Making Healthcare Whole: Integrating Spirituality into Patient care

Christina M. Puchalski, M.D.
Director, GWish
Professor, Depts of Medicine and Health Sciences
The George Washington Institute for Spirituality and Health (GWish)
The George Washington University School of Medicine and Health Sciences
Washington, D.C.

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Outline

- Spirituality and Health
- Role of spirituality in clinical setting
- Interprofessional model of care
Love/compassion
Dignity
Forgiveness
Wholeness, full-self
Other-regarding
Relationship-centered
Healing as transformational in context of relationship
Humanity of providers and patients
Definition: Spiritual Care

Interventions, individual or communal, that facilitate the ability to express the integration of the body, mind, and spirit to achieve wholeness, health, and a sense of connection to self, others, and/or a higher power.


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Why Is Spirituality Important to Care?
Spiritual/Religious/Cultural
Beliefs, Practices, and Rituals

• May be dynamic in patient’s understanding of illness
• Religious convictions/beliefs may affect healthcare decision-making
• May be a patient need
• May be important in patient coping, quality of life, and healthcare outcomes
• Integral to whole-patient care
Spiritual History: A Patient Need

- Surveys: 50-85% of patients want physicians to address their spiritual needs and incorporate into treatment.
- Why? Increases trust, helps physician understand patient more, helps physician with treatment plan, makes patients feel listened to and cared for, helps encourage realistic hope, and provides compassionate care.
- Conclusion: Patients want spiritual issues addressed and integrated into their care.
Attitudes about Spiritual Care
Pretest: Are We Really Meeting Our Patients’ Needs?

- 75% of staff felt it was important to talk about spiritual care
- 71% of staff responded to spiritual concerns
- 73% of staff assessed spiritual issues
- 15% of patients said healthcare professionals asked about spiritual concerns
Integral to Whole-Person Care
What Is Whole-Person Care?

- Transcends control of a disease process and the relief of symptoms
- Aims at full health, understood as the recovery of an integrated and authentic self
- Maintains focus on the patient as a whole person, regardless of how intractable, expensive, or complicated the patient’s problems might appear to be
Whole Person Care: The Biopsychosocial-spiritual Model of Care

- Physical
- Social
- Spiritual
- Emotional
Profile of Suffering

Puchalski, Bull 2009 (adapted from RJ Butler)
Biopsychosocial-spiritual Model

- Integrated; e.g., pain as multifactorial—physical, emotional, social, and spiritual pain
- All dimensions treated equally
- Implies team approach—different levels of expertise
- Recognition of the whole person—does not obscure the humanity of each individual
- Respect for dignity and inherent value of each human being
- Better likelihood of good diagnosis by being attentive to all aspects of presenting symptoms and issues
Improving the Quality of Spiritual Care as a Dimension of Palliative Care: A Consensus Conference

Convened February 2009
Christina Puchalski, MD, MS, FACP
Betty Ferrell, PhD, MA, FAAN, FPCN, RN
George Handzo, MDiv, BCC, MA
Shirley Otis-Green, MSW, LCSW, ACSW, OSW-C

Supported by the Archstone Foundation, Long Beach, CA, as a part of their End-of-Life Initiative.
The goal of palliative care is to prevent and relieve suffering (NCP, 2009)
Palliative Care supports the best possible quality of life for patients and their families (NCP, 2009)
Palliative care is viewed as applying to patients from the time of diagnosis of serious illness to death
NCP Guidelines Address 8 Domains of Care

- Structure and processes
- Physical aspects
- Psychological and psychiatric aspects
- Social aspects
- Spiritual, religious, and existential aspects
- Cultural aspects
- Imminent death
- Ethical and legal aspects
• 40 national leaders representing physicians, nurses, chaplains and clergy, psychologists, social workers, other spiritual care providers, and healthcare administrators
• Develop a consensus-driven definition of spirituality
• Make recommendations to improve spiritual care in palliative care settings
• Identify resources to advance the quality of spiritual care
“Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred.”

Consensus Conference: Recommendations

Recommendations for improving spiritual care are divided into seven keys areas:

I. Spiritual Care Models
II. Spiritual Assessment
III. Spiritual Treatment/Care Plans
IV. Interprofessional Team
V. Training/Certification
VI. Personal and Professional Development
VII. Quality Improvement

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Recommendations

• Integral to any patient-centered healthcare system
• Based on honoring dignity
• Spiritual distress treated the same as any other medical problem
• Spirituality should be considered a “vital sign”
• Interdisciplinary
Consensus Conference: Spiritual Care Models

Clinicians and Spiritual care providers

Key

- Pt process
- Transformative interaction

Clinicians: Chaplains, doctors, nurses, social workers
Community providers: Community religious leaders, spiritual director, pastoral and community counselors, faith community nurses, PIVOT, and others

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Communicating About Spiritual Issues

- Recognizing spiritual themes, diagnosis or resources of strength
- Following a patient’s lead
- Responding to spiritual cues
- Spiritual screening/spiritual history/
- Spiritual assessment (full assessment done by BCC)
Spiritual Distress Is Evidenced By:

- Questioning the credibility of one’s belief system.
- Demonstrating discouragement or despair.
- Inability to practice usual religious rituals.
- Ambivalent feelings (doubts) about beliefs.
- Expressing that he/she has no reason for living.
- Feeling a sense of spiritual emptiness.
- Showing emotional detachment from self and others.
- Expressing concern, anger, resentment, fear - over the meaning of life, suffering, death.
- Requesting spiritual assistance for a disturbance in belief system.

(RN Central Online, 2007)
<table>
<thead>
<tr>
<th>Diagnoses (Primary)</th>
<th>Key feature from history</th>
<th>Example Statements</th>
</tr>
</thead>
</table>
| Existential                            | Lack of meaning / questions meaning about one’s own existence / Concern about afterlife / Questions the meaning of suffering / Seeks spiritual assistance | “My life is meaningless”  
“I feel useless”                                                                 |
| Abandonment God or others              | lack of love, loneliness / Not being remembered / No Sense of Relatedness                 | “God has abandoned me”  
“No one comes by anymore”                                                                |
| Anger at God or others                 | Displaces anger toward religious representatives / Inability to Forgive                   | “Why would God take my child…it's not fair”                                         |
| Concerns about relationship with deity | Closeness to God, deepening relationship                                                 | “I want to have a deeper relationship with God”                                     |
| Conflicted or challenged belief systems| Verbalizes inner conflicts or questions about beliefs or faith  
Conflicts between religious beliefs and recommended treatments / Questions moral or ethical implications of therapeutic regimen / Express concern with life/death and/or belief system | “I am not sure if God is with me anymore”                                            |
| Despair / Hopelessness                  | Hopelessness about future health, life  
Despair as absolute hopelessness, no hope for value in life                               | “Life is being cut short”  
“There is nothing left for me to live for”                                                |
| Grief/loss                             | Grief is the feeling and process associated with a loss of person, health, etc           | “I miss my loved one so much”  
“I wish I could run again”                                                                 |
| Guilt/shame                            | Guilt is feeling that the person has done something wrong or evil; shame is a feeling that the person is bad or evil | “I do not deserve to die pain-free”                                                   |
| Reconciliation                         | Need for forgiveness and/or reconciliation of self or others                              | I need to be forgiven for what I did  
I would like my wife to forgive me                                                        |
| Isolation                              | From religious community or other                                                        | “Since moving to the assisted living I am not able to go to my church anymore”        |
| Religious specific                     | Ritual needs / Unable to practice in usual religious practices                           | “I just can’t pray anymore”                                                          |
| Religious / Spiritual Struggle         | Loss of faith and/or meaning / Religious or spiritual beliefs and/or community not helping with coping | “What if all that I believe is not true”                                                |
Spiritual Treatment Plans

1. Make a diagnosis
2. Distinguish simple from complex
3. Recommend interventions
4. Referral to chaplain
5. Write up plan
6. Follow up
II. Spiritual Assessment of Patients and Families

- **Recommendations**
- Spiritual screening, history
- Assessment tools
- All staff members should be trained to recognize spiritual distress
- HCP’s should incorporate spiritual screening and history as a part of routine history/evaluation
- Formal assessment by Board Certified Chaplain
- Documentation
- Follow-up
- Chaplain Response within 24 hours
Recommendations

Screen and access

All healthcare professionals should do spiritual screening

Clinicians who refer should do spiritual histories and develop appropriate treatment plans working with Board Certified Chaplains if possible

Diagnostic labels/codes

Treatment plans

Support/encourage in expression of needs and beliefs
III. Treatment plan cont’d

- Spiritual care referral (BCC, pastoral counselor, spiritual director, clergy as appropriate)
- Documentation of spiritual support resources
- Follow up evaluations
- Treatment algorithms
- Discharge plans of care
- Bereavement care
- Establish procedure
Ms. Harper is a 75 yo previously healthy person with HTN diagnosed 5 yrs ago now comes in with cva two ago with residual hemiparesis and mild cognitive impairment.
Spiritual History

- F: Spiritual? I am a card carrying atheist. Meaning for me was my work--- I worked with the homeless.

- I: Look at me now---I can’t do anything. I cannot do what I did all my life to help others. I am nothing.

- C: My activist community. But I am not seen them in awhile—the stroke, it changed everything for me.
**Narrative example: Biopsychosocial-Spiritual Model Assessment and Plan**

<table>
<thead>
<tr>
<th>Component</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms. Harper is a 75 yo s/ cva with hemiparesis and mild cognitive impairment</td>
<td></td>
</tr>
<tr>
<td><strong>Physical</strong></td>
<td>Ongoing physical therapy, rehab</td>
</tr>
<tr>
<td><strong>Emotional</strong></td>
<td>Grief rxn over loss of previous state of functioning</td>
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<tr>
<td></td>
<td>Supportive counseling, presence.</td>
</tr>
<tr>
<td><strong>Social</strong></td>
<td>Engage activist community in her care as much as possible</td>
</tr>
<tr>
<td></td>
<td>Needs home health aid</td>
</tr>
<tr>
<td></td>
<td>Financial issues about long term care</td>
</tr>
<tr>
<td><strong>Spiritual</strong></td>
<td>Meaninglessness, consider referral to pastoral counselor or chaplain, connection with younger people at medical school interested in helping homeless.</td>
</tr>
</tbody>
</table>
IV. Interprofessional considerations: Roles and Team Functioning

- **Recommendations**
- Policies are needed
- Policies developed by clinical sites
- Create healing environments
- Respect of HCPs reflected in policies
- Document assessment of patient needs
- Need for Board Certified Chaplains
- Workplace activity/programs to enhance spirit
V. Training and Certification

• **Recommendations**
  • All members of the team should be trained in spiritual care
  • Team members should have training in spiritual self-care
  • Administrative support for professional development
  • Spiritual care education/support
  • Clinical site education
  • Development of certification/training
  • Competencies
  • Interdisciplinary models
VI. Personal and Professional Development

- **Recommendations**
- Healthcare settings/organizations should support HCP’s attention to self-care/stress management
  - > training/orientation
  - > staff meetings/educational programs
  - > environmental aesthetics
- **Spiritual development**
  - > resources
  - > continuing education
  - > clinical context
VI. Personal and Professional Develop cont’d

• Time encouraged for self-examination or reflection
• Developing a spiritual or reflective practice
• Opportunities for sense of connectedness and community
  > interprofessional teams
  > ritual and reflections
  > staff support
• Discussion of ethical issues
  > power imbalances
  > virtual based approach
  > opportunity to discuss
VII Quality Improvement

- **Recommendations**
- Domain of spiritual care to be included in QI plans
- Assessment tools
- QI frameworks based on NCP Guidelines
- QI specific to spiritual care
- Research needed
- Funding needed for research and clinical services
Potential Impact

- Improved patient satisfaction
- Improved team cohesiveness
- Decreased provider burnout
- Improved provider satisfaction
- Decreased medical error
- Improved difficult conversations (e.g. withdrawal of life support)
“When people are overwhelmed by illness, we must give them physical relief, but it is equally important to encourage the spirit through a constant show of love and compassion. It is shameful how often we fail to see that what people desperately require is human affection. Deprived of human warmth and a sense of value, other forms of treatment prove less effective.”

His Holiness, The Dalai Lama
Time for Listening and Caring (Puchalski (ed))
“Real care of the sick does not begin with costly procedures, but with the simple gifts of affection, love, and concern.” His Holiness, The Dalai Lama
GWish
www.gwish.org

- Education resources (SOERCE, National Competencies)
- Interprofessional Initiative in Spirituality Education (nursing, medicine, social work, pharm, psychology)
- Retreats for healthcare professionals (Assisi, US)
- *Time for Listening and Caring*: Oxford University Press
- *Making Healthcare Whole*, Templeton Press
- FICA Assessment Tool—online DVD
- Spiritual and Health Summer Institute, July, GW campus
- INSPIR
- Christina Puchalski, MD, 202-994-6220
  hscmp@gwumc.edu

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