
TRADITION, HERITAGE AND SPIRITUALITY

Formal and Informal Spiritual Assessment

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Abstract

Spirituality is increasingly recognized as an essential element of health. A novel model of interprofessional spiritual care was developed by a national consensus conference of experts in spiritual care and palliative care. Integral to this model is a spiritual screening, history or assessment as part of the routine history of patients. Spiritual screening can be done by a clinician on an intake into a hospital setting. Clinicians who make diagnosis and assessments and plans, and make referrals to appropriate experts do spiritual histories. In spiritual care, board certified chaplains, spiritual directors and pastoral counselors are the typical spiritual care referrals. Board certified chaplain do a spiritual assessment that is a more detailed assessment of religious and spiritual beliefs and how those impact care or patient's healthcare decision-making. There are several screening and history tools. One history tool named FICA, was developed by a group of primary care physicians and recently validated at study at the City of Hope. This tool is widely used in a variety of clinical settings in the US and Canada. The spiritual history tools allow the clinician the opportunity to diagnose spiritual distress or identify patients' spiritual resources of strength and then integrate that information into the clinical treatment or care plan.

Keywords: Cancer death - spiritual care - palliative care - spiritual screening

Asian Pacific J Cancer Prev, **11**, MECC Supplement, 51-57

Introduction

Spirituality is increasingly recognized as an essential element of health. Spirituality speaks to what gives ultimate meaning and purpose in a person's life. It is that part of people that seeks healing and reconciliation with self or others (Foglio & Brody, 1988; Puchalski, 2002). Spirituality, broadly defined, is inclusive of the non-believers as well as the religious. Atheists, agnostics, spiritual but not religious, and religious patients all have an inner life that may be described in the overall understanding of spirituality. There is also institutional support for the inclusion of spirituality, broadly defined, into healthcare. JCAHO requires that when a hospitalized patient requests spiritual care, it should be provided (JCAHO, 1996).

Numerous surveys support patient requests for spiritual care from physicians and other healthcare professionals. Initial research suggests that between 41% and 94% of patients want their physicians to address these issues. In one survey, even half of the non-religious patients thought that physicians should inquire politely about patients' spiritual needs (Ehman et al., 1999). In these surveys, patients indicate their preference to have a more integrated approach to their care with their spiritual issues addressed by their healthcare professionals. In one study, 85% of patients noted that their trust in their physician increases

if that physician addresses their spiritual concerns (Ehman et al., 1999). Ninety five percent of the patients who report that spirituality is important want their doctor to be sensitive to their spiritual needs and to integrate it in their treatment. In another study, McCord et al (McCord et al., 2004) reported that patients in a family practice setting felt that it was important for physicians and healthcare providers to address their spiritual issues and beliefs. In this study, 95% of patients wanted their spiritual beliefs addressed in the case of serious illness, 86% when admitted to a hospital and 60% during a routine history. These results are also corroborated by surveys regarding patients' desire for nursing attention to their spiritual concerns.

A novel model of interprofessional spiritual care was developed by a national consensus conference of experts in spiritual care and palliative care and co-sponsored by the City of Hope, the George Washington Institute for Spirituality and Health and the Archstone Foundation (Puchalski et al., 2009). Integral to this model is a spiritual screening, history or assessment as part of the routine history of patients. One goal of spiritual assessment is to diagnose spiritual distress as well as spiritual resources of strength of patients. Figure 1 below outlines a model of interprofessional spiritual care implementation developed at the National Consensus Conference which shows how spirituality is addressed with patients in an

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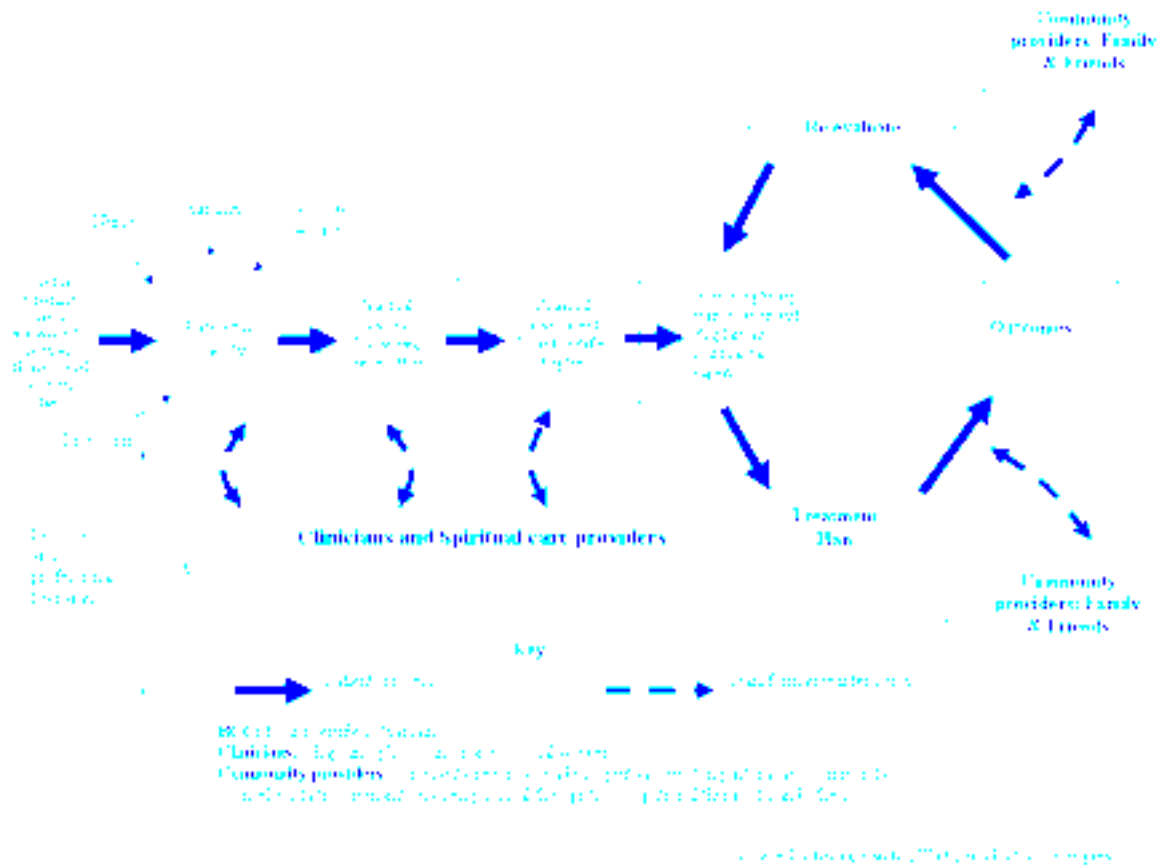


Figure 1. A Model of Interprofessional Spiritual Care Implementation Developed at the National Consensus Conference

in-patient setting, and how spiritual issues are integrated into a treatment plan. The model is based on a generalist-specialist model in which the Board Certified Chaplain is recognized as the spiritual care expert on the medical team. While all clinicians ask about spiritual issues of patients and do initial diagnosis and assessment, the chaplains are the experts that treat or counsel patients in spiritual care. Chaplains can also recommend appropriate interventions that non-chaplain clinicians can do (Puchalski et al., 2009).

Spiritual Distress

Spiritual distress can be manifested in many different ways. The inability to find meaning and purpose can lead to depression and anxiety. People find many sources of meaning and purpose throughout their lives that may be transient--jobs, relationships, accomplishments, and financial success. However, the challenge for all people is to find meaning and purpose even in the midst of failed jobs, relationships, accomplishment and unattained successes especially at the end of life. Ultimate meaning and purpose is meaning that sustains individuals in the emptiness of their external lives, or as people face their dying. Spiritual and religious beliefs play a significant role in how people transcend their suffering in order to find such ultimate meaning (Wong & Fry, 1998).

Hopelessness often arises in the midst of serious illness. Studies have indicated that people who are more hopeful do better with regard to depression and other health indicators (Synder et al., 1991; Breitbart, 2003).

How people come to understand hope also varies. Initially, hope may be lodged in cure or recovery but when that is not possible, people may have a hard time tapping into resources of hope. In those times hope may be manifested as acceptance, completing important goals or activities, living life fully in the face of difficulty, finding meaning and eventually experiencing a good quality of life and death. Helping people restructure their thinking so that they can see hopefulness in the midst of despair is an essential part of therapy. Spiritual and religious beliefs offer people a language of hope. Religious and spiritual communities offer support in the quest to find hope and meaning.

Others spiritual issues include forgiveness and/or resentment. Illness can trigger many of the spiritual issues and therefore the clinical setting may be the first place where these spiritual issues arise. Religious issues can also cause distress in people's lives. Anger at God is common in the face of serious illness. Yet, it can lead to conflict, guilt and despair. It is important in the clinical setting to allow people to talk about that anger in a safe environment where they do not feel they will be judged. In their religious communities patients may be told that it is wrong to be angry at God, or that it reflects a weakening in one's faith to be angry at or feel abandoned by God. Yet, in the clinician's office, the patient may find a safe haven to explore these feelings in greater depth.

Many of the spiritual issues faced by patients are summarized in Table 1. This was developed as part of the National Consensus Conference on Interprofessional

Table 1. Diagnoses, Key Features and Examples of Statements by Patients (After Puchalski et al., 2009)

Feeling (Primary)	Key feature from history	Example Statements
<u>Existential:</u>	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"
<u>Abandonment:</u> sense	God or others lack of love, loneliness / not being remembered / no sense of relatedness	"God has abandoned me" "No one comes by anymore"
<u>Anger:</u>	at God or others/ displaces anger toward religious representatives / inability to forgive	"Why would God take my child away from me?"
<u>Concerns about deity:</u>	Closeness to God, deepening relationship	"I want to have a deeper relationship with God"
<u>Conflicted or challenged belief systems</u>	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"
<u>Despair</u> <u>/Hopelessness:</u>	hopelessness about future health, life despair as absolute hopelessness, no hope for value in life	"Life is being cut short" "There is nothing left to live for"
<u>Grief/loss:</u>	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"
<u>Guilt/shame:</u>	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" "I need to be forgiven for what I did"
<u>Reconciliation:</u>	need for forgiveness and/or reconciliation of self or others	"I would like my wife to forgive me"
<u>Isolation:</u>	from religious community or other	"Since moving to the assisted living I am not able to go to my church anymore"
<u>Religion specific:</u>	ritual needs / unable to practice usual religious practices	"I just can't pray anymore"
<u>Religious/Spiritual Struggle:</u>	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 Care. This table identifies these issues as spiritual distress diagnosis. It also gives examples as well as statements that patients might use in communicating about these issues with clinicians.

Spiritual Resources of Strength

Spirituality can also provide support for patients. Spiritual and religious beliefs and practices have been shown to have an impact in stress management, providing resiliency, as well as in coping with suffering (Boston et al., 2006). Spiritual groups such as faith based groups, yoga, or other types of spiritual groups can offer people social support. The ability to find hope in the midst of despair or meaning in suffering is examples of spiritual resources of strength. Having a purpose in one's life is immensely important for people.

Communication about Spiritual Issues

Communication with patients and families about spiritual issues ranges from identification of spiritual issues to formal assessment (Puchalski & Romer, 2000; Lo et al., 2002).

Thus there are four basic ways to approach communication about spiritual issues. The first three can be considered informal the forth is a formal part of the clinical encounter.

1. Recognition of spiritual themes, spiritual distress or suffering, and resources of strength.
2. Response to patients' statements about spiritual, religious or existential issues.
3. Response to patient's cues such as what they are wearing or reading.
4. Formal spiritual history, screening or assessment.

The first three approaches can be done by anyone on the care team. During the clinical encounter, one should listen for expressions of these themes and then follow up with an appropriate comment or question. For example, a patient may allude to a sense of hopelessness. The professional may elicit more conversation with the patient and identify appropriate treatment options. Patients may express spiritual or existential issues, for example, in asking "why is this happening to me?". It is important to respond to these types of questions with open-ended questions, such as "Tell me more", or "Why do you think this is happening to you?" By trying to answer these often-unanswerable questions, the clinician could signal a lack of interest in hearing the patient's existential distress.

Patients may also voice explicit spiritual and/or religious beliefs. For example, a patient may make references to God or a higher power, or may mention helpful practices such as meditation or yoga. The clinician can follow up by asking more about these practices. Clinicians do not need to be experts in all spiritual or religious beliefs and practices; they can learn from their

patients about what is important to them.

Patients may wear religious or spiritual jewelry, or have religious or spiritual reading material at their bedside. Clinicians can acknowledge these objects and ask questions in reference to what the patient is wearing or reading.

Spiritual Screening, History, Assessment

A spiritual history, screening or assessment is a more formal part of the medical history in which the patient or family is asked about their spiritual and/or religious beliefs. In general, non-chaplain clinicians do a spiritual screening or a spiritual history; chaplains do a spiritual assessment. These are further defined below:

Spiritual Screening

Spiritual screening or triage is a quick determination of whether a person is experiencing a serious spiritual crisis and therefore needs an immediate referral to a professional chaplain. Spiritual screening helps identify which patients may benefit from an in-depth spiritual assessment by a professional chaplain. Good models of religious or spiritual screening employ a few, simple questions, which can be asked by any health care professional in the course of an overall screening. Examples of questions could be, "How important is religion and spirituality in your coping?" and "How well are those resources working for you at this time?"

Spiritual History

Spiritual history taking is the process of interviewing a patient, asking them questions about their life, in order to come to a better understanding of their needs and resources. Compared to screening, history taking employs a broader set of questions to capture salient information about needs, hopes, and resources. The history questions are usually asked in the context of a comprehensive examination, by the clinician who is primarily responsible for providing direct care or referrals to specialists such as professional chaplains. The information from the history permits the clinician to understand how spiritual concerns could either complement or complicate the patient's overall care. It also allows the clinician to incorporate spiritual care into the patient's overall care plan. Unlike spiritual screening which requires virtually no training, those doing a spiritual history should have some training in and comfort with issues and how to engage patients comfortably in this discussion.

Spiritual Assessment

Spiritual assessment refers to a more extensive [in-depth, on-going] process of active listening to a patient's story as it unfolds in a relationship with a professional chaplain and summarizing the needs and resources that emerge in that process. The summary includes a spiritual care plan with expected outcomes, which should be communicated, to the rest of the treatment team. Unlike history taking, the major models for assessment are not built on a set of questions that can be employed in an interview. Rather, the models are interpretive frameworks

that are applied based on listening to the patient's story as it unfolds in the clinical relationship. Because of the complex nature of these assessments and the special clinical training necessary to engage in them, only professional chaplains should do them.

When each of these inquiries occur depends on the setting as well as who is asking the question. In hospitals, long-term care sites or hospices, the nurse or social worker upon triage or admission does the spiritual screening. The purpose is to assess for spiritual emergencies that may require a chaplain immediately. Once the initial admission process is completed, then a spiritual history is taken as part of the intake or complete history after the initial triage. In outpatient settings, the spiritual screening might not occur. If the patient comes to the physician's office and is in distress, a spiritual screening might be done as part of the initial conversation with the physician, nurse practitioner or physician-assistant.

Spiritual History Tools

For non-chaplains, there are clinical history tools that are used to collect and document clinical information. The spiritual history can be integrated into these tools; so for example, the spiritual history has been integrated into the social history section of the clinical database in many settings. A spiritual history is as important as any other part of the clinical history. When doing a clinical history, clinicians target specific areas. Simply listening to themes alone will not elicit all the information needed to provide good medical care. Thus, specific questions need to be asked to target areas of information regarding life events such as depression, social support, domestic violence, sexual preferences and practices. Patients may not volunteer information to a clinician unless they are invited to share in sensitive areas. This is particularly true of spirituality. While patients are interested in having spirituality integrated into their care, it is not yet a common practice to have physicians or others address spiritual issues; patients may need an invitation to share their experiences. A spiritual history is simply a set of targeted questions aimed at inviting patients to share their spiritual and/or religious beliefs if desired and to guide them to delve into the meaning of life events.

The goals of the spiritual history are to:

Invite the patient to share spiritual and religious beliefs if they chose.

Invite patients to define what spirituality is for them and what are their spiritual goals.

Learn about the patient's beliefs and values.

Assess for spiritual distress (meaninglessness, hopelessness etc) as well as for spiritual resources of strength (hope, meaning and purpose, resiliency, spiritual community).

Provide an opportunity for compassionate care whereby the healthcare professional connects to the patient in a deep and profound way.

Empower the patient to find inner resources of healing and acceptance.

Identify patients' spiritual and religious beliefs that

<p>F. "Do you consider yourself spiritual or religious?" - or - "Do you have spiritual beliefs that help you cope with stress (contextualize to the situation, for e.g. with what you are going through right now, with dying, with dealing with pain)?" If the patient responds "No" the physician might ask, "What gives your life meaning?"</p>	<p>Sometimes patients respond with answers such as family, career, or nature. Patients who respond "yes" to the spiritual question should also be asked about meaning.</p>
<p>I. "What importance does your faith or belief have in your life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?"</p>	<p>These questions can help lead into questions about advance directives and proxies who can represent the patient's beliefs and values. One can also ask about spiritual practices and rituals that might be important to people.</p>
<p>C. "Are you part of a spiritual or religious community? Is this of support to you and how? Is there a group of people you really love or who are important to you?"</p>	<p>Communities such as churches, temples, and mosques, or a group of like-minded friends can serve as strong support systems for some patients.</p>
<p>A. "How would you like me, your health care provider, to address these issues in your health care?" Or ask the patient, "What action steps do you need to take in your spiritual journey?"</p>	<p>Often it is not necessary to ask this question but to think about what spiritual issues need to be addressed in the treatment plan. Examples include, referral to chaplains, pastoral counselors, spiritual directors, journaling, and music or art therapy. Sometimes the plan may be simply to listen and support the person in their journey.</p>

Figure 2. FICI, A Spiritual History. F – Faith and Belief; I – Importance; C – Community; A – Address in Care or Action (Puchalski and Romer, 2000)

might impact healthcare decision-making.

Identify spiritual practices or rituals that might be helpful in the treatment or care plan.

There are several tools that have been developed for this purpose. These include FICA, (see Figure 2)(Puchalski & Romer, 2000; Puchalski, 2006) HOPE [see

H:	Sources of hope, strength, comfort, meaning, peace, love and connection
O:	The role of organized religion for the patient
P:	Personal spirituality and practices
E:	Effects on medical care and end-of-life decisions

Figure 3. HOPE- A Spiritual History – (Anandarajah & Hight, 2001)

Figure 3) (Anandarajah & Hight, 2001) and SPIRIT [see Figure 4] (Maugans, 1996). Generally, these tools include objective data (religious affiliation, spiritual identification, community, spiritual practices) as well as provide an open ended part of the conversation to assess for spiritual aspects such as meaning, importance of belief and/or faith, beliefs in afterlife, sources of hope or distress. These tools are shown in the Figures 2-4. Of the three tools mentioned, the FICA tool is the only one that has been validated. In a study at City of Hope, FICA was correlated with the spiritual domain of the City of Hope Quality of Life questionnaire and demonstrated to assess for spiritual and religious issues in patients.

While these tools ask specific questions, they are not

S	<u>Spiritual belief system</u> : Do you have a formal religious affiliation? Can you describe this? Do you have a spiritual life that is important to you? What is your clearest sense of the meaning of your life at this time?
P	<u>Personal spirituality</u> : Describe the beliefs and practices of your religion that you personally accept. Describe those beliefs and practices that you do not accept or follow. In what ways is your spirituality/ religion important to you? How is your spirituality/ religion important to you in daily life?
I	<u>Integration with a spiritual community</u> : Do you belong to any religious or spiritual groups or communities? How do you participate in this group / community? What is your role? What importance does this group have for you? In what ways is this group a source of support for you? What type of support and help does or could this group provide for you in dealing with health issues?
R	<u>Ritualized practices and restrictions</u> : What specific practices do you carry out as part of your religious and spiritual life (e.g. prayer, meditation, service, etc.) What lifestyle activities or practices does your religion encourage, discourage, or forbid? What meaning do these practices and restrictions have for you? To what extent have you followed these guidelines?
I	<u>Implications for medical care</u> : Are there specific elements of medical care that your religion discourages or forbids? To what extent have you followed these guidelines? What aspects of your religion / spirituality would you like to keep in mind as I care for you? What knowledge or understanding would strengthen our relationship as physician and patient? Are there barriers to our relationship based upon religious or spiritual issues? Would you like to discuss religious or spiritual implications of health care?
T	<u>Terminal events planning</u> : Are there particular aspects of medical care that you wish to forgo or have withheld because of your religion / spirituality? Are there religious or spiritual practices or rituals that you would like to have available in the hospital or at home? Are there religious or spiritual practices that you wish to plan for at the time of death, or following death? From what source do you draw strength in order to cope with this illness?

Figure 4. SPIRIT- Taking a Spiritual History (Maugans, 1996)

meant to be used as checklist but rather as a guide to open the conversation with patients to deeper questions about a patient's inner life. The spiritual history should be done routinely during the social history section of the initial assessment or the annual history and physical exam. An example of a social history is in table 2 below taken from the curriculum at the George Washington University School of Medicine. However, one can ask a spiritual history in the context of a specific clinical issue. For example, if the patient is coming for a routine visit, one might address spirituality in the context of stress management or health. If the patient has just been told of a serious diagnosis, then the questions might be phrased differently. For example "Do you have spiritual beliefs that have helped you in difficult times before?" or "It must be hard to hear difficult news like this; do you have spiritual beliefs that might help you right now?"

The goal of all these tools is to obtain a comprehensive understanding of a patient's relationship to spirituality, what the patient's spiritual beliefs are, and what their goals are for spiritual health. These tools are not meant for use as a checklist but rather to give people the opportunity to share about their beliefs, hopes, fears and concerns. The spiritual history helps the clinician understand how the spirituality of the patient helps that patient understand their illness and health, cope with suffering and find meaning in the midst of what is happening to them.

Ethical Guidelines

In addressing spiritual issues with patients, it is important to recognize that the conversation is always patient centered and patient led. Proselytizing is not ethical in the clinical encounter nor is ridiculing patients for their beliefs. There is a power differential between patients and clinicians; clinicians should never abuse that power nor the trust patients place in them. A clinician that might want to share his or her beliefs with a patient might inadvertently encourage that patient to agree with or adopt the clinician's beliefs out of fear that the clinician will not treat the patient well if the patient does not agree with the clinician. Questions about spirituality should also be asked in a manner that conveys openness to all types of beliefs, humanistic, religious and non-theist alike. A spiritual history or assessment must be sensitive enough to identify concerns in all patients and ask general questions that invite all patients to share what is important to them and their care.

Integration into Treatment or Care Plans

Once spiritual issues are assessed clinicians can then integrate those issues into a treatment plan. Clinicians need to make the appropriate referrals to expert spiritual care professionals such as Board Certified Chaplains or Pastoral Counselors or Spiritual Directors. In table X below, an algorithm is described of how spiritual distress can be identified by clinicians that normally develop clinical assessment and plans and make referrals to experts depending on the issues. As noted in this figure there are complex spiritual issues that need an immediate referral

to a chaplain. Simple issues may be able to be handled appropriately by the non-chaplain clinician with a variety of interventions such as compassionate presence, supporting a patient's self described spiritual resources of strength such as meditation, hope, strong sense of meaning, referral for breath work, encouraging journaling or other reflective practices. Spiritual issues need to be assessed on an ongoing basis as with any other clinical issues and especially addressed if there is any change in clinical situation with the patient.

Two examples of the process is described below:

Case 1: "My life is meaningless"

Ms. Harper is a 75-year-old former advocate for the homeless, who recently suffered a stroke that left her with mild cognitive impairment and hemiparesis. The meaning in her life came from her work, and since the stroke she is unable to work and feels life has no meaning anymore.

Spiritual History

F: Atheist; meaning in social activism

I: Work is her life and her whole sense of who she is

C: Activist community

A: Interested in passing on her dreams to younger people who will carry on her work when she dies. Referral to pastoral counselor, find resources for patient to work with students, continued presence, journaling (patient may be interested in recording her narrative or history)

Interventions

The goal is to help Ms. Harper move beyond defining herself by what she did to a deeper intrinsic meaning and value of herself as a person. Cognitive-oriented therapy can help. One can ask questions such as:

What have been important events in your life?

What is the most important event in your life?

Have you loved?

The chaplain's spiritual assessment would explore Ms. Harper's sense of meaning and existential concerns more completely. The assumption should be that it is not the work per se that gives her meaning. If that were the case, any work would do. It is something about this particular work and what it produces or the good it brings to the world that has particular salience for her. Some of the questions might be:

Explore Ms Harper's sense of meaning and existential concerns more completely. Work per se may not give meaning—what is it about the work

What is it about social activism that is meaningful?

Why is it meaningful?

Why is she drawn to the homeless?

What events in her life made her who she is?

Ms. Harper has obviously already considered how she might pass on her passion and commitment to those who will follow her. The "how" of this process is fairly straightforward. The "what" is more complicated and should also be part of an assessment.

What ideas and beliefs does she have about the world and our duty to it that she wants to pass on?

On an existential level, why be an activist? (Example- Judaism calls all Jews to participate in the healing of the

world.)

As always, this process is both an assessment and an intervention in that it gives the patient insight that can help her move on and find the same meaning through activities that she is still capable of. Sometimes people find meaning in their struggle, sometimes not. But as caregivers, we can support them in looking beyond the extrinsic and into an intrinsic sense of value in them and find some meaning for themselves in their struggle. Interventions by the non-chaplain clinicians on the team could include: Help patient create a dream list and facilitate passing onto others, ongoing compassionate presence and providing connection and listening to Ms Harper's life story.

The Assessment and Plan for this patient might be:

Ms. Harper: 75 yo s/ cva with hemiparesis and mild cognitive impairment

Physical: ongoing physical therapy, d/c to rehab when stable

Psychological: grief reaction over loss of previous state of functioning: supportive counseling and continued presence

Social: engage activist community in her care as much as possible, home health aid, and financial issues about long-term care

Spiritual: meaninglessness, consider referral to pastoral counselor or chaplain, connection with younger people at medical school interested in helping homeless, ongoing presence, provide connection, elicit life story.

Case 2: "Hopelessness"

Ronda is a 58-year old female with end stage ovarian cancer. Seven and one half years after multiple surgeries and chemotherapy with good outcomes, she is now faced with advanced disease for which there is no longer any treatment. Her hope has always been for a cure. Now she faces a deep sense of hopelessness.

Hope can be expressed in many ways. It may initially be for a cure, but when that is no longer possible, people may still find hope in finding important projects, making peace with others, and having a peaceful death.

Hope/hopelessness can also be related to other spiritual diagnoses. These would include feelings of abandonment by God and isolation from an important community, religious or otherwise. In general, hopelessness is often generated by a sense of abandonment or isolation- being abandoned by our communities, being abandoned by our higher power, or as in this case, being abandoned by our own bodies. Thus, the chaplain will always assess for all of the possible sources of the hopelessness.

Spiritual History

F: Raised Jewish culturally; meaning has always been in nature and not in religion

I: Spirituality is important and now that she is dying she would like to know how Judaism views dying and what rituals might help her

C: Friends are her spiritual support

A: Would like to see a Rabbi to discuss her spiritual

questions with him. Referral to chaplain to help connect patient with Rabbi, dream list, explore sources of hope While the spiritual history suggests that Rhonda's support to this point has come from friends, there are strong indications that she wants to explore her Jewish history as a source of spiritual support. Thus the chaplain's assessment questions would include:

What was her upbringing from a Jewish perspective?

What is her experience with Jewish ritual?

If she did have some level of Jewish practice earlier in her life, why did she leave that?

What does it mean to her to be a "good Jew"?

What is her belief about an afterlife?

The interventions by the non chaplain clinicians on the team might include helping Ronda create a dream list, listening to her story and her relationships with people and with God, talking about her sources of hope in past times as well as current and helping her accomplish her dreams and wishes if possible.

Ronda's Assessment and Plan might be:

Ronda 52 yo with end stage ovarian ca .

Physical: pain is well controlled; continue with current medication regimen. Nausea; still has episodes of nausea and vomiting, likely secondary to partial small bowel obstruction (SBO). Add octreotide to current regimen

Psychological: grief reaction that "fight is over". Tearful, difficulty sleeping. Supportive counseling and continued presence.

Social: Ronda concerned about how to tell family she is dying; social worker to arrange for family meeting

Spiritual: hopelessness, main source of meaning in "winning the fight", active in ovarian cancer alliance and seen as inspiration. Not religious but now wants to learn how "Jewish Patients die?"

Dream List, legacy building, encourage talking with Ovarian Cancer Alliance, referral to chaplain and to Rabbi (choice of Rabbi might be impact by chaplain assessment above)

Conclusion

Spirituality is an essential element of the care of patients. A National Consensus Conference developed a model for interprofessional spiritual care where all members of the healthcare team address patients' spirituality and refer to the spiritual care professionals on the team, such as board certified chaplains, pastoral counselors and spiritual directors. There are formal and informal ways of communicating with patients about their spiritual issues. Formal ways include doing a spiritual screening, history and assessment. Spirituality should be integrated into the assessment and plan of patients' treatment and care plans and followed up as with any other clinical issue.

References

- Anandarajah G, Hight E (2001). Spirituality and medical practice: Using the HOPE questions as a practical tool for spiritual assessment. *Am Family Physician*, **63**, 81-9.

- Boston P, Puchalski CM, O'Donnell JF (2006). American association for cancer education membership perspectives of spirituality in cancer education. *J Cancer Educ*, **21**, 8-12.
- Breitbart W (2003). Reframing hope: Meaning-centered care for patients near the end of life. interview by Karen S. Heller. *J Palliat Med*, **6**, 979-88.
- Ehman JW, Ott BB, Short TH, Ciampa RC, Hansen-Flaschen J (1999). Do patients want physicians to inquire about their spiritual or religious beliefs if they become gravely ill? *Arch Int Med*, **159**, 1803-6.
- Foglio JP, Brody H (1988). Religion, faith, and family medicine. *J Family Pract*, **27**, 473-4.
- Lo B, Ruston D, Kates LW, et al (2002). Discussing religious and spiritual issues at the end of life: A practical guide for physicians. *JAMA*, **287**, 749-54.
- Maugans TA (1996). The SPIRITual history. *Arch Family Med*, **5**, 11-6.
- McCord G, Gilchrist VJ, Grossman SD, et al (2004). Discussing spirituality with patients: A rational and ethical approach. *Ann Family Med*, **2**, 356-61.
- Puchalski CM (2002). Spirituality and end-of-life care: A time for listening and caring. *J Palliat Med*, **5**, 289-94.
- Puchalski CM (2006). Spiritual assessment in clinical practice. *Psychiatric Annals*, **36**, 150.
- Puchalski CM, Ferrell B, Virani R, et al (2009). Improving the quality of spiritual care as a dimension of palliative care: Consensus conference report. *J Palliat Med*, **12**, 885-904.
- Puchalski C, Romer AL (2000). Taking a spiritual history allows clinicians to understand patients more fully. *J Palliat Med*, **3**, 129-37.
- Snyder CR, Irving LM, Anderson JR (1991). Hope and health: Measuring the will and the ways. In CR Snyder, DR Forsyth (Eds.), *Handbook of Social and Clinical Psychology: The Health Perspective* (pp. 285-307). Elmsford, NY: Pergamon Press.