Inviting a Spiritual Dialogue:

A Loma Linda University Perspective

Two experiences contributed to this article. One was a colleague's loss of her elderly mother just before the close of the academic school year. During her mother's preceding hospitalization in an Adventist medical center, our colleague found herself torn between attending to the demands of work and her mother's needs. Although she faithfully checked on her mother several times a day, she was shocked when her mother died unexpectedly. During the hospitalization, her mother's medical needs had taken precedence, and she had not had a chance to explore her spiritual needs. When she heard that two of her nursing students had prayed with her mother just prior to her passing, she found solace in knowing her mom had been supported as she passed.

The second experience came from a qualitative research study conducted a few years ago at Loma Linda University (California).[1] The first author surveyed registered nurses working in acute tertiary care about a significant encounter they had experienced with spirituality while at work. Although most respondents reported positive encounters in offering spiritual care, one staff nurse expressed doubts about the educational preparation she had received at an Adventist university to equip her for the role of spiritual-care provider. She shared that she had been taught to offer prayer (and a backrub) during her evening rounds. This had not created any difficulties until she started working outside of a faith-based hospital. One day, she found herself in the uncomfortable situation of being reprimanded by her supervisor because a patient had complained.

These two situations warrant reflection. One interaction was received as a precious gift and gratefully remembered; whereas the other, at minimum, ended in a patient's irritation and a nurse's discouragement. Clearly, nursing students need to be equipped with tools to navigate patients' spiritual needs in multi-faith societies. As educators, we have a responsibility to prepare them to recognize spiritual cues and teach them how to invite a spiritual conversation in diverse patient-care contexts. Our students need to be sensitized to potential pitfalls and taught how to connect with people of all walks of life in a way that ensures that each patient always feels respected and honored. Therefore, teaching students about spiritual care deserves thoughtful preparation on the part of the nurse educator.

Adventist health care embraces a wholistic approach to care, one that is inclusive of patients' spirituality. Given its longstanding legacy, it is easy to assume that professionals in this field who have been educated in and work for Adventist institutions are therefore trained in spiritual care. Yet there is scant literature—aside from Ellen White's writings to medical professionals—that clearly explains an Adventist perspective on spiritual care and how it should be taught. If indeed spiritual care is core to Adventist health care, then a

BY IRIS MAMIER, EDELWEISS RAMAL, ANNE BERIT PETERSEN, and HARVEY ELDER

more overt discussion of these questions seems warranted.

The purpose of this article is to provide Adventist nurses and nurse educators with a practical guide for inviting a spiritual conversation. In what follows, we review two significant encounters from the Gospels and draw on advice given by Ellen White in her book, *The Ministry of Healing*, to set the stage. Reflecting on our own experiences and the insights of those who have mentored us, we situate these recommendations in the context of collaborative interdisciplinary practice at Loma Linda University Health and suggest that the combination of experience, research, and guidance from inspired sources provides a unique perspective on how to teach nurses to offer wholistic care. We hope to stimulate more thought and reflection in practice and academic settings.

Biblical Encounters of Wholistic Healing

Jesus' life and ministry exemplified how spiritual care is integral to caring for the sick. His actions in healing two paralytic men reflected a true "whole-person-care" approach that connected physical, mental, and spiritual well-being.

Healing at Bethesda

John 5 reports on the restoration of a paralyzed man. Bethesda, meaning "House of Mercy," was a site of concentrated misery in Jerusalem where crowds of sick, blind, lame, and paralyzed individuals awaited care and sought healing. Jesus deliberately visited this "hospital" one Sabbath, unaccompanied by His disciples.[2] He was drawn to a man who had been paralyzed for a very long time. After nearly four decades of suffering, feeling lonely, friendless, and discouraged, he had almost lost all hope. To get the man's attention, Jesus stooped down, looked into his eyes, and asked a question that may have seemed obvious but that invited the man to share his story: "'Do you want to be made well?'"[3]

The man's response informs us about the lament of his soul. "'Sir, I have no one to put me into the pool when the water is stirred up; and while I am making my way, someone else steps down ahead of me.'"[4] His expectation for healing was focused on a magical cure supposedly resulting from getting into the pool at the right time. He had no idea to whom he was speaking. Jesus then summoned him to do the impossible: "'Stand up, take your mat and walk!'"[5] Empowered by these words, the man complied and was healed. He then quickly left the place and headed straight to the temple—still carrying his mat—intending to praise God for his recovery.

But no sooner had the jubilant man arrived at the temple

than the Jewish leaders confronted him for breaking the Sabbath. According to them, he had sinned again; how distressing this must have been to the recipient of Jesus' miracle. But just then, Jesus initiated a second encounter at the temple: Healing, part two!

Addressing the real issues, Jesus shared with the man how he could stay well: "'See, you have been made well! Do not sin anymore so that nothing worse happens to you.'"[6] Having experienced physical restoration, the man had reason to trust that Jesus had his best interest in mind and that His advice mattered.

The question: "What keeps you from getting trapped and helpless again?" remains relevant for us today. The man needed an external power sufficiently strong and reliable to keep him from sin—a power that we as Christians believe comes only from a relationship with God. The success of spiritually based programs, such as Alcoholics Anonymous and similar programs directed at other addictions, testify to this reality. They have been successful because they connect patients to a "higher power" and reestablish spiritual values.[7]

As soon as the religious leaders found out who the healer was, they confronted Jesus sternly about His healing on the Sabbath. Jesus calmly responded: "'My Father is still working, and I also am working.'"[8] Here Jesus explained the larger perspective of spiritual caregiving: Ever since humans chose to distrust their Creator, God has been working tirelessly—and especially on the Sabbath day[9]—to restore a trusting relationship. "The Father's ongoing redemptive involvement on this earth is then the basis for Jesus joining the Father in His work."[10]

Because Jesus operated on the basis of following the Father, we too should focus on the signs of God's work in a patient's life. Spiritual cues may surface as expressions of worthlessness, shame, guilt, fractured relationships, hopelessness, etc., pointing to a spiritual need for forgiveness, acceptance, hope, or reconciliation. These will often not be evident unless the health-care provider first meets the physical needs in an empathetic and competent manner. Once these have been addressed and trust has been established, patients may reveal deeper concerns about their lives and their illness. The expressed lament of the soul then provides direction for spiritual caregiving and/or referral to specialists (e.g., pastoral care).

Healing at Capernaum

The second story, recorded in three of the four Gospels, is about the paralytic at Capernaum (Matthew 9:1-8; Mark 2:1-12; and Luke 5:17-26). This paralyzed man was so helpless that he depended on his friends' determination and strength to bring him to Jesus. When they realized it was impossible to navigate the crowd, they removed parts of the roof of the house in which Jesus was preaching and lowered him into the Master's presence. The man's misery was likely compounded by carrying the stigma of being a sinner abandoned by God,[11] adding mental anguish and spiritual hopelessness to an already devastating physical condition. Therefore, Jesus' first words to him were received as a healing balm: "'Take heart, son; your sins are forgiven.'"[12]

We can take inspiration from this case. For example, when we ask patients how an illness has influenced the way they view themselves or God, it is not unusual for them to express remorse, guilt, or shame. Some attribute their illness to God as punishment for past misdeeds. Such an understanding of God makes it very difficult for suffering people to imagine that God will regard them with love rather than contempt and rejection. Guilt and shame therefore prevent them from accessing the most valuable resource they might otherwise access: refuge in the loving presence of a forgiving God who knows them personally and welcomes them into a trusting relationship with Him. For the paralytic man, Jesus' assurance of forgiveness told him that God had not rejected him and instead loved him infinitely.

With a renewed identity as a beloved child of God and his sense of self-worth restored, the man began to experience emotional and spiritual healing. Therefore, when Jesus spoke the powerful words "'Get up, pick up your bed, and go home,'"[13] the man was made whole spiritually, physically, and mentally. What was deemed a blasphemous act by the religious authorities actually revealed Jesus' divine power and authority as the Son of Man, evidenced by the man's restored physical health.

Application to Modern Health Care

In both of these accounts, Jesus is portrayed as a spiritual caregiver. Whether or not these men were aware of their spiritual needs before their healing, or focused mainly on their felt needs for physical healing and hope, Jesus viewed them wholistically, connected with them authentically, and worked to restore them—not only physically, but also spiritually and mentally.

As Adventist health-care providers, we are reminded that the Holy Spirit works in people's lives before, during, and after the patient encounter. Our experience and perception of a patient and his or her situation is limited. By contrast, God knows each patient's life story and current need. As nurses

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become aware of patients' spiritual needs and respond to them, they, in essence, are stepping on "holy ground."[14] When following Jesus' model, nurses look for evidence of God working in the life of a patient. Freed of any agenda and guided by the Holy Spirit, they listen for the lament of the soul, empathizing and validating underlying needs. Nurses cannot force this process, nor should they be made to feel that their primary duty is the spiritual restoration and salvation of the patient. Instead, nurses can ensure that they are personally attuned to the Holy Spirit by surrendering to God and submitting to His guidance. The foundation of spiritual caregiving, therefore, lies in connecting with God through prayer and the study of His Word to detect the felt and at times disguised needs of patients. This was Jesus' method, and it can be ours.

The Savior's example in healing the paralytic men also demonstrates that spiritual care is not about debating doctrine, but about revealing the love of the Father. Ellen White put it this way: "At the bedside of the sick no word of creed or controversy should be spoken. Let the sufferer be pointed to the One who is willing to save all that come to Him in faith. Earnestly, tenderly strive to help the soul that is hovering between life and death."[15] The wisdom needed for this approach to spiritual caregiving is promised to all who ask. "The Savior is willing to help all who call upon Him for wisdom and clearness of thought. And who needs wisdom and clearness of thought more than does the physician [or nurse] upon whose decisions so much depends? Let the one who is trying to prolong life look in faith to Christ to direct his or her every movement. The Savior will give the necessary tact and skill in dealing with difficult cases."[16]

How Do We Teach It?

Adventist nurse educators take pride in training competent and qualified health-care professionals. We leave little to chance. Curricula are designed to address all aspects of physical and mental health. As educators, we are intentional about what we teach in the classroom; in practice environments, we test and evaluate students' knowledge and skills, and carefully monitor program outcomes. We also invest much effort in nurturing students' spirituality because we believe that their spiritual life and personal relationship with God will shape all aspects of their future, including their professional practice.

Therefore, students at Adventist colleges and universities generally take a minimum of one religion course for every year of their professional education. We believe that as a graduate's spiritual awareness and faith experience grow, he or she will be more sensitive to the spiritual needs of others. We must ask, however, "Is this enough for students to be equipped to provide whole-person care? Will they have the skills needed to invite a conversation about patients' spiritual needs? What frameworks, tools, and principles can we provide that nurses can use to guide their practice?" Spiritual care is an art, and just as with development of other nursing skills and competencies, proficiency is gained as the practitioner grows from novice to expert.[17]

Approaches Explored at Loma Linda University

Scholars at Loma Linda University have wrestled with these questions. Drs. Harvey Elder and Wil Alexander[18] have specifically asked how we might transform an art—led by the Holy Spirit—into practical and applied principles that students can develop into skills, confidence, and expertise. Their approach has pioneered whole-person care at Loma Linda University Health and mentored countless health-care providers over the past decades through workshops and patient rounds.

• *Spiritual Care in the Context of Whole-person Care*. Rather than reducing the patient to a disease process, a whole-person care approach tries to understand patients as individuals with their own stories, and in their complex physical, emotional, relational, and spiritual dimensions. The spiritual core is seen as the integrating dimension of all other dimensions of personhood. Drawing on more than four decades of caring for patients with HIV/AIDS, Dr. Elder has reflected extensively on practical and biblically based approaches to teaching spiritual-care techniques to Christian health professionals.[19] He recommends that educators model and encourage students to commit to following a series of steps in their practice. These include (1) asking the Holy Spirit for passion, love, and genuine care for one's patients; (2) remaining committed to listening to and hearing what one's patients and the Holy Spirit say; and (3) inviting patients to tell their stories, while staying attuned to hearing the "anguish of their cry" or the pain associated with their experiences. After a patient has shared his or her story, he advises health-care providers to ask questions that invite a spiritual dialogue. In the following paragraphs, we share a practical approach to soliciting and listening for spiritual themes that has been used at Loma Linda University Health.

• *Applied Training in Spiritual-care Practice*. During the past 10 years, Drs. Harvey Elder and Carla Gober-Park, at the Center for Spiritual Life and Wholeness at Loma Linda University (http://www.religion.llu.edu/wholeness), have conducted multiple spiritual-care workshops for health-care professionals. These typically involve a practicum in the patient-care units of the Loma Linda University medical facilities. The goal of the activity is to invite a spiritual conversation with patients who are willing to talk to a group of two to three health professionals.

The unit charge nurse provides direction regarding which patients to approach—and not to approach. Upon entering a patient's room, the group introduces themselves as health-care professionals who are not part of the patient's treatment team but who are attending a conference. The practicum leader informs the patient that the group wants to learn to really listen to the patient's concerns, and asks if he or she is willing to talk with them. If the patient declines, the group wishes him or her well and leaves. If the patient agrees to talk with the group, the leader asks if they may sit while they speak with him or her. (The rationale is to avoid a posture of looking down at the patient during the conversation.) The practicum leader proceeds by saying: "If at any point you are

uncomfortable and do not want to continue talking to us, just say 'I'm tired!' and we will leave." These simple and practical steps are important in establishing consent and giving the patient control over the interaction.

During the workshop, the participants receive a sequence of questions to guide the conversation (see Box 1). The opening question: "How long have you had this illness/injury?" focuses the conversation on the individual's experience with the illness/injury rather than the details of his or her diagnosis and its implications. It allows patients to reveal as much or as little as desired about their medical history and take the conversation in the direction they choose. They can refocus the question to their preferred timeframe. For example, during one conversation, a middle-aged woman told us how she had suffered a stroke while honeymooning on a houseboat in a neighboring state. She then expressed her sense of gratitude for her husband, who ensured that she received the medical help she needed, and supported her through the ordeal.

The second question, "What about your illness/injury concerns you most?" seeks to explore and understand the patient's primary lament, or the "chief complaint." It is easy for nurses, like other health-care professionals, to assume that they understand patients' primary concerns. Yet asking this question has repeatedly revealed that these concerns are not necessarily related to the diagnosis or treatment plan. We have discovered that a nurse can go through an entire shift while remaining unaware of the patient's primary source of distress. For example, in one conversation, when we asked this question of a muscular young man who was sitting up in his bed, his response was, "Will God forgive me?" Unbeknownst to the small group, he had been involved in a shooting altercation and had lost his lower leg. Rather than focusing on his immediate physical suffering or loss, his unspoken distress stemmed from feelings of guilt and condemnation. Strikingly, when invited to share, he instantly conveyed his spiritual lament.

This model of inquiry then asks about patients' source(s) of strength and/or support: "What helps you get through hard times?" At this point, patients often refer to their support system: family, friends, or colleagues. Some mention their church, a club to which they belong, or a particular person. God may or may not be in the picture.

A follow-up question can probe further: "Do you have a religious heritage or a faith community that is relevant to you?" Followed by, "Is that a source of support to you right now?"

While the first author (Iris Mamier) shadowed Dr. Elder in an HIV/AIDS clinic as he saw a man with Kaposi sarcoma, it became apparent that the patient was not taking his antiretroviral medications. During their interaction, Dr. Elder asked about his religious heritage. The patient explained that he had grown up in a Protestant denomination but figured that God didn't like him because of lifestyle choices he had made. This encounter illustrated how underlying spiritual beliefs (e.g., guilt, feelings of worthlessness, a punitive picture of God) can have a significant impact on patient health-care decision-making (e.g., medication adherence). In this case, the spiritual dimension was key to understanding why this patient had stopped caring for himself, and addressing his spirituality was vital for effective treatment to occur.

Likewise, when patients identify as atheist or agnostic, there is typically a story in the background, often one of disappointment with a particular religious person or faith group that explains why they have given up on God altogether. Patients may find it therapeutic to be given the opportunity to share this without being judged. Similarly, patients who are believers may appreciate sharing how their faith helps them cope with life's challenges, giving the health-care provider a chance to affirm their faith.

The fourth question asks: "How has this experience changed the way you see yourself?"

This question allows patients to reflect on how the illness experience has affected them personally. Facing their own vulnerability, they may share: "I've always felt like I am strong and independent. It's scary to be so weak and helpless all of a sudden!" Or: "After this fall, I am afraid I am becoming a burden to my family!" Both of these responses reveal that the patient's sense of self-worth has been shaken, reflecting the paradigm: "I'm worthwhile only when I'm strong, when I'm a productive member of the family or community." It is not uncommon for illness experiences to generate questions about one's life course, purpose, and sources of meaning. Allowing oneself to be vulnerable and to receive gracious nursing and medical care can lead to renewed perspectives on life and what really matters, which patients may wish to share.

Finally, depending on whether or not the individual has acknowledged a belief in God, we may follow up by asking: "How has this experience affected the way you see God or whatever ultimate meaning you hold in life?" This question openly probes the patient's conception or picture of God and the existential questions in his or her life. These beliefs have the potential to greatly shape the illness experience. In a study aimed at exploring religious coping, Kenneth Pargament[20] surveyed 310 Christian church members six weeks after the Oklahoma bombing tragedy. Using factor analysis, he categorized underlying religious beliefs as "helpful" ver-

Box 1. Questions to Guide a Spiritually Focused Conversation.

1. How long have you had [or been living with] this illness/injury?

2. What about your illness/injury concerns you most?

3. What is your source of strength?

4. How has this experience changed the way you see yourself?

5. How has this experience affected how you see God/Higher Power/life?

sus "harmful" religious coping. While helpful coping drew on spiritual support and benevolent religious reframing, harmful religious coping was characterized by religious pain and turmoil, discontent with God, the church, and reframing of negative life events as punishment from God. Pargament found that those who primarily engaged in helpful religious coping held benevolent beliefs about God and grew spiritually and psychologically in the aftermath of this trying life situation, while negative religious coping was associated with more callousness toward others.

For patients who welcome such a discussion, these five questions can generate substantive and meaningful conversations that validate their experiences. The sequence is not designed as a rigid structure but rather as prompts to steer the conversation in a meaningful direction. Based on our experience, patients and/or family members appreciate being able to have the undivided attention of health-care providers. This in itself can be experienced as a gift and as therapeutic.

When patients thank us for taking the time to talk to them, we know that the conversation has meant something to them. However, generally the blessing goes both ways. For this reason, the practicum leader always thanks the patient and/or family member for sharing with the group. If deemed appropriate, the leader may also ask: "Would it be helpful to you if we prayed with you before we leave?" Not only do we believe that it is imperative that patients be asked to consent before we pray with them, we also recommend wording the offer in such a way that the patient knows that prayer is not driven by the health-care providers' needs. The suggested wording keeps the focus on the patient and what would be supportive for him or her. The alternative, "Can I pray for you?" risks placing the patient in a situation where he or she worries about disappointing or hurting the feelings of a well-intended health professional. Our recommended phrasing allows the patient to say, "No thank you, I don't think that would be helpful for me." Recognizing that prayer is an intimate, personal, as well as communal practice, we also recommend a working knowledge of world religions and diverse faith-traditions[21] to be more attuned to patients' perspectives. If requested or welcomed by the patient, a short prayer such as the following may be helpful:

Dear God, thank you for the privilege of talking with [Mrs. Smith]. She is your beloved daughter—thank you for being with her through these trying times. We are grateful that she is recovering from her surgery and that her son has been so supportive through this experience [mention things that the patient named as being important]. Please be with her as she goes to rehab tomorrow [include specific concerns or requests that the patient mentioned]. Bless her, Lord, and continue to grant her healing and Your peace. In Your name we pray. Amen.

Once the group has left the patient's room, the practicum leader should take them to a quiet corner or small conference room to debrief the experience. This is an essential part of the practicum, as much of the learning often occurs after the patient encounter. The practicum leader and the group reflect on what they heard and observed, and discuss cues they followed or missed. Suggested questions that can be directed to the group include the following: How does the person who asked the questions feel? What spiritual needs did the patient identify? Should there be a referral/follow-up? The debriefing process allows students and participants to identify emerging spiritual themes. These sessions also provide an opportunity to affirm participants' individual strengths, provide feedback, and suggest alternative approaches. Finally, they provide a framework from which to evaluate one's own effectiveness.

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Final Thoughts

The two stories at the onset of this article illustrate that meeting *patients'* spiritual needs is what ought to drive any spiritual care. While in the first case, spiritual support allowed the patient to pass peacefully, and this knowledge comforted the bereaved daughter, the second scenario raised concerns because prayer was offered without prior assessment and regard for context. We suggest that the context in which prayer or any other spiritual care is offered matters: Has the nurse connected genuinely with the patient? Assessed and explored the patient's wholistic needs? And, fundamentally, does the spiritual intervention meet the actual expressed needs of the patient? The suggested questions inviting a spiritual conversation can provide helpful guidance. The art of listening for spiritual cues can be taught best in the clinical environment in small-group patient encounters followed by debriefings or post-conferences.

In conclusion, when modeling spiritual caregiving and teaching students how to become spiritual caregivers, instructors would do well to communicate the deep joy and sense of calling that comes from intentionally engaging in this sacred work. As we become increasingly attuned to the unique opportunity and privilege nurses have to "step on holy ground," we are reminded that the most powerful posture and truth from which we can approach our patients is to view them as beloved children of God. This love is transformative: "The love Christ diffuses through the whole being is a life-giving power. Every vital part—the brain, the heart,

and the nerves—it touches with healing. By it the highest energies of the being are roused to activity. It frees the soul from the guilt and sorrow, the anxiety and care that crush the life forces. With it come serenity and composure. In the soul it implants joy that nothing earthly can destroy—joy in the Holy Spirit—health-giving, life-giving joy."[22] This is the optimal outcome of spiritual caregiving; that through our interactions with patients, they experience this life-giving love, and recognize the Great Healer at work in their lives. ✐

The authors acknowledge with appreciation the valuable contributions to this article from Dr. Patricia S. Jones and Mrs. Adelaide Caroci Durkin.

This article has been peer reviewed.

Iris Mamier, PhD, MSN, RN, *is an Associate Professor in the PhD program at the Loma Linda University School of Nursing (LLUSN) in Loma Linda, California, U.S.A. She holds a PhD from Loma Linda University, a Master's degree in nursing education from Humboldt University, Berlin, Germany, and completed her undergraduate nursing at Heidelberg University, Germany. She has practiced and taught nursing across programs in Germany, Switzerland, and the United States, and was the Dean of Waldfriede School of Nursing in Berlin, Germany. For the past 15 years, she has been involved in whole-person care and nursing spiritual care from practical, conceptual, teaching, and research perspectives.*

Edelweiss Ramal, PhD, RN, *is an Associate Professor in the graduate nursing programs at LLUSN. She has been a nurse educator for 40 years; 25 of which were spent in Mexico and Botswana, 15 in the United States.*

Anne Berit Petersen, PhD, MPH, APRN-CNS, *is an Assistant Professor in the graduate program at LLUSN. She has worked as a nurse educator in China, Tanzania, Ethiopia, and the United States. She completed a bachelor's degree in English at Washington Adventist University, a bachelor's degree in nursing at Andrews University, Master's degrees in nursing and public health at Loma Linda University, and a PhD and postdoctoral fellowship at the University of California San Francisco. Dr. Petersen is passionate about equipping nurses to provide wholistic care, and her current program of research focuses on tobacco control and the prevention of non-communicable diseases locally and globally.*

Harvey Elder, MD, *graduated from the Loma Linda University School of Medicine in 1957 and completed an internal medicine residency at the University of California at San Francisco and San Francisco General Hospital. He also completed a fellowship in infectious diseases at Harvard University. Dr. Elder developed the hospital infection-control program at the LLU Medical Center and Jerry L. Pettis Memorial Veterans Administration Hospital in Loma Linda. Over the past three decades, his clinical practice has focused on the care of persons with HIV and AIDS. He pioneered whole-person care by clinicians at LLU by helping patients find spiritual strength and courage as they dealt with life and health-related challenges.*

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