

CME 5 The Spiritual Care Team (physicians, nurses, chaplains, and practice staff)
by Harold G. Koenig, R.N., M.D.

Part 5, Section 1

Welcome to Part 5 in this educational series. This video is focused on the entire Spiritual Care Team, including physicians, nurses, the clinic manager, and other practice staff. Special attention, though, is paid to the role of the chaplain on the team. First, I describe the common goals and purposes of the spiritual care team. Next, I review material covered in Parts 1 through 4. I then focus on the role of the chaplain or pastoral counselor. This includes the training of the chaplain, what the chaplain does, and what the chaplain needs from and gives to the spiritual care team. I follow this with a discussion of the role of the social worker, particularly in hospital settings. Our objective here is to describe how the spiritual care team, whether operating in an outpatient or inpatient setting, can work effectively together.



First, what are the **Goals** of the Spiritual Care Team? They are to...

- (1) “Identify” patients’ spiritual needs related to medical illness
- (2) “Address” patients’ spiritual needs
- (3) “Follow-up” later to ensure that the spiritual needs have been adequately addressed
- (4) “Create an atmosphere” where patients feel comfortable talking about their spiritual needs with the physician and other team members
- (5) “Address” the whole-person needs of team members related to providing patient care, and...
- (6) “Provide” whole-person medical care, including spiritual care, to all patients

Part 5, Section 2

I now review the material covered in the initial 4 parts of this educational series, starting out with what we mean by “Integrating Spirituality into Patient Care”.

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 the chaplain (or pastoral counselor) 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 healthcare

Why should health professionals take the time to assess and address the spiritual needs of patients? 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) Religious beliefs influence coping with illness and may affect the patient’s emotional state and motivation towards recovery
- (3) Religious beliefs affect important health-related behaviors and likely influence medical outcomes
- (4) Religious beliefs influence medical decisions made by the patient *and*, the religious beliefs of the physician influence the medical decisions that he or she makes for the patient
- (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) Support from a religious community may increase patient monitoring and improve compliance with treatment
- (7) Finally, addressing spiritual issues may benefit the health professional, by providing intrinsic rewards that are associated with delivering “whole person” healthcare.

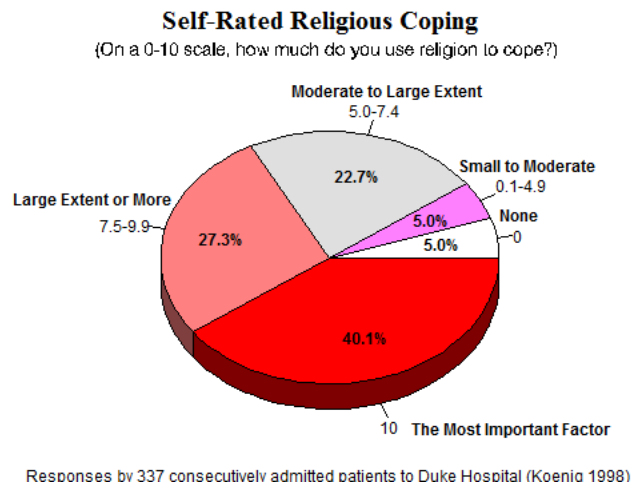
Part 5, Section 3

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, Part 2 in this educational series focuses on the research. I begin with mental health, and then move on to social health, health behaviors, and physical health. This summary is based on a

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)

systematic examination of the peer-reviewed academic literature published prior to 2010 in the *Handbook of Religion and Health*.¹

In some areas of the U.S. and elsewhere in the world, up to 90% of medical patients **use religion to cope**.² 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 behaviors that give a sense of control (such as prayer). Beliefs of this kind have been repeatedly linked with better mental health in medical patients.



Part 5, Section 4

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

¹ Koenig HG, King DE, Carson VB (2012). *Handbook of Religion and Health*, 2nd edition. NY, NY: Oxford University Press

² Koenig HG (1998). Religious beliefs and practices of hospitalized medically ill older adults. *International Journal of Geriatric Psychiatry* 13: 213–224

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 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}

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

Part 5, Section 5

In **Conclusion**, based on this systematic 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;.
- (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 5, Section 6

Therefore, what are we expecting of the Physician? This is important for other team members to know about, since a major task of the team is to support the work of the physician.



We are asking **physicians** to do the following:

- (1) Conduct a brief “spiritual assessment” in order to identify spiritual needs,
- (2) Arrange for someone to address those needs,
- (3) Follow up to ensure that spiritual needs are met, and
- (4) Be willing to discuss this subject with patients, while appreciating the health benefits of doing so.

What 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 care plan, (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 it, 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. This is 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 5, Section 7

WHO does the spiritual assessment (SA) apply to? In other words, what types of patients need a SA by the physician? Five categories of patients where a SA is indicated are:

- (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

In contrast, **who does NOT typically need a SA?**

- (1) Patients seen for an acute problem without long-term implications, such as an URI, 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 problem; and
- (4) Patients who are not religious or spiritual, and 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 5, Section 8

Although some patients may not need a “spiritual assessment,” a major goal of the spiritual care team is to provide “Spiritual Care” to ALL patients as part of **whole-person** healthcare.

So, what is **Spiritual Care**?

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 team members 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

Part 5, Section 9

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 medicine. Doing so, however, is not easy to do. There are many barriers to providing Spiritual Care. These include:

- (1) Limited time to assess and address spiritual needs
- (2) Discomfort with the subject
- (3) Fear of making patient uncomfortable by asking Q’s about spirituality or religion
- (4) Religion or spirituality is not important to the HP personally
- (5) The topic too personal and there is no private space to discuss
- (6) The belief that spiritual care is done better by others
- (7) The belief that patients don’t want spiritual care
- (8) The power inequity between HP and patient
- (9) The religious beliefs of HP and patient differ
- (10) The belief that spiritual care not part of the HP’s role

I have discussed how to overcome each of these barriers in earlier parts of this educational series. However, the bottom line is that (a) training, (b) careful division of tasks between team members, and (c) regular practice are the best ways to overcome these barriers.

Finally, in order for the physician and other team members to deliver “whole person” spiritual care to patients, they need to be “whole persons” themselves. The difficult task of caring for sick patients day-in and day-out challenges the physical, emotional and spiritual resources of most clinicians. For that reason, one major task of the spiritual care team is to support each other’s spiritual needs that arise during the course of providing healthcare. Throughout this educational series, I’ve emphasized the role of the Spiritual Care Coordinator and the Chaplain in ensuring that the spiritual needs of team members are met. I’ve also provided a list of spiritual resources to help in this regard.

Part 5, Section 10

There are, however, also **boundaries** to providing Spiritual Care. Sometimes HPs go beyond their expertise and do things that are neither sensible nor ethically justifiable.

Here are five “don’ts”, 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 5, Section 11

Now, I'd like to say a few words about Spiritual Care from a "team perspective".



Although the physician has the responsibility to assess and document spiritual needs, he or she is not alone. The physician is surrounded and supported by the Spiritual Care Team, whose responsibility is to address the spiritual needs of patients and ensure adequate follow-up.

So, who are the members of the spiritual care team and what are their roles?

First, is the Physician, whose role is to assess and document the patient's spiritual needs.



Next is the Spiritual Care Coordinator, who obtains information from MD's assessment, coordinates the addressing of spiritual needs, prepares the patient for pastoral care referral, and provides spiritual support to other team members.



Next, is the chaplain or pastoral counselor, whose responsibilities I will outline in just a minute.



In hospital inpatient settings, the Social Worker will work with the chaplain to develop a spiritual care plan and arrange for long-term follow-up and feedback to the team.



Finally, there is the receptionist whose responsibility is to record the patient's religious affiliation in the medical record.



Part 5, Section 12

Now, I'd like to focus on the responsibilities of the Chaplain or pastoral counselor.



I will examine (a) the unique role of the chaplain, (b) the training of the chaplain, (c) what a chaplain needs from the team with a referral, (d) what the chaplain provides the team in response to the referral, and (e) how to fully integrate the chaplain as part of the healthcare team.

First, what is the role of the Chaplain?

Role of the Chaplain

1. Only health professional trained to address spiritual needs
2. Performs a comprehensive spiritual assessment
3. Develops a “spiritual care plan”
4. Implements the spiritual care plan
5. Follows up to ensure that spiritual needs are met
6. Helps to address spiritual needs of other team members

The chaplain plays many roles, but there is one that is unique to this health professional. The chaplain is the only person on the spiritual care team trained to address spiritual needs. No one has training to assess and address the patient’s spiritual needs like the chaplain does. After receiving a referral, the chaplain will do a comprehensive spiritual assessment, which is quite different from physician’s brief “screening” assessment. The chaplain will clarify spiritual needs that are present and then will develop a “spiritual care plan” to address those needs. The chaplain will work with the social worker (if available) to implement the spiritual care plan after discharge from the hospital or from the clinic. He or she will also follow up to ensure that spiritual needs are met, and provide feedback to the team. Finally, the chaplain will work with the Spiritual Care Coordinator to address the spiritual needs of team members that are related to patient care.

Part 5, Section 13

What is the training of the Board Certified Chaplain?

Training of Board Certified Chaplain (BCC)

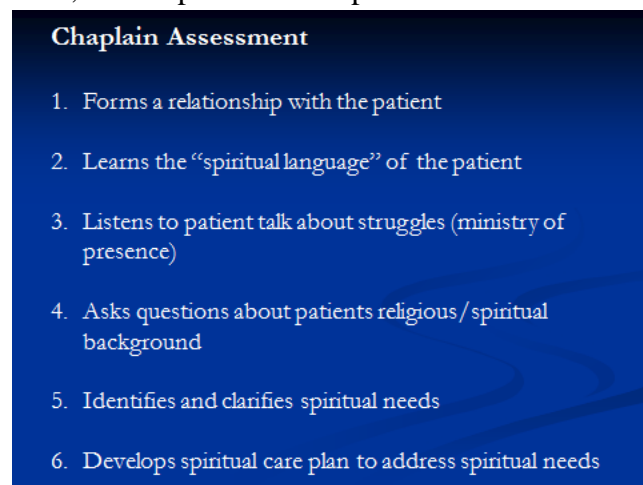
1. 4 years of college
2. 3 years of divinity school
3. 1-4 years of clinical pastoral education (1,625 hrs)
4. Letter of endorsement from denomination
5. Pass written board exam
6. Pass oral exam by certifying body
7. 2,000 hrs or 1 year of experience
8. 50 hrs per year of continuing education

To become a BCC, a person must complete a 4-year college degree; a 3-year master's degree in divinity; and 1 to 4 years of Clinical Pastoral Education in the hospital, with a minimum of 1625 hours of clinical supervision. He or she must then obtain a letter of endorsement from their denomination, successfully pass a written board exam, and complete a personal interview by the chaplain organization that is certifying them. After that, he or she must complete 2000 hours or 1 year of experience prior to actual certification. After certification, chaplains need 50 hours of approved Continuing Education each year in order to remain board certified. Thus, board certified healthcare chaplains are well-trained to do the work they do. Pastoral counselors have similar training requirements.

Part 5, Section 14

After an interfaith chaplain receives a referral and sees a patient, what exactly does he or she do? SC team members need to know what the chaplain might do because they will have to explain this to the patient when a referral is made. I've divided the activities of the chaplain here into ASSESSMENT and INTERVENTION.

First, the chaplain does a spiritual ASSESSMENT to identify and clarify spiritual needs.



This assessment is very different from the one that the Physician does. The SA that the chaplain does will differ depending on their individual style. Generally, though, the chaplain will make contact with the patient and spend time forming a relationship. During this time, the chaplain learns the “spiritual language” of the patient, which may or may not be religious. Much of the assessment will be spent listening to the patient talk about his or her struggles. No advice or spiritual counsel is usually offered. This is also called “the ministry of **presence**.” After this, the chaplain may ask questions about patient’s religious or spiritual background, and inquire about positive and negative experiences with religion. When the assessment has been completed, the chaplain will develop a spiritual care plan to address the spiritual needs identified.

The chaplain will then perform one or more specific INTERVENTIONS.

Chaplain Interventions

1. Provide emotional support (ministry of presence)
2. Pray with patient
3. Refer to appropriate Scriptures in patient's tradition
4. Provide spiritual support or advice
5. Provide religious resources (spiritual reading, etc.)
6. Contact patient's clergy

Note that the “ministry of presence,” which involves simply sitting with the patient and listening, **is a powerful intervention** by itself. The chaplain may or may not pray with the patient, depending on the patient’s preference. The chaplain may or may not read a Holy Scripture related to the patient’s illness, again depending on the patient’s preference. The chaplain may or may not provide spiritual advice, depending on patient’s request and on the patient’s readiness for such advice. The chaplain may provide religious resources to the patient, as requested, such as spiritual reading materials, prayer beads, a prayer rug, etc. The chaplain may contact the patient’s clergy or mobilize the patient’s faith community for support, after -- of course -- obtaining explicit consent from the patient. All of this activity is **HIGHLY** patient-centered and focused on the patient’s particular religious tradition or humanistic worldview. Finally, the chaplain will re-contact the patient at some future time to get follow-up on how effective the interventions were in addressing the patient’s spiritual needs.

What are some other activities of the chaplain? The chaplain may after each one] listen to, counsel, pray, or provide spiritual and emotional support to **family members**. The chaplain may do the same for other members of the **spiritual care team**. In hospital settings, the chaplain may hold chapel services and administer sacraments or perform other rituals at bedside. The chaplain may also serve on the ethics committees or the institutional review board at the hospital. Finally, the chaplain works with community clergy, who may be trained to fill in for the chaplain during emergencies or during situations when the chaplain is absent.

In a survey of 1591 patients at the Mayo Clinic, researchers found that 70% of hospitalized patients wanted to see a chaplain, but only 43% were visited by a chaplain, which is over double the national rate, which is about 20%. The proportion of **OUTPATIENTS** seen by a chaplain or pastoral counselor is probably in the single digits.

Part 5, Section 15

When accepting a referral, what does the chaplain need from the spiritual care coordinator? Here is a list of information that would be helpful:

- (1) Demographics, such as age, gender, racial background, marital status, relevant family members, and where the patient lives.
- (2) Religious denomination or background (if any) and prior religious involvement (if known)
- (3) Medical diagnoses, including severity and prognosis
- (4) Who initiated the referral, i.e., the patient, family, physician, nurse, or SW, and finally...
- (5) Reason for the referral, i.e., details on the particular spiritual need present, including what exactly the referring person wants from the chaplain

After completing a referral, what does the chaplain provide to the spiritual care team? Usually, the following will be provided:

- (1) Information on spiritual needs identified during the comprehensive chaplain assessment;
- (2) A “spiritual care plan” detailing the interventions performed or interventions planned to address those needs;
- (3) Follow-up on how effective spiritual interventions were in addressing spiritual needs;
- (4) Input to the medical care plan to help craft it around the patient’s spiritual and cultural beliefs, which is likely to enhance treatment compliance;
- (5) Advice on how to negotiate sensitive ethical issues that other HPs may have little experience with; and...
- (6) Communicate with the patient’s clergy and faith group to ensure that monitoring occurs in the community or to provide transportation to clinic visits if necessary.

Whether in an outpatient or an inpatient setting, the chaplain should be **fully integrated into the healthcare team**. As I indicated before, the chaplain or pastoral counselor is at the core of the spiritual care team because he or she is the only person fully trained to address spiritual needs. Consequently, the chaplain should be actively involved in hospital rounds and in discussions involving patients in the clinic.



Part 5, Section 16

In hospital settings, the chaplain will often have a close relationship with the team Social Worker, and some hospitals have actually combined pastoral care and social services into a single department. The reason is that spiritual needs are often closely linked with social issues. And as a result, the social worker may provide important input into the “spiritual care plan.”



In this regard, the social worker may...

- (1) contact members of the patient’s faith community for support after hospital discharge;
- (2) identify a local faith community for the patient, if desired;
- (3) identify a pastoral counselor after discharge and set up appointments;
- (4) help the chaplain do follow-up to determine whether spiritual needs were effectively addressed

Role of Social Worker on Spiritual Care Team

- (1) contact members of the patient’s faith community for support
- (2) identify a local faith community
- (3) identify a pastoral counselor and set up appointment
- (4) help the chaplain do follow-up

Other activities

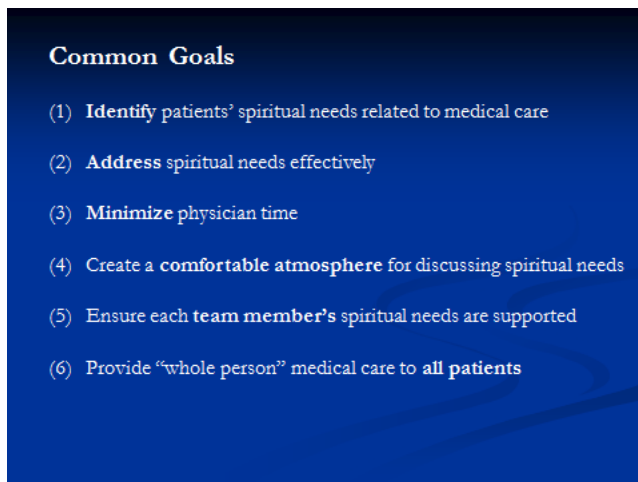
- (5) identify spiritual needs during routine social work assessment
- (6) help arrange referral to chaplain or pastoral counselor
- (7) address simple spiritual needs if chaplain unavailable

There are many other contributions that the social worker can make to the spiritual care team. These include...

- (1) identifying spiritual needs during routine social assessment (however, this would never replace the physician's assessment);
- (2) arranging referral to the chaplain or pastoral counselor if the Spiritual Care Coordinator is not available; alternatively, the SW may work with the SCC in arranging the referral; and finally...
- (3) addressing simple spiritual needs if a chaplain is unavailable or is refused by the patient (this is only for "simple" spiritual needs, since most SWs are not trained to address this area)

Part 5, Section 17

In concluding Part 5 this educational series that focuses on the Spiritual Care Team, I now summarize the key points involved in working together AS A TEAM to achieve a set of COMMON GOALS.



Each member of the team has a specific role to play, and if each person does their job, the following will be accomplished:

- (1) Patients' spiritual needs related to medical care will be identified and effectively addressed, and the physician's time will be minimized;
- (2) An atmosphere will be created where the patient and family feel free to discuss spiritual issues related to medical care;
- (3) Each member of the team will feel emotionally and spiritually supported; and finally...
- (4) "Whole-person" medical care, which includes Spiritual Care, will be delivered by all team members to every patient.

Part 5, Section 18

I conclude this 5-part educational series by driving home the main points we are trying to convey:

- First, there is every reason to assess and address spiritual needs related to medical care, based on common sense, good clinical practice, and a firm scientific rationale.
- Second, the Physician is responsible for a brief spiritual assessment that is designed to identify spiritual needs and create an atmosphere where spiritual issues related to medical care can be discussed.
- Third, the rest of the “spiritual care team,” led by the Spiritual Care Coordinator, supports the physician by ensuring that spiritual needs are effectively addressed.
- Fourth, the chaplain or pastoral counselor is at the core of the spiritual care team, and is responsible for conducting a comprehensive spiritual assessment to clarify spiritual needs and develop a spiritual care plan to address them.
- Finally, in hospital settings, the social worker helps the chaplain to develop and implement the spiritual care plan, and to arrange for follow-up to ensure that spiritual needs are met.

For more information on how health professionals 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 our website at <http://www.spiritualityandhealth.duke.edu/> .



Thank you!