

CME 3 Clinical Applications (physicians)

by Harold G. Koenig, M.D.

Part 3, Section 1

Welcome to Part 3 of this educational series on Integrating Spirituality into Patient Care. This video focuses on *Clinical Applications* **by physicians**. I begin by briefly summarizing:

- (1) What we are asking physicians to do;
- (2) Definitions of the terms I'll be using;
- (3) Why physicians should do a spiritual assessment; and...
- (4) The research that justifies taking the time to do so

Although viewers who have watched Parts 1 and 2 may find some of this material repetitive, the points being made provide a background for understanding why physicians should take time to address these issues. After this introduction, I will dive into the heart of the presentation that focuses on the “how to” of integrating spirituality into patient care. In that section I'll be covering topics such as the spiritual assessment, the minimum physician requirement, optional activities beyond the minimum, barriers to spiritual assessment, whole-person needs of physicians, the role of the spiritual care team, spiritual resources for physicians, and boundaries that should not be crossed.

Part 3, Section 2

First, what are we asking physicians to do? We are asking physicians to:

- (1) **Conduct** a brief “spiritual assessment” (ask 3 questions)
- (2) **Identify** spiritual needs related to medical illness and health care
- (3) **Ensure** that someone meets those needs
- (4) **Be willing** to discuss this subject with patients in a supportive manner
- (5) **Be aware** of the health benefits of doing so

Part 3, Section 3

Next, what do we mean by terms such as “religion” and “spirituality,” and how is this relevant to the physician's tasks I just listed?

Religion involves beliefs and practices related to the Transcendent, which in Western religious traditions is often called God. Religion usually has rules to guide behavior on earth and doctrines about life after death. Religion is often organized as a community, but can also exist outside of an institution and may be practiced alone and in private. So, religion doesn't always have to involve attending church, synagogue or mosque, but can also involve private expressions of devotion to the Transcendent. Private expressions might include such activities as prayer or

meditation, reading Holy Scriptures, watching religious TV, listening to religious programs on the radio or listening to religious music. When doing research, religious involvement is relatively easy to measure and quantify. This is why most of the research that I reviewed in Part 2 and will be summarizing here examined relationships between “religious involvement and health.”

However, religion can also be divisive – since people believe different things and believe them passionately. Furthermore, pluralistic healthcare settings will likely involve patients and providers from a number of different religions, and everyone must respect each other’s beliefs. Therefore, the term “spirituality” has arisen.

The word spirituality does not carry the “baggage” associated with religion, and is often viewed as common to all. Spirituality provides a universal language that patients define for themselves. Spirituality for many patients will be their religious beliefs and practices. For others, it may not involve religion at all -- although will likely involve something close to it. Therefore, physicians should communicate with patients using the term “spiritual” or “spirituality” and allow the patient to define whatever that means to him or her.

Part 3, Section 4

So that’s it for definitions. Now, **why** should physicians do a spiritual assessment?

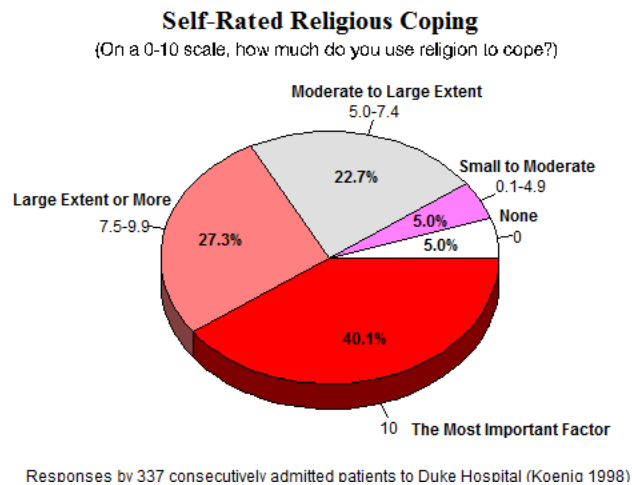
- (1) First, many patients have spiritual needs that influence satisfaction with care and can have a dramatic effect on healthcare costs, especially towards the end of life
- (2) Religious beliefs influence coping with illness and may affect the patient’s emotional state and motivation towards recovery
- (3) Religion affects important health-related behaviors and likely influences medical outcomes
- (4) Religious beliefs influence medical decisions made by both patients and physicians
- (5) The “standards of care” require that providers respect patients’ cultural and spiritual beliefs, and assessment is the only way to know what those beliefs are
- (6) Involvement in a religious community may influence health by increasing patient monitoring and thereby improving treatment compliance
- (7) Finally, addressing spiritual issues may benefit the physician by providing intrinsic rewards associated with practicing “whole person” healthcare.

Part 3, Section 5

There is also scientific rationale for assessing and addressing patients’ spiritual needs. I will briefly review some of that research here, although for a closer look at the research, go to **Part 2** in this educational series. I begin here by reviewing the research on mental health, and then move on to examine social health, health behaviors, and physical health. The systematic review

of the research reported here is documented in the *Handbook of Religion and Health*, 2nd edition, Oxford University Press (2012).

First, in some areas of the United States and elsewhere in the world, up to 90% of medical patients use religion to cope.¹ And the overwhelming majority of these patients report that it helps them. Religious beliefs are commonly used to deal with the distress caused by medical illness. Religious beliefs give meaning to illness, promote hope for recovery, and provide behaviors that make the person feel more in control (such as prayer). Beliefs of this kind have been repeatedly linked to better coping with medical problems and physical disability.



With regard to *Mental and Social Health*, religious involvement is related to ...

- less depression in over 60% of 444 quantitative studies
- greater well-being and happiness in nearly 80% of 326 studies
- greater meaning and purpose in over 90% of 45 studies
- greater hope and optimism in over 75% of 72 studies
- and because religious beliefs provide greater meaning, purpose and hope, they are related to more negative attitudes toward suicide, fewer suicide attempts, and less completed suicide in 75% of 141 studies. Religious beliefs are also related to:
 - less alcohol and drug use/abuse in over 85% of nearly 300 studies, and...
 - greater social support, marital stability, & prosocial behavior in > 80% of 257 studies

What about *Health Behaviors*, such as exercise, diet, cigarette smoking, sexual activity, and weight control? These behaviors are **responsible for** nearly 80% of all chronic medical illness. The research shows that religious persons are more likely ...

¹ Koenig HG (1998). Religious beliefs and practices of hospitalized medically ill older adults. *International Journal of Geriatric Psychiatry* 13: 213–224

- to exercise or be physically active in nearly 70% of 37 studies
- eat a better diet in over 60% of 21 studies
- have lower cholesterol in over 50% of 23 studies
- participate in less extra-marital sex in 86% of 95 studies, and...
- do not smoke or smoke fewer cigarettes in 90% of 137 studies

Weight, though, appears to be a problem. Religious persons had lower weight in only 20% of studies, and actually were significantly heavier than non-religious persons in 40% of studies. Yes, those potluck suppers!

Despite being heavier, though, religious persons have better *Physical Health* than non-religious persons in the majority of studies so far. This includes...

- better immune function in over 50% of 25 studies
- better endocrine function in nearly 75% of 31 studies
- better cardiovascular functions in close to 70% of 16 studies
- less coronary heart disease in nearly two-thirds of 19 studies
- lower blood pressure in nearly 60% of 63 studies
- less cancer or better prognosis in more than half of 25 studies, and...
- greater longevity overall in 68% of 121 studies, including over 75% of the best designed studies

Finally, research indicates that religious or spiritual needs are widespread among medical patients, and when these needs are not addressed by the medical team, this reduces the patient's quality of life and satisfaction with care, and *doubles or triples healthcare costs* at least towards the end of life.² Furthermore, randomized clinical trials show that when physicians conduct a spiritual assessment, this results in a better doctor-patient relationship, better compliance with clinic visits, lower depression, and greater functional well-being.^{3,4}

Based on this systematic review of the research, we conclude that:

- (1) Religion is often used to cope with stress in general and medical illness in particular;
- (2) Religious or spiritual involvement is associated with greater well-being, less emotional disorder, less substance abuse, greater social support, and better health behaviors;
- (3) Religiosity is related to less physical illness, better medical outcomes, and greater longevity;

² Balboni et al. (2011). Support of cancer patients' spiritual needs and associations with medical care costs at the end of life. Cancer 117(23):5383-5391

³ Kristeller et al. (2005). Oncologist Assisted Spiritual Intervention Study (OASIS): Patient acceptability and initial evidence of effects. International Journal of Psychiatry in Medicine 35: 329-347

⁴ Huguelet et al. (2011). A randomized trial of spiritual assessment of outpatients with schizophrenia: patients' and clinicians' experience. Psychiatric Services 62(1):79-86

- (4) Spiritual needs are widespread in medical settings, especially in patients with serious, life-threatening disease;
- (5) Assessing and addressing patients' spiritual needs is related to greater satisfaction with care, better QOL, less depression, fewer unnecessary health services, better functioning, and a better doctor-patient relationship.
- (6) More research is needed to (a) better understand relationships between religion and health; (b) determine the underlying biological mechanisms involved; AND (c) develop new interventions that harness these effects.
- (7) Given the results of the research already done, however, there is every reason for physicians to begin to integrate spirituality into patient care.

Part 3, Section 6

The First Step, in this regard, is for physicians to conduct a "Spiritual Assessment."

What do I mean by "spiritual assessment"?

The spiritual assessment involves asking a few simple questions to identify the presence of spiritual needs. The purpose is to:

- (1) Make physician aware of the patient's religious background
- (2) Determine if the patient has religious or spiritual support
- (3) Identify beliefs that might influence medical decisions and compliance with treatment
- (4) Identify unmet spiritual needs related to medical illness
- (5) Determine if engagement of the "spiritual care team" is necessary, and...
- (6) Create an atmosphere where the patient feels comfortable talking with their physician about spiritual needs affecting medical care

The receptionist should record the patient's religious affiliation in the EMR when the patient signs in for the clinic visit or is admitted to the hospital. There is no reason for the physician to take time to do this, when this can be done by the receptionist prior to the visit.

Assuming that the religious affiliation has been recorded and the physician has access to this information, the spiritual assessment consists of three questions:

1. Do you have a religious or spiritual support system to help you in times of need?
2. Do you have any religious beliefs that might influence your medical decisions?
3. Do you have any other spiritual concerns that you would like someone to address?

Depending on the patient's response, the patient should be encouraged to briefly elaborate.

The manner in which these 3 questions are asked is crucial. The physician should verbally and non-verbally demonstrate respect for the patient's religious or spiritual beliefs, regardless of what those beliefs are. This also involves showing respect for the "absence" of such beliefs, so that no unintended message is sent suggesting that the patient should be religious or spiritual. Let's now see how this is done:

Part 3, Section 7

How did this 3-question spiritual assessment come about?

The assessment was developed in response to the need for a brief evaluation that targeted practical information that physicians need to practice whole-person medicine.

First, given the role that religion or spirituality plays in coping with illness, the physician needs to know if the patient **has support** in this area. If not, then the patient may be at greater risk for social isolation or for lack of community monitoring, and so other sources of support should be identified.

Second, given the research that shows patients' **medical decisions** are often based on their religious beliefs, physicians need to know about this. Research also shows that the religious beliefs of physicians affect their medical decisions, such as prescribing medication for pain control, prescribing birth control pills, and referring patients for procedures such as abortion.

Third, given that unmet spiritual needs can adversely affect quality of life and healthcare cost, a question is needed that identifies spiritual needs related to medical illness.

Five [5] questions were initially chosen to make up the spiritual assessment. These were published in JAMA in 2002.⁵ In order to minimize physician time and increase compliance, these questions were edited and shortened from 5 to 3 to arrive at the minimum questions necessary.

⁵ Koenig, H. G. (2002). An 83-year-old woman with chronic illness and strong religious beliefs. Journal of the American Medical Association 288 (4): 487-493

JAMA July 24, 2007.pdf (SECURED) - Adobe Reader
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CLINICAL CROSSROADS

Box. Taking a Spiritual History

Do your religious or spiritual beliefs provide comfort and support or do they cause stress?

How would these beliefs influence your medical decisions if you became really sick?

Do you have any beliefs that might interfere or conflict with your medical care?

Are you a member of a religious or spiritual community and is it supportive?

Do you have any spiritual needs that someone should address?


connect thoughts and emotions in the brain to the circulatory system, coronary arteries, lymph nodes, bone marrow, and spleen.^{49,50} If religious beliefs and prayer help patients cope better with illness and result in less stress, anxiety, and depression and greater social support, then they may counteract stress-related physiological changes that impair healing. Preliminary evidence suggests that religious involvement may be related to stronger immune functioning⁵¹⁻⁵⁴ and lower cortisol levels.^{51,53} Religious involvement is also associated with less substance abuse (98/120 stud-

struggle predict worse mental and physical health outcomes after hospital discharge.⁶² In a prospective study of 595 hospitalized patients, those who believed that God was punishing them, had abandoned them, didn't love them, or didn't have the power to help or felt their church had deserted them experienced 19% to 28% higher mortality during a 2-year period following hospital discharge (relative risk for death ranging from 1.19 [95% CI, 1.05-1.33] to 1.28 [95% CI, 1.07-1.50]). This effect was statistically significant and independent of physical health, mental health, and social support. Such patients may refuse to speak with clergy because they are angry with God and have cut themselves off from this source of support.

Would religious beliefs influence medical decisions if the patient becomes seriously or terminally ill?⁶³ One cross-sectional survey of 177 outpatients attending a university-based pulmonary clinic found that nearly half of patients (45%) indicated that religious beliefs would influence their medical decisions if they became gravely ill. End-of-life decisions are often influenced by religious beliefs, especially do-not-resuscitate or discontinuation-of-treatment decisions.⁶⁴ Patients or families with strong beliefs may not agree to a do-not-resuscitate order or withdrawal of life support because they are praying for a miracle and determined not


Part 3, Section 8



Next, not all patients need a spiritual assessment by the physician. Only certain types of patients need it, such as:



Who Needs a Spiritual Assessment

- (1) Patients with serious, life-threatening conditions
- (2) Patients with chronic, disabling medical illness
- (3) Patients with depression or significant anxiety
- (4) Patients newly admitted to the hospital or a nursing home
- (5) Patients seen for a well-patient exam, when more time to deal with social issues



Who does NOT need a spiritual assessment?

Who does NOT need a Spiritual Assessment

- (1) Patients seen for an acute problem without long-term complications
- (2) Patients seen for follow-up of a time-limited problem without significant disability or challenges to coping
- (3) Children, teenagers or young adults without chronic illness, life-threatening or disabling medical conditions
- (4) Patients who are not religious or spiritual, and have indicated this area is not relevant to them

Part 3, Section 9

What, then, does the physician do with the information gathered during a spiritual assessment? The physician should first document the patient’s responses in the EMR, along with any comments. If spiritual needs are identified, a member of the “spiritual care team” should be alerted so that arrangements can be made to address those needs. Finally, there must be some kind of follow-up later on to ensure that spiritual needs have been adequately addressed. Although the spiritual care team may assist in this regard, it is the physician who must ensure that such follow-up occurs.

Social History - Lifestyle

Sleep Patterns: Changes in sleep patterns: No Yes

Lifestyle:

Activity level: Sedentary Moderate Vigorous

Health club member: Now Previously Never

Type of exercise: _____ Hours/week: _____

Exercise frequency: Occasional Regular _____ Hours/week: _____

Hobbies/activities: _____ Hours/week: _____

Diet history: No follow lipids _____

Animals in the home: No Yes

Religious/Spiritual:

Do you have a religious affiliation? No Yes Religion: _____

Do you practice your religion? No Yes

Do you have spiritual beliefs? No Yes

Is religion/spirituality an important part of your life? No Yes

Do you use tobacco or alcohol products? No Yes

Home Environment/Safety:

Smoke detectors in home? No Yes

Carbon monoxide detectors in home? No Yes

Is the patient at risk for falls? No Yes

Falls in the last year? No Yes

Did the falls result in injury? No Yes

Radon in the home? No Yes

Firearms at home? No Yes

Recent Travel:

Out of state

Out of country

Travel exposure

Spirituality Assessment Project

Comments

1. Do you have a faith-based support system to help you in times of need?
 Yes No

2. Do you have any religious beliefs that might influence your medical decisions?

3. Do you have any other spiritual concerns that you would like someone to address?

Mimic for all three questions- carry forward items

Add to note

Part 3, Section 10

So, you may be thinking, “What is the ‘least amount’ that I can do as a physician and still address this area competently?” The minimum involvement is the following:

1. Conduct the 3-question spiritual assessment in patients with challenging illnesses that require coping, as I described earlier
2. Document patients’ responses in the EMR
3. Alert the spiritual care team if spiritual needs are identified, and...
4. Follow-up to ensure that spiritual needs are met (as I said earlier, the spiritual care team can help with this, but the physician must ensure it happens)

The spiritual assessment is NOT a one-time event. Whenever there is a significant change in the patient’s condition, the physician will want to check whether any new spiritual needs have arisen that the patient needs help with.

Part 3, Section 11

What else might physicians do? You may find that doing the spiritual assessment is quite rewarding, and may wish to do more. Beyond the minimum requirement, what are some other activities? Here are a few:

1. **Listen.** Listen to and try to understand the patient’s spiritual concerns. This involves taking the time to sit with the patient and just let them talk – not advise or try to find solutions.



2. **Support.** Support the patient’s religious or spiritual beliefs, even if beliefs appear to conflict with the medical care plan. Such support will always pay off in the end. The payoff is a better doctor-patient relationship and better compliance.



3. **Pray** for or with the patient. Praying for the patient during the *physician’s own time* requires no consent. However, praying “with” the patient does require consent, and should not be done unless the patient initiates the request for prayer. If the patient requests and if the MD feels comfortable with it, the physician should then ask what the patient wants prayer for. With that information, it is now appropriate for either the physician or the patient to say a brief 30 second prayer that is comforting and addresses whatever the patient wishes.



4. **Accommodate.** In acute hospital or other inpatient settings, accommodate the environment to meet that patient’s spiritual needs. This may involve providing a “prayer rug” to a Muslim patient or arranging for a priest to deliver “Holy Communion” to a Catholic patient.



5. Finally, provide “**spiritual care**” to the patient. What exactly does that mean?

Part 3, Section 12

Up until now I’ve been talking about spiritual assessment and the addressing of spiritual needs of patients. However, I have not yet addressed the issue of “Spiritual Care.” Here goes.

Although assessing and addressing spiritual needs is part of it, Spiritual Care goes far beyond that (and takes no extra time). The way that **ordinary health care** is provided by the physician can be “spiritual.” By that, I mean recognizing the Sacred nature of the person being cared for and the Holy obligation and privilege that physicians have.

More specifically, this means...

- (1) Providing care with respect for the individual patient, a person with a unique life story
- (2) Inquiring about how the patient wishes to be cared for, rather than providing the same care in the same way to everyone
- (3) Providing care in a kind and gentle manner, even to difficult patients
- (4) Providing care in a “competent” manner (we know that kindness can kill just as easily as it can comfort), and finally...

(5) Taking extra time with patients who really need it

Spiritual Care is the heart of what whole-person care is really about, and has the potential to bring “life” back into the patient and into the practice of medicine. However, it is not easy to do. Indeed, there are many barriers that prevent the delivery of Spiritual Care.

Part 3, Section 13

Research indicates that only about 10% of physicians conduct a spiritual assessment. Why is this so?⁶



The following are 10 barriers that stand in the way of spiritual care. These barriers are based on research by the Harvard oncology group at the Dana Farber Institute⁷.

The screenshot shows the top portion of a ScienceDirect article page. At the top, there are navigation options: 'Download PDF', 'Export', 'More options...', a search bar with 'Search ScienceDirect', and 'Advanced search'. Below this is the journal information: 'Journal of Pain and Symptom Management', 'Volume 48, Issue 3, September 2014, Pages 400-410'. The article title is 'Nurse and Physician Barriers to Spiritual Care Provision at the End of Life'. The authors listed are Michael J. Balboni, Adam Sullivan, Andrea C. Enzinger, Zachary D. Epstein-Peterson, Yolanda D. Tseng, Christine Mitchell, Joshua Niska, Angelika Zollfrank, Tyler J. VanderWeele, and Tracy A. Balboni. The DOI is 10.1016/j.jpainsymman.2013.09.020. The abstract begins with 'Spiritual care (SC) from medical practitioners is infrequent at the end of life (EOL) despite national standards.'

⁶ Curlin et al. (2006). The association of physicians' religious characteristics with their attitudes and self-reported behaviors regarding religion and spirituality in the clinical encounter. Medical Care 44(5), 446-453

⁷ Balboni et al. (2014). Nurse and physician barriers to spiritual care provision at the end of life. Journal of Pain & Symptom Management 48(3):400-10

They asked oncologists and oncology nurses why they did not routinely assess and address the spiritual needs of patients. Here is how they responded. After each barrier, I will suggest how to overcome it:

(1) Lack of Time. A spiritual assessment is just one more thing that physicians are now being asked to do. We barely have enough time to do our required duties and document the results. Asking such questions might open up Pandora's box. There is great temptation, then, to eliminate this "optional" activity.



Response: Doing a brief spiritual assessment should be a priority. It is not optional, but central to providing "whole-person" medical care. The Spiritual Assessment can often save time in the long run, improve the doctor-patient relationship, and make the practice of medicine more rewarding.

(2) Discomfort. Many physicians are not comfortable addressing this topic, particularly if the physician is not religious him or herself. Few physicians are trained on how to address this topic in a sensible and timely manner. They don't know what to do if spiritual needs are identified.



Response: Comfort comes with training and practice. You are getting the training now, and it's up to you to practice what you learn here. Physicians have a spiritual care team to support them in doing this.

(3) Fear of making patient uncomfortable or not knowing what to say if the patient asks: “Why are you asking these questions?”



Response: Research has shown that most patients are not offended or made uncomfortable when the physician performs a SA, and in fact, the majority of patients are often quite pleased. If a patient asks why these questions are being asked, an appropriate response would be: “We are doing this routinely as a show of respect for the beliefs and values of our patients, which may influence their medical care.”

(4) Spirituality is not important to the physician, and is afraid that the patient will ask about his or her own beliefs.

Response: First, patients seldom ask physicians about their personal beliefs. If they do ask, then a brief or general response usually satisfies the patient. The reason why most patients ask is that they are worried how the physician will treat their beliefs. Reassuring the patient that their beliefs will always be respected and honored usually allays this concern. Regardless, I wouldn't give a response like the one that is illustrated here:

NO, I'M
NOT RELIGIOUS.
AND I FIND IT DEEPLY INSULTING
THAT YOU WOULD PRESUME
THAT SOMEONE AS SMART AS
ME SHARES YOUR NARROW,
DELUSIONAL WORLD VIEW.
©S. J. T. 2005

(5) The topic is too personal or there is no private space to discuss it.



Response: Physicians deal with sensitive areas related to health more personal than asking about religious beliefs. Sensitive areas include sexual behaviors or personal health habits such as smoking, drinking, diet, and weight control. Fear that these areas are too personal does not prevent the physician from thoroughly assessing them.

(6) The belief that spiritual assessment is done better by others.



Response: The physician is the leader of the healthcare team and needs to know about factors that could affect the patient's health and their compliance with the medical care plan.

(7) The belief that patients don't want the physician to address these issues.



Response: Patient surveys suggest otherwise. Those surveys indicate that only a minority of patients show resistance to such inquiry, and wish to keep medicine and religion separate.

(8) Concern about power inequality [PP33] between patient and physician that might lead to coercion.



Response: Realize that coercion in this area is a violation of civil rights, and so is never appropriate. I will discuss this boundary further in the next section.

(9) Religious beliefs of the physician differ from those of the patient.



Response: Realize that in this era of patient-centered medicine, the focus should always be on respecting and supporting the spiritual beliefs of the patient, whether or not the physician agrees with those beliefs.

(10) Spiritual care is not part of the physician's role



Response: Realize that providing whole-person care IS part of the physician's role and whole-person care includes addressing this area.

Part 3, Section 14

To provide whole-person care, however, **the physician has to be a whole person.** Physicians have needs too – physical, emotional, social, and spiritual. Let me review these briefly.

(1) **Physical needs.** These include the need for regular exercise, a healthy diet, controlling weight, regular medical check-ups, limitation of alcohol use, and time for rest and relaxation.



(2) **Emotional needs.** These involve the ability to comfortably handle the anxiety and stress that go along with providing healthcare in a high pressure environment. In particular, physicians need to be able to cope with the loss of patients and the inability to cure a patient's disease. They need to be able to empathize with patients and not be afraid of caring for them. And, they need to see purpose and meaning in the work that they do.



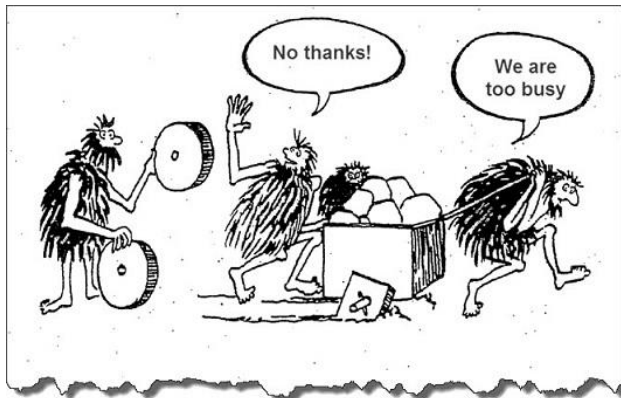
(3) **Social needs.** These include spending time with spouse and children, time with friends and colleagues outside of work, and time spent in supportive interactions with colleagues during work.



And finally...

(4) **Spiritual needs.** I will talk about those in a minute.

When the physical, emotional, social and spiritual needs of physicians are **not met**, the ability to provide whole-person compassionate care will suffer, and they will forget what is really important in the work that they do. This is perhaps the #1 reason why many physicians are not assessing and addressing the spiritual needs of patients.



Part 3, Section 15

Many of the barriers to spiritual care described earlier can be overcome through training and practice. It's the practice part that will make physicians comfortable and fluent. Remember also that the physician is NOT ALONE.

Although spiritual assessment is the physician's job and cannot be deferred to others, he or she has a "**spiritual care team**" to help address spiritual issues that come up during the assessment. The people who make up this team are the spiritual care coordinator, nurse, chaplain or pastoral counselor, social worker, and other office or hospital staff. I will now talk a bit more about the spiritual care team.



The physician has very little time, and may have limited emotional and spiritual reserves. Therefore, other team members need to take up the slack by providing practical assistance and

support. Each member of the spiritual care team has a specific role to play in helping the physician provide whole-person spiritual care to patients.

What are the roles of each team member?

(1) **The physician.** This is the person who conducts the spiritual assessment, documents the results, and is ultimately responsible for ensuring that spiritual needs are met.



(2) **The “spiritual care coordinator.”** This person, a nurse or clinic manager, obtains information from the spiritual assessment; coordinates the addressing of spiritual needs; prepares the patient for pastoral care referral; and, along with the chaplain, provides spiritual support to other team members.



(3) **The “chaplain”** or pastoral counselor. This person addresses the spiritual needs of the patient; provides feedback to the spiritual care team; provides spiritual support to other team members; works with the social worker (if available) to develop a spiritual care plan; and follows up to ensure that spiritual needs are fully addressed.



(4) **The “social worker.”** In hospital settings, this is the person who works with the chaplain to develop a spiritual care plan for implementation after hospital discharge, and helps with follow-up to ensure that spiritual needs are met.



(5) **The “receptionist”** or other clinic or hospital staff. This person ensures that the patient’s religious affiliation is recorded in the EMR.

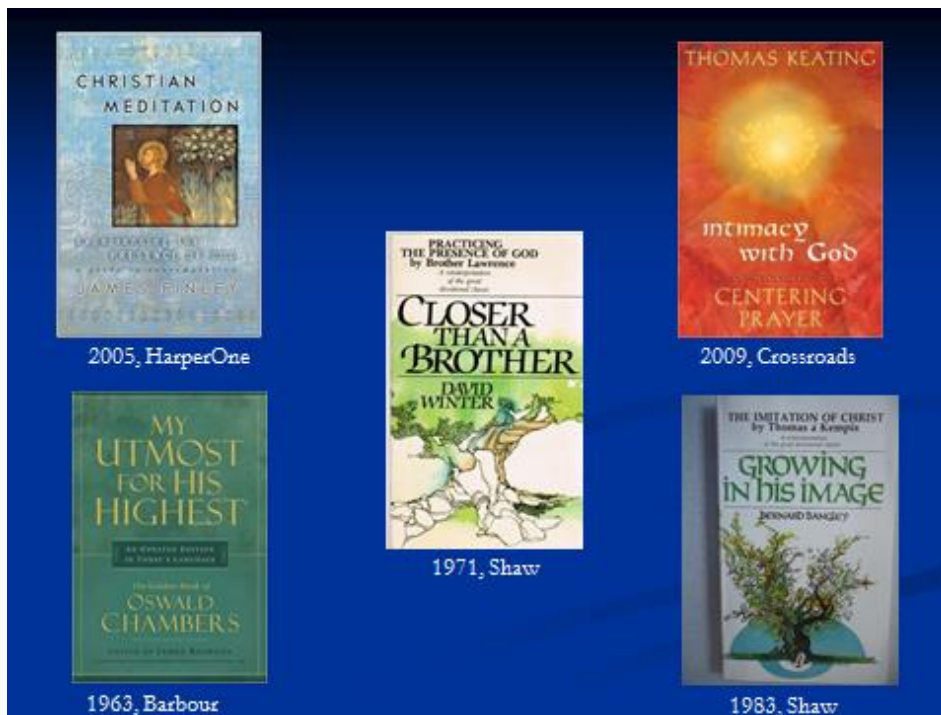


Part 3, Section 16

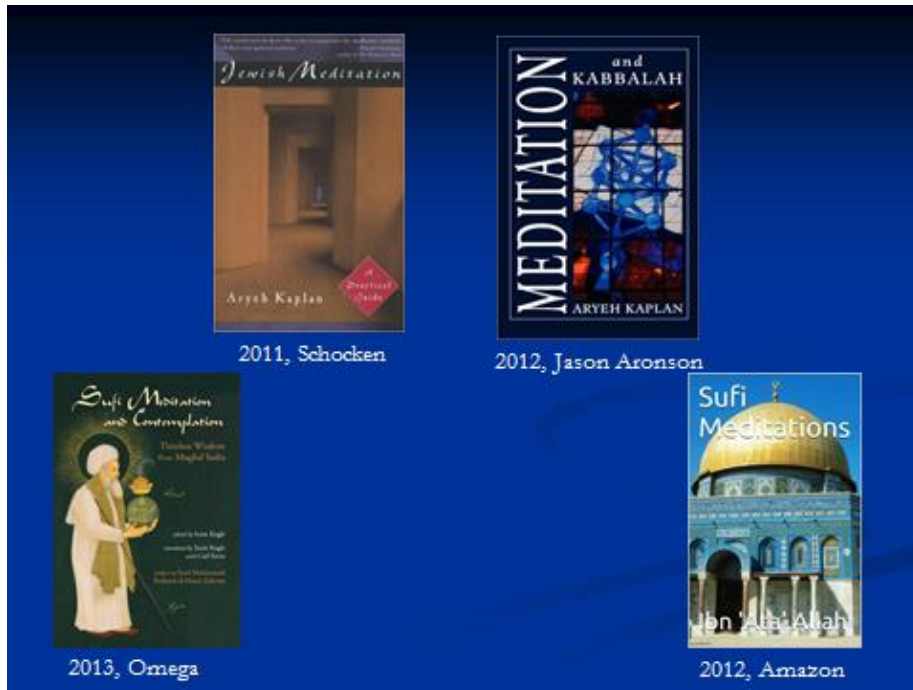
The success of the spiritual care team depends on the availability and use of *Spiritual Resources*. Physicians may choose to develop their own spiritual resources through a variety of activities. These include quiet time spent in prayer or meditation, reading scripture or other inspirational literature, or participating in a faith community.

For example, meditation, prayer, or “practicing the presence of God” may help the physician to achieve a relaxed, open state that fosters compassion, increases energy, and enables him or her to provide whole-person care to patients. Several forms of meditation exist, although the form a physician chooses will depend on their faith tradition. For Buddhist physicians, mindfulness meditation may be chosen. For Hindu physicians, there is transcendental meditation, which is often combined with Yoga.

There are also many forms of meditation for Christian, Jewish, and Muslim physicians. For Christian physicians, there’s a book by James Finley, a former Trappist monk and student of Thomas Merton, called “Christian Meditation: Experiencing the Presence of God.” There is also a form of meditation called “Centering Prayer” that was developed by Fr. Thomas Keating and has become quite popular these days. There are also a variety of inspirational books that can be used to develop the Christian physician’s spiritual life. These include “The Imitation of Christ” by Thomas a Kempis, “My Utmost for His Highest” by World War I chaplain Oswald Chambers, and “Closer than a Brother” by Brother Lawrence, a 16th century monk. Modern, easy to read editions of each of these books are displayed here.



Several forms of meditation for Jewish physicians are also available. These are described in two books by Aryeh Kaplan titled “Jewish Meditation: A Practical Guide” and “Meditation and Kabbalah.” Rae Shagalov has also written a book called “The Secret Art of Talking to God.” These books and their publishers are displayed here.



There are also many forms of Muslim meditation. A ritualistic prayer called Salat can be considered a meditation. Any short phrases or prayers recited silently or aloud while counting on a string of beads or knotted cord can be consider meditation because the focus is on God. For example, meditation could involve reciting and thinking about the meaning of the saying, SUB-HAN-ALLAH or “glorious is God.” Islamic meditations are also described in the book “Sufi Meditations” by Ibn ‘Ata’ Allah and in “Sufi Meditation and Contemplation” by Scott Kugle. These books and their publishers are displayed here.

Part 3, Section 17

It’s now time to describe the boundaries that physicians should seldom cross. Problems occur when the physician does more than is sensible or ethically justifiable in this area. Here are five “don’ts”, most of which are pretty obvious:



- (1) Don't prescribe religion to non-religious patients. The physician may think, "If religion is good for health, maybe non-believers should be encouraged to become religious." Not a good idea.
- (2) Don't force a spiritual assessment if the patient is not religious. In that case, quickly switch to ask about what gives life meaning and purpose in the context of illness and how this can be supported.
- (3) Don't pray with a patient before doing a spiritual assessment and unless the patient asks, or be ready for a lawsuit. While more than two-thirds to three-quarters of patients would like to pray with their physician and deeply appreciate the offer, others do not.
- (4) Don't spiritually counsel patients. Instead, always refer to trained professional chaplains or pastoral counselors. The only exceptions might be if the physician has pastoral care training, or if addressing spiritual issues is urgent and the patient refuses pastoral care or pastoral care is not available.
- (5) Don't do any activity that is not patient-centered and patient-directed. Remember, it's about the patient – not the physician. Addressing spiritual issues is like a ballroom dance. The patient leads and the physician tries not to step on his or her toes.

Part 3, Section 18

In Conclusion, then:

- (1) There are many reasons why physicians should identify and address spiritual needs related to medical illness
- (2) Research, common sense, and good clinical practice justify taking the time to do so
- (3) The physician is responsible for doing the spiritual assessment
- (4) The physician may choose to integrate spirituality into patient care in other ways as well
- (5) The physician is responsible, but not alone, and is backed up by a Spiritual Care Team, and...
- (6) There are spiritual resources available to support the physician and the spiritual care team

For more information on how to assess and address the spiritual needs of patients, I suggest *Spirituality in Patient Care*, 3rd edition. There is also a lot of information available on our website at <http://www.spiritualityandhealth.duke.edu/>.

