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SPIRITUAL CARE:
What It Means,
Why It Matters in
Health Care

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HealthCare Chaplaincy Network™ is a global health care nonprofit organization founded in 1961 that offers spiritual-related information and resources, and professional chaplaincy services in hospitals, other health care settings, and online. Its mission is to advance the integration of spiritual care in health care through clinical practice, research and education in order to improve patient experience and satisfaction and to help people faced with illness and grief find comfort and meaning—whoever they are, whatever they believe, wherever they are.

HCCN's affiliate, the Spiritual Care Association, is the first multidisciplinary, international professional membership association for providers of spiritual care in health care that establishes evidence-based quality indicators, scope of practice, knowledge base, and testing to become a Board Certified or Credentialed Chaplain. Membership is open to chaplains and other health care professionals, clergy and organizations.

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WHAT IS SPIRITUAL CARE?

In his treatise “De Anima (On the Soul),” Aristotle teaches that the “psyche”—the soul—is the full actualization of a person, incorporating the body, the purpose, and ultimately the sum total of the operations of being human.¹ For Aristotle, the body and the soul are not different entities, but distinct aspects of the same thing, with the body being the matter and the soul being the meaning or purpose. For a human then, one’s soul is one’s essence and purpose, one’s meaning and significance.

Rooted in such articulations of reality, spirituality and medicine have intertwined for millennia. As modern Western medicine evolved, it emphasized a kind of compartmentalized scientific and physiological approach to disease and treatment. Spirituality and its important role within the lives of patients, families, and health care professionals are often overlooked and undervalued. However, since the early 1990s, there has been a renewed interest in research about spirituality and its potential impact on health care.

Spirituality and religion have always been central to the lives of the vast majority of Americans. Attesting to present day concerns, 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.” While there recently has been growth of the so-called “nones”—atheists, agnostics, and those who claim no religious affiliations—now making up roughly 23 percent of the U.S. population (up from 16 percent just seven years prior), a recent Gallup survey finds that 89 percent of Americans believe in God. Although spiritual and religious expression can be highly idiosyncratic and diverse, it remains relevant 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, 37 percent claims to be “spiritual but not religious.”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 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).”⁷ 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.⁸ 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 institutional religious system.

KEY DEFINITIONS

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.

Health Care

The field of health care is broadly defined as the field concerned with the maintenance or restoration of health of the body or mind.

Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Spiritual Distress

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.

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.”⁹ More and more, health care is moving toward becoming “patient-centered care” in which, as Rev. Eric J. Hall explains, “The patient is the source of control for their care. 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.”¹⁰ Patient-centered care takes into account a patient’s social, emotional and spiritual concerns, not just the patient’s physiological disease. The patient with brain cancer in room 341 is also a mother of two, plays piano in her Lutheran church, and fears she will suffer excruciating pain like her own mother did as she slowly trudged through aggressive medical care 22 years earlier. Patient-centered care allows the entire interdisciplinary team to consider all of these factors as they partner with the patient and her family to make the best decisions regarding her plan of care.

Unlike the former more physiologically-compartmentalized focus, patients in their often-complex entirety are becoming the central focus of health care, and as such are playing a much more pro-active role in the care they receive. Much research demonstrates that they turn to their spiritual beliefs and resources in order to cope with a wide variety of diseases and experiences of hospitalization.¹¹ Research among patients across a spectrum of health care concerns, including, for example, geriatrics,¹² HIV/AIDS,¹³ cancer,¹⁴ chronic pain,¹⁵ trauma,¹⁶ cardiac hospitalizations,¹⁷ rheumatoid arthritis,¹⁸ mental illness,¹⁹ sickle cell disease,²⁰ chronic illness,²¹ and end of life,²² all confirm this trend. Yet despite the fact that The Joint Commission 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,²³ only 54 percent to 63 percent of hospitals fulfill these requirements through employing chaplains.²⁴

One of the leading paradigms for patient-centered care within health care is palliative care. Briefly put, palliative care is a pro-active holistic care that seeks to focus on quality of life rather than exclusively quantity, and is most often utilized closer to the end of life and with patients with chronic or debilitating diseases. In the words of researcher Cecilia Sepúlveda, palliative care “is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.”²⁵

Palliative care “developed as a reaction to the compartmentalized technical approach of modern medicine.”²⁶ Dame Cicely Saunders, considered to be the founder of contemporary end-of-life care, echoes Aristotle as she advocates that people are indivisibly physical and spiritual beings.²⁷ Patient-centered care requires the entire interprofessional 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.²⁸ 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.²⁹

Patient-centered care requires the entire team to be able to consider spirituality in deciding how to best optimize a patient’s quality of life.

SPIRITUAL WELL-BEING

Patients and families prioritize spirituality in the health care setting. Studies of patients' beliefs have shown that 87 percent of patients would call spirituality important in their lives,³⁰ while between 51 percent to 77 percent, depending on the study, consider religion to be important.³¹

Moreover, studies consistently demonstrate that there is a positive relationship between spirituality and health and well-being.³² 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.³³ 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."³⁴ 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.

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Studies have shown, depending on the group of patients surveyed, that 28 percent (of cancer inpatients),³⁵ 40.8 percent (of cancer patients undergoing chemotherapy),³⁶ and even 65 percent (of older inpatients)³⁷ have spiritual distress. That is, patients may be struggling to make meaning or find purpose, often in light of their new or ongoing medical situation and circumstance. They are often having to redefine their beliefs about themselves, about mortality, 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.³⁸ And yet, 72 percent of patients in one study articulated that they received minimal or no spiritual support from the medical team.³⁹

Spiritual distress, moreover, can directly impair health. Studies show that people with relatively higher levels of spiritual distress are more likely to have pain, more likely to be depressed,⁴⁰ be at higher suicide risk,⁴¹ have higher levels of clinically impactful anxiety,⁴² and have higher resting heart rates.⁴³ 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."⁴⁴

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."⁴⁵ One large study, conducted at the Dana-Farber Cancer Institute, found that patients who did not receive adequate spiritual support are less likely to receive a week or more in hospice, and are more likely to die receiving aggressive care in the intensive care unit (ICU).⁴⁶ Another large study of 3,585 hospitals, from Memorial Sloan Kettering Cancer Center, showed that providing chaplaincy services is related to lower rates of deaths in the hospital and higher rates of hospice enrollment.⁴⁷ The potential impact of spiritual care on pain severity has been demonstrated in numerous studies as well.⁴⁸ 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).⁴⁹ 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 demonstrates that the single most unmet need as it relates to the overall patient satisfaction with the care they received in a hospital is that the "staff addressed my emotional and spiritual needs."⁵⁰ 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 quality of care.⁵¹ 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."⁵²

In addition, a study by the University of Chicago-Pritzker 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.⁵³ 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.⁵⁴

SPIRITUAL CARE GENERALISTS AND SPECIALISTS

Even though all health care professionals should provide some spiritual care, most are not trained to do so in-depth.⁵⁵ 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.⁵⁶ Studies consistently demonstrate that a high percentage of patients wish their health care providers would ask about or discuss spirituality and/or religion.⁵⁷

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."⁵⁸ The same should ultimately be true for spiritual care. Handzo and Harold Koenig, M.D., contend that we need spiritual care

KEY STATISTICS

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generalists—physicians, nurses, social workers, etc.—and spiritual care specialists—board certified chaplains.⁵⁹ 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. The nurse or social worker can perform a spiritual care screen,⁶⁰ a physician can take a spiritual history,⁶¹ and the chaplain can provide complex spiritual care in response to their referrals.

“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.⁶² Creating the opportunity for patients and carers to discuss spiritual issues, if they wish, requires highly developed communication skills and adequate time.”⁶³ While half (51 percent) of patients in one ethnically diverse patient population stated they would feel comfortable having their doctor inquire as to their spiritual or religious needs,⁶⁴ few physicians feel equipped and comfortable providing such care.⁶⁵ The National Consensus Project for Quality Palliative Care Clinical Practice Guidelines calls for a board certified chaplain to be a member of the health care team, especially in palliative care.⁶⁶ In one nationwide study of 1,144 physicians, 89 percent had experience working with a chaplain, and 90 percent reported being satisfied or very satisfied with their collaboration with the chaplain.⁶⁷

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.”⁶⁸ 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.⁶⁹ Some research has begun to reveal how community faith leaders view a good versus a poor death,⁷⁰ and 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.

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 pro-active and robust research to help develop and evaluate conversations by health care professionals and chaplains about patient spirituality.⁷¹ They also expressed that health care providers need more training in how to screen and assess spiritual needs. Board certified chaplains are in a unique position to help physicians, nurses, and social workers better address the spirituality of their patients through training, modeling, and equipping them to provide basic levels of empathic spiritual support.

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ROLE OF BOARD CERTIFIED CHAPLAINS

Board certified 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, most commonly a three-year Master of Divinity or an equivalent 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.⁷²

Once the chaplain-in-training has completed both the Master's degree and the in-depth clinical training, he or she then 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, written submissions of competency essays, or, most recently, passing a standardized clinical knowledge test and a demonstration of clinical competencies through written work or 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 interprofessional 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.⁷³ 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."⁷⁴ 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."⁷⁵

Chaplains are not just about prayer and death. Board certified chaplains seek to provide spiritual care to patients of all faith traditions and none.⁷⁶ 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.⁷⁷

Chaplains assess patients, families and staff for spiritual and emotional needs; they provide in-depth and specialized patient-centered spiritual care interventions that are sensitive to the unique spiritual, emotional, religious and cultural needs of the person being served; and chaplains identify and contribute toward a specific positive outcome. Chaplains then clearly communicate their assessment, intervention and outcome to the other health care professionals through charting.

Board certified chaplains are the spiritual care specialists, and bring a wealth of depth, breadth and expertise in assisting people in making meaning.

Chaplains should provide spiritual assessments for every patient and family visit. This can often require that considerable amount of 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."⁷⁸ The board certified chaplain then seeks to address the issues that have been assessed through providing spiritual care interventions.

Board certified chaplains have a wide variety of spiritual care interventions from which to choose in providing spiritual care for patients, families and staff. A recent article presented an in-depth chaplaincy intervention taxonomy—meaning a descriptive list of what it is chaplains do in providing spiritual care.⁷⁹ 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.⁸⁰

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, have the potential to 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.⁸¹

A recent study by the Mayo Clinic of its physicians found that 65.2 percent believe in God, while 51.2 percent consider themselves to be religious.⁸² Further, 29 percent of respondents report that their religious or spiritual beliefs contributed to their decision to become physicians. While 44.7 percent of doctors surveyed pray regularly, 20.7 percent 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 percent of doctors in the U.S. exhibit one or more symptoms of burnout,⁸³ with physicians-in-training scoring much higher at 76 percent.⁸⁴ "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,"⁸⁵ and burnout also impacts the physician's ability to empathically communicate with patients and their loved ones.⁸⁶

The same potential issues and impact arise within nursing. Studies show that, depending on the clinical setting and other variables, anywhere from 33 percent to 44 percent⁸⁷ and upwards of 86 percent⁸⁸ 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

KEY AUTHORITATIVE STATEMENTS

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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, and have a positive impact on physician engagement with their institutions and ultimately retention and turnover.

In addition, the aforementioned Dana-Farber study concluded that patients who receive less than adequate spiritual support results in higher cost of care, as provider's 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 an even greater savings for minority patients (\$4,257) and "high religious copers" (\$3,913).⁸⁹ 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.⁹⁰ And a two-year study by Duke University Medical Center revealed that religious struggle is a predictor of mortality in medically ill elderly patients.⁹¹ A measure called "negative religious coping," which is related to spiritual distress, was shown in a study of stem cell transplant patients, out of the University of Arkansas for Medical Science, to be associated with increased incidence of depression, distress, mental health, pain and fatigue.⁹² 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.⁹³ If a spiritual care specialist, a 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

Aristotle's articulation of the soul of a person being intertwined with the body is reflected in this discussion of spirituality within health care. With few exceptions, most people come to the acute care hospital setting because something is dramatically wrong. They have a disease, an illness, an injury, or a wound. And patient-centered care seeks to address the entirety of the impact of that disease through providing exemplary evidence-based best practice physiologically, clinically and spiritually.

Board certified chaplains are the spiritual care specialists, and bring a wealth of depth, breadth and expertise in assisting people in making meaning, addressing their spiritual distress, and walking with them through their medical journey. As integral members of the interprofessional 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 in the process.

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