

CME 4 Health Professionals on Practice Staff (nurses, etc.)

by Harold G. Koenig, RN, MD

Part 4, Section 1

Welcome to Part 4 in this educational series on Integrating Spirituality into Patient Care. This video focuses on health professionals (HPs) who work with physicians, especially nurses, practice managers, and the person we call the “spiritual care coordinator.” I begin this section by briefly summarizing four key points that we covered in Parts 1 through 3 of this series:

- (1) First, what does “integrating spirituality into patient care” mean;
- (2) Second, how do we define the terms spirituality and religion;
- (3) Third, what we are expecting of physicians and why; and...
- (4) Finally, what is the **research base** that justifies taking the time to do this

Although viewers who have watched Parts 1, 2 and 3 may find some of this introductory material repetitive, the points being made are essential for understanding why HPs should take time to assess and address patients’ spiritual needs.

After this introduction, I will move into the heart of Part 4 – which focuses on the **spiritual care team**, the **spiritual care coordinator** as the “coach” of the team, the **meaning** of “spiritual care,” **barriers** to providing spiritual care, the “**whole-person**” **needs** of spiritual care team members, and **boundaries** that should not be crossed.

Part 4, Section 2

So, what does “Integrating Spirituality into Patient Care” mean for the healthcare team? Stripped down to the basics, integrating spirituality involves four activities:

- (1) First, the physician conducts a brief “**spiritual assessment**” to identify spiritual needs related to medical care
- (2) Second, the “**spiritual care coordinator**” arranges for other “**spiritual care team**” members to address the spiritual needs identified by the physician
- (3) Third, efforts are made to **create an atmosphere** where the patient feels comfortable talking about spiritual needs with the physician and other team members, and finally...
- (4) “**Spiritual Care**” is provided to all patients as part of whole-person medicine

Part 4, Section 3

I’ve mentioned the word spirituality and spiritual several times now. What do we mean by the term “spirituality”, how does it relate to “religion,” and how are these terms used when providing whole-person medical care to patients?

First, let's examine the term "religion." Most of the research that I reviewed in Part 2 of this series, and that I'll be reviewing briefly here, has examined relationships between "religious involvement" and health. **Religion** involves beliefs and practices related to the Transcendent, often called God in Western traditions. Religion usually has rules to guide behavior during life here on earth and doctrines about life after death. Religion is often organized as a community, but can also 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, or listening to religious programs or music on the radio. When it comes to doing research, religion is relatively easy to measure and quantify, and it is religious involvement that seems to be related to 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 terms "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 are allowed to define for themselves. Health professionals should communicate with patients using the patient's definition of spirituality -- whatever that is. 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.

Part 4, Section 4

Next, what are we asking physicians to do? This is important for other team members to know about, since a major task of the spiritual care team is to support the work of the physician:

We are asking physicians to do the following:

- (1) First, conduct a brief "spiritual assessment" in order to identify spiritual needs;
- (2) Second, arrange for someone to address those needs;
- (3) Third, follow up to ensure that spiritual needs are met; and
- (4) Finally, **be willing** to discuss this subject with patients, while appreciating the health benefits of doing so.

Part 4, Section 5

What exactly do I mean by the "spiritual assessment"? The spiritual assessment involves asking a few simple questions to identify spiritual needs related to medical illness.

The purpose of the SA is to (1) make the 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 affect compliance with medical treatments, (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.

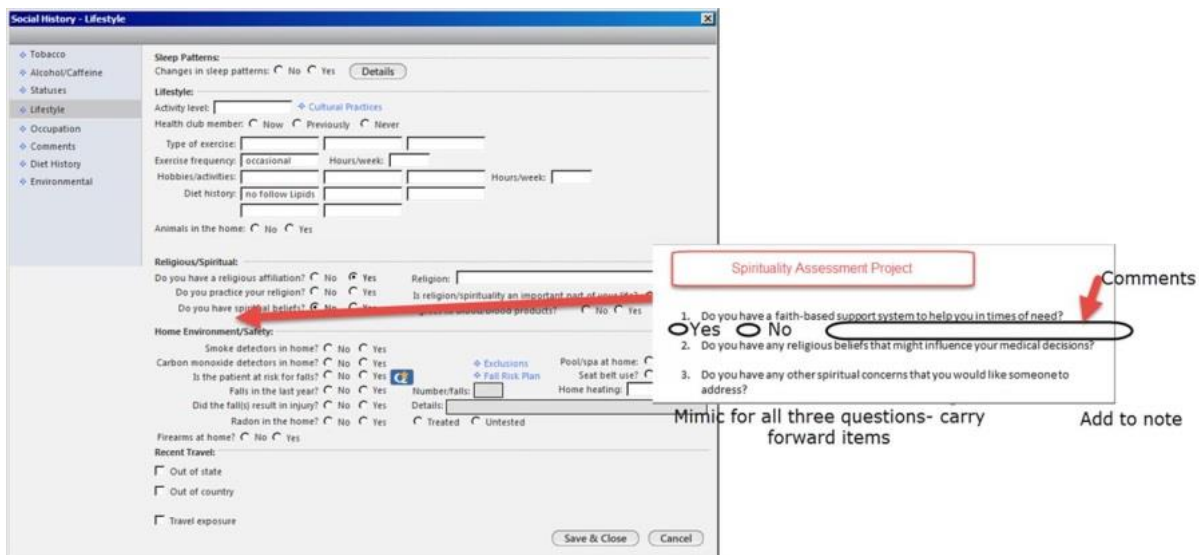
Assuming that *the receptionist* has recorded the patient’s **religious affiliation** in the EMR, and the physician has access to this information, the physician’s spiritual assessment consists of the following three questions:

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?

The physician will then document the patient’s responses **in the EMR**. If spiritual needs are identified, the physician will alert the Spiritual Care Coordinator so that arrangements can be made to address those needs. Finally, there should be follow-up down the road to determine if spiritual needs have been adequately addressed. The Spiritual Care Team will assist in this regard, although the physician is responsible for ensuring that such follow-up occurs. These actions are the minimum requirement that we are requesting of physicians.

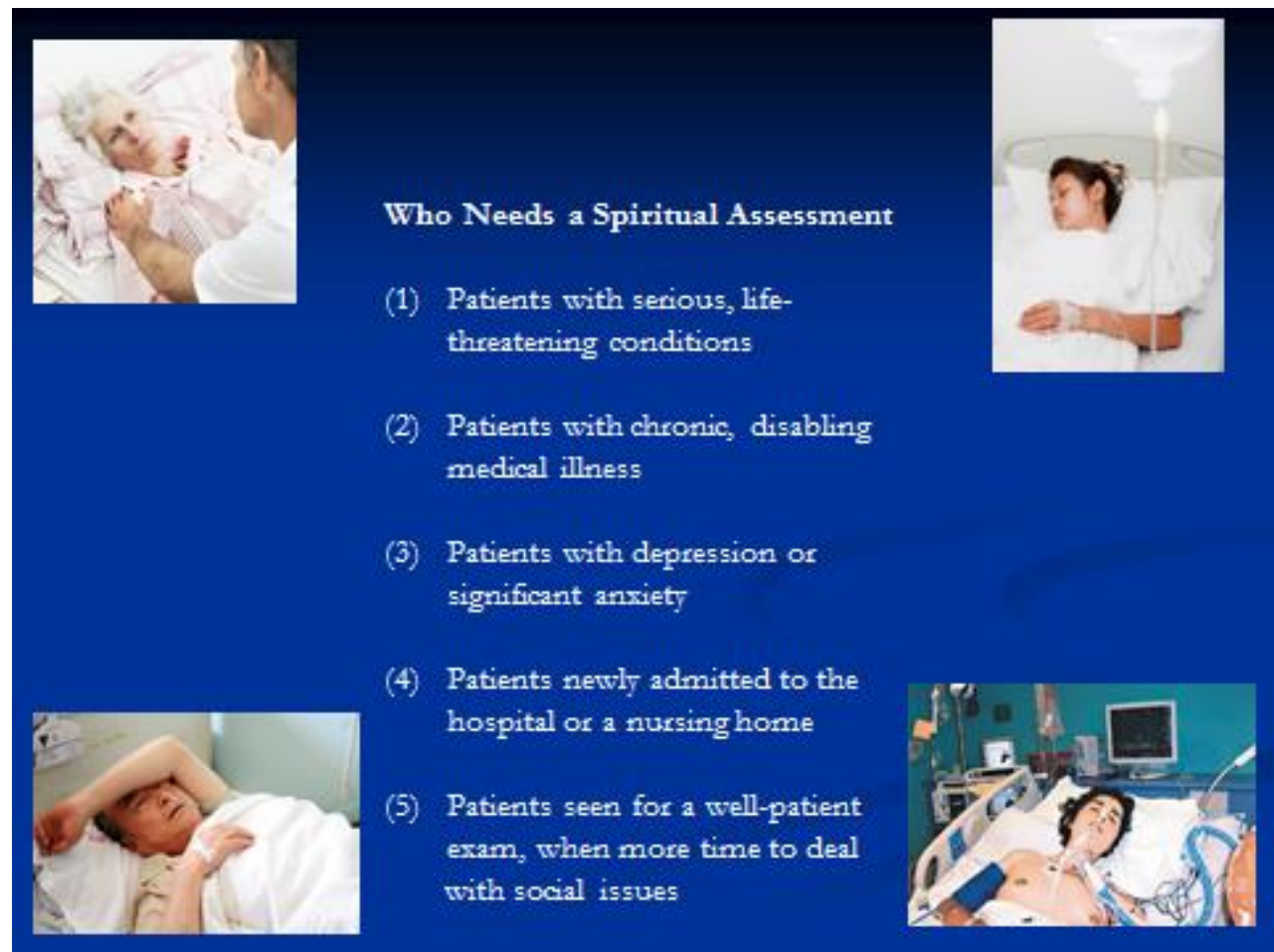


The spiritual assessment is NOT a one-time event. Whenever there is a significant change in the patient's condition, the physician will want to check whether any new spiritual needs have arisen that the patient needs help with.

Part 4, Section 6

WHO does the spiritual assessment (SA) apply to? In other words, what types of patients need a SA by the physician? There are five categories of patients who need a SA:

- (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 to a nursing home; and
- (5) Patients being seen for a well-patient exam, when time is available to address social issues





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

The slide features four photographs: top-left shows an elderly patient being held by a caregiver; top-right shows a woman in a hospital bed; bottom-left shows a patient lying in bed with their hand on their forehead; bottom-right shows a patient in a hospital bed with medical equipment.



In contrast, who does NOT typically need a SA? [PP10]

- (1) Patients seen for an acute problem without long-term implications, such as an upper respiratory infection, minor surgical procedure, routine pelvic exam, or some other specific, well-defined condition;
- (2) Patients seen for follow-up of a time-limited problem where there is no significant disability or challenges to coping;
- (3) Children, teenagers or young adults without chronic illness, life-threatening conditions, or disabling serious medical problems; and
- (4) Patients who are not religious or spiritual, who have indicated this area is not relevant to them



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 4, Section 7

Why should physicians do a spiritual assessment and why should other team members address the spiritual needs uncovered? Here are 7 reasons:

- (1) First, many patients have spiritual needs related to illness, *and* addressing those needs affects satisfaction with care, quality of life, and interestingly, may also reduce healthcare costs
- (2) Second, religious beliefs influence coping with illness and may affect the patient’s emotional state and motivation towards recovery
- (3) Third, religious beliefs affect important health-related behaviors and likely influence medical outcomes
- (4) Fourth, religious beliefs influence medical decisions made by *both* the patient *and* the physician
- (5) The “standards of care” established by JCAHO require that providers respect patients’ cultural and spiritual beliefs ((RI.01.01.01 EP 6; RI.01.01.01 EP 9; PC.01.02.01 EP 4; PC.01.02.11 EP 5; PC 01.02.13 EP3),¹ and assessment is the only way to know what those beliefs are
- (6) Sixth, support from a religious community may increase patient monitoring and improve compliance with treatment, and...
- (7) Finally, addressing spiritual issues may benefit the health professional, as well, by providing intrinsic rewards that are associated with delivering “whole person” healthcare.

There is also **scientific rationale** for assessing and addressing patients’ spiritual needs. I will quickly review some of that research here. However, for a more detailed examination of these studies, viewers are encouraged to watch Part 2 in this educational series. I begin with mental health, and then move on to social health, health behaviors, and physical health. This summary is based on a systematic review of the literature published in the *Handbook of Religion and Health*.²

Part 4, Section 8

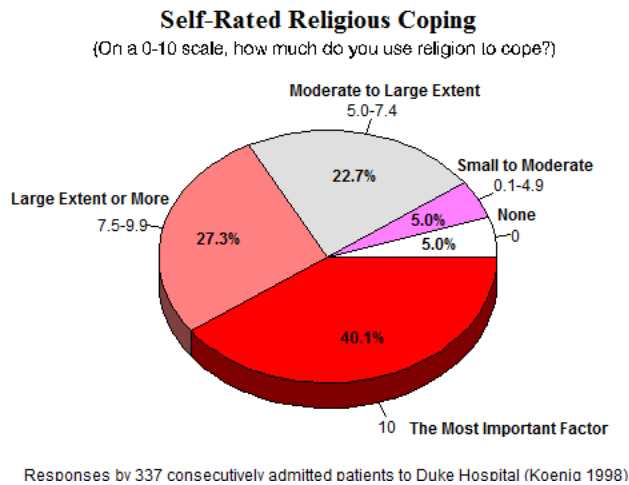
In some areas of the U.S. and elsewhere in the world, up to 90% of medical patients **use religion to cope**.³ Research indicates that the overwhelming majority of these patients report that religion helps them. Religious beliefs are commonly used to endure the distress caused by health problems. Religious beliefs give **meaning** to illness, promote **hope** for recovery, and provide

¹ Information contained here on the standards are based on a series of communications between Dr. Koenig and JCAHO staff, particularly Doreen Finn (DFinn@jointcommission.org), Senior Associate Director, who works under Mark Pelletier (MPelletier@jointcommission.org), Executive Director, JCAHO, Hospital Accreditation (January 6-12, 2012)

² Koenig HG, King DE, Carson VB (2012). *Handbook of Religion and Health*, 2nd edition. NY, NY: Oxford University Press

³ Koenig HG (1998). Religious beliefs and practices of hospitalized medically ill older adults. International Journal of Geriatric Psychiatry 13: 213–224

behaviors that make the individual feel **more in control** (such as prayer). Beliefs of this kind have been repeatedly linked with better mental health in medical patients.



How, though, is religion related to *health more generally*?

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
- because they convey greater meaning, purpose and hope, religious beliefs and activities are related to less suicide, fewer suicide attempts, and more negative attitudes toward suicide in 75% of 141 studies

Religious involvement is also related to...

- less alcohol and drug use/abuse in over 85% of nearly 300 studies, and..
- greater social support, greater marital stability, & more prosocial behaviors 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 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...
- less likely to smoke cigarettes in 90% of 137 studies

Unfortunately, the more religious had lower weight in only 20% of studies...oops... and were heavier than non-religious persons in 40% of studies. Yes, those potluck suppers!

Despite being heavier on average, 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 a 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 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.¹ 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.^{2,3}

Part 4, Section 9

In **conclusion**, based on this review of the research:

- (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;
- (4) Spiritual needs are widespread in medical settings, especially in those 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.

¹ 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

² 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

³ Huguelet et al. (2011). A randomized trial of spiritual assessment of outpatients with schizophrenia: patients' and clinicians' experience. Psychiatric Services 62(1):79-86

(6) Much research is now being done to: better understand relationships between religion and health; determine the underlying biological mechanisms involved; AND develop new interventions that harness these effects.

(7) Given the results of this research, there is **every reason** for health professionals to assess and address the spiritual needs of patients.

Part 4, Section 10

Now, I'd like to talk about the **Spiritual Care Team**.



Physicians have very little time, and may have limited emotional and spiritual reserves. Therefore, they need assistance and support in providing “whole-person” medical care. Each member of the spiritual care team has a specific role to play.

First, who makes up the Spiritual Care Team?

- (1) The physician
- (2) The spiritual care coordinator (nurse or clinic manager)
- (3) The chaplain or pastoral counselor
- (4) The social worker
- (5) The receptionist

What are the roles of each member of the spiritual care team?

(1) **The physician** conducts the spiritual assessment, documents the results, and ensures that spiritual needs are met by someone.



(2) **The spiritual care coordinator** basically coordinates everything. I will be describing the duties and training of the SCC in a moment.



(3) **The chaplain** or pastoral counselor 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 patients' spiritual needs are met.



(4) In hospital settings, **the social worker** 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) is to ensure that the patient’s religious affiliation is recorded in the EMR and available to the physician.



Part 4, Section 11

Now, I’d like to focus on the Spiritual Care Coordinator. The SCC is often a nurse or a clinic manager. The SCC could be considered the “coach” of the team.



The DUTIES of the SCC are to:

(1) Review the results of the physician’s spiritual assessment, and prioritize the spiritual needs that require addressing. The SCC does not conduct the assessment. I want to be very clear on that. The assessment cannot be deferred to the SCC, since the physician needs to collect this information first hand.

(2) Next, the SCC manages each step to ensure that the patients' spiritual needs are addressed, providing resources as needed (for example, information on local faith communities, spiritual reading materials, information on pastoral care services, and so forth).

(3) If a chaplain or pastoral care referral is necessary, the SCC **prepares the patient** to see the chaplain, i.e., explains the reasons for the referral, describes the training that a chaplain has, and discusses what the chaplain will do.

(4) The SCC also prepares the chaplain (or pastoral counselor) for the referral, informing him or her about the spiritual needs identified and why the physician or SCC is referring the patient.

(5) After the chaplain referral is completed, the SCC **follows up** to obtain feedback from chaplain on the results of the evaluation and information about spiritual care plan, and then communicates this to the physician.

(6) The SCC then helps the chaplain follow-up with patient to ensure that spiritual needs identified during the physician's assessment were adequately addressed by the spiritual care plan.

(7) Finally, together with the chaplain, the SCC provides spiritual support to the physician and other members of the spiritual care team, helping them to provide whole-person Spiritual Care to all patients.

Part 4, Section 12

Up until now we've been talking about spiritual assessment and addressing spiritual needs. However, I haven't explained exactly what I mean by "Spiritual Care." It's time to do that, especially since a major task of the SCC is to ensure that all patients receive this.

Although assessing and addressing the spiritual needs of patients is an important part of it, Spiritual Care goes far beyond that. The way that *ordinary health care* is provided by the physician and other members of the healthcare team can be "spiritual." By that, I mean recognizing the Sacred nature of the person being cared for and the Holy obligation and privilege that health professionals 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;

(4) Providing care in a “competent” manner – we know that kindness can kill just as easily as it can comfort; and...

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

Spiritual Care is the heart of what whole-person healthcare is all about, and has the potential to bring “life” back into the patient and into the practice of healthcare. However, it is not easy to do, and there are many challenges to providing Spiritual Care.

Part 4, Section 13

Research indicates that only about 10% of physicians conduct a spiritual assessment.¹ Why is this so?



The following are at least 10 barriers that stand in the way of spiritual assessment and spiritual care. These barriers are based on research by the Harvard oncology group at the Dana Farber Institute.²

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Original Article

Nurse and Physician Barriers to Spiritual Care Provision at the End of Life

Michael J. Balboni, PhD^{1,2,3,4,5,6}, Adam Sullivan, MS¹, Andrea C. Enzinger, MD^{2,6,7}, Zachary D. Epstein-Peterson, BA¹, Yolanda D. Tseng, MD¹, Christine Mitchell, MDiv¹, Joshua Niska, BA¹, Angelika Zollfrank, MDiv, BCC¹, Tyler J. VanderWeele, PhD¹, Tracy A. Balboni, MD, MPH^{1,2,3,4,5,6,7}

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Abstract

Context

Spiritual care (SC) from medical practitioners is infrequent at the end of life (EOL) despite national standards.

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¹ 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

² 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 physicians and nurses responded. After each barrier, I will suggest how to overcome it:

(1) Lack of Time. Spiritual Care is just one more thing that health professionals are now being asked to do. They barely have enough time to perform required duties and document the results. Many are concerned about opening Pandora's box and not having adequate time to address the issues uncovered. There is temptation, then, to eliminate this "optional" activity (or defer it to others).



Response: Doing a brief spiritual assessment must be a priority for the Physician. It is not optional, but central to providing "whole-person" medical care. The SA can actually save time, improve the relationship with the patient, improve compliance, and make the physician's work more rewarding. The physician cannot defer the SA to anyone else. The spiritual care team, though, must "take the ball" from the physician and **take the time** to run across the field with it and cross the goal line (i.e., fully address the patient's spiritual needs).

(2) Discomfort. Many health professionals are not comfortable addressing this topic, particularly if he or she is not religious or particularly spiritual. Few HPs have training on how to assess or address the spiritual needs of patients in a sensible and timely manner, or 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.

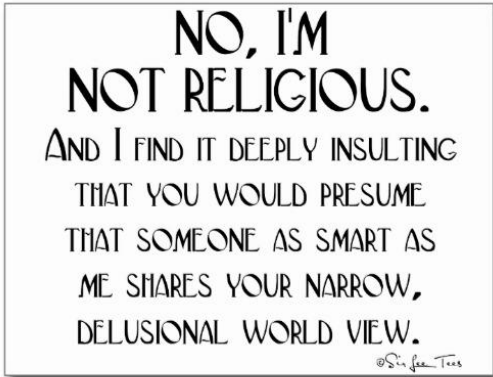
(3) Fear of making the patient uncomfortable or not knowing how to respond if the patient says: "Why are you asking these questions?"



Response: Research shows that most patients are not offended or made uncomfortable when the physician performs a SA, and in fact, the majority of patients are thrilled with this. 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 patients, which may influence their medical care."

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

Response: First, patients seldom ask HPs 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 about how the HP 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 the response in this slide.



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



Response: HPs deal with other sensitive areas related to health much more personal than asking about religious beliefs. Sensitive areas include sexual behavior or personal health habits such as smoking, drinking, diet, or weight control. Fear that these areas are too personal does not prevent HPs 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 to the medical care plan.

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



Response: As I noted before, patient surveys suggest otherwise. Those surveys indicate that only a minority of patients show resistance to such inquiry, or wish to keep medicine and religion separate (i.e., about 25%). One large study even found that when patients who did not want a visit from a chaplain and actually got one, they reported more satisfaction with their overall healthcare than did non-visited patients.

(8) Concern about the power inequality between patient and HP 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) Discomfort because religious beliefs of the HP 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 HP agrees with those beliefs.

(10) Finally, spiritual care is not part of the HP's role



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

All of these barriers can be overcome through training and practice. It's the practice part that will make HP comfortable and fluent in spiritual care.

Part 4, Section 14

However, there is one major barrier that we have not yet discussed. **In order to provide whole-person care, the HP needs to be a whole person.** Little attention has been paid to the whole-person needs of HPs, so we focus on those now. HPs have physical, emotional, social, and spiritual needs that must be met for them to fully function as a whole person in a clinical setting. Let us now briefly review those needs here.

(1) **Physical needs.** These include the need for regular exercise, eating 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 associated with providing healthcare in a high pressure environment. HPs need to be able to cope with the loss of patients and the inability to cure a patient's illness. They need to be able to empathize with patients and not be afraid of caring for them. They need to see the purpose and meaning in the work they do.

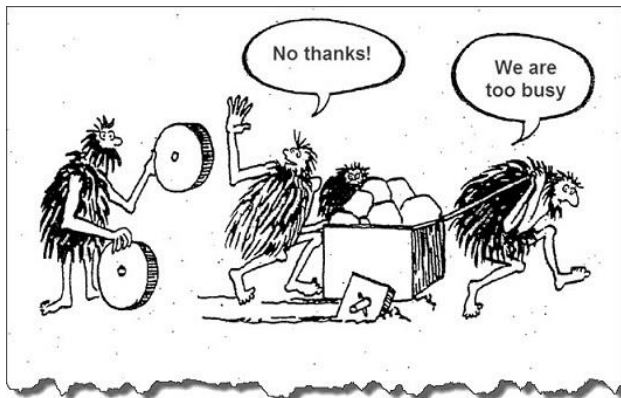


(3) **Social needs.** These include spending time with spouse and children [PP45], time with friends and colleagues outside of work, and supportive interactions with colleagues during work.



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

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



As I noted earlier, “integrating spirituality into patient care” can’t be done by the physician alone. For that reason, we are surrounding the physician with a spiritual care team made up of HPs who will provide both practical assistance and emotional or spiritual support to the physician and each other.

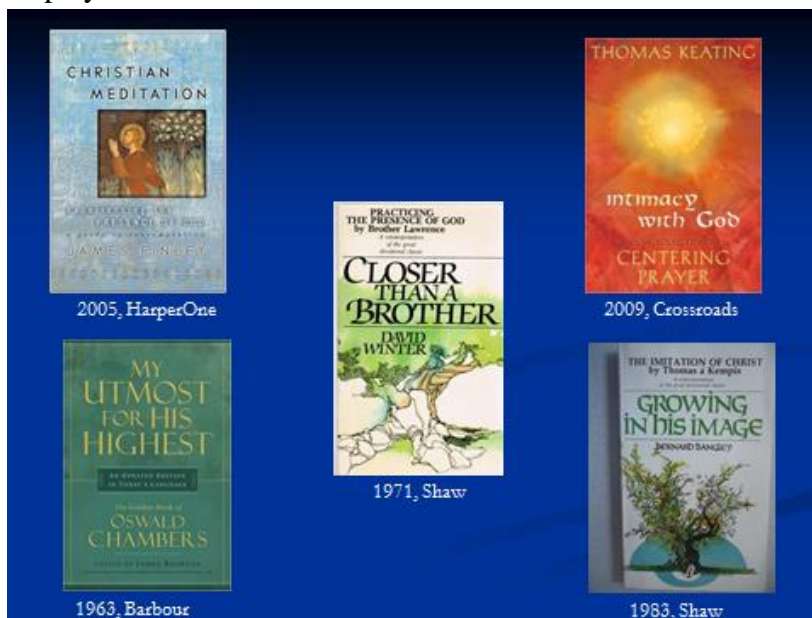
Part 4, Section 15

The *success* of the spiritual care team, we think, depends on the availability and use of **Spiritual Resources**.

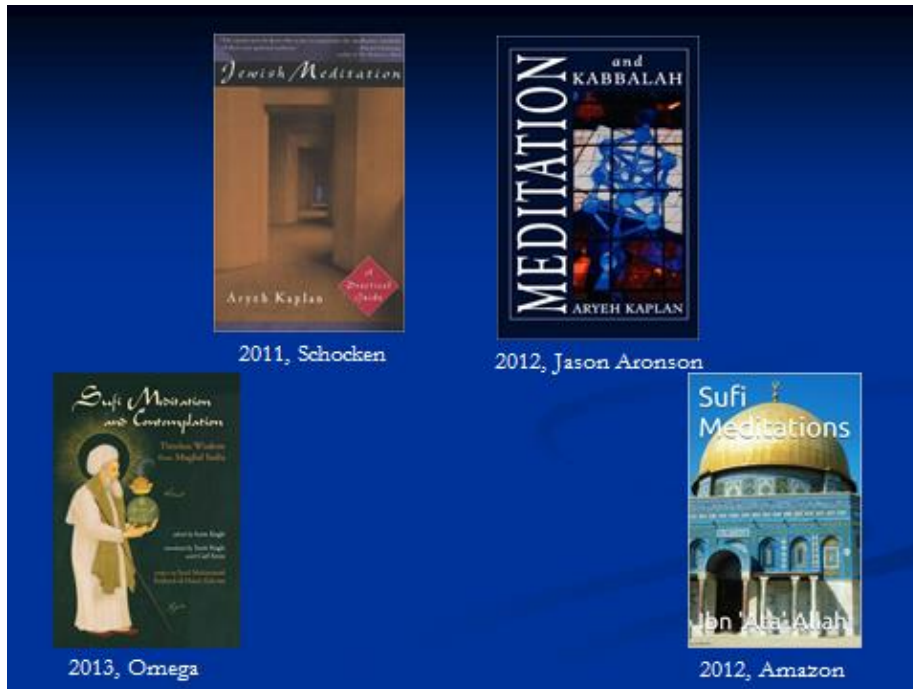
HPs may choose to develop their own spiritual resources through quiet time spent in prayer, meditation, scripture/inspirational reading, or participation in a faith community. *The Spiritual Care Coordinator is in charge of ensuring that other team members have the spiritual resources they need, especially the physician.*

Spiritual resources, such as meditation, prayer, or “practicing the presence of God,” may help the HP to achieve a relaxed, open state that fosters compassion, increases energy, and enables him or her to provide whole-person care. Several forms of meditation exist, although the form chosen to practice will depend on the person’s faith tradition. For Buddhist HPs, mindfulness meditation may be chosen. For Hindu HPs, there is transcendental meditation, which is often combined with Yoga.

There are also many forms of meditation for Christian, Jewish, and Muslim HPs. For the Christian HP, there is 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 many inspirational books that can be used to develop the Christian HP’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. Modern, easy to read editions of each of these books are displayed here.



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



There are forms of Muslim meditation as well. A form of prayer called Salat can be considered a meditation. Any short phrase or prayer recited silently or aloud while counting on a string of beads or knotted cord can be considered meditation when the focus is on God. For example, one 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.

Part 4, Section 16

While the barriers I've been describing prevent many HPs from providing spiritual care, sometimes they go beyond their expertise and do things that are neither sensible nor ethically justifiable. Therefore, I describe boundaries that we think HPs should seldom cross. I describe five "don'ts" here, most of which are pretty obvious:



- (1) Don't prescribe religion to non-religious patients. 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 asking 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 a health professional and deeply appreciate this, 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 HP 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 HP. Addressing spiritual issues is like a ballroom dance. The patient leads and the HP tries not to step on his or her toes.

Part 4, Section 17

In Conclusion, here are the main points we made in Part 4:

- (1) There are many reasons why HPs should identify and address patients' spiritual concerns related to medical illness, including research, common sense, and good clinical practice;

- (2) The physician is responsible for doing the spiritual assessment and for ensuring that the spiritual needs of patients are addressed;
- (3) However, the physician cannot do this alone, and is backed up by the Spiritual Care Coordinator and the spiritual care team;
- (4) The Spiritual Care Coordinator obtains information from the spiritual assessment and ensures that spiritual needs are fully addressed and spiritual care is provided;
- (5) The Spiritual Care Coordinator, along with the chaplain, provides spiritual support to members of the team; and finally...
- (6) There are many spiritual resources available to the Spiritual Care Coordinator to support the physician and the spiritual care team. Those resources will be needed.

For more information on how HPs can assess and address the spiritual needs of patients, I suggest the book *Spirituality in Patient Care*, 3rd ed.. There is also a lot of information available on Duke's Center for Spirituality, Theology and Health website at <http://www.spiritualityandhealth.duke.edu/>.



Thank you!