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Spiritual Care and Physicians: Understanding Spirituality in Medical Practice



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HealthCare Chaplaincy Network™ (HCCN), founded in 1961, is a global health care nonprofit organization that offers spiritual care-related information and resources, and professional chaplaincy services in hospitals, other health care settings, and online. Its mission is to advance the integration of spiritual care in health care through clinical practice, research and education in order to improve patient experience and satisfaction and to help people faced with illness and grief find comfort and meaning--whoever they are, whatever they believe, wherever they are.

The Spiritual Care Association (SCA) is the first multidisciplinary, international professional membership association for spiritual care providers that includes a comprehensive evidence-based model that defines, delivers, trains and tests for the provision of high-quality spiritual care. Membership is open to health care professionals, including chaplains, social workers, nurses and doctors; clergy and religious leaders; and organizations. SCA, with offices in New York and Los Angeles, is a nonprofit affiliate of HealthCare Chaplaincy Network.

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INTRODUCTION

All physicians, over the course of their clinical activities, are likely to be impacted by the spiritual beliefs of their patients and their families. The leadership of the American Medical Association (AMA) has recently defined the need for patient access to spiritual services. Citing six past AMA House of Delegate policies, the AMA leadership emphasized that 41% of patients want to discuss religious or spiritual concerns in the health care setting, but less than half reported being offered the opportunity to receive such care.¹ The document resolves “That our AMA encourages expanded patient access to spiritual care services and resources beyond trained health care professionals”.

The AMA resolution follows recommendations by the World Health Organization contained in the Sixty-seventh World Health Assembly agenda item “Strengthening of palliative care as a component of comprehensive care throughout the life course,” to enhance the training of health care professionals in spiritual needs as well as foster partnerships between government and civil society on this issue.² This evolving national and international guidance validates the need to develop programs that strengthen chaplaincy training, encourage the expansion of spiritual services within the clinical settings and define available research that can guide this process. The Health Care Chaplaincy Network’s (HCCN) expert clinical panel has developed a comprehensive review of peer-reviewed published data on the clinical needs, existing practices and clinical outcomes for spiritual care. This white paper defines the scientific framework by which HCCN seeks to address obstacles to better spiritual care and propose evidence-based solutions for the medical setting.

HISTORY

Medicine has been practiced by human beings since millennia and considerable progress in medicine was made during the times of the ancient Egyptians, Greeks and Romans. The first of the hospitals known were built by the Greeks. However, during ancient times, distinctions between physical causes and spiritual/religious causes of illness were frequently blurred. Subsequent to the fall of the Roman Empire, Western Europe entered a period of medical stagnation and there were few advances in medicine throughout the Middle Ages. The Roman Catholic Church dominated all aspects of life in Europe and hospitals built during the Middle Ages were associated with monasteries and/or were run by monks and nuns. Medicine was steeped in superstition, and any thinking that veered from the church’s established doctrine, bordered on heresy. Following the Renaissance in Europe, the evolution of medicine advanced, helped by new scientific developments, and took a path away from any influence of religion on medical care.

From the 19th century onward, advances in modern medicine accelerated and beginning in the 20th century, medicine became highly compartmentalized into a multitude of specialties with each specialty developing an increasingly narrow focus on specific systems of the human body. While medicine in ancient times considered a mix of physical and spiritual/religious causes of physical or mental illness, modern medicine explicitly moved away from any role of religion or spirituality in medicine.

MODERN MEDICINE

By the middle of the 20th century, modern medicine was firmly anchored in science and developing technologies and had completely negated the role that religion and spirituality played in the health of people. However, there was gradual awareness among medical practitioners that, with all the advances in modern medicine, some aspect of care was being missed. Medicine, in fact, accepted very little input from patients and their families in treatment planning, once they consented to treatment. Patients were viewed as little more than passive receivers of medical interventions. The medical establishment, it was felt, had become dehumanized.³

The shift towards engaging patients as more active participants in their medical care began in the second half of the 20th century when, in the 1960s, psychologist Carl Rogers coined the term “person-centered” care in relation to psychotherapy.⁴ In the 1970s, psychiatrist George Engel recommended the use of the term “biopsychosocial model” of health as opposed to the existing “biomedical model” of health.⁵ For Engel, the psychological states of patients as human beings, as well as their significant interpersonal relationships, were equally important as their biological states. By the 1990s, these terms were used in mainstream medicine and in 1999 the Association of American Medical Colleges (AAMC) recommended that physicians should discuss their patients’ spiritual and religious beliefs and medical schools should develop curricula to teach courses in religion and spirituality.⁶ In 2001, the Institute of Medicine incorporated the term “patient-centered care” as one of its six aims of health care quality. Patient-centeredness is similar to the person-centered term of Carl Rogers but more specifically “encompasses qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient.”⁷

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RELIGION AND SPIRITUALITY

The 1990s also saw the emergence of literature that reexamined the role of religion and spirituality in patient care. While there is no unanimous agreement,⁸ the preponderance of the literature suggests that both concepts are important for patients and play a role in health behaviors, compliance with medical treatments, provision of social support and coping with their illness.^{9,10} Indeed, there is growing consensus that the study of the interplay between spirituality and medicine is here to stay. This is particularly true in the United States where spirituality and religion have been central to the lives of millions of Americans.

In a recent survey of the religious landscape of the United States, 70.6% of Americans endorsed themselves as Christians, of whom 46.5% were Protestants, 20.8% were Catholics and 3.3% were other Christians including Mormons, Jehovah’s Witness and Orthodox Christians. An additional 5.9% of the population endorsed non-Christian faiths, including Judaism, Islam, Buddhism, Hinduism and other, whereas 22.8% of the population endorsed themselves as unaffiliated and included atheists, agnostic and none.¹¹ Thus, 76.5% of Americans consider themselves to belong to a faith. Of the 22.8% unaffiliated, 18% described themselves as religious; 37% described themselves as spiritual, but not religious and the remaining 42% said they were neither.¹² Since spiritual and religious expression can be diverse and idiosyncratic, it is therefore important to differentiate between the two concepts. Additionally, in order to further research in the role that religion and spirituality play in our health, clear definitions of these concepts are essential.

BIOPSYCHOSOCIAL-SPIRITUAL MODEL

A recent consensus conference comprising international experts from the fields of medicine, psychology, and spiritual care defined spirituality as “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.”¹³

Spirituality is considered a broader concept than religion. Religion has been described as “a subset of spirituality, encompassing a system of beliefs and practices observed by a community, supported by rituals that acknowledge, worship, communicate with, or approach the Sacred, the Divine, God (in Western cultures), or Ultimate Truth, Reality or Nirvana (in Eastern cultures).”¹⁴

Thus, religion is one way for spiritual persons to express their spirituality. It also clarifies that religious people, by definition, are spiritual people, but not all spiritual people have to be religious. A related concept is a secular existential orientation which consists of concepts that do not require a belief in a transcendent reality. These include personal values, the value of life, responsibility to others, and freedom.¹⁵ A common thread within all three constructs is our attempt to make meaning of our lives. A “meaning” systems framework has been proposed and includes cognitive and affective components geared towards global beliefs and goals¹⁶. These beliefs and goals help us find meaning and purpose in life and a sense that we are connected to something of greater significance than us.^{16,17}

In the last two decades, efforts have been made to further broaden the biopsychosocial model of health proposed by George Engel to include the concept of spirituality. According to researchers in the field of spirituality, the biopsychosocial model does not provide any kind of metaphysical grounding for the notion of a patient as a person. Thus, the proposed biopsychosocial-spiritual model takes into consideration, not only the psychological and interpersonal states of the individual along with their biological state, but also addresses their spiritual state.¹⁸ This model has far reaching implications for research in spirituality and its relationship to health and it is likely to have a significant impact on clinical practice of physicians. This discussion about religion, spirituality and health is at the heart of our attempts to practice a more humane medicine.

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NEUROBIOLOGY OF SPIRITUALITY

Mindfulness and spirituality share some psychometric features, but also differ as mindfulness focuses on self while spirituality focuses on both self and other-than-self such as a higher power. Structural, functional and neural network brain imaging research provides new insights into the neurobiology of mindfulness, meditation and spirituality.¹⁹ Meta-analysis of 21 morphometric human brain studies with 300 subjects identify consistent alterations of eight brain regions that impact meta-awareness, exteroceptive and interoceptive body awareness memory, and emotional regulation.²⁰ Recent meta-analytic reviews of MRI studies suggest that meditation reduces default mode network activity with enhancement of focus and attention. Meta-analytic assessment of MRI studies indicate that meditation improves working memory, attention, and emotional regulation through functional activation of a wide network that include bilateral middle frontal cortex, cingulate and insular cortex among others.²¹ Frontal, insular and temporal cortices have been reported as altered by meditation and mindfulness meditation with the hypothesis that these mental activities may cause “neuroplastic changes” in the structure and function of brain regions involved with regulation of emotion, attention and self-awareness.²² Limited data on the neurobiology of religious/spiritual practices as compared to meditation suggest differences in the balance between prefrontal and parietal cortex activation although numerous similarities also occur.²³ In summary, the identified neuroanatomical regions correlated with components of spiritual thought or experience including a sense of self (insular regions), emotional modulation (frontal and cingulate regions) and executive planning (prefrontal cortex).

The molecular neurobiology of mindfulness meditation is undefined, but the documented reduction of stress induced cortisol may be protective through increasing levels of BDNF.²² Applied research on the clinical efficacy of spirituality is evolving. Recent evidence support mindfulness-based stress reduction as an effective treatment option for improving function in chronic low back pain that equals cognitive behavioral therapy.²⁴

PATIENTS DO WANT TO DISCUSS THEIR SPIRITUALITY AND RELIGION

There is a considerable literature examining whether patients would prefer if their physicians would inquire about their religious or spiritual beliefs as part of routine history taking, especially in palliative care.²⁵⁻²⁷ "A university teaching hospital surveyed 177 adult patients attending an office practice to examine patient acceptance of the following question in the medical history, "Do you have spiritual or religious beliefs that would influence your medical decisions if you became gravely ill?" Of responding patients, 66% stated that they would like their beliefs and the same percentage felt that it would enhance their trust in the physician.²⁸

Similarly, a multicenter survey in primary care clinics of six academic medical centers in three states (NC, FL, VT) was conducted to determine patient preferences for addressing religion and spiritual beliefs during their office visit. A total of 456 patients participated in the study: 65% of patients felt that physicians should be aware of their preferences, while 35% preferred that the physician ask them about their beliefs. Further, patients' desire for spiritual interaction with their physician increased with severity of illness.²⁹

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In a multisite survey of family practice sites in Ohio, 83% of respondents wanted the physicians to inquire about their beliefs, especially in life threatening situations (77%), chronic medical illnesses (74%), and when a loved one was lost (70%). The most common reason for having a conversation about religion and spirituality was that the patients expected an improvement in the understanding between the physician and the patient.²⁷ One hindrance to patients' initiating these discussions is that they believe their doctors are not prepared to address these concerns.^{26,27,30} While, it is clear that not all patients want a discussion of their religious or spiritual beliefs, the majority do. Religion and spirituality consistently emerge as important domains in end-of-life care and communication, particularly with African-Americans.³¹⁻³⁵ It is therefore incumbent upon physicians to inquire about patients' beliefs in a thoughtful, rational and ethical manner, while respecting differing perspectives.³⁶⁻³⁸

SPIRITUAL CARE AFFECTS PATIENT SATISFACTION WITH CARE

Integrating spiritual care into patient care significantly enhances patients' satisfaction with the care they receive at a hospital. A study of nearly 9,000 patients found that chaplaincy visits increase patients' willingness to recommend the hospital and are more satisfied with their overall care, as measured by both Press Ganey (one of the most widely used patient satisfaction companies) and the Centers for Medicare and Medicaid Services' survey, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).³⁹ The Press Ganey survey specifically found that patients who have a chaplain visit are significantly more likely to endorse positive responses to questions regarding whether the "staff addressed my emotional needs" and "staff addressed my spiritual needs."

Press Ganey's own research among more than 1.7 million patients demonstrates that responses to the question "staff addressed my emotional and spiritual needs" is one of the three main drivers of patient satisfaction with the hospital experience.⁴⁰ A study of over 3,000 inpatients found that those who reported that their spiritual needs were met were more likely to be satisfied with their care⁴¹. Another study with cancer patients also demonstrated that when patients' spiritual needs go unmet, their rating of both satisfaction with care as well as the quality of their care received are significantly lower.⁴²

SPIRITUAL CARE AND HEALTH CARE OUTCOMES

A prospective multisite study of cancer patients has demonstrated that the amount of patient-reported receipt of spiritual support from the health care team has significant effects on several end-of-life experiences.⁴³⁻⁴⁵ Greater spiritual support from the health care team was associated with a substantial increase in quality-of-life scores near death, as reported by patients' caregivers.⁴⁵ Patients who reported a high level of spiritual support were more likely to receive hospice care and less likely to die in an intensive care unit, which were in turn associated with significantly lower health care costs.⁴⁴ In another study, those patients who reported high spiritual support from their local religious communities were less likely to receive hospice care and were more likely to receive aggressive end of life care.⁴³ Of note was the finding among patients who were well-supported by religious communities. Those receiving a high level of spiritual support from the medical team were associated with higher rates of hospice use, fewer ICU deaths, and fewer aggressive interventions. All of these findings demonstrate how spiritual care affords patients and their loved ones the opportunity to choose their preferred choices for end-of-life treatment, thereby highlighting how spiritual care may be a key component in end of life medical care guidelines.⁴³

It is estimated that 40% of medical inpatients do not have the capacity to make medical decisions.⁴⁶ In such situations, physicians are likely to have discussions with patients' surrogates, who in turn may include spirituality and religion considerations to inform their decisions for the patient.⁴⁷ A multisite study that included interviews with surrogate decision makers found that, based on religious grounds, including belief in a miracle, 36% doubted physicians' ability to predict futility.⁴⁸ Those surrogate decision makers who doubted the ability of physicians to predict futility on religious grounds were more likely to request continued life support in spite of a poor prognosis. A recent prospective multisite ICU study that audio recorded family meetings in which goals of care were discussed with surrogates of critically ill patients provides important information regarding how physicians' address religious or spiritual issues.⁴⁹ While 78% of the surrogates considered religion to be important, only 16% of the conferences included any reference to spirituality or religion. Surrogates initiated these discussions 65% of the time and a health care professional raised spiritual concepts only 6% of the time. When surrogates did raise spiritual concepts, health care professionals usually changed the subject to the medical realities at hand.

CHAPLAINS AND COMMUNITY CLERGY

The work of health care chaplains differs from that of community clergy in several ways. Community clergy are ordained or authorized by a religious body to perform certain rituals, to teach and preach, and represent certain religious communities. Health care chaplains may or may not be ordained or authorized to perform any rituals, to teach any doctrine, or to represent a specific community. Community clergy tend to stay current in theological literature, whereas health care chaplains remain apprised of theological literature as well as scientific literature related to spirituality and health. Community clergy provide care that enables patients and their families to remain faithful to specific religious beliefs and practices while facing a health crisis, whereas health care chaplains provide care that helps patients and families access their own spiritual resources, however eclectic and diverse, to find meaning and comfort during periods of illness.

Because the work of health care chaplains and community clergy differ in these ways, each group has developed distinct educational and training requirements. The educational requirements of community clergy vary significantly. For example, in some Jewish movements, rabbis and cantors must study at a graduate level for four to five years. In some Christian denominations, no academic preparation is required other than reading the Bible from cover to cover whereas other Christian denominations require graduate theological degrees. Health care chaplains' education and training requirements, conversely, are standardized by professional associations and do not depend on the practitioner's religious affiliation.⁵⁰

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In fact, health care chaplains are spiritual care practitioners who have undergone approximately eight years of training to become board certified. This usually includes four years of undergraduate education followed by at least three years of graduate theological education. Prospective chaplains must then complete one year of clinical training in a health care setting, known as Clinical Pastoral Education (CPE). CPE focuses on the formation of a reflective practitioner who is knowledgeable about world religions and spiritual systems, outcomes oriented chaplaincy, health care ethics, and research.⁵¹ The comprehensive nature of chaplaincy training explains why health care chaplains are uniquely suited to assess and address patients' and their loved ones' religious and spiritual needs.

PHYSICIANS' PERSPECTIVES ON ADDRESSING SPIRITUALITY AND RELIGIOUS CONCERNS

Fortunately, the majority of physicians recognize the importance of providing spiritual care, particularly at end of life. In a national survey of over 1,000 physicians, 50% of physicians reported that they often or always inquire about religious or spiritual issues when patients are facing the end of life.^{52,53} In general, physicians see the value of spirituality and religion in assisting patients in decision-making and in attempting to understand their illness. They also see the value that religion provides by way of social support. Some physicians also recognize the deleterious effect of religion, as when the patients' religious beliefs conflict with medical recommendations or when an illness may be viewed by the patient as a punishment for past sins. Most physicians would accept the importance of spirituality and religion in the same vein as they accept the importance of cultural competency, but physicians appear less willing to accept that spirituality and religion also have an impact on health outcomes, despite evidence to the contrary.⁵⁴⁻⁵⁹

BARRIERS

There are a few reasons why physicians are not engaged in providing spiritual care to patients or their families. Although there is a paucity of research in this area, the findings of the few studies that have examined this issue specifically, are remarkably striking. Almost three quarters of physician express that the foremost reason they cannot provide spiritual care to patients is that they do not have enough time during the medical encounter. The second most common reason given is that they do not have adequate training to provide spiritual care to patients and that such care is better provided by others. Thirdly, physicians also expressed discomfort about engaging in discussion on spirituality and faith with patients who were not of the same faith as the physician while others endorsed that they did not personally feel comfortable having discussions about spirituality and faith. A significant minority felt that it was not the physician's role to have these conversations with patients. Finally, physicians expressed concern that there was a power inequity between the patient and physician and that the patient would be uncomfortable having a discussion about spirituality and faith with them. Physicians who are more spiritual or religious are more likely to have a conversation with their patients about spiritual concerns when compared to those physicians who are less spiritual or religious.⁶⁰ Physicians state that they feel comfortable about discussing these issues only if their patients begin the conversation about their spiritual concerns.^{31,36,37,61}

IMPLICATIONS FOR PRACTICE

A plethora of emerging literature has identified the importance of religious/spiritual beliefs on the health outcomes. Therefore, it is important for physicians to incorporate understanding of these beliefs in their clinical work. It should not be expected that physicians will undertake spiritual assessments of their patients. Rather, the ability to recognize spiritual distress in their patients and thus make appropriate referrals to chaplains is desirable. Among physicians, the concept of an internist/generalist and a specialist is well established. It has been observed that, "every physician is taught something about cardiology, including how to assess and at least preliminarily diagnose cardiac issues. The internist/generalist is also able to treat a

few of these issues, especially in their less severe forms, without referring to a cardiologist. Nonetheless, at some point, for some patients, a referral will be necessary.”⁶² A similar model exists for spiritual care. Health care today needs spiritual care generalists i.e., physicians as well other members of the health care team, along with spiritual care specialists who are board certified chaplains (BCCs).⁶³ The physician, in the role of a spiritual care generalist, should be capable of assessing the need for spiritual care for their patient and make appropriate referrals to the spiritual care specialist, the chaplain, when more in-depth spiritual care is deemed necessary.⁶⁴

A spiritual screen, spiritual history and spiritual assessment are three distinct mechanisms for providing well-integrated spiritual care. Many institutions today have various versions of these three spiritual care tools and may assign different members of the health care team to each. Best practice expectations are for the admissions person, or a social worker, or nurse to perform the spiritual screen as a part of their initial assessment. This may, in turn, trigger a report or referral to the chaplain for those experiencing spiritual distress. Additionally, the physician would be the health care provider who would conduct a spiritual history as part of the initial history and physical examination. For those who have expressed a spiritual need or are experiencing spiritual distress that was not identified during the spiritual screen, a referral to a board certified chaplain would be initiated, who would then conduct an in-depth, specialized spiritual assessment and intervene to ameliorate the spiritual distress and/or meet the spiritual need. Unfortunately, there are many organizations where the actual practice does not meet the best practice of spiritual care, and do not use each distinct spiritual tool. Education, familiarity with the research, and communication are essential.

The spiritual screen is a triage tool seeking to identify spiritual distress in patients or families for referral to the chaplain. The spiritual care screen includes “a few questions to elicit basic preferences and any obvious distress that warrants follow up, with minimal expertise and time required.”⁶⁵ It serves to identify patients who may be experiencing spiritual distress.

The spiritual history instrument, on the other hand, looks more in-depth at the spiritual and religious context of the patient (much as a cultural assessment would), and determines what kind of spiritual support may be most helpful. The spiritual history includes a patient’s spirituality (however they define that), what gives their life meaning, the importance of their beliefs and values, a spiritual community (broadly defined to include faith communities and/or other types of spiritual communities such as family, yoga groups or others. There are several popular spiritual history instruments in use today, including the HOPE⁶⁶ and SPIRIT⁶⁷ instruments, Christina Puchalski, M.D., at the George Washington Institute for Spirituality and Health (GWISH), developed the FICA Spiritual History Tool, which has become one of the most utilized.⁶⁸

F – FAITH AND BELIEF: “Do you consider yourself spiritual or religious” or “Do you have spiritual beliefs that help you cope with stress?” (or contextualize to whatever the clinical situation is) If the patient responds with “No,” the history-taker might ask, “What gives your life meaning?” Sometimes patients respond with answers such as family, career or nature.

I – IMPORTANCE: “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 your health?”

C – COMMUNITY: “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?” Communities such as churches, temples and mosques, or a group of like-minded friends can serve as strong support systems for some patients.

A – ADDRESS IN CARE: “How would you like me, and the entire medical care team, to address these issues in your health care?”

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Finally, the spiritual assessment by the board certified chaplain is defined as “a detailed process of listening to, interpreting and evaluating spiritual needs and resources (significant expertise and often more time required).”⁶⁵ A professional chaplain’s spiritual assessment is communicated clearly in the patient’s chart. This may take different forms depending on the Electronic Medical Record (EMR) platform in use in a particular health care organization.

Physicians can facilitate the provision of spiritual care to patients and their loved ones by including chaplains in patient management, particularly in the following situations:

- Any patient or family member spiritual request or apparent need that the physician is personally uncomfortable fulfilling or that the physician believes they are not adequately trained to engage
- If a patient is connected to a community clergy person, that clergy person may be invited to participate in the patient’s care. Chaplains are a good resource for communicating with local clergy as they often have a network of community clergy with whom they regularly interact. Chaplains can also educate community clergy about what constitutes optimal care of the patient
- A patient or their representative request to see a chaplain or priest
- There is the belief that the illness is a punishment from God
- Based on a religious belief, the patient or their surrogate is not agreeing with what is considered to be safe medical care
- End of life care is being considered

THE NEED FOR MORE RESEARCH

While there are compelling data supporting the importance of addressing patients’ and their families’ spiritual and religious beliefs and needs, there is a paucity of research that examines best practices in providing this important aspect of medical care. Physicians need training in order to increase their comfort and effectiveness in addressing their patients’ and loved ones’ spiritual and religious needs. In addition, we do not have data describing which chaplain interventions have the most impact on patient outcomes. Funding of research for these important endeavors is critical to moving the field of spiritual care forward.

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