Ethics, Medicine and Public Health (2019) 9, 45—56

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RESEARCH UPDATES

Time to follow the evidence — Spiritual care in health care

Les communautés de foi ont-elles un rôle à jouer dans la prestation de soins spirituels en matière de santé?

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Received 13 February 2019; received in revised form 26 April 2019; accepted 29 April 2019

KEYWORDS
Chaplaincy;
Health care;
Spirituality;
Spiritual care

Summary Spiritual care is increasingly integral within the provision of health care. As with every other aspect of health care, spiritual care providers have growing, evidence-based support for their work. This paper presents the evidence as it relates to spiritual care terminology, structure, paradigm, scope of practice, and outcomes, specifically within the context of healthcare within the United States of America.

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https://doi.org/10.1016/j.jemep.2019.04.011
2352-5525/

MOTS CLÉS
Aumônerie ;
Soins de la santé ;
Spiritualité ;
Soins spirituels

Résumé La professionnalisation des soins spirituels dans les soins de la santé est à l'ordre du jour au plan international depuis plusieurs décennies. Comme ce mouvement a pris de l'ampleur, une attention croissante a été portée sur l'identification des meilleurs modèles de pratiques pour la prestation de soins spirituels. Dans le contexte de l'Australie, les modèles mixtes qui sont en place et la domination persistante des communautés de foi (en particulier, les églises chrétiennes) ont été soulignés. Le mouvement international vers la professionnalisation des soins spirituels, les changements démographiques et les résultats de la Commission royale australienne sur les réponses institutionnelles aux abus sexuels envers les mineurs indiquent tous la nécessité de réexaminer les modèles existants et d'établir une approche cohérente pour fournir des soins spirituels. Avec une attention particulière portée sur la qualité des soins et l'expérience des patients, le Spiritual Health Victoria (SHV) a entamé une étude examinant le rôle des communautés de foi dans la prestation de soins spirituels. Cette recherche a pour but de déterminer s'il existe une demande pour des soins spirituels spécifiques à une foi. Ce projet tente de répondre à trois questions: 1. Lorsque les patients déclarent une appartenance à une foi spécifique, souhaitent-ils recevoir leurs soins spirituels par quelqu'un de leur propre tradition religieuse ? 2. Lorsque les patients reçoivent les soins spirituels de quelqu'un de la même tradition religieuse, est-ce que leurs besoins spirituels sont satisfaits ? 3. À la lumière des réponses aux deux premières questions, quel serait le meilleur modèle pour la prestation de soins spirituels ?

We, as whole human beings, are greater than the sum of our organ functions. We use these organs, particularly our brains, to contemplate ourselves, to create art and beauty, to create new ideas, to create an existence that transcends our human biological limitations. . .I experience it as something that is unique to the human experience and is at the essence of what makes us uniquely human. And the term spiritual, as opposed to religious or existential, makes more sense to me. It is more poetic than ''the electrical activity in your amygdala.''

William Breitbart, MD [1]

What is spiritual care?

Spirituality and religion have always been central to the lives of the vast majority of Americans. Researcher William Miller claims that ''most people want to live with better health, less disease, greater inner peace, and a fuller sense of meaning, direction and satisfaction in their lives [2].'' While recently there has been growth of the so-called ''nones''—atheists, agnostics, and those who claim no religious affiliations — now making up roughly as high as 36% of the U.S population [3], a 2018 Pew survey found that 90% of Americans believe in ''some kind of higher power [4].'' Because spiritual and religious expression can be highly individualized and diverse, addressing it in a proactive, nuanced, and expert manner is essential in the pursuit of providing the best possible health care.

It is important for our discussion to differentiate spirituality from religion. Among the U.S population, 27% claim to be ''spiritual but not religious,'' an increase of eight percentage points in just five years [5]. A recent international panel of medical, psychological, and spiritual care experts offered this consensus definition for spirituality: ''Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices [6]. Spirituality is ''the essence of one's humanity and therefore a key factor in how people cope with illness and find healing and a sense of coherence [7].'' Religion, on the other hand, is defined as ''a subset of spirituality, encompassing a system of beliefs and practices observed by a community, supported by rituals that acknowledge, worship, communicate with, or approach the Sacred, the Divine, God (in Western cultures), or Ultimate Truth, Reality, or nirvana (in Eastern cultures) [8].'' In other words, religion is one way in which many people express their spirituality, but not the only way; and it is more about systems or social institutions of people who share beliefs or values [9]. For example, people may find spiritual connections in relationships, in nature, or in a set of beliefs (such as the scientific method), and yet may not belong to a community of faith or a distinct institutional religious system.

For the purpose of this ongoing discussion, we will focus on spirituality within the field of health care, broadly defined as ''the field concerned with the maintenance or restoration of health of the body or mind [10].'' Heath care is rediscovering and beginning to reclaim its holistic roots,

anchored in whole person care. The compassionate relationship between the health care provider, patient, and family is central to this approach. More and more, health care is moving toward becoming ''patient and family engaged care'' in which, as Rev. Eric J. Hall explains, ''The care is customized, encourages patient participation and empowerment, and reflects the patient's needs, values, and choices. Transparency between providers and patients, as well as between providers, is required. Families and friends are considered an essential part of the care team [11].'' Patient and family engaged care ''is care planned, delivered, managed, and continuously improved in active partnership with patients and their families (or care partners as defined by the patient) to ensure integration of their health and health care goals, preferences, and values. It includes explicit and partnered determination of goals and care options, and it requires an ongoing assessment of the care match with patient goals [12].'' The ''brain cancer in room 341'' is also a mother of two, plays piano in her Lutheran church, and fears she will suffer excruciating pain just like her own mother did as she slowly trudged through aggressive medical care 22 years earlier. Patient and family engaged care dictates that the entire interdisciplinary team should consider all of these factors as they partner with the patient and her family to make the best decisions regarding her plan of care. It requires engaging patients and their care partners about their values and then assisting them to better make a medical plan of care that is consistent with those values. For many people, these values are an outgrowth of their spiritual or religious perspectives. This is one place where a chaplain should make a unique, positive contribution to the overall plan of providing exemplary patient and family engaged care.

Most patients are no longer content to only have their physical and medical needs addressed, they rightfully insist that the oftencomplex entirety of their personhood be the central focus of health care. As a result, they are playing a much more proactive role in the care they receive. For some relatively vulnerable populations, this should be an even higher priority for the inter-professional team [13]. Research demonstrates that many turn to their spiritual and/or religious beliefs and resources in order to cope with a wide variety of diseases and experiences of hospitalization [14,15]. Research among patients across a spectrum of health care concerns including, for example, geriatrics [16,17], dementia [18], HIV/AIDS [19—21], cancer [22—27], chronic pain [28], trauma [29], cardiac hospitalizations [30—33], pediatrics [34—36], veterans' health care [37,38], rheumatoid arthritis [39], mental health [40—42], sickle cell disease [43,44], spinal cord injury [45], chronic illness [46], and end of life [47—49] all confirm this trend. Yet despite the fact that The Joint Commission (one of the primary accrediting bodies for hospitals within the United States) recognizes this significance and consequently requires that all patients be assessed in order to ascertain religious affiliation and any spiritual practices or beliefs that have the potential to impact their care [50], only 54 -63% of hospitals fulfill these requirements through employing chaplains [51].

One of the leading paradigms for patient-centered care within health care is palliative care. Briefly put, palliative care is a proactive, holistic care that seeks to focus on the quality of life rather than exclusively quantity, and it is most often utilized closer to the end of life and with patients suffering from chronic or debilitative diseases. The recent release of the 4th edition of the US-based National Consensus Project Clinical Practical Guidelines for Quality Palliative Care (NCP Guidelines), defines palliative care as follows:

Palliative care focuses on expert assessment and management of pain and other symptoms, assessment and support of caregiver needs, and coordination of care. Palliative care attends to the physical, functional, psychological, practical, and spiritual consequences of a serious illness. It is a person- and family-centered approach to care, providing seriously ill people relief from the symptoms and stress of an illness. Through early integration into the care plan of seriously ill people, palliative care improves quality of life for both the patient and the family [52].

The 4th edition of the NCP Guidelines is particularly helpful in that Domain 5: Spiritual, Religious, and Existential Aspects of Care were authored, for the first time, by chaplaincy leaders. The guidelines echo this paper in the following ways:

- the definition of the chaplain, and frame of the chaplain, as the spiritual care specialist and emotional care generalist;
- the description of spiritual care screening, history, and assessment as distinct tools for use by different inter-professional team members;
- the assertion that spiritual care is an essential component of quality palliative care, and;
- that spiritual care interventions using professional standards of practice are part of the basic provision of quality care available to all palliative care patients.

Also of note in the NCP guidelines is an evaluation of the overall supporting evidence for spiritual care interventions and their impact. The highest quality evidence that supports the positive impact of a specific spiritual care intervention on spiritual well-being is that of life review/dignity therapy [53].

Palliative care ''developed as a reaction to the compartmentalized technical approach of modern medicine [54].'' Dame Cicely Saunders, considered to be the founder of contemporary end of life care, advocates that people are indivisibly physical and spiritual beings [55]. Patient and family engaged care requires the entire inter-professional health care team to be able to consider spirituality among other relevant factors in deciding how to best optimize a patient's quality of life. Consequently, the Institute of Medicine, in its seminal report and call to action, ''Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life,'' states that frequent assessment of a patient's spiritual well-being and attention to a patient's spiritual and religious needs should be among the core components of quality end of life care across all settings and providers [56]. In fact, psychosocial and spiritual considerations are considered to be so important that the American Board of Internal Medicine, which offers palliative medicine board certification for physicians, places them second only to medical management within their allotment of content for their board exam [57].

The conversation about proactive spiritual care as a part of palliative care should include the important discussion of vulnerable populations and how chaplains may work toward addressing some of the structural inequities related

to their care. For example, one study determined ''Black and Hispanic patients receive care from hospices with poorer average quality of care. Across all hospices, emotional and spiritual support of Black and Hispanic patients is an important dimension to target for quality improvement [58].'' Another study found Black dialysis patients were far more likely to request aggressive end of life treatments (wanting to be a ''full code'') and also had far fewer executed living wills than their white counterparts [59]. Chaplains can and should be leaders in the discussions about how to bridge health care and palliative care inequities with vulnerable populations.

Spiritual well-being

Most administrators from within the United States will immediately identify the quadruple aims of health care: patient clinical outcomes, financial profit, patient experiences/satisfaction, and employee engagement/retention. As the research below will demonstrate, spiritual care, and chaplains, in particular, make a unique positive contribution to each of these four categories.

Patients and families prioritize spirituality in the health care setting. Studies of patients' beliefs have shown that 87% of patients would call spirituality important in their lives [60], while between 51-77%, depending on the study, consider religion to be important [61,62]. Moreover, studies consistently demonstrate that there is a positive relationship between spirituality and health and well-being [63]. In the research, spirituality is often studied on a spectrum of well-being, from spiritual well-being (also referred to as resilience) on the healthy end through spiritual concerns and spiritual distress/struggle to spiritual despair at the unhealthy end [64,65]. Ultimately, the term ''spiritual distress'' has emerged as the term most used and consistently assessed [66]. Spiritual distress can be defined as ''the impaired ability to experience and integrate meaning and purpose in life through connectedness with self, others, art, music, literature, nature, and/or a power greater than oneself [67].'' Therefore, when a patient, family, or health care professional is experiencing spiritual distress, his or her ability to make meaning or positively cope in the midst of this intense experience is compromised. As a result, a person's well-being and overall health is jeopardized. Experiencing spiritual distress can also make it much more difficult to align one's deeply held values, often connected to one's spirituality, with the clinical goals of care.

Studies have shown, depending on the group of patients surveyed, that 28% (of cancer inpatients) [68], 40.8% (of cancer patients undergoing chemotherapy) [69], and even 65% (of older inpatients) [70] have spiritual distress. That is, patients may be struggling to make meaning or find purpose, often in light of their new or ongoing medical circumstance. They are often forced to redefine their beliefs about themselves, about mortality, about fairness, or about God, the Divine, or religion. In study after study, among a wide variety of clinical settings, patients consistently state that they have spiritual struggles or needs [71—75]., and yet 72% of patients in one study articulated that they received minimal or no spiritual support from the medical team [61].

Spiritual distress, can directly impair health. Rabow and colleagues found that an increase in spiritual well-being was associated with a decrease in depression, anxiety, fatigue, and an increase in overall quality of life [76]. Studies show that people with relatively higher levels of spiritual distress are more likely to have pain [77], be depressed [78], be at higher suicide risk [79], have higher levels of clinically impactful anxiety [80], and have higher resting heart rates [81]. As Professor Neal Krause's research team reports, ''Research indicates that spiritual struggles... are associated with greater psychological distress and diminished levels of well-being [81].''

Yet, ''for a large proportion of either medically ill or mental health patients, spirituality/religion may provide coping resources, enhance pain management, improve surgical outcomes, protect against depression, and reduce risk of substance abuse and suicide [82].'' One large study, conducted at the Dana-Farber Cancer Institute, found that patients who did not receive adequate spiritual support are less likely to spend a week or more in hospice, and are more likely to die receiving aggressive care in the intensive care unit (ICU) [83]. Another large study of 3,585 hospitals showed that providing chaplaincy services is related to lower rates of deaths in the hospital and higher rates of hospice enrollment [84]. The potential impact of spiritual care on pain severity has been demonstrated in numerous studies as well [85,86]. Spirituality is often used as a coping strategy, with prayer, meditation, and mindfulness among the many spiritual resources patients use to help cope with the intensity of the pain they experience.

Spiritual care and patient satisfaction

By supporting patient resiliency, integrating chaplaincy care into health care directly enhances patients' overall expressions of satisfaction with the care they receive at a hospital. A recent study of nearly 9,000 patients at Mount Sinai Hospital concluded that chaplaincy visits increase the patient's willingness to recommend the hospital, as measured by both Press Ganey (one of the most widely used patient satisfaction companies) and the Centers for Medicare and Medicaid Services' survey, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) [87]. Patients receiving a chaplain visit are more satisfied with their overall care, according to both the Press Ganey and the HCAHPS surveys. The Press Ganey survey specifically found that patients who have a chaplain visit are more likely to indicate positive responses to questions regarding whether the ''staff addressed my emotional needs'' and ''staff addressed my spiritual needs.''

Press Ganey's own research among the more than 2 million patients in its worldwide database also demonstrates that the most unmet need related to patients' overall satisfaction with their hospital care is that the ''staff addressed my emotional and spiritual needs [88].'' Patients who have been unable to have their spiritual needs adequately addressed are more likely to have lower levels of satisfaction with and perception of the quality of care [89]. The Joint Commission concludes that the ''emotional and spiritual experience of hospitalization remains a prime opportunity for QI (Quality Improvement). Suggestions for improvement

include the immediate availability of resources, appropriate referrals to chaplains or leaders in the religious community, a team dedicated to evaluating and improving the emotional and spiritual care experience, and standardized elicitation and meeting of emotional and spiritual needs [90].''

Professional chaplains are also particularly trained and positioned to help empower, equip, and train health care providers on patient and family engaged care strategies and behaviors with the potential to have a significant impact on patient satisfaction. One systematic review of the most impactful behaviors relating to patient satisfaction found ''health providers' interpersonal care quality was the essential determinant of patient satisfaction [91].'' Another palliative care-focused study found that ''prognostication, conflict mediation, empathic communication, and family-centered aspects of care are the most important identified competencies for patient- and family-centered PC in critical care settings [92].'' Both findings suggest that areas of strength and competence for chaplaincy are sorely needed throughout the health care team, and that chaplains should provide leadership in helping their institutions with efforts aimed at addressing these cultural norms and expected behaviors.

In addition, a study by the University of Chicago-Pritzer School of Medicine concluded that addressing spiritual concerns not only positively impacts overall patient satisfaction, but also serves to increase trust in the medical team [93]. A study from Saint Vincent Comprehensive Cancer Center demonstrates that when patients' spiritual needs go unmet, patients' rating of both their satisfaction with their care as well as the quality of their care received are significantly lower [71]. Astrow also found that patients who had higher spiritual needs had lower satisfaction with care, and lower perception of quality of care [94]. Sharma and colleagues found that many chaplaincy skills positively impact patient satisfaction, and that those with the religious or spiritual dimension were most impactful [95]. And Johnson and team found that providing spiritual care can also have a direct positive impact on family satisfaction [96].

Spiritual care generalists and specialists

All members of the health care team are responsible for addressing the spiritual issues of patients that arise within the bio-psycho-social-spiritual framework [97]. Even though all health care professionals should provide some spiritual care, most are not trained to do so in-depth [98,99]. While patients do not typically expect to receive in-depth, specialized spiritual care from their physicians or nurses, they do express a strong preference for some basic spiritual care, including listening, communicating and expressing compassion [100]. Studies consistently demonstrate that a high percentage of patients wish that their health care providers would ask about or discuss spirituality and/or religion [101].

Within the practice of medicine, there are both generalists and specialists. As Rev. George Handzo, BCC, states, ''Every physician is taught something about cardiology, certainly including how to assess and at least preliminarily diagnose cardiac issues. The general internist will also be able to treat some number of these issues, especially in their less severe forms, without referring to a cardiologist. However, at some point for some patients, a referral will be necessary [102].'' The same should ultimately be true for spiritual care. Handzo and Harold Koenig, M.D., contend that we need spiritual care generalists—physicians, nurses, social workers, etc.—and spiritual care specialists-in the form of board-certified chaplains [103]. The board-certified chaplain is the spiritual care specialist on the inter-professional team, and also functions as an emotional care generalist.

Paralleling the medical model, the spiritual care generalist is responsible for screening for spiritual need and making referrals to the spiritual care specialist when more in-depth spiritual care is appropriate. In a typical case, the admissions personnel, nurse or social worker would ask spiritual care screening question(s) as part of the overall screening process [104,105]. The goal of the screen is generally to determine the degree of the patient's spiritual distress. An algorithm would then govern whether that patient is referred to the chaplain based on the initial screen. The patient is then screened regularly throughout their health care journey, as situations may change a response. Then, a physician or advanced practice health care provider would take spiritual history as a part of the entire history and physical [106]. The goal of the spiritual history would be to assist the clinician in better understanding their patient from a whole-person perspective, to assist in identifying spiritual, religious, and existential sources of strength and coping, and to discover any spiritual distress. The chaplain would then provide a full spiritual assessment and complex spiritual care in response to their referrals. There are recently standardized spiritual assessment tools chaplains use, such as Outcomes Oriented Chaplaincy [107], Spiritual AIM [108], and the Spiritual Distress Assessment Tool [65,70]. The NCP Guidelines call for the chaplain to use such standardized spiritual assessments in their care, as this is best practice.

''Spiritual issues were significant for many patients in their last year of life and their carers. Many health professionals lack the necessary time and skills to uncover and address such issues. Creating the opportunity for patients and carers to discuss spiritual issues, if they wish, requires highly developed communication skills and adequate time [109].'' While half (51%) of patients in one ethnically diverse patient population stated they would feel comfortable having their doctor inquire as to their spiritual or religious needs [89], few physicians feel equipped and comfortable providing such care [110]. The 4th edition of the NCP Guidelines calls for a board-certified chaplain to be a member of the health care team, especially in palliative care [52]. In one nationwide study of 1,144 physicians, 89% had experience working with a chaplain, and 90% reported being satisfied or very satisfied with their collaboration with the chaplain [111].

Community faith leaders also have a potentially significant role to play in health care, as they are often the ones who have an ongoing relationship with a patient and family. ''Despite playing a central role in end-of-life care, clergy report feeling ill-equipped to spiritually support patients in this context. Significant gaps exist in understanding how clergy beliefs and practices influence end-of-life care [112].'' Current research demonstrates that the potential impact of community faith leaders on end-of-life care is dependent on many variables. For some patients, the

involvement of their faith leader results in more aggressive care and less utilization of support services such as hospice; and, for others, faith leader involvement assists the health care team in facilitating a transition into less aggressive care focused more on quality, as opposed to length, of life [113].

Clergy hold their own religious values that have been shown to impact end-of-life discussions, including their views on: God performing a miracle, pursuing treatment because of the sanctity of life, postponement of medical decision-making because God is in control, and enduring painful treatment because suffering is redemptive [114]. Some research reveals how community faith leaders view a good versus a poor death [115], and has shown that clergy often have poor knowledge about end-of-life care overall [116]. Much more research is needed on how professional chaplains can best partner with community faith leaders to work for the overall best interests of the patients and families they serve. This may include more proactive communication, education and collaboration, as well as more ''upstream'' dialogue and relationships in order to best coordinate care when patients and families are in the acute care setting. Local faith leader involvement can be especially helpful with vulnerable or minority populations, as their faith community may well be best suited to address whatever layers of difference may exist for a specific group of people [117].

Health care professionals from many disciplines across many geographic and clinical settings understand the need to provide spiritual care for patients and their families, but few feel prepared to do so. One study, which looked at prioritizing future research in spiritual care within health care, found that out of almost 1,000 palliative care physicians, nurses and chaplains from 87 different countries, each expressed a strong need for robust research to help develop and evaluate conversations by health care professionals and chaplains about patient spirituality [118]. They also expressed that health care providers need more training on i how to screen and assess spiritual needs. Another study revealed a disconnect between what patients are wanting in spiritual care from health care providers, and what health care providers assume they want. This ''set up the strong possibility for a [health care professional] to 'miss the moment' in providing spiritual care. These key misses include the perception that spiritual care is simply not something they can provide... and that the focus on spiritual care... as 'task oriented', often with an emphasis on meaning making or finding purpose, whereas patients much more commonly described spiritual care as listening deeply, being present, and helping them live in the moment [119].'' Board-certified chaplains have the specialty training, knowledge and skills to help physicians, nurses, and social workers address the spirituality of their patients through training, modeling, and equipping them to provide basic levels of compassionate, empathic spiritual support.

Role of board-certified chaplains

Board-certified professional chaplains are uniquely trained to be the spiritual care specialists within health care. Most patients, families, and health care professionals remain unaware of the extensive training and certification process for professional chaplaincy, often mistakenly assuming that chaplains are ministers or faith leaders who simply like to visit sick people but have little if any additional training beyond their studies to become a faith leader. This may have been the case a generation or two ago, but it is no longer the case today. Board-certified chaplaincy is a career that requires intensive post-graduate training and a clinical residency, akin in many ways to the graduate medical education physicians experience after medical school in their residency.

In order to be eligible for board certification, a chaplain must complete a Master's degree in a content area relevant to professional chaplaincy. In addition, a chaplain must also have substantial and in-depth clinical training. Clinical Pastoral Education (CPE) is one of the most popular clinical chaplaincy training paradigms. Within CPE, in addition to didactic sessions for gaining a knowledge base and skill set for chaplaincy, chaplains-in-training provide spiritual care for patients, families, and staff in order to gain clinical experience. The chaplain then returns to his or her peer group to analyze what worked well, what did not, and why; this informs the chaplain's clinical interactions moving forward. This action-reflection-action model allows for chaplains to learn insights into their own spiritual care tendencies and to gain awareness of how their tendencies impact the patient, family, or staff with whom they work [120].

Once the chaplain-in-training has completed both the Master's degree and the in-depth clinical training, he or she must go through a review process in order to become board-certified. Depending on the certifying body, this may take the form of a formal interview with board-certified chaplains with written submissions of competency essays. In another certification model, the chaplain must pass a standardized clinical knowledge test and a standardized patient exam (simulated patient encounter). Only once these steps have been completed can a chaplain serve as a board-certified chaplain—the spiritual care specialist on the inter-professional team.

Within the field of professional chaplaincy, there are common Standards of Practice, communicating the professionalism and specific objectives of the role of board-certified chaplains [121]. To standardize the field, interdisciplinary expert panels recently developed and published two important evidence-based documents: Quality Indicators and Scope of Practice. The Quality Indicators document summarizes the research on the ''indicators of quality spiritual care in health care, the metrics that indicate quality care is present, and suggested evidence-based tools to measure that quality [122].'' The Scope of Practice document provides a synthesis of the research ''to articulate the scope of practice that chaplains need to effectively and reliably produce quality spiritual care...[and] to establish what chaplains need to be doing to meet those indicators and provide evidence-based quality care [123].''

Chaplains are not just about prayer and death. Board-certified chaplains seek to provide spiritual care to patients of all faith traditions and none [107]. An explicit ethic of professional chaplaincy is that the board-certified chaplain seeks to connect the patient, family, or staff person to their

own spiritual frame of reference, not superimpose or proselytize any specific religious or spiritual tradition [124] [125]. One author describes the work of the chaplain as that of being a ''story catcher [126].'' The primary activities of the chaplain include relationship building, care at time of death, goals of care conversations, and helping patients with existential or spiritual distress [127]. Another researcher found that chaplains are most focused on patient and family practices, beliefs, coping mechanisms, concerns, emotional resources and needs, family and faith support, medical decision-making, and medical communication [128]. They often facilitate goals of care discussions and family meetings, facilitate palliative care meetings, assist the health care providers in breaking bad news, are present with patients and families before, during, and after the time of death and generally support institutional patient experience initiatives. The chaplain is also often regarded as a cultural broker on the team [129].

Chaplains assess patients, families, and staff for spiritual and emotional needs; they provide in-depth and specialized patient and family-engaged spiritual care interventions that are sensitive to the unique spiritual, emotional, religious, and cultural needs of the person(s) being served; and chaplains identify and contribute toward a specific positive outcome. One widely used frame for spiritual assessment focuses on the needs, hopes, and resources, for a patient's spiritual, emotional, and relational domains [130]. Chaplains then clearly communicate their assessment, intervention and outcome to the other health care professionals through charting.

The standard of practice for chaplains is to provide spiritual assessments for every patient and family visit. This can often require that considerable time be spent with the patient or family. The chaplain seeks to understand the patient's spiritual, religious, cultural, and emotional context and narrative, and from that generates a spiritual care plan. Part of the assessment may well be to assess the way in which the patient or family may be experiencing ''issues of purpose and meaning, loss of any of the many aspects of self-control, or spiritual pain or suffering [131].'' The board-certified chaplain then seeks to address the issues that have been assessed through providing spiritual care interventions in service of a desired contributing outcome [132].

Board-certified chaplains have a wide variety of spiritual care interventions from which to choose in providing spiritual care for patients, families, and staff. Recent efforts have been made to standardize the terminology of the praxis of chaplaincy, resulting in an in-depth chaplaincy intervention taxonomy—meaning a descriptive list of what it is chaplains do in providing spiritual care [66]. This list helps articulate the nuts and bolts of chaplaincy care, using the language that chaplains use to convey their spiritual care interventions—empathetic listening, prayer, religious rituals, etc.—to the interdisciplinary care team in clinical communications like charting. Another recent article differentiates between the interventions that are more ''being'' versus those that are ''doing,'' and conversation topics that are ''practical matters'' versus ''ultimate concerns.'' Chaplains articulated that they felt their care is most effective when all four of these are included in a visit [133].

Bottom-line impact of spiritual care

One of the unique aspects of chaplaincy care is that chaplains are explicitly charged to bring their spiritual care not just to patients and their loved ones, but to health care providers as well. Chaplains provide proactive spiritual and emotional support to colleagues, and in doing so, can directly impact an organization's bottom-line. As chaplains help health care providers cope with the intensity of their profession and its duties and dramas, the health care professionals are more likely to foster resilience, which leads to better professional engagement and quality of care [134,135].

A recent study by the Mayo Clinic of its physicians found that 65.2% believe in God, while 51.2 % consider themselves to be religious [136]. Further, 29% of respondents report that their religious or spiritual beliefs contributed to their decision to become physicians. While 44.7% of doctors surveyed pray regularly, 20.7% have actually prayed with their patients. With physicians at one of the nation's leading medical institutions placing this high an importance on spirituality and religion, chaplains are in a position to potentially have a significant positive impact on doctors' ability to foster spiritual well-being and mitigate potential burnout.

Studies show significant problems with compassion fatigue and burnout among physicians. One states that 45.8% of doctors in the U.S. exhibit one or more symptoms of burnout [137], with physicians-in-training scoring much higher at 76% [138]. Another systematic review of studies of physician burnout found a prevalence of 67.0% for overall burnout, 72.0% for emotional exhaustion, 68.1% for depersonalization, and 63.2% on low personal accomplishment [139]. ''Symptoms of burnout can lead to physician error, and these errors can, in turn,contribute to burnout. Given the potential human costs of medical mistakes, the emotional impact of actual or perceived errors can be devastating for physicians [140],'' and burnout also impacts the physician's ability to empathically communicate with patients and their loved ones [141]. From strictly a financial impact perspective, ''for an organization, the cost of physician burnout can range from $500,000 to more than $1 million per doctor [142].'' The New England Journal of Medicine, in November 2018, also released an entire multifaceted collection of articles discussing physician burnout, ways it can be understood, the impact it has on health care, and how it might be addressed [143].

The same potential issues and impact arise within nursing. Studies show that, depending on the clinical setting and other variables, anywhere from 33% [144] to upwards of 86% [145] of nurses show significant signs of compassion fatigue and burnout. As with physicians, chaplains are in a unique position to provide spiritual and emotional support to nursing staff. Chaplains often have the added benefit of ''getting it,'' as the chaplains are more closely experiencing the same clinical setting and intensity that the nurses are. As a result, chaplains are often viewed as approachable and likely to understand the issues nurses may be having. Therefore, chaplains, in providing proactive spiritual and emotional support to physicians, nurses and other staff, can potentially positively contribute to an institution's bottom-line through helping to address and support positive coping strategies for the health care professionals suffering from burnout. They

may also and have a positive impact on providers' engagement with their institutions, and ultimately, retention and turnover.

The scope of practice of board-certified chaplains explicitly states that they provide spiritual and emotional support for the health care providers with whom they work. They help the team, individually and as a group, process its own spiritual issues, and help use its spiritual resources to provide better care. These activities might include memorial services, cleansing of space, blessing of hands, meditations as part of staff meetings, Tea for the Soul, spirituality or spiritually related reading groups for staff, debriefing, and individual counseling.

In addition, the aforementioned Dana-Farber study concluded that less than adequate spiritual support for patients' results in higher cost of care, as patients spend less time in hospice and have more aggressive, more costly care in the ICU. The researchers were even able to quantify the cost savings, in 2010 dollars, at $2,114 per patient, with even greater savings for minority patients ($4,257) and ''high religious copers'' ($3,913) [83]. Another study, conducted by Columbia University Medical Center, showed that congestive heart failure patients who experience spiritual struggle also have poorer physical function and increased hospitalizations [146]. And a two-year study by Duke University Medical Center revealed that religious struggle is a predictor of mortality in medically ill elderly patients [147]. A measure called ''negative religious coping,'' which is related to spiritual distress, was shown in a study of stem cell transplant patients, at the University of Arkansas for Medical Science, to be associated with an increased incidence of depression, distress, mental health, pain and fatigue [148]. And palliative care programs, which place a central focus on the provision of spiritual care for the patient and family, when compared to patients not on palliative care service, contribute to a cost savings, in 2008 dollars, of $1,696 in direct costs per admission for patients who are discharged, and $4,908 per admission for patients who die in the hospital [149]. If a spiritual care specialist or board-certified chaplain is able to work with both palliative care and non-palliative care patients during their hospitalization, this specialist would likely be able to help mitigate some of the severity of the health outcomes the research demonstrates as being related to spiritual distress. In doing so, the chaplain has the potential to positively impact the bottom-line of the institutions providing that care.

Conclusion

Spirituality is important for patients, families, and staff. With few exceptions, most people who come to health care settings have a disease, an illness, an injury, a wound, or are suffering from the consequences of ageing. Patient-centered care seeks to address the entirety of the impact of that condition through physiologically, clinically, and spiritually providing exemplary evidence-based best practice.

Board-certified chaplains function as the spiritual care specialists and bring a wealth of expertise in assisting people in making meaning, addressing their spiritual distress, and walking with them through their medical journey. As integral members of the inter-professional team, chaplains uniquely contribute to the well-being and overall health of patients, their families, and health care professionals—–improving patient satisfaction, positively impacting health outcomes, and ultimately saving institutions money.

Disclosure of interest

The authors declare that they have no competing interest.

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