Lifting the Patient: A Healing Encounter

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The (GWish)
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Compassion in Health

• Journey with suffering…. We provide witness ...

Ferrell, Coyle: The Nature of Suffering and The Goals of Nursing

Healthcare: Its about relationships

• Form deeply meaningful relationships with our patients
• Our patients’ suffering affects us, it raises deep spiritual questions about loss, meaning, life and death

The journey in this field started with..

• Family, Teresa, John of the Cross
• “Where there is no love put love and you will find love.”
• The NIH experience– the story of Mike
• Starting medical school– no room for the spirit

Curricular Initiatives....

History of GWish Curricular Awards Program

• 1980’s--three schools with topics related to spirituality or religion discussed in ethics courses, medical anthropology, religious traditions and healthcare (Catholic and Seventh Day Adventist schools).
• 1992-- first formal elective course in Spirituality and Health GW
• 1995-- JTF Award Program in Spirituality and Health begins (medical school, psychiatry and primary care residency programs)
History of GWish Curricular Awards Program

- 1996 -- first required, integrated course in Spirituality and health GW
- Award programs for medical schools, residencies
- 1999 -- consensus conference with AAMC to determine definition, learning objectives
- 2003 -- consensus Ethics conference with AAMC to determine ethical guidelines
- 2004 -- Compendium survey by Gwish shows 102 schools with courses in spirituality

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US Schools Teaching Courses on Spirituality and Health

1992

Schools with Courses

Schools without Courses

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2004

Schools with Courses

Schools without Courses

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MSOP Report III: Spirituality, Cultural Issues and End of Life Care

Spirituality is recognized as a factor that contributes to health in many persons. The concept of spirituality is found in all cultures and societies. It is expressed in an individual’s search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism and the arts. All these factors can influence how patients and health care professionals perceive health and illness and how they interact with one another.

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Outcome Goals

Students will:

- be aware of the need to incorporate awareness of spirituality into the care of patients in a variety of clinical contexts.
- will recognize that their own spirituality might affect the ways they relate to, and provide care to, patients.
- will be aware of the need to respond not only to the physical needs that occur at the end of life (and in life any illness) but also the emotional, socio-cultural, and spiritual needs that occur.

© GWish-AAMC Consensus conference 1999

Language: Talking to Colleagues

Reductionism: language of medicine
Sharing stories: language of chaplains
The Challenge: how to blend the two....
**Theoretical, Ethical and Empirical Framework or Models**

We know it's more than this but we need to start on common ground......

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**Spirituality/Religion associated with:**

- Better healthcare outcomes (coping, will to live, recovery from surgery, depression, increased hope, less death anxiety). Effective additive over social support.
- Spirituality associated with greater quality of life with patients with advanced disease if they have meaning and purpose, fulfillment in life goals (Cohen SR, Mount BM, et al, 1995)
- Lower stress-associated biological markers, changes in area of brain associated with stress/emotions
- Resiliency
- Mind-body interventions have positive benefits on health
- Patient need data (surveys)
- Spiritual care outcome measure (Balboni, 2010)

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**Patients’ spiritual needs** (Flannelly, K.J., et al Hospital Topics, 2005)

- Love and belonging
- Meaning and purpose
- Appreciation of nature and beauty
- Spiritual/religious practices and guidance
- Positivity, gratitude and peace
- Resolution of issues involving life and death
- (National survey of US hospitals HCC)

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**IT’s not just about illness:**

The World Health Organization’s definition of health:

“Health is a dynamic state of complete physical, mental, spiritual and social well-being, and not merely the absence of disease or infirmity”.


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**Theoretical, Ethical, Professional Framework For Integrating Spirituality into Healthcare**

- Compassionate Care (AMA, AAMC, ACP, Code of Nursing, St Louis)
- Patient-Centered Care (Picker Institute 2004)
- Biopsychosocial spiritual model (Sulmasy, 2002, Barnum, 1996)
- National Consensus Project for Quality Palliative Care (2006)

Physicians are obligated to attend to all dimension of suffering including spiritual and existential suffering (ACP)

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**GWish-AAMC Ethics Consensus Conference 2003**

- Obligation to respond to suffering and provide compassionate care.
- Spirituality is essential to healthcare and not an amenity.
- Spiritual needs important to patients.
- Spiritual care is interdisciplinary; not intended to replace Chaplains.
- Non-coercive / patient-centered.
- Professional boundaries; no abuse patients’ trust
- Definition of spirituality is broad.
An Essential Partnership ...

Chaplains, doctors and other clinicians working side by side

Journey continues—Patients and Others

- Fr Val
- Sally—"tell your students not to wait until you are my age to look deeply within....and to deal with this stuff, you know the ‘who am I’ question.
- Ronda— “I am a statistic of one.”

Quotes from medical students

- "Caring for Ms Lee made me aware that I too will die one day."
- "It’s too hard...I don’t know what to do with my feelings. I got so attached to my patient. I came one day for rounds and she had died that night."
- “What do I do if I feel sad about what my patient is saying. Is it ok to cry?”
- ‘I don’t know what it was about this patient. But she gave me back the compassion I had when I started med school but which somehow got lost along the way”

Assisi: Sharing Stories, Finding Meaning

- "As I renew myself I am better able to connect with my professional life more holistically."
- "Finding like-minded colleagues gives me hope."
- "I feel energized to be a change agent."
- "We are a community here...this will continue even when we go back to our different places...”
- "My plan is to build this type of community back at my workplace.”

What do these stories tell us

- Burnout from not working out of our call
- Need to reconnect the inner call to the outer work
- Learn skills in order to be able to be fully present and compassionate
- Grounded in a mission to serve; work out of call to altruism
- NEED TO BE A COMPASSIONATE PRESENCE TO OURSELVES FIRST BEFORE WE CAN BE THAT TO OTHERS

“To heal a person, you must first be a person”  Abraham Heschel
To be a person…

- Recognize our own fears,
- Face our own mortality
- Be honest with ourselves and our patients about our sadness, our grief
- Let go of perfection
- Accept the mystery
- Walk authentically through life’s journey

GWish National Competencies

- Seven competitively chosen schools-interdisciplinary teams including chaplains
- Discovery and Action Dialogues
- Consensus conference (Café format)
- Developed list of competencies (ACGME-based),
- Schools currently piloting projects
- Plans to submit special section in Academic Medicine if approved

Health Care Systems

- Describe importance of incorporating spirituality into a healthcare system
- Describe and evaluate spiritual resources in the community
- Discuss ways healthcare systems my complicate spiritual care
- Describe methods of reimbursement for spiritual care
- Discuss legal, political and economic factors of healthcare that influence spiritual care

Knowledge

- Compare and contrast spirituality and religion, culture
- Differentiate between spirituality and psychological factors
- Describe boundary issues in spirituality and health
- Outline key findings in research in spirituality and health

Compassionate Presence

- Discuss why it’s a privilege to serve the patient
- Describe personal and external factors that limit your ability to be present to others
- Describe strategies to be more present with patients
- Describe how you as a clinician/student can be changed by your relationship with your patient

The National Initiative to Develop Competencies in Spirituality for Medical Education

**Patient Care**
- Perform a spiritual history, ongoing f/u of spiritual distress
- Integrate patients’ spiritual issues into the treatment plan
- Collaborate with staff, family, pastoral care and other members of the healthcare team
- Invite patients to identify their own spiritual or inner life
- Make timely referrals to chaplains

**Communication**
- Practice deep listening, non judgmental presence
- Communicate professionally with spiritual care professionals and others on the team about patient spiritual issues
- Demonstrate the use of silence in patient communication
- Use appropriate non-verbal behaviors to signal interest and care in the patient

**Personal and Professional Development**
- Explain the reasons that drew you to the medical profession (call)
- Explore the role of spirituality in your professional life
- Reflect on signs of spiritual crisis
- Identify your personal and professional support communities
- Identify your sources of spiritual strength

**Our work as spiritual practice**
Illness is a spiritual event; thus caring for the ill and suffering becomes a spiritual practice

**Formation of Doctors**
- GTRR Reflection Rounds
  - RFP
  - Eight schools
  - Use of modified verbatim as structure for reflection
  - Measuring outcomes
  - Chaplains required to be part of teams
  - Gwish Reflection Mentor Program

**How to create healing environments**
- Focus on spirituality as an essential element of care
- Recognize spiritual development as an important part of professional development
- Education in interprofessional spiritual care including compassion, spiritual assessment of patients

  - Puchalski, C. McSkimming, S Creating Healing Environments, 2007
Creating Healing Environments

- 7 hospital leadership teams met for 3 day retreat implemented spiritual care initiatives
- Outcomes measured and showed:
  - Improved patient satisfaction scores (>90% in one site-med unit)
  - Fewer staff sick days
  - Staff volunteer to extra shifts when needed
  - Increased sense of “joy at work”
  - Stronger teams–more cohesive, stronger, communicate better
  - Greater sense of meaning and purpose at work

Improving the Quality of Spiritual Care as a Dimension of Palliative Care:

A Consensus Conference Convened February 2009
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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.

Advisors

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- Daniel Sulmasy, OPM, MD, PhD, Professor of Medicine and Medical Ethics, Schools of Medicine and Divinity, University of Chicago, Chicago, IL

Background

- 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

Consensus Conference Design and Organization

- 40 national leaders representing physicians, nurses, psychologists, social workers, chaplains and clergy, spiritual directors and healthcare administrators
- Develop a consensus-driven definition of spirituality
- Identify points of agreement
- Make recommendations to improve spiritual care in palliative care settings
- Identify resources to advance the quality of spiritual care
Consensus Conference Goal

• Identify points of agreement about spirituality as it applies to health care
• Make recommendations to advance the delivery of quality spiritual care in palliative care
• Five Key Elements of Spiritual Care provided the framework: spiritual assessment; models of care and care plans; interprofessional team training; quality improvement; and personal and professional development

A Consensus Definition of Spirituality was Developed:

• “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.”

Conference Recommendations

• Recommendations for improving spiritual care are divided into seven key 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

I. Spiritual Care Models

Recommendations

• Integral to any patient-centered health care system
• Based on honoring dignity
• Spiritual distress treated the same as any other medical problem
• Spirituality should be considered a "vital sign"
• Interdisciplinary

Inpatient Spiritual Care Implementation Model

Spirital Assessment Examples

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<th>Diagnosis (Primary)</th>
<th>Key Feature From Notes</th>
<th>Example Statements</th>
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<td>&quot;My life is meaningless&quot; &quot;I feel useless&quot;</td>
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<td>God or others lack of love, loneliness / Not being remembered / No Sense of Relatedness</td>
<td>&quot;God has abandoned me&quot; &quot;No one comes by anymore&quot;</td>
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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

III. Formulation of a Spiritual Treatment Care Plan

- **Recommendations**
  - Screen & Access
  - All HCPs should do spiritual screening
  - Clinicians who refer should do spiritual histories and develop appropriate treatment plans working with Board Certified Chaplain if possible
  - Diagnostic labels/codes
  - Treatment plans
  - Support/encourage in expression of needs and beliefs

Four Target Areas

- **Four Target Areas for Projects**
  - Spiritual Care Models
  - Spiritual Assessment of Patients and Families
  - Spiritual Treatment Plan
  - Quality Improvement

Scripps Memorial Hospital Encinitas

- Will formalize the spiritual “assessment” process in alignment with the Hospital's mission, vision, and values
- Will add a dedicated Social Worker to the Palliative Care.
- Will increase Chaplain position by .2 FTE to total 1.0 FTE Chaplain
- Will fully train all of the clinical members of the palliative care team in the use of the spiritual “assessment” and re-evaluation
- Chaplain shadowing PCRN to determine workflow of referrals from PC to SC
- Team reviewing current spiritual assessment tool and electronic documentation utilized by Spiritual Care providers for applicability within the project.
Whole-person care:

Our hope is that these demonstration and curricular projects will serve as a model for others to improve the total care for patients by integrating spirituality as foundational to that care.

Call to Chaplains to....

- Be leaders in interdisciplinary spiritual care model implementation
- Educate the other members of the IDT
- Teach courses in medical, nursing schools
- Teach your colleagues why and when they should refer to you and then provide feedback to them about what to do next for their patients
- Develop formation tracks in medical, nursing and other professional training
- Develop accountability measures for your profession

Do Research: Come up with creative ways to lift the stories of what we all do within a research oriented world

- Spiritual care outcome measures
- Guidelines in spiritual care
- Develop tools for assessment
- Develop standardized notes for chaplains for documentation
- Demonstrate why spirituality should be a vital sign
- Develop spiritual diagnosis codes, "evidence based" treatment or intervention
- Differentiation of spiritual vs emotional
- Reimbursement criteria for spiritual care
- Study outpatient models for chaplaincy (e.g. medical home, wellness or survivorship clinics...)

Gwish’s Big Dream:

- Whole-person clinic where the biopsychosocialspiritual model is fully integrated, where doctors, chaplains, nurses, social workers, PT, exercise physiology, nutrition, work together to meet the needs of the patient—
- where healing is recognized as fundamentally spiritual
- Where the healing encounter is valued most over efficiency, money and purely scientific outcomes.
Being a compassionate presence means connecting to the sacred in another from the sacred place within us.

“The Face of the Sacred”

In the healing relationships we find the transcendent, the holy, the sacred.

GWish: www.gwish.org

- Education resources (SOERGE, National Competencies etc)
- Interprofessional Initiative In Spirituality Education (nursing, medicine, social work, pharm, psychology)
- Retreats in for Healthcare Professionals (Assisi, US)
- FICA Assessment tool--- online DVD
- Summer Institute in spirituality and health at GWU
- National Demonstration Sites in Spirituality and Health

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