variables that are interactive in bringing about the requirements for nursing and the human variables that are interactive in the production of nursing in interpersonal or group situations" ("Why Theory Based Nursing." n.d.).

Nursing is steeped in a traditional, task oriented approach to the delivery of patient care. Conceptual models expand the conceptualizations of nursing as a profession and of the interactions that occur during the process of caring. The use of a spiritual approach in the interactions between nurse and client and/or the client's family requires that the nurse develop insights and skills in determining appropriate interventions that will empower the client and/or family member during a crisis or life changing event. Spiritual conceptualizations invite nurses to engage in these processes.

Benefits of examining nursing practice from a variety of perspectives
Without a diversity of perspectives and approaches, the focus of nursing would remain narrow

and lack the creativity and inventiveness that characterizes the art and science of nursing. Each perspective provides an alternative knowledge base that sets nursing apart from the traditional medical model of practice and brings credibility to the profession of nursing (Fawcett, 2000, p. 693). Perspectives gained from examining a variety of conceptual models enable those nurses who are inspired to develop new theory to move forward undeterred by harsh criticisms from colleagues who have yet to appreciate the impact of nursing theory on the practice of nursing.

To take a relevant example, the process of considering a variety of theoretical conceptualizations can benefit the spiritual practice of nursing. Nurses practice in a multicultural arena. It is therefore judicious to expect that nurses will be educated regarding the diversity in trans-cultural approaches to providing spiritual care, especially at the approach of the client's death. It is prudent to be aware of cultural practices regarding death and bereavement, since these practices and beliefs can greatly influence the feelings and attitudes of \ dying clients and their families.

Conclusions

The lack of formal training in spiritual issues during basic nursing education renders the nurse virtually unprepared to meet the challenges of providing effective, therapeutic spiritual care for the client and/or the client's family, particularly with reference to EOL issues. Nursing educators cannot continue to ignore the professional, trans-cultural, and uniquely individual nature of meeting the spiritual needs of the dying client. Therefore, nurses, as a collective group must become advocates for change at a grassroots level in order to provide the impetus for altering the approach that nursing schools take towards the concept and practice of spirituality and spiritual facilitation/intervention.

It is imperative that nurses link the concepts of spiritual facilitation to existing nursing theories that will command credibility. This contextual relationship will also serve to set forth the educative process required to meet and exceed the standards of care pertaining to spiritual care as stated by JCAHO. Broadening the knowledge and experience of the nurse in the provision of spiritual care will serve not only to enlighten the profession as a whole, but will ensure that clients have the opportunity to be availed a caregiver that subscribes to the concept of the multidimensional, integrated, holistic self.

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