

Article

Spiritual Care: When Spirituality Engages Medicine

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Abstract

This paper analyzes contemporary medicine as a prime arena for the expression of “engaged spirituality”, understood as an action-oriented approach aimed at social and clinical change. The focus is on palliative care, a person-centered model that challenges biomedical reductionism by integrating the physical, psychological, and spiritual dimensions of the patient. Through a review of the state of the art, the article reconstructs the historical separation between “health” and “salvation”, highlighting the critical issues of the Italian context: “institutional inattention” and difficulties in managing religious pluralism. In contrast, international experiences and the adoption of technical tools demonstrate that spiritual care is now measurable and essential clinical competency. The analysis presents the results of empirical research which, through the voices of healthcare professionals, shows how palliative care translates spirituality into operational practice. By valuing the concept of “total pain”, this approach not only improves quality of life at the end of life but also serves as a holistic paradigm exportable to other medical fields, ensuring the recognition of the person’s integral dignity.

Keywords: healthcare; spirituality; religion; spiritual care; palliative care; engaged spirituality

1. Introduction

In this article, we intend to demonstrate how the field of medicine is currently one of the areas where spirituality is a major source of active engagement among healthcare personnel. Indeed, one of the primary themes of discussion is “spiritual care” and the possibility of training “spiritual assistants” or professionals who are competent in “spiritual assistance”. A particularly eloquent sector in this regard is palliative care which, as we shall see, aims to integrate the patient’s spiritual dimension with their physical, psychological, and social dimensions, in accordance with its founding philosophy. This represents a new model of care that challenges biomedical reductionism in favor of a holistic approach to patient care, respecting the individual in their entirety.

Spirituality becomes engaged when it is oriented toward action and social change (Stanczak 2006). This is not a vague or generic approach by the individuals involved; on the contrary, moved by their spiritual values, they work to bring about individual or collective changes within their communities, in social, healthcare, and religious policies, as well as in the functioning of social services. In the medical field, as we will observe, this becomes the driving force for supporting holistic medicine that considers all aspects of the patient to improve their quality of life. Although the concept of engaged spirituality is never explicitly used in the medical-nursing field, practical proposals for guidelines, training programs for healthcare staff, and the creation of technical tools are moving in this direction. Spiritual care professionals become the carriers of a new vision of care that respects the patient’s



Academic Editor: Hans Zollner

Received: 18 May 2026

Revised: 11 June 2026

Accepted: 18 June 2026

Published: 6 August 2026

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wholeness, adding complexity not only to the experience of illness (by recognizing the repercussions it can have on every aspect of life) but also to the person themselves, who requires physical, psychological, social, emotional, and spiritual care. Consequently, this is a particularly fertile field where the application of the concept of engaged spirituality proves extremely effective in recognizing the dimension of social action.

In the following section (Section 2), we will provide a review of the literature regarding the relationship between spirituality, religion, care, and medicine, showing how the connection between these elements has evolved over time and how the medical-nursing field is currently attempting to bridge the gap between them. In Section 3, we will illustrate the empirical research underlying this reflection. In Section 4, we present the research results through the voices of care professionals to demonstrate how palliative care brings engaged spirituality into play. Brief conclusions will follow.

2. Spirituality, Care, and Medicine: A Literature Review

In recent years, there has been a marked growth in pluralism both in Italy and throughout Europe (Garelli 2020; Pace 2021), leading to a reflection on the presence of religion and spirituality within healthcare settings. The public debate has identified two issues in particular: (1.) the recognition and governance of religious pluralism and (2.) the management of patients' spiritual needs in hospital wards. However, these are usually understood as separate issues rather than as directions of the same phenomenon and therefore result in analyses belonging to different disciplines that rarely engage in dialogue. The first pertains to sociology, the second to medical-nursing sciences.

In Italy, the dialogue between these disciplines is further hindered by an "institutional inattention" regarding healthcare that stems from three interconnected factors: 1. national government health policy has almost entirely neglected the issue of spiritual assistance (Giorgi et al. 2022), except in the case of the regulation of the institution of the Catholic chaplaincy guaranteed by the Lateran Pacts; 2. many hospitals, both public and private, do not ask for the patient's religious affiliation, considering it sensitive data of little relevance to the clinical pathway; and 3. healthcare institutions are rarely prepared to respond to the religious and spiritual needs of non-Catholic patients (Giorda and Mastromarino 2020).

Above all, the management of religion and spirituality within healthcare institutions has been problematic ever since. This relationship is often understood as a health/salvation nexus (Bontempi and Maturo 2010; Camassa 2016; Dei 2004; Di Placido 2025; Di Placido and Palmisano 2025; Morandi 2007; Schirripa 2012), visible in all religious traditions as well as in spirituality-based wellness practices such as reiki, yoga, and acupuncture (Camassa 2015; Dericquebourg 2004; Filoramo 1999; Lofton 2015; Secondufo 2009). The separation between health and salvation that occurred with the development of biomedicine led to two consequences. First, the figures of the doctor and the priest split over time, becoming juxtaposed; this led to a progressive replacement of the latter by the former and a gradual emptying of the sacred sphere in favor of medical knowledge alone. Second, illness lost its metaphysical dimension to become a fact—an object of relevance and discursive value in and of itself—within a new way of conceiving the body and everything concerning it (Foucault [1963] 1969; Dei 2004; Spinsanti 2021). In this sense, illness is no longer an expression of evil, but becomes a bodily condition that must be addressed solely and exclusively by medicine, while religion is tasked with the salvation of the soul. Furthermore, the development of medical technology and diagnostics based on objective procedures and elements has indeed led to great results in terms of recovery and an increase in both life expectancy and quality of life; however, on the other hand, it has led to an increased distance between doctor and patient. In fact, a relational dimension that considers the patient's personal aspects is lacking (Clerici and Proserpio 2022). In this context, terminal

illness still represents an open challenge for biomedicine today; it is not only a clear sign of the limits of technology, but the failure of a promise of well-being and recovery (Giarelli and Venneri 2009). This relational problem becomes even deeper when considering that diagnoses are permeated with symbolic and cultural meanings: the person must not only live with the physical symptom, but also with all the meanings associated with it in the case of serious illnesses such as cancer or AIDS (Sontag 1979; Toombs 1995).

The consideration of illness as a mere organic failure developed between the 14th and 18th centuries, leading to a mechanistic view of the human being. Illness became something that could be resolved with drugs and surgery, excluding—at least initially—any possibility of environmental or subjective contributing causes (Rota 2011). There was a transition from traditional “bedside medicine”, based on a personal relationship with the patient cared for in their psychosomatic integrity, to a “hospital medicine”, where the body becomes a material object and illness a physical and chemical process that can be explained through the laws of natural science (Jewson 1976; Cardano et al. 2020). Biomedicine understood in this way is characterized by: (1.) individualism: when illness manifests, it is an isolated problem and not a possible result of the subject’s relationship with the environment; (2.) reductionism: it is based on a simplistic model of pathophysiological cause-and-effect; and (3.) scientific neutrality: there is a belief in objectivity and rationality, which are considered devoid of values and ethical or moral implications (Annandale 2014).

This biological approach remained predominant until an initial critique in the 1950s by Parsons. The scholar moved illness, and consequently health, out of the reductionist logic of the biomedical model, turning them into social facts (Rota 2011). His theory claims that illness is a form of involuntary social deviance that prevents the subject from conforming to the social role expectations regarding them (Cardano et al. 2020). From this moment on, illness returned to being viewed as a complex system, leading to the development of various theoretical perspectives increasingly attentive to the individual. Spirituality entered the medical field with the transition from *patient-centered* medicine to *person-centered* medicine. The latter is a sociological approach that distinguishes the concept of the individual—defined by mental faculties such as intellect, will, or affectivity—from that of the person, which adds characteristics such as uniqueness, relationality, and historicity (Cesareo and Vaccarini 2006; Cesareo and Giarelli 2007; Cesareo 2017). The patient is, therefore, considered unique because they possess a specific set of values, preferences, needs, and hopes. Furthermore, they are embedded in their relational network—the space they occupy within the web of bonds established also with the healthcare staff (Lombi 2024)—and possess their own temporal dimension as they remember the past and project themselves into the future (Cesareo 2017).

Simultaneously, scholars who point to the 1960s witness what was known in the literature as the “re-enchantment of the world”. During those years, a rebirth of fascination for the sacred and the divine emerged, taking on not only a transcendent dimension but also an immanent one (Camorrino 2012). This revolution encouraged a renewed sacralization of life, spreading a holistic perspective of the world and the individual, and bringing the practical-discursive universes of health and salvation back together¹ (Schirripa 2012; Di Placido and Palmisano 2025).

These shifts are recorded by a vast body of medical-nursing literature showing that spirituality is a fundamental dimension of a person’s health and well-being (Cobb et al. 2012; Fisher 2011; Lucchetti et al. 2019; Robinson et al. 2003; Oman 2018; Timmins and Caldeira 2019). For this reason, it must be taken into consideration during the care pathway as a crucial resource for a high quality of life, especially regarding the sense of personal self and the relationship with others, for both patients and healthcare providers (Ho et al. 2016). The COVID-19 pandemic emergency further highlighted the need for centralized strategies

to equip socio-sanitary systems for spiritual care, improving not only routine operations but also the management of health crises (Papadopoulos et al. 2021).

Severe illness or a terminal diagnosis, which places the patient in a perspective of finitude, can cause alterations that create or expand spiritual needs (Spinsanti 2021); the failure to meet these needs can result in spiritual distress (Monod et al. 2010). If not properly managed, this can lead to a decrease in the patient's quality of life, particularly during the terminal phase (Puchalski et al. 2019). Conversely, when care intervention is effective, it becomes potentially beneficial in accompanying the sick person because it can provide the individual with the interpretive tools to assign meaning to their own experience of illness, fostering active participation and involvement in the therapeutic process of which they are the recipient. Indeed, evidence shows that adequately managing spiritual care can significantly improve the patient's life (Yang et al. 2016; Gusman 2016), providing the person with the tools to recognize meaning in their illness and achieve active involvement in the therapeutic pathway (Bisinella 2011).

Furthermore, high-quality spiritual care can contain anxiety levels and provide adequate tools for moments of crisis (Meraviglia 1999; Baldacchino 2003; Kociszewski 2003). Moreover, several lines of evidence show how the nurses' own spirituality can lead to better care outcomes, as it improves their level of comfort and confidence in providing spiritual care (Giske 2012). The obstacles to the effective integration of spirituality into the care pathway are various, but the most frequently cited are the lack of adequate space and time (Balboni 2015) and gaps in specific competence among healthcare providers (Chan 2010; Murray et al. 2004; Balboni et al. 2013).

2.1. Spiritual Care Experiences in the United States, the United Kingdom, and Italy

Placing the person at the center compels healthcare professionals to take responsibility for all qualifying aspects concerning them, including the spiritual dimension. On an international level, the debate is more articulated compared to Italy. Attention to religious and spiritual suffering on the part of caregivers is urged in contemporary studies on spiritual care, where the importance of adequate training is emphasized. Consequently, private training contexts have emerged, such as the George Washington University Institute for Spirituality & Health (GWish), founded in 2001 by Christina Puchalski, which place the United States at the forefront of reflection on the spiritual training of medical and nursing students. The introduction of university courses on the relationship between spirituality and medicine dates back to the mid-1990s, following the development of the first definition of spirituality (1996)—others would follow—proposed by the Association of American Medical Colleges (AAMC) within the Medical School Objectives Project. In 2017, such courses were present in four of the ten leading U.S. universities (Ritossa 2023). GWish itself, now one of the most important centers for reflection on the subject, took shape from the first course proposed by Puchalski in 1992. In this context, the relationship between the chaplaincy and healthcare personnel becomes a crucial turning point for effective spiritual care of the patient; not surprisingly, in these contexts, the chaplain is considered part of the interdisciplinary spiritual care team.

Recently, another significant project, this time European, was launched: Enhancing Nurses' and Midwives' Competences in Providing Spiritual Care through Innovative Education and Compassionate Care (EPICC, 2016–2019)². The objective is the development of spiritual care competences in the training of nursing and midwifery students and the construction of a network of practitioners, researchers, and stakeholders to communicate virtuous policies in the field of spiritual care. The main output was the creation of a training protocol called the Spiritual Care Education Standard, which identified four fundamental areas of competence for practitioners. The first is intrapersonal spirituality, which concerns

the awareness of the importance of spirituality for health and well-being. The second is interpersonal spirituality, namely the ability to pay attention to the other person's spirituality, recognizing the uniqueness of their worldview, beliefs, and spiritual practices. The third is the assessment and planning of spiritual care, through the development of skills that allow for the preliminary examination of spiritual needs and the programming of the intervention. Finally, the fourth is the delivery of spiritual assistance, based on skills that enable the practitioner to establish a compassionate care relationship to respond to the patient's needs, followed by the final evaluation of effectiveness (Ross et al. 2014; McSherry et al. 2020).

At the international level, therefore, various methodological tools are being developed to meet patients' spiritual needs. Some of these are formal and utilize questionnaire formats, with varying degrees of rigidity and synthesis. This technique is frequently used in the international landscape, designed to be easily administered even within organizational contexts with demanding work rhythms. The FICA questionnaire (Puchalski and Romer 2000; Puchalski 2014), created in the 1990s at the George Washington Institute for Spirituality & Health (GWish), is widely used. It investigates: (1.) religious faith and spiritual orientation (Faith); (2.) how important faith is in the person's life (Importance/Influence); (3.) whether or not they belong to an organized community (Community); (4.) the circumstances in which spirituality can influence the therapeutic path (Address). Equally famous is the HOPE questionnaire (Anandarajah and Hight 2001), which also investigates four areas: (1.) sources of hope (Hope); (2.) forms of community (Organized religion); (3.) personal definition of spirituality and related practices (Personal spirituality and practices); and (4.) the effects that spiritual beliefs have on the end of life and more generally on the therapeutic path (Effects on medical care and end-of-life issues). Finally, the FAITH questionnaire investigates (1.) faith or spiritual beliefs (Faith/spiritual beliefs), (2.) how these manifest in daily life (Application), (3.) what place they hold for the individual (Influence/importance), (4.) how they intersect with the end-of-life journey (Talk/terminal events planning), and (5.) what help is desired or expected from the process (Help).

In informal approaches, however, the tools employed originate within the field of narrative medicine. The aim is to leverage relationship and dialogue to avoid the potentially intrusive questions of standard questionnaires. Narrative-Based Medicine (NBM) is a theoretical and operational approach proposed by Rita Charon in the early 2000s, which aims to introduce storytelling as a tool for collecting and interpreting information regarding the patient's experience of illness (Charon 2019). It represents a successful attempt to combine social and biomedical disciplines within the clinical field. This approach is not limited to its ethical value but has a significant practical implication: it bridges the gap between doctor and patient, allowing for greater diagnostic and therapeutic efficacy (Cardano 2015).

The processes for operationalizing these areas of intervention—to create tools for patient history, intervention, and evaluation—are currently at the heart of medical-nursing research. The tools presented originated in specific clinical fields, such as oncology, but exhibit a high degree of standardization. This makes them adaptable to other clinical and cultural contexts (Timmins and Caldeira 2017). Although these tools are used both nationally and internationally, they have been developed strictly within the medical-nursing field, without any interaction with disciplines such as sociology or cultural anthropology, which deal extensively with these themes.

The definition of spirituality to which these tools are linked was developed during the International Consensus Conference on Improving the Spiritual Dimension of Whole Person Care held in Pasadena in 2013. The event brought together experts in health professions,

economics, law, education, and pastoral services from forty-four nations. According to this definition:

“Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices”. (Puchalski et al. 2014, p. 646)

While it is a reworking of previous definitions, it attempts to introduce an innovative element by explicating the ways in which spirituality can manifest itself. It is an inclusive definition that places religious experience within the broader macro-area of spirituality. It refers to a biological dimension of the spiritual attitude that echoes the words of Luckmann (1967) when he emphasizes that:

“It is keeping with an elementary sense of the concept of religion to call the transcendence of biological nature by the human organism as the religious phenomenon. [...] The transcendence of biological nature is a universal phenomenon of mankind”. (Luckmann 1967, p. 49)

Lenski (1963, pp. 331–32) writes even more clearly:

“Given this definition of religion, it quickly becomes apparent that every normal adult member of any human society is religious [...]. There are some people, of course, who profess to be agnostics, but any examination of their patterns of action reveals that all agnostics act as though they accepted one or another of the different systems of belief. Human existence *compels* men to act on unproven and unprovable assumptions, and it makes no exceptions.”

Finally, the 2013 definition of spirituality seeks to avoid sharp boundaries between those who belong and those who do not belong to a religious community, focusing instead on hope—whether transcendent or immanent, open to the afterlife or confined to the earthly horizon.

The international proposals described above qualify as virtuous examples which, however, have little impact in Italy, partly due to the traditional Catholic presence in healthcare institutions. The Italian hospital chaplaincy is tied to its Catholic identity which, as we will see later on, guarantees it strong legal protection, making it a relevant actor within the public institution even when the latter is experiencing secularizing pressures. These are tensions that must necessarily be kept in mind when adapting proposals to the context so that they can engage in dialogue and lead to cultural validation.

In Italy, the main promoters of spiritual care in the palliative field are associations that support various initiatives aimed at refining the role of the spiritual assistant. In 2019, a core curriculum³ was drafted by some of the leading promoters of spiritual care in Italy. This document outlined the fundamental knowledge and skills for the professional figure of the spiritual assistant, while recognizing that this is an aptitude requiring transversal reflection among all practitioners involved in the palliative field.

Currently, in Italy, there are two primary pathways to becoming a spiritual assistant: the “Non-university Advanced Training Master’s in spiritual accompaniment in sickness and dying” and the “School of Advanced Training for the spiritual assistant in palliative care”, both of which are organized by the TuttoèVita ETS Association. The School of Advanced Training, in particular, is organized in collaboration with all the major bodies involved in palliative care in Italy, namely the aforementioned Italian Society of Palliative Care (SICP), the Palliative Care Federation (FCP), and the Luce per la Vita Foundation.

2.2. Palliative Care: A Pioneer in the Reflection on Care and Spirituality

Palliative care is the specialized branch dedicated to treating terminally ill patients; since its beginnings, there has been a profound reflection on spirituality and religion as essential tools for “total care”. A disease with a poor prognosis represents an open challenge to biomedicine, as it not only exposes its limitations but also marks the space where biomedicine is defeated (Giarelli and Venneri 2009). In post-industrial societies such as ours, death has been marginalized, becoming a taboo (Ariès [1974] 1988). Images of death are perceived as illicit, as is speaking openly about it, unless it is sensationalized and dissociated from the painful feelings and emotions typical of mourning and its rites (Gorer 1965). Consequently, a terminal diagnosis overwhelms the world of the recipient, triggering a crisis. First and foremost, the news likely represents the individual’s first perception of finitude and conditions their family and significant relationships, who must share this new horizon (Bury 1982; Giarelli and Venneri 2009). The patient must live not only with the physical symptom but also with all the personal and cultural meanings associated with it: grave illnesses such as cancer or AIDS carry a symbolic weight of particular impact⁴ (Sontag 1979; Toombs 1995).

The very name of this approach, palliative care, reveals its profound meaning: it does not *cure*—the disease is not healed in the biomedical sense through an intervention aimed at fixing a biological failure—but rather, it *takes care* of the person and the time remaining to them, however long or short that period may be.

The birth of modern palliative care is ideally traced back to the founding of St Christopher’s Hospice in 1967, thanks to the commitment of Cicely Saunders (Milligan and Potts 2009). Following her nursing training in the 1940s, Saunders worked at St Thomas’ Hospital in London as a medical social worker at the bedside of various end-of-life patients. Among them was David Tasma, a forty-year-old Polish cancer patient of intense faith, with whom Saunders developed a deep bond of exchange and reflection. It was precisely through her encounter and dialogue with him that Saunders realized not only how important it was to allow terminal patients to die with peace and dignity, but also to enable them to live their remaining time to the fullest by satisfying their physical, psychological, and spiritual needs (Saunders 2000).

Palliative care was subsequently defined for the first time in 1990 by the World Health Organization in the report *Cancer pain relief and palliative care: report of a WHO expert committee* as: “the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems, is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families”.

Today, this definition has been refined while maintaining its core principles. The WHO website now states that it is “[...] a crucial part of integrated, person-centered health services. Relieving serious health-related suffering, be it physical, psychological, social, or spiritual, is a global ethical responsibility. Therefore, whether the cause of suffering is cardiovascular disease, cancer, major organ failure, drug-resistant tuberculosis, severe burns, end-stage chronic illness, acute trauma, extreme prematurity at birth, or extreme frailty of old age, palliative care may be needed and should be available at all levels of care.”⁵

The pillars of this approach are the promotion of relief from distressing symptoms, the guarantee of the best possible quality of life, and the consideration of death as a natural event that should be neither accelerated nor postponed. It is a holistic model of care that aims to take responsibility not only for the body but also for the psychological, emotional, social, and spiritual spheres of the patient, the family, and the caregivers. There is an aspiration toward the de-medicalization of death; medicine, therefore, does not aim to

subdue the body and the pathology but intervenes through an interdisciplinary lens to value the feelings and identity of the ill person, ensuring empowerment even within the care pathway (Moretti 2020; Petroccia 2024). Ideally, palliative care is applied from the moment of a serious diagnosis until death. In this way, it is possible to introduce all the strategies and resources necessary to care for the whole person and, in the case of spiritual care, to apply its principles across all possible stages and environments, respecting culture, religious tradition, and value systems (Puchalski et al. 2009).

In Italy, palliative care is regulated by Law 38 of 15 March 2010, which establishes provisions to guarantee access to palliative care and pain therapy. Article 1 of the law sets forth three ethical pillars for healthcare facilities: the protection of the patient's dignity and autonomy without discrimination; the protection and promotion of the quality of life until its end; and the guarantee of adequate health and social assistance for the ill person and their family. These are considered inviolable rights of the citizen and represent "the set of therapeutic, diagnostic, and welfare interventions, aimed at both the ill person and their family unit, finalized toward the active and total care of patients whose underlying disease—characterized by an unstoppable progression and a poor prognosis—no longer responds to specific treatments" (Art. 2)⁶. No distinction is made between oncological and non-oncological diseases; palliative care is intended for all chronic progressive illnesses with no possibility of recovery. On a national level, these services are essentially delivered in three ways: home care, hospice care, and hospital day-care⁷.

In a palliative context, the primary interventions by healthcare personnel are directed mainly toward alleviating pain. However, this sphere is extremely complex to navigate in light of the complexity of the concept itself. Indeed, in common parlance, pain refers to both an unpleasant physical sensation and an emotional state of existential anguish and suffering. This duality makes it an inescapable aspect of the human experience (Kleinman 2007; Giarelli 2018; Han 2020). One of the current obstacles to pain management is the fact that the body is identity, and suffering is rejected to the point of developing a phobia (Han 2020). This attitude produces new, often silent forms of malaise that compound the social removal of suffering within a hedonistic culture (Giarelli 2018; Baudrillard 2006). Pain has become a taboo, much like death (Ariès [1974] 1988), and its medicalization, rather than alleviating it, risks generating further anguish and helplessness (Giarelli 2018). In such a scenario, incurable illness and palliative care struggle to find symbolic and narrative space within the broader cultural context. Cicely Saunders, however, formulated the concept of *total pain*⁸, namely a state of suffering whose origin is not only physical and biological, but also psychological, emotional, social, and spiritual (Saunders 2000, 2006).

Saunders proposes a holistic management of the patient's pain to embrace them in their entirety, with the aim of optimizing pharmacological care levels. This prevents the premature sedation of the dying person, as effective management of emotional, social, or spiritual pain reduces anxiety and allows for a better quality of life (Clarke 2006). Considering the multidimensionality of pain and giving attention and relevance to patient narratives makes it possible to understand how even physical manifestations are often more than just symptoms. While the healthcare provider may focus on etiology and nociception, for the patient, pain is projected into the future, extending beyond the acute moment, triggering the fear of recurrence and causing states of anxiety and paralysis that prevent any possible openness to the world (Raho and Raho 2023).

Total pain is composed of different types of pain that can arise and mutually influence one another. The first of these is mental pain: ignoring the feelings and emotions of patients leads to the exacerbation of pain and creates a sense of loneliness that undermines the capacity to react, increasing weakness and states of anxiety. To address psychological pain, one must commit to communication with the dying person and offer support through a

mindful presence, even in the final stage of the illness. Furthermore, a dialogue based on respect and trust must be thought of as a human attitude, rather than a specialized one, as dying is not a psychiatric illness and does not necessarily require the intervention of a technical expert.

There is then social pain, which can arise because, as every individual is embedded in their own network of relations, these bonds can be wounded. The sources of suffering can vary and are often linked to where and how the patient lives the final period of their life. It is not unusual for problems and suffering related to “unfinished business” or old, unresolved tensions to emerge, and attempts at reconciliation are not infrequent. Competent support from healthcare staff can help buffer the concerns of relatives and caregivers, allowing for a peaceful death.

Finally, there is spiritual pain, which may express itself in an explicitly religious manner with clear references to a specific corpus of beliefs, but can sometimes be more elusive, linked to the general sense of existence, manifesting as deep anguish. One’s own faith can be a help, but due to the state of illness, it can also weaken or even become a significant obstacle, becoming a source of anxiety. One of the main issues that emerges is the search for meaning and the confrontation with the fear of its absence. Noticing and caring for this suffering is complex for care staff, who must be attentive and ready to stop and listen. Only those with significant experience and confidence can openly investigate these manifestations which, from the patient’s perspective, can take on angry or otherwise negative forms such as self-pity, guilt, or fear, and which very often translate into the unanswered question: Why? Attention to these questions is fundamental and obliges the professional to listen and maintain a mindful presence alongside the ill person, being challenged by the fact that listening is often requested without the search for a true answer (Saunders et al. 1995; Saunders 2006).

3. Empirical Research—A Qualitative Approach to Spiritual Care

The qualitative empirical research⁹ upon which this reflection is based intended to investigate how spirituality manifests within the context of palliative care in Italy, and how it is identified and managed by healthcare professionals in hospital wards and dedicated care facilities—hospices and home care—in response to patient needs. Interviews conducted with healthcare staff reveal that the spiritual resource is perceived as the source of a new person-centered care model that respects and values life, however brief it may be. The attempt to intertwine care and spirituality interfaces with the existence of other projects addressed toward the governance of religious diversity within the institutions examined.

In the literature, research on this topic stems from a definition of religion and spirituality consistent with the heuristic orientation of biomedicine and mostly adopts the quantitative approach typical of medical and nursing research. In our research, conversely, the concept of spirituality—used as a sensitizing concept (Blumer 1969)—has been re-defined, both operationally and theoretically, to make it “employable” in a sociological analysis. To this end, we opted for a de-structured, open research design capable of adapting to the context (Corbetta 2014). The need to operationalize concepts such as spirituality and religion in the medical and nursing fields has, until now, led the scientific community to overshadow the importance and centrality of the healthcare professional along with their personal background, which is instead, as we shall discuss in this article, the core of the reflection on this theme.

To study how care settings identify and respond to the spiritual needs of patients with a poor prognosis, we conducted a comparative study in two Italian cities. The research units chosen for comparison are two local health authorities (Asl Città di Torino and Asl

Roma 1) that were pioneers in spiritual care, having initiated projects in the early 2000s aimed at accommodating the religious and spiritual needs of non-Catholic patients.

These two projects share a common origin, as both arose from a civic audit conducted in 2006 by *CittadinanzAttiva's Tribunale per i diritti del malato* in collaboration with the Ministry of Health; however, they took two different directions. In Turin, the “Cura dello Spirito”¹⁰ (Care of the Spirit) project was established in 2006 with the aim of providing religious and spiritual assistance to non-Catholic patients; it was subsequently expanded through the dietary project “Nutrire l’Anima” (Nourishing the Soul)—consisting of specific dietary guidelines based on different faiths—and the integration of mortuary police protocols for the treatment of the body (differentiated by religious tradition). The Roman project, on the other hand, involved the development of guidelines for healthcare professionals titled “L’accoglienza delle differenze, specificità culturali e religiose, le strutture sanitarie ospedaliere e territoriali della Regione Lazio. Raccomandazioni per gli operatori sanitari da parte delle comunità religiose”¹¹ (The welcoming of differences, cultural and religious specificities, hospital and territorial health facilities of the Lazio Region. Recommendations for healthcare workers from religious communities) (2010). This project evolved in 2019 into the “Interreligious Manifesto of End-of-Life Rights”¹² which outlines nine fundamental rights for end-of-life patients and explicitly guarantees care, dignity, and religious and spiritual support.

Within the two health authorities subject to comparison, facilities covering the three modes of palliative care delivery (hospital, hospice, and home care) were identified in order to compare the spiritual care work occurring within them. In Turin, the Humanitas Gradenigo hospital and the Fondazione Faro ETS (providing home and hospice care) were selected; in Rome, the Policlinico Universitario Fondazione Agostino Gemelli and the Gemelli Medical Center (providing home and hospice care) were chosen.

To recruit the sample of professionals whose work involves spiritual care, we opted for snowball sampling (Corbetta 2014): the managers of the identified facilities provided the contacts of the healthcare workers. The main inclusion criterion was that the interviewees had to be actively working within the selected facility. The core of the empirical material consists of 48 semi-structured, low-directivity interviews, which allowed for a free flow of thought from the respondents.

As we shall see in the next section, palliative care presents itself as an intrinsically spiritual approach to care that aims to embrace the dying patient in their entirety. However, institutional support for this model is lacking, both in terms of religious diversity management projects—which often fail to have an impact on the wards—and in terms of staff training. The latter leaves caregivers at the mercy of their own personal sensitivity without receiving assistance, even from hospital chaplaincies, in the daily management of suffering. This institutional neglect prevents the diffusion of a holistic care model for patients with grave or terminal diagnoses, relegating it solely to the palliative context. Supporting care professionals and providing better training on the subject could shift the general approach to the patient even in other contexts, improving overall patient care.

4. Findings—Spirituality as a Tool for a New Model of Care

In this complex context, the role of healthcare personnel is fundamental. Care professionals find themselves at the center of a crossroads of contingencies, tensions, and dilemmas that they are tasked with managing. On one hand, there are projects for integrating care and spirituality and managing religious diversity introduced by the healthcare institutions for which they work; on the other, there is the day-to-day operation of the wards and the commitment to the relationship with the individual patient, which is unique and difficult to standardize. Between these poles lie the educational offerings and training

updates (both mandatory and optional) and, above all, the private lives of individuals and their own approach to religion and/or spirituality. Even the presence of the Catholic chaplaincy acts, in this context, as an intervening variable. Given this perimeter, what emerges from the interviews with healthcare personnel regarding spiritual care work aimed at recognizing spirituality as a fundamental element of a good care relationship? To answer this question, we move from literature on the subject to focus on what emerged from field research.

The importance of the health professional's commitment to spiritual care in a palliative context is already present in the philosophy of Cicely Saunders, who urged colleagues not to leave the entire burden on the shoulders of hospital chaplains and suggested a profound attention to the "other" and their discourse in order to grasp the unspoken questions that require presence and compassion (Saunders et al. 1995). More generally, international literature identifies the nurse as the most suitable professional figure by virtue of the ethical principles and intrinsic philosophy that characterize the role. The need to pay attention to the patient's spirituality stems from the legacy of the founder of the modern nursing movement, Florence Nightingale, who considered the religious and spiritual needs of patients to be closely connected to their physical needs (Cadge 2012). Today, this has translated into specific attention to educational curricula: focus is placed on developing and enhancing programs that can train nurses to be competent in managing the global care of the ill person, as this is considered to be in line with the deontological ethics of the profession itself (The ICN Code of Ethics for Nurses 2021).¹³ It is of them, in fact, that outside the context of the chaplaincy, medical-nursing literature asks to be able to provide spiritual care as part of holistic, person-centered care (McSherry et al. 2020; van Leeuwen and Cusveller 2004). Within the scope of spiritual care, nurses—and hospital staff in general—are required as an essential condition to have a deep awareness of themselves and their own beliefs even before meeting the patient (Baldacchino 2006). In a palliative context, the importance of the team necessitates a relationship between professional figures who have different educational backgrounds and, therefore, different sensitivities.

These theoretical premises reveal that it is necessary to give a voice to the protagonists of care, who are rarely listened to. The interviews conducted during our research highlight both the critical issues in the processes of implementing spirituality in care and the potential to be seized in this area.

The main criticisms stem from the institutional context, as religious diversity management projects have a top-down origin. They arise, in fact, from the healthcare company's need to meet the minimum requirements of an offering to the patient understood as a "client". It is a ceremonial (rather than substantive) response that does not directly address the needs of patients and healthcare workers but originates from hospital governance planning intended to show how the hospital is up to the task of meeting patient demands at 360°, including on the spiritual front (Di Placido and Palmisano 2023). From a sociological point of view, we are witnessing a process of institutional isomorphism: as highlighted by the neo-institutionalist school, organizations apply models recognized and perceived as "appropriate" or "cutting-edge", regardless of their practical effectiveness or consultation with the project's recipients (DiMaggio and Powell 1983). There is, therefore, a disconnect between the projects put in place by the hospital to govern religious diversity and the daily life of those who work in the wards and respond to patient needs. Contrary to the declarations of hospital governance, a network of non-Catholic spiritual assistants has been neither incentivized nor developed to support healthcare teams; consequently, these teams have found themselves alone in satisfying the spiritual needs of the sick and their families. Furthermore, the aforementioned projects have not translated into training

programs for staff on themes of religion, religious diversity, and spirituality, leaving any further exploration to the sensitivity of individuals.

The Catholic chaplaincy has also contributed to slowing the development of projects aimed at non-Catholic patients. The chaplaincy boasts a historical presence in hospitals worldwide; however, in Italy, in light of the Catholic cultural background, it has a peculiar status guaranteed by law. Its existence is provided for in the Constitution and regulated by Law 833/1978, Article 38, which ensures religious assistance in the inpatient facilities of the National Health Service “respecting the will and freedom of conscience of the citizen”, delegating each local health unit to organize the Catholic religious assistance service in agreement with the competent territorial diocesan ordinaries, and potentially involving other cults in agreement with their respective local authorities. From a practical point of view, therefore, each region and their respective Episcopal Conferences, through the Health Pastoral (established in 1989), define the roles and competencies of individual chaplaincies (Clerici and Proserpio 2022). Regarding the involvement of other religions in hospital assistance, however, we must wait for more recent times (and ad hoc projects like those examined). This legislation has perpetuated unequal treatment of different religions and their representatives, exemplified by the fact that the chaplain on the ward, unlike other ministers of worship, is provided for, paid, and protected. During the pandemic period, this became evident: restrictions and the radical redefinition of access to care facilities excluded external figures, while Catholic chaplains, integrated into the hospital staff, were able to continue their work (Di Placido et al. 2023). Such unequal treatment has hindered the development of interreligious dialogue initiatives in both the ASLs examined.

Furthermore, this asymmetry ensures that only the chaplain participates in teamwork in a palliative context; any summoning of other ministers of worship depends exclusively on a direct request from the patient, their family, or the staff itself. Upon closer inspection, however, even the chaplain’s involvement appears marginal: while they are present (more or less) for ward assistance, they are not for home care, which thus remains entirely uncovered. In the latter case, when the family does not have its own religious contacts, it is the healthcare staff who act in the local area to obtain the required support.

This separation between the institutional sphere and the daily life of the wards also emerges when analyzing training projects for healthcare personnel. First, there is a lack of programs targeted at the specificities of different professional figures and various clinical contexts. In addition, modules dedicated to spiritual care within continuing education are episodic and non-mandatory, taking the form of isolated interventions rather than structural ones.

On the other hand, opportunities for the development of spiritual care come directly from the ethics of palliative care itself, but they take shape only when care professionals are made protagonists. Those ethical guidelines emphasize the need to enter into contact with the dying person by stepping out of one’s comfort zone and entering into a deep relationship that guarantees human dignity beyond the suffering of the body. Suffering in a palliative context does not nullify the person; on the contrary, it enhances their specificity and dignity (Spinsanti 2019). This concept requires recognizing the inalienable uniqueness of the individual precisely at the moment of their experience of pain. Consequently, care cannot be limited to the clinical dimension alone but must actively and simultaneously embrace emotional, social, and, crucially, spiritual aspects, thus ensuring a holistic and fully human approach to the suffering person. From the words of the interviewees, fundamental characteristics of this care approach emerge, which are traced back to an intrinsically spiritual sphere such as: (1.) the empathic encounter that precedes a (2.) relationship of trust where (3.) the great questions of meaning can be asked, while remaining in a state of (4.) silence and active listening.

It follows that one's personal definition of spiritual care arises from a complex triangulation between the personal dimension, professional life, and experience within religious communities. From the field research, as emerges from the two excerpts proposed here, we learn that it is not unusual for the spirituality of the care professional to manifest in the encounter and relationship with the patient:

Well, spirituality is an extremely kaleidoscopic dimension because, how can I put it, I believe it is difficult to define it in an academic way; perhaps it is more necessary to listen to it from the people you interact with. Certainly, I believe no one can contradict you on that very deep dimension that has to do with meaning, with one's biography, with one's values. In my opinion, if you have a certain capacity for perspective, even regarding values, regardless of religious faith, I believe it can help you in moments of difficulty. Something very personal, in my view, which also depends very much on the desire that the single person has to deepen that sense of meaning. [Physician—Hospice]

Spirituality is an integrated part of the person—that part that leads you to approach nature, your psychology, your beliefs, your values. I don't know how to say it, it's a bit like the ether, the cytoplasm of the cells of our body. So, it is something that envelops everything, which from a certain point of view you never fully grasp. [...] Without spirituality, one suffers. [Nurse—Home care]

In literature, spirituality is generally considered to be a deep, personal, and intimate sphere that has to do with the search for self and meaning. It is a dynamic dimension in constant evolution and is the human attempt to give meaning to life, death, and suffering. It is that element that allows for the creation of a deep bond with the surrounding world, both with people and with nature. It is seen as a positioning toward the unknown in order to face it. References to the value sphere are common, such as the importance of behaving well, helping people, relating without judgment, and paying attention to the other. In our interviews, across the various health professions, this is expressed in the choice of palliative care as a career path. In more than one conversation, an osmotic dynamic emerged whereby the professional path in palliative care led to the development of a spirituality that influenced private life and, vice versa, where personal reflection then poured into professional life. Spirituality emerges, therefore, as the interpretive key that allows the care professional to actively access a holistic care model that takes the whole person into account. The attention and respect toward the dying patient force the practitioner to bring a spiritual sentiment into play to meet them in their totality as a human being. Palliative care is, ultimately, a person-centered care model that can be exported to other areas of medicine. This is clearly seen in the words of this interview:

For me, the field of palliative care is the “must” of assistance. I believe it is my nursing suit and also, objectively, I think that here we provide Care with a capital C more than in other fields. [...] It is that process of interest, of welcoming the person and all that is their world—in this case, including the family—not sectorized. It is a complex process of care that starts precisely from consideration for the individual. The pace in other work environments sometimes does not allow for this great attention, this centrality of the individual. Perhaps they tend to secure the assistance provided, the care, or to take charge of only some aspects, whereas in palliative care, one tries to take everything the person is in their final stretch of life. Being able to do so, anyway. That is the mission here. [Nurse—Home care]

In the perspective of spiritual care, therefore, this spiritual sense must be developed, on one hand, by providing care professionals with training tools to understand and apply it toward patients and, on the other, by offering them the consultation of professionals capable of supporting such relational work. All the practitioners interviewed recount that

spirituality manifests in the encounter itself with the patient, as it is the first step for the care relationship. From the moment the patient is taken into care, every moment is fundamental to creating a condition of safety and trust.

Empathy proves, therefore, to be a fundamental requirement upon meeting the patient. From the interviews with physicians, in particular, it emerges that the administration of drugs is only a minimal part of their work—a technical element that with experience becomes almost automatic—while the demanding part is that of attention to the patient and the construction of the relationship. The empathic relationship is the prerequisite to a deeply spiritual bond, because it requires stepping out of oneself and meeting the other without barriers in an honest way. The connection with the patient necessitates a reduction in professional distance, forcing the practitioner to reveal themselves even in their most personal sphere. The dying person places the caregiver in a position of vulnerability that breaks down professional barriers and allows for a deep encounter that touches the spiritual sphere of the practitioner themselves. It is only in that moment of extreme fragility for both patient and professional that the great questions are asked—those that question the meaning of life itself, the “why” of death and suffering, the fear and hope of the afterlife, the problem of legacy, the need to re-read and confirm one’s own life path. The two interview excerpts that follow clearly highlight the importance of entering into an honest and open relationship with the patient—a relationship that is the heart of this care model:

For me, spirituality with my patients is established—allow me to say it in a somewhat strange way—when trust is established. I don’t know how to say it, when you enter into things, you feel the spirituality of things. So, when I enter with trust and in trust with a person, our talks, our silences, everything, takes on a spiritual value. Whereas before that moment, it remained something a bit more ephemeral. “Empathy” is a big word, overused, perhaps worn out, and I like to think of the “arrow of trust”. When you enter with trust, with empathy, you notice this little magic of spirituality. I don’t know how to say it, it’s as if it were an added value, as if spirituality were more vivid, more active. Let’s call it that: active. [Nurse—Home Care]

With the patient [the help goes] beyond physical symptoms, beyond problems inherent to the classic medical field, but [it has to do] with listening, becoming—I won’t say a confidant—but nonetheless a person to whom they say even personal things, and it happens often. The patient, but also the relative, opens up at times telling us things that go beyond what might be the simple professional relationship, the simple medical problem of pain control rather than the control of anxiety or agitation. They tell you about private, personal problems, about the fact that they weren’t able, for example, to go to dinner with a friend that day, things like that, you know. [Physician—Hospice/Home Care]

The empathic encounter is an extremely delicate moment that restores agency to the patient through the narration of their own biography. It is a “dance of interacting parts” (Bateson 1979)—that is, a dynamic that must be analyzed in its complexity rather than in its individual parts, made of rules and spontaneity—and which, in the palliative context, is realized to its full potential when a relationship of trust is established.

It is in this space that the questions of “Why?” and “What is there after?” can be asked of the caregivers, who are required to recognize this dimension of crisis and manage it in the best possible way. This emerges clearly from the words of a nurse in Turin:

[Spirituality] is an integral part of palliative care, absolutely. Especially when the patients—also from the family, but above all the conscious patient—ask you the classic question “Why me?” or “Why does this thing have to happen?”, let’s say topics that do not strictly concern the clinical part. [...] I listen and I try to let the person bring out what they feel like saying. In reality, they don’t want answers from us; it’s more the

need to speak about it out loud and so maybe comment on the great themes of life, but they certainly don't expect answers from us, also because answers don't exist. [Nurse—Home Care]

Taking responsibility for the dying patient's unanswered question obliges the professional to listen and to maintain a mindful presence at their side, accepting being challenged every time because no answer exists—but this does not mean it can be dismissed quickly or superficially (Saunders et al. 1995; Saunders 2006). It is the taking charge of the spiritual dimension of “total pain” which, like physical pain, must be managed appropriately to avoid states of anguish and anxiety in the dying.

From the interviews, some differences emerge in the approach to spiritual care dictated by the work context and the profession practiced. The hospital, for example, presents itself as a context less conducive to staff developing a sense of connection with each other compared to the hospice and home care. Furthermore, different university paths provide professionals with different interpretive tools, creating gaps in meaning that can be exacerbated by one's own personal experience. In general, in conversations guided by the interviews, reference to one's own religious orientation is spontaneous, evident, and seems inevitable. One's personal experience in perceiving and defining spirituality proves to be the starting point for the broader reflection applied also in the professional field. In the Italian cultural context, where we experience a Catholic predominance, the reference to Catholicism is common.

Therefore, in a context where the importance of working on spiritual care is recognized—not only to guarantee a better quality of life for the dying patient but also for the process of humanizing care (Batstone et al. 2020; Ross and McSherry 2025; Timmins and Caldeira 2017)—training becomes the space where an actual change can be created. First and foremost, it would provide practical tools to care professionals to manage the care of the dying patient with more ease and better efficacy, but it would also create an exportable standard outside of contexts different from the palliative one, allowing for the diffusion of this holistic approach to the patient.

5. Conclusions

As demonstrated by the empirical research underlying this article, within the field of contemporary biomedicine, the activism of spiritual care advocates acts as a disruptive force against the dominant reductionist paradigm. Their spiritual values do not remain confined to the private sphere; instead, they are translated into actions that generate projects, guidelines, and specialized training programs aimed at a radical shift in patient approach. This movement does not merely stop at humanizing medical technique; it performs a deeper cultural operation by recognizing spirituality as a constitutive dimension of the human being within a heavily secularized healthcare context. Through the creation of technical tools and validated protocols, spirituality becomes a means to reconstruct the patient's biography, thereby transforming the very experience of illness.

In conclusion, the field of medicine—and palliative care in particular—currently represents one of the most advanced laboratories for the practice of engaged spirituality. Through the analysis of the Italian context and comparison with international experiences, spirituality becomes central to countering biomedical reductionism. The introduction of spiritual care in hospital wards and home settings is not a simple therapeutic supplement, but a structural response to the limitations of the traditional model. Where mechanistic medicine has separated “health” and “salvation”, palliative care performs a recomposition. Healthcare professionals who choose to train in and act upon the spiritual dimension of the patient facilitate, for both them and the patient, a shift in approach toward embracing human complexity.

The Italian case still presents numerous challenges. The research conducted highlights the need for the cultural validation of new spiritual care models that are inclusive and pluralistic in order to address societal changes. It is therefore necessary to overcome the fragmentation between disciplines, opening a dialogue that allows for the complexity of the phenomenon to be captured without falling into reductionism. In particular, this is essential to manage the constant tension between the concepts of religion and spirituality, as they pertain to different spheres when intersecting with the public institution. Religious organizations benefit from legal protections granted by the State—in the Italian case, for example, the presence of the Catholic chaplaincy is guaranteed by law, and not all religions share the same level of recognition. Spirituality, on the other hand, eludes definitional boundaries, often manifesting as a sentiment not necessarily tied to a codified belief system, thereby complicating the interpretive framework for all actors involved: the healthcare institution, professionals, and patients. Only in this way can we achieve specific training for practitioners in spiritual care as a patient right—one that enables the humanization of technology by reconstituting the individual in their entirety and giving value to their life story.

Author Contributions: The article was jointly conceived in dialogue between the two authors. Writing, original draft and editing M.V.; Writing and review S.P. Specifically, S.P. took the lead in writing Sections 1 and 2; M.V. took the lead in writing Sections 3–5. All authors have read and agreed to the published version of the manuscript.

Funding: The main research received no external funding.

Institutional Review Board Statement: The study entitled “Spiritual Care: When Spirituality Engages Medicine” was reviewed with regard to its ethical implications. The study does not involve clinical interventions on human participants, collection of biological samples, processing of identifiable personal data, and procedures that may pose risks to participants. The research is based exclusively on fully anonymized data. Therefore, according to the applicable institutional procedures and relevant national regulations, formal approval from an Ethics Committee was not required for this study.

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The data presented in this article are based on a qualitative interview dataset that cannot be fully anonymized.

Conflicts of Interest: The authors declare no conflict of interest.

Notes

- ¹ Examples of this include the importance of the holistic framework typical of “New Age” (Berzano 1999) and “contemporary spiritualities” (Palmisano and Pannofino 2021); the centrality of collective and miraculous healing practices within the Pentecostal and charismatic revival (Charuty 1998; Schirripa 2012; Pace and Buttici 2010); and the success of so-called “complementary and alternative medicines” (CAM) and non-conventional medicines (NCM), defined as such in reference to their development outside of, or at the periphery of, Western biomedical medicine (Giarelli et al. 2007; Pretto 2005, 2009; Secondulfo 2009; Brosnan et al. 2018).
- ² <https://epicc-network.org/> (accessed on 17 May 2026). The main investigators are: Linda Ross, Professor in Nursing at University of South Wales; Josephine Attar, Head of the Midwifery Department and lecturer at the Faculty of Health Sciences, University of Malta; Wilfred McSherry Professor in Nursing in a joint appointment between Department of Nursing, School of Health and Social Care, Staffordshire University; Fiona Timmins, Professor of Nursing, Dean & Head of School at the School of Nursing, Midwifery, and Health Systems, University College Dublin, Ireland.
- ³ A core curriculum is a document that establishes the foundational knowledge and skills for a specific professional role. In the case of spiritual care, it encompasses transversal and interdisciplinary competencies accessible to any practitioner engaging with the patient’s spiritual dimension. It is a document that highlights the necessity of personal involvement, emphasizing the dynamics of proximity, reciprocity, and awareness that spiritual care requires and demands of professionals. It was drafted based not only

on national and international literature but also on practical field experience. https://www.sicp.it/wp-content/uploads/2019/12/CC-assistenza-spirituale-edited_2022.pdf (accessed on 17 May 2026).

- 4 In 1993, in their well-known text *Disease, Illness, and Sickness: Three Central Concepts in the Theory of Health*, Andrew Twaddle and Lennart Nordenfelt proposed a cognitive triad for understanding illness that challenged biomedicine (Cardano et al. 2020; Maturo 2024). According to the authors, illness can be divided into: (a.) disease, which is illness in the biomedical sense—the measurable biological failure that emerges following a diagnosis; (b.) illness, or how the individual experiences and interprets their own sickness and the resulting suffering; and (c.) sickness, which is the societal perspective and how it interprets the individual's illness—the social identity of the pathology. This perspective moves beyond the simple organic category of disease in favor of the subject's agency, through which they attribute meaning to their own experience of illness and the resulting social interactions (Twaddle and Nordenfelt 1993).
- 5 <https://www.who.int/health-topics/palliative-care> (accessed on 17 May 2026).
- 6 <https://www.gazzettaufficiale.it/eli/id/2010/03/19/010G0056/sg> (accessed on 17 May 2026).
- 7 As stated in the text of the law, the former aim to provide all therapies useful for addressing complex health needs at the patient's home, with the goal of ensuring the best possible quality of life. The latter are public and private facilities that provide care seven days a week, twenty-four hours a day, and possess formalized protocols for pain and symptom management, for the practical management of the patient and their sedation, as well as for family support, accompaniment through death and bereavement care, and psychological and emotional support. Finally, there is the day hospital regimen—a brief daytime hospital admission—to ensure the provision of particularly complex therapeutic services that cannot be performed in other facilities within the palliative care network. The outpatient clinic provides services for self-sufficient patients who require a specialist multidimensional assessment for optimal symptom control, including pain, and for family support.
- 8 The genesis of this concept reaffirms the importance of relationship and dialogue within palliative care. The formulation of this holistic perspective arose from the encounter and exchange with a dying patient who, with great clarity, was able to describe the complexity of her own symptoms and pain, framing them within a temporal perspective. This narrative led the patient to experience benefits that were first psychological—namely, a sense of security—and then physical, resulting in less pain once she felt safe and no longer perceived herself as a burden to her relatives (Saunders 2006).
- 9 This research also draws upon the findings of two different projects. The first is “Integrating Spirituality and Medicine into Care Practices” (Project, which took place between 2019 and 2022, funded by the CRT Foundation and coordinated by Professor Stefania Palmisano (University of Turin). This qualitative project aimed to evaluate the application of best practices in the governance of religious diversity within hospital settings. The field research was organized into two phases. The initial phase involved: (a) interviews with a group of kidney transplant patients, selected through the “National Association of Hemodialysis Patients” (ANED) in Turin, and (b) focus groups with undergraduate and graduate students from the Nursing degree program. The subsequent phase consisted of: (a) qualitative interviews with a group of nurses from the Onco-hematology department of the selected hospital, aimed at investigating the dimension of personal spirituality, and (b) a focus group dedicated to training on spiritual care and the development of a tool for collecting patients' spiritual histories, incorporating the professional insights and requirements of the participating nurses. The second project is the doctoral thesis by one of the authors, which investigated the manifestations of spirituality within palliative care in Italy between 2022 and 2025. The interviews, carried out in Turin (n. 35) and Rome (n. 13). The interviews lasted between thirty minutes (four interviews) and approximately ninety minutes, with an average duration of one hour.
- 10 https://www.cittadellasalute.to.it/index.php?option=com_content&view=article&id=3888:progetto-qla-cura-dello-spirito&catid=309:assistenza-spirituale&Itemid=199 (accessed on 17 May 2026).
- 11 <https://volontariatolazio.it/wp-content/uploads/2021/09/AccoglienzaDifferenzeSpecificitaCulturaliReligiose.pdf> (accessed on 17 May 2026).
- 12 <https://volontariatolazio.it/wp-content/uploads/2021/09/ManifestoInterreligiosoDirittiPercorsiFineVita.pdf> (accessed on 17 May 2026).
- 13 See https://www.icn.ch/sites/default/files/2025-10/ICN_Code-of-Ethics_EN_Web.pdf (accessed on 17 May 2026).

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