Interdisciplinary Spiritual Care for Seriously Ill and Dying Patients: A Collaborative Model

Christina M. Puchalski, MD, FACP, Beverly Lunsford, PhD, RN, Mary H. Harris, MSW, LICSW, Rabbi Tamara Miller, MA, Washington, DC

ABSTRACT

Spirituality is essential to healthcare. It is that part of human beings that seeks meaning and purpose in life. Spirituality in the clinical setting can be manifested as spiritual distress or as resources of strength. Patients’ spiritual beliefs can impact diagnosis and treatment. Spiritual care involves an intrinsic aspect of care, which underlies compassionate and altruistic caregiving and is an important element of professionalism amongst the various healthcare professionals. It also involves an extrinsic element, which includes spiritual history, assessment of spiritual issues, as well as resources of strength and incorporation of patients’ spiritual beliefs and practices into the treatment or care plan. Spiritual care is interdisciplinary care—each member of the interdisciplinary team has responsibilities to provide spiritual care. The chaplain is the trained spiritual care expert on the team. Optimally, all healthcare professionals, including the chaplain, on the team interact with each other to develop and implement the spiritual care plan for the patient in a fully collaborative model. (Cancer J 2006;12:398–416)

KEY WORDS

Spirituality, religion, interdisciplinary, palliative care, compassionate care

Palliative care is based upon the precepts that care of the seriously ill and dying patient involves care of the whole person and their families and loved ones—the physical, emotional, social and spiritual dimensions of all. The goal is to provide care that respects all of the patients needs and honors the dignity of the human being. The Health and Human Services Guidelines for Spiritual and Religious Care, the Clinical Standards for Specialist Palliative Care, National Institutes for Clinical Excellence (NICE) Guidelines and the revised World Health Organization (WHO) definition of palliative care have cited that spiritual care is essential to good palliative care. To provide excellent palliative care physicians and other healthcare professionals must be able to address all these dimensions of care, including the spiritual.

While there are many definitions of spirituality and spiritual care, the common features include some sense of a transcendence or what some people might consider a vertical relationship with the divine/holy or sacred and then a horizontal or relational aspect with others, be it family, religious community, and friends. Spirituality is concerned with a transcendent or existential way to live one’s life at a deeper level, “with the person as human being.” Spirituality can be understood as a person’s search for ultimate meaning in the context of religious values, beliefs and practices or other expressions such as relationships with families, communities or work as well as the arts, nature and the humanities. All people seek meaning and purpose in life; this search may be intensified when someone is facing death.

SPIRITUALITY IN CLINICAL CARE

Increased spiritual or existential distress can in turn exacerbate the presentation of other symptoms such as pain, agitation, anxiety and depression. Some studies suggest that existential and spiritual issues may be of greater concern to patients than pain and physical symptoms. Surveys and other studies suggest that spiritual and religious beliefs and practices are associated with better health outcomes, including better coping skills, better quality of life, and less anxiety
and depression. Fitchett and others have shown that spiritual struggles are associated with poor physical outcome and higher rates of morbidity. Research validates the relationship of spirituality to a higher quality of life, increased hardness in persons with HIV/AIDS, reduced loneliness in chronically ill and healthy adults, and reduced anxiety for hospice patients. Spiritual well-being has also been positively correlated with decreased perception of pain. In a review of spiritual and religious measures in nursing research, the most common areas of nursing research in relation to spirituality were coping and support, health status and risk factors, health promotion and awareness, and healthcare decision making. What these studies demonstrate is that patients may utilize their spiritual or religious beliefs and values as a way to understand their illness, find meaning in the midst of their suffering, find hope in the midst of grief, loss and distress and find inner peace. The Institute of Medicine has identified overall quality of life and achieving a sense of spiritual peace and well-being among the key domains of quality end-of-life care.

HEALING IN HEALTHCARE

Spirituality helps people find hope in the midst of despair. As caregivers, we need to engage our patients on that spiritual level. This is where spirituality plays such a critical role—the relationship with a transcendent being or concept can give meaning and purpose to people's lives, to their joys and to their sufferings. Our healthcare system, including hospice, has increasingly become more technical with attention focused on evidence-based medicine, technology and the physical aspect of care. Some of this has been stimulated by the drive for the cure with research focused on the physical aspect of care. Thus, when cure becomes unlikely, the focus of care abruptly ends or gets channeled into the "there is nothing more that can be done" pathway. Comfort care often gets equated with doing nothing. Yet, there is always room for healing, even in the midst of the incurable or death. Bernie Siegel wrote "Our power to heal people and their lives seems to have diminished as dramatically as our power to cure diseases has increased. This is because the knowledge of human nature, which used to be the doctor's principal resource, has been abandoned as irrelevant in an age of science." By being attentive to the spiritual dimension of care, we are opening up for the possibility of healing and hope in our patients' lives.

In this paper, we present the theoretical and ethical framework as well as practical tools for an interdisciplinary spiritual care model from the perspectives of a physician, nurse, social worker and chaplain. We will discuss these in terms of the following patient case, based on a patient from one of our practices.

CASE STUDY: MRS. MARY P.

Mrs. Mary P.* was an 82-year-old white female who was diagnosed with laryngeal carcinoma in 1999. She underwent resection of her larynx. The cancer was localized, and she was hopeful that this would be a "cure." Mary did well for several years until the cancer recurred in 2002. At this time, she required more extensive surgery that left her with some facial and neck deformity. She underwent several rounds of chemotherapy. While the surgery was devastating for Mary and her family in many ways, Mary again was hopeful that this procedure would result in a cure for her cancer. Over the next two years, Mary had local recurrences of the tumor, all of which were resected. In 2004, the tumor had grown so extensively that further surgery would be prohibited due to the location of the tumor. Mary had a feeding tube placed since she could no longer swallow safely. Mary's surgeon referred her for palliative care. Both the surgeon and oncologist anticipated that Mary might live another 3–6 months. Mary died one year later in February 2005.

Mary came from large, Italian Catholic family. She had 8 brothers and sisters; she was the seventh child and youngest girl. Mary was born and raised in New York, married when she was 22 years old, and she and her husband Frank had two children: a daughter, Stella, and a son, Tony. Mary moved with her husband to Washington, D.C. when she was 30 years old. Her siblings lived in various cities on the east coast; the closest relatives were in Pennsylvania, about 2 hours away by car. Mary worked as a clerk in the government for many years. She was a practicing and very devout Catholic all her life. Stella and her daughter Katie moved in with Mary and Frank in 2001 to help care for them. Tony, an artist, lived in California and visited regularly. Frank was diagnosed with lung cancer in 2001 and died from cancer in December of 2003.

Mary was a fighter all her life. She had strong principles that guided her life, and she often did not back down from those principles. She defended her family and was always there for her children. When told that her cancer had spread to the point of being inoperable, her response was to fight and figure out a way to “beat it.” In the first visit with me, Mary came with Stella and Katie, who were 42 and 7 years old, respectively.

That visit was in January 2004, one month after

*Names changed to protect family privacy
Frank, Mary's husband and Stella's father, had died. Mary told me that she did not want to put her children and granddaughter through another Christmas that was sad and filled with grief. She was determined to live through the next Christmas. While I had my doubts that would happen given the extent of her cancer, I did believe that her fighting spirit might help her meet her goal. Mary refused a hospice referral at that visit, even though her surgeon had talked with her about that earlier. She instead focused on what other treatments might be possible. We spent the next several weeks discussing options and why they would not work. Finally, two months later, Mary entered hospice, but only to get support for her daughter. She did not think she needed hospice. The interdisciplinary hospice team visited her regularly at home, as I did as well.

Mary never talked about dying initially. She loved talking about her granddaughter's music lessons, academic achievements, and celebrations. She also kept telling me that she would celebrate Christmas.

Over the next year, Mary gradually declined. She used humor to survive. Her faith was incredibly important to her. She prayed regularly, loved to say the rosary, and attended Mass weekly. Her faith was a steady, quiet one. She knew God existed, that her husband was in heaven, and that she would see him one day. She knew God was good and just and that he would care for her children. She was private and did not talk extensively about God or even her feelings. She was matter-of-fact about God and life. At some point, she decided that a cure was not possible, and without much ceremony just adapted to the situation.

About two months before Christmas she insisted on coming to my office for a visit. By that time, her daughter was hopeful that since she outlived her oncologist's prediction, maybe she was getting better. When her daughter said that to me, Mary just looked at me with a look that seemed to say, “It's not true, but don't burst her bubble.” She laughed and patted Stella on her shoulder, saying, “Of course—your mom is a tough old bird.” The only sign that perhaps this was not true was a tear that streamed down her face—the first time I saw her cry. In that silence, all of us knew that was a hope, but not the reality. One month before Christmas, she was so weak she could no longer walk. She watched Mass on the television; her parish priest visited regularly to give her communion and pray with her. Mary was very matter-of-fact about what was happening. She started talking more about her wishes for her family and letting people know she was “tiring.” I saw Mary two days before Christmas. The tree was decorated, Katie was dancing, and music played. They gave me a card that was very personal and emotional for me. Tears were shared, and yet, the home was joyful and grateful. It was clear that Mary's wish for a happy Christmas would come true.

Over the next two months, Mary quickly declined. She was in and out of consciousness for most of January and February. Family was around her bedside often. Big Italian dinners were made, and people ate, sang, joked, and cried around her bedside. Mary would wake up periodically to crack a joke or make a sarcastic comment that helped everyone feel as though nothing had changed. She fought all her life, and she fought while dying. Faith, humor, and love paved the way for her death. In February 2005, Mary died in the midst of family and song.

THE ROLE OF THE PHYSICIAN

Theoretical and Ethical Framework

In 1998, the Association of American Medical Colleges (AAMC), responding to concerns by the medical professional community that young doctors lacked humanitarian skills, undertook a major initiative—The Medical School Objectives Project (MSOP)—to assist medical schools in their efforts to respond to these concerns. The report notes that “Physicians must be compassionate and empathetic in caring for patients...they must act with integrity, honesty, respect for patients’ privacy, and respect for the dignity of patients as persons. In all of their interactions with patients they must seek to understand the meaning of the patients’ stories in the context of the patients’ family and cultural values.” In recognition of the importance of teaching students how to respect patients' beliefs, AAMC has supported the development of courses in spirituality and medicine in medical schools. Today the majority of medical schools have required courses in spirituality and health; it is increasing becoming a field of study within medicine. Guidelines of spiritual care have also been developed. The American College of Physicians convened an end-of-life consensus panel, which concluded that physicians should extend their care for those with serious medical illness by attentiveness to psychosocial, existential, or spiritual suffering. The American Medical Association, in its Code of Medical Ethics, states that “[t]he physician shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights.” Spiritual care supports the dignity of each patient by honoring the inherent value of that person, their beliefs and values that support them and their practices that enable them to find meaning and hope in the midst of suffering. By being attentive to the spiritual dimension of peoples’ lives, we believe that care becomes compas-
sionate and whole. Other national organizations have also supported the inclusion of spirituality in the clinical setting. The Joint Commission on Accreditation of Healthcare Organizations has a policy that states: Pastoral counseling and other spiritual services are often an integral part of the patient’s daily life. When requested, the hospital provides, or provides for, pastoral counseling services.28

Spiritual care is grounded in two fundamentally important theoretical frameworks—one in the biopsychosocial-spiritual model of care29 and the other is the patient-centered care model.30 Integral to both of these models of care is the recognition that there is more to the care of the patient than the physical. In the patient-centered model of care, there is evidence that by engaging in shared-decision making patient health outcomes are improved. Thus, the physician is encouraged to view his or her relationship with the patient as a partnership where decisions are made together and where the physician supports the patient throughout the professional relationships—e.g., “we will get through this together.” In order to be able to have shared decision-making, physicians must know the values and beliefs of the patient. This is fundamental to treating the patient with respect and dignity. Finally, involvement of a larger community of caregivers is recognized as essential in the patient-centered care model. In this sense, the interdisciplinary team becomes one community but there are other communities such as faith-based communities, families or other communities of individuals that participate in the care of patients. In fact, hospices become such communities for many dying patients.

In the case of Mary, her family is clearly the central community for her. Her daughter and granddaughter provide the most intense and immediate care for her. They are involved in her decision-making process as well as implementing any care plan. In addition, Mary’s priest and church are vitally important for her. The physician needs to interact with Mary’s family and her church community. Thus, the family and priest may come to the office with Mary for her visits or they may be present at home visits. It is important for Mary that they be involved in the decision-making process, thus they need to be part of important conversations. Sometimes, patients have a hard time discussing difficult issues, spiritual crisis or issues of symptom control with family members. The physician can help facilitate those conversations. This certainly was the case for Mary. Her daughter Stella had a hard time acknowledging the severity of her mother’s illness initially. But as the course of the illness progressed, her daughter was anxious that her mother confront her dying. It took some individual conversations with the physician and Stella, as well as the physician and Mary to help guide those conversations. The physician needed to listen to all parties—to all the spiritual and emotional angst and questioning and to help find an appropriate time for deeper conversations about Mary’s dying and her treatment plans.

Often patients and families are thinking about issues of dying, life after death, anxiety about death and the moment of dying, forgiveness issues, or questions about God. They many not think it is appropriate to discuss these in the context of a clinical setting. By opening the conversation to spiritual issues, the physician, in effect, creates the environment whereby patients can share what is concerning them. In Mary's case, initially, her spiritual beliefs were focused on praying to God to let her live as long as she could. By asking Mary about her beliefs, Mary was able to speak of her powerful desire to live as long as possible for her daughter through the language of religion. As her disease progressed, the spiritual conversations enabled her to get in touch with her fears and anxieties. It is not uncommon for a question about spiritual beliefs to open up conversations about other symptoms. For example, when Mary was asked by her physician about her sleep and anxiety, she stated “everything was fine.” But when her physician asked her about her relationship with God, Mary was able to talk about her anger at God that he would take her from her children so soon after her children's father had died. Mary then talked about the anxiety her anger at God caused her, and how she could not sleep for fear she would die in a state of not being forgiven by God about her anger.

**SPIRITUAL CARE: PRACTICAL TOOLS**

**Compassionate Presence**

How the physician handles conversations like this and how the physician practices partnership-based care is the basis of spiritual care. The physician must be prepared to let go of agendas and preset ideas of what information and how much information to share. It is critical to be fully present with patients and their loved ones in order to be able to be fully attentive and supportive. It is the obligation of the physician to create an environment where the patient feels supported and cared for and where the patient feels free to share whatever concerns the patient has. These types of conversations do not lend themselves to well mapped out strategies and plans. Most of the time, the physician uses intuition to know what the next best thing to say is and how to say it. With Mary, it was obvious at one point that it was important for
her to fight to live or at least maintain that sense of control with her daughter. It was critical to her sense of dignity and honor. To announce that she was terminal and dying would have been traumatic for Mary in that particular visit. It took time and sensitivity to know when the appropriate moment is for those types of disclosures. It is critical, therefore, that the doctor-patient relationship stems from a place of compassion and care.

Compassionate presence sets the stage for physicians to be open to their own intuition. Intuition becomes a very important part of diagnosis and treatment. While the doctor can assimilate all the facts about symptoms and presentation of illness, it is just as important to use the powers of observation and intuition to gather more data. A cough may actually be a symptom of anxiety which can be picked up if the doctor senses what is going on with the patient beyond just the words exchanged. By being fully present with patients, doctors’ intuitive skills can be strengthened.

There are studies that document the importance of the doctor-patient relationship. Dr. Francis Peabody wrote in his 1927 medical classic, *The Care of the Patient*, “One of the essential qualities of the clinician is interest in humanity, for the secret care of the patient is in caring for the patient.” Since healing springs from the therapeutic relationship, spiritual care is grounded in relationship-centered care. Spiritual care begins from the moment the healthcare professional enters the patient’s room. This means that the clinician brings his or her whole being to the encounter and places full attention on the patient, not allowing distractions to interfere with that attention. Integral to this is the ability to listen and to be attentive to all dimensions of patients’ and their family’s lives. Some clinicians suggest that current medical practices do not allow enough time for this. However, being wholly present to the patient is not time-dependent. It simply requires the intention on the part of the physician to be fully present for their patients. One becomes fully present when one approaches the patient with deep respect, respect stemming from a commitment to honoring of the whole person. This is the essence of a spiritually based relationship with others. It is also important to recognize that physicians carry for some patients, a symbol of authority. It is important that physicians do not betray the trust patients place in them as authority figures. This emphasizes the need to be respectful of patients and families at all times and to be very intentional and thoughtful in making recommendations. By being humble and recognizing that there is an element of the holy or sacred in the interactions with all our patients, physicians are more likely to come from a place of humility and respect rather than simply authority and are more likely to guide patients in an honest and sincere way.

Compassion also allows for warmth in the relationships physicians have with their patients. A Gallup survey indicated that respondents said wanted warm relationships with their physicians, wanted to be listened to, and wanted to have someone with whom to share their fears and concerns.

**Taking a Spiritual History and Formulating a Spiritual Treatment Plan**

In addition to being fully present and caring with our patients, physicians should specifically address spiritual issues in the clinical interview and follow-up in subsequent visits as appropriate. Several studies have found that the majority of patients would like their physicians to address the patients’ spiritual issues in the clinical setting.

Obtaining a spiritual history is one way to listen to what is deeply important to the patient. When one gets involved in a discussion with a patient about his or her spirituality, one enters the domain of what gives the person meaning and purpose in life and how that person copes with stress, illness, and dying. The spiritual history affords the patient the space and opportunity to address his or her suffering and hopes. A spiritual history validates the importance of a patient’s spirituality and gives the patient permission to discuss their spirituality, if they desire to. Having the physician inquire about the patient’s spiritual beliefs gives the patient an opening and an invitation to discuss spiritual beliefs, if that is what the patient would like to do. It also enables the physician to connect with the patient on a deep, caring level. In fact, many physicians who obtain spiritual histories remark that the nature of the doctor-patient relationship changes. As soon as they bring up these questions, they feel that it establishes a level of intimacy, an understanding of who the person is at a much deeper level than is typical. Patients note that they feel more trusting of a physician who addresses and respects their spiritual beliefs. In one survey, 65% of patients in a pulmonary outpatient clinic noted that a physician’s inquiry about spiritual beliefs would strengthen their trust in the physician.

The spiritual history allows the physician to:

- Identify spiritual issues or spiritual distress
- Identify spiritual resources of strength such as hope
- Help patients tap into their spiritual resources of strength
• Identify spiritual beliefs and values that impact patients’ understanding of illness, and their decision-making values
• Formulate a treatment plan that includes the spiritual dimension of care.

Examples of spiritual issues include meaninglessness, despair, hopelessness, desire to be remembered, and issues of forgiveness and reconciliation. In addition to identifying and addressing the above spiritual issues, it is important to assess the spiritual resources of strength for patients—hope, sense of meaning and purpose, ability to transcend suffering, as well as support from spiritual or religious community, family, or friends.

Communities, such as churches, temples, mosques, spiritual or other support groups or a group of like-minded friends, can serve as strong support systems for some patients. The absence of these resources could impact in an adverse way how patients cope with illness and/or dying.

Once the clinician finds out about the patient's spiritual beliefs, their issues, and their resources for coping, he or she can then address any spiritual practices that are important to the patient. These might be prayer, meditation, listening to certain music, enjoying solitude, or writing poetry, or journeying. One can then incorporate these practices as appropriate. Possible options for a spiritual care plan then are:

1. Referrals to:
   • A meaning-centered psychotherapy group or to counseling.
   • Appropriate spiritual care professionals, such as chaplains, to help with spiritual distress or lack of spiritual resources or resources of strength. Chaplains should be integrated into interdisciplinary health care teams. Hospice teams often have chaplains as part of the care team.
   • Spiritual directors
   • Parish nurses
   • Pastoral or other counselors
   • Music thanatologists
   • Art or music therapy
   • Meditation
   • Yoga, tai chi
   • Specific spiritual support groups
   • Religious or sacred spiritual reading or rituals (based on what the patient has identified as appropriate for them)

2. Incorporating spiritual practices or rituals as appropriate
3. Presence to patient as he/she works on spiritual issues with the healthcare professional

4. Journaling, reading poetry, art, dance
5. Retreats
6. Time for solitude
7. Spiritual community activities and liaisons

The spiritual history is patient-centered. One should always respect patients’ wishes and understand appropriate boundaries. Physicians and other healthcare providers must respect patients’ privacy regarding matters of spirituality and religion and should avoid imposing their own beliefs on the patient. There are several tools that can be used to take a spiritual history. These include FICA (Figure 1), SPIRIT, and HOPE.

In Mary's case, the physician assessed her spiritual beliefs in the first visit. She learned about Mary's deep faith in God and her strong will to live and protect her daughter and granddaughter during the course of the spiritual history. It was clear that Mary's priest and faith community would play a significant role in life and treatment. The physician followed up on these issues in subsequent visits. Initially Mary's beliefs supported her desire to live as long as she could. She

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<td>&quot;Do you consider yourself spiritual or religious?&quot;</td>
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<td>&quot;Do you have spiritual beliefs that help you cope with stress or difficult times?&quot;</td>
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<td>&quot;If the patient responds &quot;no,&quot; the physician might ask, &quot;What gives your life meaning?&quot; Sometimes patients respond with answers such as family, God/higher power/force, career, or nature.&quot;</td>
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<td>&quot;What importance does your faith or belief have in your life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?&quot;</td>
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<td>&quot;Are you a part of a spiritual or religious community? Is this of support to you and how? Is there a group of people you really love or who are important to you?&quot;</td>
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<td>The physician and other health care providers can think about what needs to be done with the information the patient shared—referral to chaplain, other spiritual care provider, or other resource. This is important in potentially incorporating patients spiritual beliefs and practices into the treatment plan.</td>
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**FIGURE 1** The main elements of a spiritual history that has been developed for physicians and other healthcare providers can be recalled by using the acronym “FICA.”
hoped and prayed for a miracle and a cure. But as her illness progressed, it became increasing more evident that a cure was not likely. The physician was able to talk with Mary about her prognosis in a way that helped retain some hope in Mary's life for good quality of time with her daughter, for reconciling with God and coming to terms with her dying, for having time to impact her granddaughter's future with stories and words of wisdom from her grandmother. The spiritual histories gave the physician information about what gave meaning and hope to Mary's life. In her case, Mary found meaning in her family and as she approached her death, she increasingly found meaning in her relationship with God and her belief that she had led a life guided by her Christian values. For Mary, her ultimate sense of hope and meaning came from being united fully with God at her death. Gradually, she was able to let go of the physical world around her, her worries as a mother for her children's futures and her need to control her life and her death as she turned inward to a profoundly deep spiritual place of contemplation and serenity.

Mary's spiritual beliefs also played an important role in her end of life decisions about feeding tubes, and allowing a natural, non-invasive dying. She has some conflicts about some recent changes in the Catholic Church with regard to use of feeding tubes in terminal patients. She initially agreed to a feeding tube due in part to that belief but as her death grew closer, her family and Mary started questioning the role of extraordinary means in her circumstance. Conversations with the physician as well as the priest became crucial in formulating the treatment plan.

In all of the charting about Mary, the physician wrote treatment plans based on a biopsychosocial spiritual model. Thus there was an assessment and a plan for each of the four dimensions of care at each visit whether in the office or home hospice visits. Integral to this plan was working with the other team members—the nurse, the social worker and the hospice chaplain—to modify and enrich the plan with information gathered from the whole team.

Beyond the actual discussions about spiritual beliefs and practices, it was important for Mary and her family that they felt their physician was approachable and available emotionally and spiritually to them. Thus, the physician was warm, open and willing to address any concerns, emotions and topics that Mary or the family raised. Some of the most joyous times were spent in laughter telling silly jokes and reveling in humor. The ability of the doctor to let his or her guard down and enter into a relationship with patients and their families is critical to spiritual care. What then follows is an acceptance on the part of the physician to navigate a journey for which there are no definitive knows. The physician becomes willing to be comfortable with uncertainty. In caring for patients, especially those with serious illness or those who are dying, there are no clear cut oblivious answers. So much of the physician's training is to provide answers and quick fixes, but in navigating the journey with seriously ill patients that approach does not always work. In order to be comfortable in caring for patients, it is important to interact with patients from a place of the physician's humanity, not just from his or her role as medical expert. That is again fundamental to spiritual care—the acceptance of the physician's own imperfection. When Mary wanted to know exactly how much time she had, the physician was able to relate some information based on population studies of patients with similar cancers, but always framing it in the context of Mary as the individual, not a statistic. Thus her course could be different and difficult to predict. The physician's own comfort with uncertainty enabled the family and Mary to become comfortable with the unknown thus relieving some of their anxiety.

**BARRIERS TO SPIRITUAL CARE**

Some of the barriers to practicing spiritual care that physicians often cite include not having adequate time to address spiritual issues and fear that raising the question about spirituality will open the door to uncomfortable conversations about the physician's own spiritual beliefs and practices. However, the spiritual assessment as described above is meant as a screening tool, similar to other items in the history, such as personal history, exercise history, brief depression inventory, occupational history, etc. Each of these additional items are not time consuming in and of themselves and each are included in the history because they are important to a patient-centered approach to care. It is true that some issues may arise in the assessment that may take more time. But the goal of the history is recognition of the issues and appropriate referral. Thus the physician need not be responsible for solving all the issues for the patient; he or she can rely on the interdisciplinary team for assistance. Even in the outpatient setting, the physician can utilize chaplains, spiritual directors, clergy, and other spiritual care professionals to help patients with spiritual issues that arise in the clinical context. Physicians also need not engage in conversations about their own beliefs anymore than they need to share other aspects of their personal lives in the clinical context. Appropriate boundaries of sharing should be followed so that patients do not feel coerced by physicians to share more than they are comfortable or to feel they need to adopt their physicians'
beliefs and practices simply because the physician is in a position of power. It is critical that physicians be aware of that power differential and in all their interactions with their patients be respectful of the patient and do what is in the best interest of the patient.

**THE ROLE OF THE NURSE**

**Theoretical and Ethical Framework**

Most nursing theories are based on a dynamic and holistic view of the human individual as a biologic, psychological, social, and spiritual being. This view of the individual is reinforced by the World Health Organization definition of health. Although each aspect of the individual is integrated and interacting, distinguishing each aspect enables one to appreciate its essential contribution to the functioning of the whole being.

Nursing theories include aspects of spirituality in patient care, directly or indirectly, including caring, interpersonal relationship, and spiritual variables. In addition, one of six essential features of professional nursing practice is the establishment of a caring relationship to facilitate health and healing. Spirituality has actually been described as the “cornerstone of holistic nursing practice,” and as “the integrating aspect of human wholeness... integral to quality care.” Although nursing education teaches spirituality as a basic and essential element of the individual, there is limited scholarly development of the nursing process in relation to this concept to make it a standard part of nursing education, e.g., there is not widespread acceptance of a standardized method to assess, plan, intervene and evaluate spiritual care in nursing.

Nurses apply scientific knowledge to the process of diagnosis and treatment of total human responses to health and illness, such as alteration in bowel function, hopelessness, and alteration in nutrition. In 1978, the first nursing diagnosis related to spirituality, spiritual distress, was established in the North American Nursing Diagnosis Association (NANDA). Spiritual Distress is the “impaired ability to experience and integrate meaning and purpose in life through a person’s connectedness with self, others, art, music, literature, nature, or a power greater than oneself.” Since 1978, two more diagnoses—risk for spiritual distress and readiness for enhanced spiritual well-being—have been added, and there are several other related diagnoses such as hopelessness, cultural brokerage, and religious ritual enhancement that nurses may use to document spiritual needs of patients.

NANDA is one of three widely used nursing terminologies, all of which include spiritual care. Nursing Intervention Classification (NIC) is another terminology to classify nursing interventions and includes spiritual interventions, such as spiritual support, hope instillation, spiritual growth facilitation, religious ritual enhancement and cultural brokerage. The third terminology, Nursing Outcomes Classification (NOC) includes spiritual care outcomes, such as Spiritual Health and Client Satisfaction: Cultural Needs Met. These terminologies are accepted by professional healthcare associations and included in the database endorsed by the Department of Health and Human Services, Systematized Nomenclature of Medicine, Clinical Terms (SNOMED-CT).

The Code of Ethics for professional nurses in the United States recognizes the importance of spirituality and health, illustrated by Provision 1 of the code, which states, “the nurse in all professional relationships practices with compassion and respect for the inherent dignity, worth, and uniqueness of each individual unrestricted by considerations of social and economic status, personal attributes, or the nature of health problems.” Interpretive statements for this provision of the code further asserts that “the measures nurses take to care for the patients enable the patients to live with as much physical, psychological, social and spiritual well-being as possible.” The International Council of Nurses also has a Code for Nurses, which states, “The nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected.” Both of these codes highlight the importance of including spiritual care as an essential aspect of competent and compassionate nursing practice.

Although nursing assists the individual and family with adapting to health and illness, a majority of the nursing workforce is employed in acute care settings where the focus of healthcare is on the diagnosis and treatment of illnesses. Thus, there is a large focus of nursing care on the application of science and technology to curing disease. The spiritual dimension of health and healthcare is often overlooked. There is a corresponding decreased emphasis on compassionate care for suffering and healing.

**Barriers to Spiritual Care**

There are several barriers to nurses providing spiritual care. First, nurses often lack the theoretical knowledge and preparation to provide spiritual care due to the limited content in nursing education on spiritual assessment and intervention. Second, nurses have been conditioned that they aren’t supposed to talk about religion with patients and vulnerable individuals. In fact, spirituality was used interchangeably with religion until the past 20 years, in which nurse authors began to distinguish spirituality as a broader concept than religion. Thus spiritual conversations
may include conversations about religion or broader concepts as well.

Another barrier to spiritual care by nurses is the increasing pressure to spend less time with individual patients (clients) and their families; there is little institutional support for “being with” or “present” to patient suffering. Finally, nurses may also suffer from their own spiritual distress with a loss of meaning and purpose in their work due to the pressure they are under to care for too many patients and to maintain the bottom line. The focus on aggressive technological treatment for acute physical conditions relegates caring and compassionate presence to a nonessential, unsupported aspect of healthcare. The result may be nurses who are feeling burned out and these nurses are more likely to distance themselves from patients and family, than to draw themselves into areas of spirituality and spiritual care giving.

In the case study of Mary, nursing care to address spiritual needs will be discussed in relation to 1) building trusting relationship and conveying dignity and respect; 2) providing a supportive, peaceful environment; 3) changing goals of care and hope; 4) active listening, presence, and attending; 5) spiritual care assessment; and 6) collaborating with the interdisciplinary team.

**Personal Care Conveys Dignity, Respect, Trust**

The nurse(s) caring for Mary were in many palliative care settings in which cancer patients receive health care—in the hospital, hospital outpatient clinics, community clinic, emergency facilities and at home—from diagnosis through death and bereavement. Regardless of the setting, an initial goal for the nurse will be to build trust and convey dignity and respect through the competent and compassionate use of self. First, the nurse conveys caring, dignity, and respect by touching with tenderness, sensitivity to pain and discomfort, and intentionality when assessing and assisting with basic activities of daily living, such as bathing, dressing, nutrition, toileting, and mobility; or changing dressings and administering intravenous medications.

The nurse conveys dignity and respect by the provision of a safe, supportive, and peaceful environment during hospital stays, during office visits, and even in the home, which in turn provides greater opportunity to talk about patient concerns, including spiritual concerns when immediate needs are addressed. It also provides time and space for the patient to practice spiritual rituals, such as meditation, reading, journaling, and prayer.

The nurse builds trust with the patient and family both in performing personal care and/or in teaching family members to participate in care for the patient. Whether teaching the patient self care, or teaching significant others how to participate in the care, the nurse increases the patient's sense of connectedness and relationship among family members, significant others, and even healthcare providers while building patient and caregiver skills, confidence, and interdependence.

During the act of performing or teaching personal care, the nurse is also able to assess the patient's physical, psychological, social and spiritual aspects. For instance, if the patient is unable to accomplish toileting without the assistance of an adult child, the nurse may observe the patient and family member's level of comfort in this very intimate exchange. Frequently the adult child may accept this task with the comment of how many times the parent did this willingly for the child, and likewise, the adult child accepts this as reasonable expectation to do now for the parent. The parent may accept the role reversal or they may indicate that increasing disability renders them useless, and devoid of meaning and purpose. This provides opportunity to acknowledge the patients suffering and explore the loss of meaning and purpose.

**Spiritual Assessment**

A spiritual assessment should be conducted as part of the nursing history. For the outpatient, this may already be a part of the patient record. But with the dramatic change in health status with the diagnosis of cancer, the nurse must determine how the new illness is affecting the individual and family's ability to cope, the challenge to one's sense of meaning and purpose, the limitations for engaging in important spiritual and/or religious practices, the challenge to one's sense of connectedness. This may be accomplished by “starting the conversation” or by listening for (observing) cues by the patient or family that they are suffering or grappling with spiritual questions. Many times the simple question, “what gives you hope, or how does this affect your relationship with family members or significant others” will facilitate the conversation regarding spiritual matters.

When the nurse encounters Mary in the inpatient setting, the spiritual assessment may be conducted with the initial nursing assessment. There are several tools that healthcare providers may use, and most tools have at least four commonalities, e.g., the individual's concept of God or transcendence, their sources of strength and hope, important religious or spiritual practices, and the relationships between the individual's spiritual beliefs and their health. It is important for the initial assessment to “offer” spiritual care. By talking about spiritual care as a part of healthcare, the nurse also indicates to the patient and their family, that even if they do not want to talk about spiritual or religious issues at this time, it gives
“permission” for the patient to talk about spiritual concerns with the nurse or other healthcare providers in the future.

**Changing Goals of Care and Hope Trigger Spiritual Issues**

The changing goals of care during the last four years of Mary's life may be one of the primary challenges to Mary's spiritual well being from curing with the initial treatment, to compassionate and comprehensive caring during the subsequent recurrences of cancer. The nurse's role in the initial phase of diagnosis and treatment may involve helping the patient and their family deal with facing a life-threatening cancer, including support as the patient and their family considers treatment options, care during surgery, and support for an uncertain future. Supportive spiritual care would include discussing the patient and families source(s) of hope, coping strategies, and support systems. It will be important to determine how the patient and family have dealt with prior challenges, whether they think previous strategies will be useful now, or whether they need to develop new strategies. Listening will be a critical spiritual care intervention, as direct questions regarding source of hope, support systems, coping strategies are unlikely to evoke substantive response, these terms may not be part of the patient's common language. For instance, the patient may not view meditation as a “coping strategy,” but rather as something she does to “get focused.” Thus, the nurse will need to build a relationship of trust and attentiveness to speaking of coping strategies and even spirituality in language the patient and their family understands.

The hope of cure and longer life may shift to other sources of hope, i.e., honest and supportive family relationships, time with family and friends, living well in the days remaining, a pain free death, the ability to continuing growing into death, and the ability to live and die at home. The nurse can help the patient consider and reflect on her wants and desires, as well as negotiate the family's needs and desires if they seem inconsistent with the patients. Besides the adaptation to a life-threatening illness, Mary needed to adapt to a changing self concept of a well person, to a person with cancer and progressive disability, frailty, and potential physical disfigurement.

When individuals have faced a threat to their livelihood or living, they frequently reevaluate what is important to them. So in subsequent visits with Mary, it will be important to determine how this event has changed her sense of meaning and purpose, what is important for her, what gives her hope, how relationships have changed. The nurse has an opportunity to explore ways the patient has grown spiritually in this experience, and perhaps ways the patient may continue to grow regardless of the physical condition.

**Three Qualities for Providing Spiritual Care**

Listening, being present, and attending are three tools that nurses may use to assess, intervene, and evaluate spiritual care. In order to listen effectively, the “spacious” listener does not identify solely with roles and functions; rather they use silence as a means to personal and contemplation.51 The listener provides an open and free interpersonal space, in which the patient and family may find total acceptance and hospitality.

Presence is a second quality required for spiritual care that is more than just physical presence. The compassionate listener must convey the sense that “I'm here for you” where “I” is more than “myself.”51 The compassionate listener is present in a way that transcends time and space in a manner that is life-giving for both the nurse and the patient. It is a personal realization of having more than enough, and the nurse may also be nourished and not depleted reducing the possibility of burnout.

Attention is a third tool, which may be described as giving heed, consideration, thoughtfulness and intense concentration coupled with a broad awareness of theological and spiritual implications. Patients offer clues of their spiritual ponderings, through symbolic language and metaphors (family narratives or stories of death) or through nonverbal (deep sighs) and verbal cues. (What have I done to deserve this, I hope . . . .) Nurses and other caregivers make choices to acknowledge these indications, making space and providing nonjudgmental acceptance for the patient to talk about such comments or indications. Or they may choose to ignore the indications and remain at a superficial level of conversation and relationship.52

As Mary progressed from a disease with reasonable expectation of a cure, to a recurrence of the disease, which was likely to result in a timely death, these three qualities of listening, presence, and attending are very important. In Mary's case, her religion and spiritual nature are described as “matter-of-fact.” The healthcare providers described a spiritual health and satisfaction in this patient with a strong sense of self in relation to others. She was able to utilize her sources of strength and hope, she was able to continue important religious practices, and she was able to maintain relationship with those who were important to her. This illustrates how much of spiritual care involves not so much doing something for patients and their family, as much as “being present” and providing space to facilitate the growth that is possible as people are able to anticipate and prepare for their death with those who are in closest to them.
Spiritual Care Requires an Interdisciplinary Team

The case study of Mary illustrates the use of several different professional caregivers to provide competent and caring palliative care, including spiritual care. Mary's family, the parish priest, her religious practices, physicians, oncologists, hospice team all supported her sense of spirituality. Nurses are in a unique position with 24/7 patient care management in the hospital, as a primary point of consistent contact in primary care, and as one of the most frequent visitors in hospice and home care, to facilitate spiritual care. Nurses spend a great deal of time providing basic patient care and are very likely to encounter cues from the patient of ways to provide, enhance, or regain spiritual integrity. Frequently, nurses provide coordination of many healthcare services, including medical visits, physical therapy, social services, and pastoral care. Thus, nurses are in a pivotal role for communicating patients' needs and preferences for spiritual care to other collaborators in the patient's care, such as physicians, social workers, chaplains, and alternative medicine practitioners (massage, music, and art therapists). In addition, nurses can provide the supportive and peaceful environment that enhances or precludes the patient's ability to engage in supportive spiritual care.

Requirements for Spiritual Care Interventions

For some nurses, spiritual care may be intuitive. But most nurses need to develop the knowledge and skills for providing high quality and competent spiritual care. The ability to listen, be present and attend to the spiritual care needs of patients and families requires awareness and growth in one's own spiritual journey. A relationship with, and probably regular conversations with confidential and supportive persons can facilitate one's own reflection, spiritual growth, and spiritual renewal.

Nurses must be skilled not only in interpersonal and communication skills, but also in creating a comfortable and culturally hospitable environment. Compassionate and spiritual care is as much about the personal attributes of the caregiver, as it is the services provided by the caregiver.

The Role of the Social Worker

Theoretical/Ethical Obligations

The National Association of Social Workers' Code of Ethics declares that a social worker must include spirituality when completing an assessment.\textsuperscript{51,52} This would be especially important when a patient is dealing with a life-threatening illness. Cancer brings out the deep questions of life regarding pain and suffering, the meaning of life and evil and death, what happens after death, etc. How do various faith groups deal with these questions? For example:

- A fundamentalist Christian might believe that suffering is God's punishment for the person's sins, where a Buddhist might think suffering is all in a person's mind and can be relieved by redirecting the mind through meditation.
- A Roman Catholic might think it especially important to pray for the soul of the deceased, propelling loved one to heaven, whereas a mainline Protestant might believe that the soul is already in heaven and that the bereaved family members should be the focus of care.

However, many social workers are not comfortable dealing with the spiritual dimensions of life. Toni Cascio asserts that social workers are uncomfortable with spiritual issues due to fears, lack of knowledge, negative associations concerning religion and spirituality, and strong feelings about separation of church and state. Generally research shows social workers to be more comfortable with medical models (Toni Cascio, Ph.D., University of Maryland, personal communication).

For starters, it is critical that social workers have awareness about their own spirituality and faith. For example, a social worker needs to reflect on her own spiritual histories and understand where she is in her spiritual journey. This or another self-assessment of spirituality is the beginning of being objective and being able to assess the patient's spiritual states.

With this greater self-awareness, it is vital that social workers are reasonably cognizant of the religious diversity in the United States. No longer is this a primarily Judeo-Christian culture. Beliefs range from traditional world religions, such as Islam and Buddhism, to Wicca and new-age spiritualities. Many people are simply not interested in religion at all. Some conservative Christian groups are growing, though not all. Many mainline Protestant denominations are declining, though some churches in all the mainline denominations are flourishing. It is a fair assessment to say that more people are interested in spiritual issues, but fewer are associating with an organized religious group. The social worker needs to be flexible and open to the spiritual perspective of the patient.

Practical Aspects

Social workers are trained to be a compassionate presence: to listen with empathy, assess a person's psychosocial network, and help draw in appropriate resources to help the patient do as well as possible.
They are trained to be partners with the patient, open to the patient's agenda, and know how to listen to the patient's fears, hopes, and dreams. How does a social worker draw out a patient's deeper spiritual questions? By asking questions that sometimes the patient has not addressed or is afraid to confront. Questions might proceed in something like the following order, beginning with more objective data and then proceeding to the deeper but less measurable spiritual aspects.

- Do you consider yourself a person of religious faith? If so, what is your religion?
- Do you participate in any church, synagogue or other religious organization? If so, what is it? How actively do you participate?
- Who is the pastor/rabbi/spiritual leader? Does this person know you are sick?
- What support have you received from your church/synagogue, etc.?

The social worker might then proceed to assess such deeper questions such as the patient's acceptance of reality, beliefs in life after death, serenity, spiritual disciplines, etc. Figure 2 shows a sample form used by chaplains serving the Community Hospices of Washington illustrating some of these assessment criteria.

It is highly unlikely that many social workers would be knowledgeable about various perspectives or practices of the different religions and subgroups within religions on life and death issues. Patients can provide this information when a social worker is asking questions, e.g., “Tell me about what it was like when your mother died. How do you remember that time?”

It is important for social workers to remember that beliefs vary within family systems and encourage discussions of those differences with and among family members. This was a major issue in the 1980s when assisting families with AIDS. In the 1980s social workers frequently were challenged when families came from out of town or out of state to visit a son and learned simultaneously that their son was gay and dying of AIDS. The parents needed to face their grief at their son’s condition, but also the challenge to their religious values as it pertained to sexual identity.

A social worker or physician might think that asking questions to assess a patient's spirituality might seem redundant if there is a full-time chaplain. However, a different person's assessment of spiritual resources often leads to better information for the interdisciplinary team. It is helpful for the team to gather information and then to share and compare their data. As has been mentioned, it is helpful to have a common form or process to gather data.

Further the interdisciplinary team may assess whether a patient's religious/spiritual perspectives are in line with the primary beliefs of his/her faith or are pathological. For example, a caregiver who is Christian or Jewish might be mired in guilt because she didn't notice symptoms of her husband's cancer until it was too late. A social worker might ask the caregiver what role grace and forgiveness has in her life.

After assessment there is a need to discuss whether religion/spirituality is a healthy or unhealthy factor in the care for the patient. The team needs to decide who on the team is best suited to address these issues with the patient.

In Mary’s case religion was an important and life-giving factor. Hope was not centered in cure from her cancer. Rather, focus was on helping her have spiritual peace in anticipating her death and reunion with her husband and also on helping the family accept and be at peace with her condition. Both social worker and chaplain would be primarily cheerleaders in encouraging the family to rely on faith and their priest and church community.

Thus, social workers are especially helpful in an interdisciplinary team as they listen compassionately; draw out the patient's hopes and fears, and help the patient and caregivers mine the resources of their faith. To do all this, social workers must know themselves and their own spiritual center and the team must be able to discuss candidly their own spiritual issues and learn from each other and other professionals.

**THE ROLE OF THE CHAPLAIN**

**What Do Chaplains Do?**

All pastoral/spiritual care has a basic fundamental role: to attempt to help others, through words, acts and relationships to experience the reality of God's presence and love in their lives. The chaplain works with patients on issues of meaning and purpose and helps them with issues of existential distress and suffering. The chaplain works with religious and non-religious patients alike. The chaplain can help people with issues about God or divine, higher power but also work with patients on existential and spiritual issues that are not theistically centered. The chaplain,
unlike other healthcare professionals, has no agenda to explain, cure or eliminate disease. The chaplain seeks only to engage the sufferer and to reframe his/her perspective of suffering in the context of life’s incongruities. The chaplain is trained to provide in-depth spiritual counseling.

The desires of the soul are heightened through the inquiry between chaplain and patient. Primary concerns of origin and destiny, existence and extinction are reintroduced as patients reflect and review their life’s mission or lack thereof. The chaplain listens to the voices of the suffering from the patient’s truth telling. The chaplain serves as a witness to their story and attentively and diligently mirrors unconditional love. The chaplain conveys and maintains hope so that the patient will absorb the hope and the commit-

### FIGURE 2
Assessment forms for pastoral care and hospice. (Forms courtesy of Community Hospices of Washington, D.C., 3720 Upton Street, NW, Washington, D.C. 20016.)
mien that is present and available to him through the respectful and dignified way he/she is treated by the spiritual caregiver.

It has been said by those in the field of pastoral care that the chaplain “needs no passport” to enter a patient’s room. The chaplain’s visits are unannounced and unscheduled, and they are at risk of rejection and disdain in every encounter. Rarely, however, is the chaplain unwanted. The spontaneous visit, when done gracefully, is a welcome guest bearing gifts of solace and the ultimate gift of human contact. The chaplain attends to the person and not the disease.

The chaplain has no quick fix. The chaplain has the clock of understanding and so the patient feels reassured by the chaplain's non-busyness attitude. Most visits average 15–30 minutes, although in times of crises, the chaplain may make several visits during the hospital day and during the hospital stay.

In home hospice, chaplains are offered to the patient and their families. A scheduled visit is often the reality, although advance notice can vary from one hour to two days depending on current assessments. Again, the role of the chaplain is to attentively listen to the patients’ and the families’ moment to moment.

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**Hospice Care Plan: Pastoral Care**

| Patient Name: ___________________________  | Medical Record Number: __________________ |
| Plan developed by: _________________________________  | Date: ________________________ |

**Spiritual Needs:**

- 1. Spiritual concern/disconnection
- 2. No Spiritual concern/issues

- Patient and/or PT Caregiver _____ requests Pastoral Care support or
- Patient and/or PT Caregiver declines(s) Pastoral Care support

Anticipated frequency of visits ____________

Referral made to ____________________________ for ________________________________

**Desired Outcomes:** check those that apply

- Patient/caregiver will utilize community resources
- Patient/caregiver will address spiritual issues causing concern and/or additional suffering
- Patient/caregiver will use spiritual strengths/resources to cope with illness, death, grief and loss
- Patient/caregiver unable to respond/interact with PC (Ministry of Presence only)

**Skilled Interventions:**

<table>
<thead>
<tr>
<th>Observation/Assessment</th>
<th>Teach/Instruct</th>
<th>Direct Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's spiritual condition</td>
<td>Available resources</td>
<td>Contact patient/caregiver clergy</td>
</tr>
<tr>
<td>Patient's belief system</td>
<td>Anticipatory grief and uncomplicated reactions to grief and loss</td>
<td>Spiritual support: prayers, hymns, readings</td>
</tr>
<tr>
<td>Caregiver's spiritual condition</td>
<td>Advance directives education</td>
<td>Assist with spiritual practices</td>
</tr>
<tr>
<td>Caregiver's belief system</td>
<td>Other</td>
<td>Funeral/memorial service: plan/conduct</td>
</tr>
<tr>
<td>Spiritual supports</td>
<td>Other</td>
<td>Other</td>
</tr>
</tbody>
</table>
emotional concerns. Connecting to their grief process, the chaplain rides the waves with them as they cautiously and carefully untie the many knots that keep them attached to their loved ones. From the context of love and loss, meaning and madness, the chaplain enters into the painful drama of the dying and uncovers the love and the courage hidden from view.

Professional Training for Chaplains

Most chaplains are ordained clergy from the various religious traditions who, in addition, have acquired an extended education in pastoral care. Others may not be ordained but are involved in their religious institutions as lay pastors, Eucharistic ministers, elders, para-rabbis, etc., and are similarly educated through clinical pastoral education units of learning. Chaplains can work with religious patients but may also work with non-religious patients as well. Chaplains are trained to provide spiritual care and not necessarily religious care. Chaplains link with clergy and other spiritual care providers from the community for patients as needed.

Clinical pastoral education units are accredited in hospital institutions through their certifying organizations. In North America, chaplains are certified by at least one of the national organizations that are recognized by the Joint Commission for Accreditation of Pastoral Services:

- Association for Clinical Pastoral Education (approximately 1000 members)
- Association of Professional Chaplains (approximately 3700 members)
- The Canadian Association for Pastoral Practice and Education (approximately 1000 members)
- National Association of Catholic Chaplains (approximately 4000 members)
- National Association of Jewish Chaplains (approximately 400 members)

Clinical work in the hospital setting, didactic group process, individual supervision and peer review create the environment for the chaplain’s spiritual and psychological growth. Guidance is given pre and post hospital visits with patients and families. The supervisor has been trained through many years of self-introspection and therapy, group dynamics and theological reflections to enhance the chaplain’s awareness and effectiveness.

All chaplains adhere to a code of professional ethics for healthcare chaplains and continue to complete annual education requirements. Confidentiality and sensitivity to multi-cultural and multi-faith realities are core to the spiritual engagement of chaplain and patient. Chaplains focus a lot of their attention on how patients find meaning and how they cope in the midst of their illness or suffering. The chaplain is also able to provide more in-depth counseling on spiritual or religious issues and conflicts as well as existential conflicts and distress. This specialized education enables chaplains to mobilize their spiritual resources so that their pastoral encounters and interventions fully address the needs of their hospital constituency.

Case Study: Mary P.

Faith in God is Mary P’s most powerful resource. God stands as the priority in her life. And, still, faith has many doors. During crises, faith is oftentimes ignored, pacified, questioned and tackled with an array of early childhood platitudes and myths. Carcinoma is the real thing and the only thing that can awaken Mary to a deepening of her relationship with God, herself and her family.

Beginning with Mary’s grief at the loss of her beloved husband, the chaplain engages Mary in dialogue about her own losses and not just about the carcinoma. In the context of her spiritual life, the chaplain could have her reflect on losses, regrets, frustrations, and resentments she may have stored away during a lifetime of service to others. The hospital or hospice chaplain affords her the precious commodity of attentive time in which to perform her life review.

Mary may be too proud to be vulnerable in the light of her family. Everyone sees her as strong and unshakeable. She must maintain this image even in the light of her yearning to be cared for and understood in her simple devout cloak. Courage, perseverance, fearlessness are all good qualities when presented with a diagnosis of cancer. When a religious person solicits prayer and God’s grace to help them through this crisis, a step is taken to ground oneself in a daily practice that will nourish and sustain them through their roller-coaster ride of fear and joy. The chaplain, however, can listen to her suffering from her truest wounded/ness without judgment or advice, without conjuring up defeat or dismissiveness without self-criticism and family expectations and dynamics. The chaplain offers her a place of repose, a place of being/ness and not doing/ness, a place to be honest, a place to be held in the agony of her situation in God’s lap of unconditional loving and grace. And, finally, the chaplain offers her the presence of
God in the green pastures of her restoration (both physical and spiritual) and adds another way for her to emphatically say, Amen. “God is my Shepherd and I lack nothing.”

**Chaplain’s Role/Spiritual Assessments/Interdisciplinary**

The Joint Commission requires organizations to include a spiritual assessment as part of the overall assessment of a patient to determine how the patient’s spiritual outlook can affect his or her care, treatment and services. The assessment’s goal is to determine the patient’s needs, hopes, resources which will help discover and determine the appropriate next steps in their care plan. It also helps chaplains identify spiritual or existential issues or distress. The patient herself/himself may decide how to utilize their spiritual insights and/or religious beliefs to affect their healing.

When we approach a patient as chaplains, we keep these spiritual guidelines as a prelude to our encounters with them.

- What is sacred to the patient and what is their personal awareness of the Holy?
- Do they acknowledge a Divine Purpose or intention toward Providence?
- What is this person’s dimension of faith in their private world?
- Does the word or theology of grace or gratitude inform their daily life?
- Does the patient take responsibility for his actions and does he/she see themselves in the process of changing, repenting, and transforming?
- Where is their sense of communion with the rest of humankind and nature?
- What gives people meaning and purpose in their lives?
- How do they make sense of what is happening to them on an existential level?
- What are the patient’s sources of hope, of strength, of deep understanding and insight?

Mary P.’s spiritual assessment would have elicited a profile of someone who had many community resources to help her navigate her cancer. The chaplain’s presence would have afforded Mary an opportunity for reflection on her true beliefs and given her a space to incorporate her life-long insights into practical theology. Mary’s spiritual practices would have been examined as to their efficacy and the use of ritual would have been encouraged and acknowledged as a healing instrument.

The chaplain might ask: “Mary, in the midst your pain and suffering, what is your faith telling you?” Or, “where do you feel yourself changing in light of this experience? Are you in sync with your God and is God in sync with you? What do you fear the most? Where is there no fear at all?”

The chaplain would continue to ask probing questions to encourage Mary to find theological clarity and comfort. Even with all these spiritual resources and a powerful belief system, Mary would be undergoing spiritual distress. In the honoring of the distress, comes the healing antidote.

The chaplain is bound by ethical standards and confidentiality like other healthcare providers. The chaplain has a moral code and an ethical duty to provide an advocacy role for the patient and family. Professional chaplains reach across faith group boundaries and do not proselytize. They are required to protect patients from being confronted by others who may intrude on the spiritual care in the hospital setting, i.e., other clergy, nurses, visitors, staff, etc.

Professional chaplains work as part of the interdisciplinary team of healthcare professionals. Each member of the team has an expertise in their field. The chaplain’s expertise is spiritual counseling and spiritual care. A chaplain is seen by the patient and family as a spiritual guide, a representative of God, an educated theologian, a person of faith, someone to confess to, and one who offers prayer and sacraments. When working with nurses and physicians, the chaplain offers a different perspective on the well-being of the patient. While the nurses and physicians are tending to the body, the chaplain is concentrating on the soul aspects of the patient’s divine attributes. The question, “How are your spirits?” is an honest question when it comes from the chaplain’s lips. The chaplain wants to know where you are in your spiritual distress and spiritual access.

The caregivers when working in tune with each other’s assessments can offer the patient the greatest gift: complete attention to the wholeness and the holiness of each individual person. The patient is not her/his disease. The patient is a vital human being who happens to be in a horizontal position in a hospital setting.

The professional chaplain helps the staff to encounter the patient from a place of respect, dignity and divinity. When working with the staff, the chaplain can interpret a patient’s religious and spiritual issues so that the healing process can be accelerated.

**Conclusion: An Interdisciplinary Spiritual Care Model**

Spirituality is essential to the care of all patients and particularly to those who are seriously ill or dying. The barriers to good spiritual care usually stem from lack of training, fear of time limitations or a lack of
appreciation of the role of spirituality in the care of patients. Yet, increasing evidence suggests that spiritual beliefs and practices can impact healthcare outcomes and that patients want their spiritual beliefs addressed in their care. Spiritual assessment tools that are available for healthcare professionals enable conversations to occur in a timely and meaningful manner. And, increasing evidence shows that a patient-centered approach to care is the foundation of good quality care. The best model of care comes from an interdisciplinary model where all members of the healthcare team bring their expertise and experience to the care of the patient. It is only when healthcare professionals can work together for the good of the patient and family that the best care can be given to that patient and family. In this article we focused on four members of that team, but it is important to recognize that additional members of the team include allied health, nutrition, physical therapy, housekeeping services, as well as individuals in the community that could include parish nurses, pastors, spiritual directors, other spiritual leaders, counselors, therapists, music and art therapists, family and friends. Figure 3 shows a depiction of how all members of the healthcare team interact with each other and with the patient, family, and community. In this model each member of the interdisciplinary team interacts with the patient and the family. Some members of the interdisciplinary team may also interact with the community members involved (pastor, parish nurse, spiritual director, spiritual community members, etc). The community also interacts with the patient and family. Within the interdisciplinary team the professional that is in the center circle changes depending on what the clinical issue is. In the circle depicted in Figure 3, the chaplain is in the center as that is the trained spiritual care professional. If the issue being addressed is physical, then perhaps the physician or nurse is in the center circle; if the issue is social services, then the social worker is, and if the issue is nutrition or physical therapy, then the center circle for that issue would be the nutritionist or the social worker. But everyone on the team deals with all those issues. The chaplain may interact with the patient around pain issues and bring that to the attention of the nurse or physician. The physician may assess and discuss spiritual issues with the patient and bring those to the attention of the chaplain for more in-depth spiritual counseling. Each member of the team contributes to each aspect adding their particular areas of expertise to the plan developed by the whole team. The synergy between all those interacting with the patient enhances the overall care and well being of the patient. But it also makes the work of each individual healthcare professional richer in that the contribution of each healthcare member to the treatment plan potentiates each individual contribution. The whole is more than the sum of its parts.

The critical elements of spiritual care involve an intrinsic dimension which is what the healthcare professional brings of themselves to the patient encounter. Compassion, caring, intuitive listening, comfort with uncertainty, openness to the unexpected in the encounter and commitment to a relationship-centered focus of care make up intrinsic spiritual care. In order to do this the healthcare professional has to have a sense of who they are as spiritual beings—what gives their personal and professional lives meaning and purpose, how are they nurtured spiritually and how they find hope in the midst of caring for patients who are seriously ill and dying (Table 1).

Extrinsic spiritual care is that part of spiritual care that involves communication with patients about their spiritual issues, recognitions of spiritual distress, conflicts, resources of strength and beliefs and practices that impact the health of the patient. It is that part of spiritual care that involves treatment planning and working with other members of the healthcare team to develop a treatment plan that takes into consideration all dimensions of the patient’s life—physical, emotional, social and spiritual. How each healthcare professional does this is slightly different based on training and clinical context but the fundamental aspects of this model are similar. A physician may obtain data from a spiritual history, the nurse during bathing of the patient, and the social worker during a family conference. The chaplain, as the trained spiritual care professional works with the rest of the team by addressing the spiritual issues with patients more in-depth and assisting the rest of the team with creation and implementation of the spiritual treatment plan.

**FIGURE 3** Interdisciplinary spiritual care model.
Excellence in quality of care will depend on adherence to a biopsychosocial–spiritual model of care that is practiced by all members of the healthcare team. Good, ongoing communication between the interdisciplinary team members will ensure that the patient and family have the most comprehensive compassionate treatment plan and care.

### REFERENCES

28. Joint Commission on Accreditation of Healthcare Organizza-


