

Article

The Spiritual Care Team: Enabling the Practice of Whole Person Medicine

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Abstract: We will soon be piloting a project titled “Integrating Spirituality into Patient Care” that will form “spiritual care teams” to assess and address patients’ spiritual needs in physician outpatient practices within Adventist Health System, the largest Protestant healthcare system in the United States. This paper describes the goals, the rationale, and the structure of the spiritual care teams that will soon be implemented, and discusses the barriers to providing spiritual care that health professionals are likely to encounter. Spiritual care teams may operate in an outpatient or an inpatient setting, and their purpose is to provide health professionals with resources necessary to practice whole person healthcare that includes spiritual care. We believe that this project will serve as a model for faith-based health systems seeking to visibly demonstrate their mission in a way that makes them unique and expresses their values. Not only does this model have the potential to be cost-effective, but also the capacity to increase the quality of patient care and the satisfaction that health professionals derive from providing care. If successful, this model could spread beyond faith-based systems to secular systems as well both in the U.S. and worldwide.

Keywords: spirituality; religion; spiritual history; spiritual care; spiritual care team

1. Introduction

Research is rapidly accumulating that demonstrates a link between religious involvement and health [1]. As a result, clinicians are searching for ways to apply the findings from these studies to patient care. Perhaps just in time. Healthcare systems and healthcare professionals are struggling. As public health measures improve and healthcare becomes more widely available, people are living longer. Consequently, healthcare systems around the world are beginning to feel the strain involved in caring for more and more patients with chronic health problems as people advance in years. This is especially true in countries such as China, India, the Middle East, and some of the African and South American countries as well [2–5]. The problem is becoming particularly acute in developed countries, such as the United States, where rising healthcare costs are threatening to bankrupt the nation [6], leaving little room for other government-sponsored programs (social security, Medicaid, *etc.*) and encroaching on budgets to preserve the environment, invest in education, infrastructure and research, public safety and security, and defense [7].

Healthcare systems have sought to adapt to increasing numbers of patients by increasing the volume of patients that providers see, creating stress on providers and resulting in an estimated 30%–40% of physicians in the U.S. experiencing burnout (figures which are now about five years old, and the situation has worsened since then) [8]. The stressful healthcare environment limits clinicians' ability to provide whole person care that considers the physical, psychological, social, and spiritual needs of those with chronic disabling illness. These needs are closely interconnected, as research in the field of psychoneuroimmunology is demonstrating [9]. The mind, the body, the social environment, and people's spiritual beliefs and practices all influence each other in complex ways that make focusing on the physical body alone—especially when illness is chronic—incomplete and less effective than might otherwise be. In the days when diseases were primarily acute and occurred in the young or middle-aged, treating the physical body was often enough. That is not the case today, however, with chronic illnesses that may last many years and not only increase medical costs, but cause functional disability, adversely affect quality of life (of both the afflicted person and their family), and often raise questions about the meaning and purpose of life [10].

2. The Spiritual Care Team and Its Goals

The “spiritual care team” (SCT), a phrase coined by Emmer and Brown [11], is made up of a group of health professionals and staff who seek to integrate spirituality into patient care in a way that enhances their ability to provide “whole-person” healthcare that includes “spiritual care”. The model described here is being developed at Duke University's Center for Spirituality, Theology and Health for implementation in the Adventist Health System, the largest Protestant healthcare system in the United States [12]. The goals of the SCT are to: (1) identify the spiritual needs of patients related to medical illness; (2) competently address those spiritual needs; (3) create an atmosphere where patients feel comfortable talking about their spiritual needs with the physician and other team members; (4) address the whole-person needs of healthcare team members related to patient care; and (5) provide whole-person health care to all patients they serve. Spiritual needs are those related to the Transcendent (however that is understood by the patient). For example, a patient may feel that their medical

condition is a punishment from God or that God has deserted them or that their faith community has abandoned them. Alternatively, a patient may be struggling with where he or she is going after death, fearful perhaps of going to hell or concerned that there actually is a hereafter. A patient may have a need for prayer or a desire to be visited by members of their faith community. These are examples of spiritual needs.

3. The Rationale

Why should health professionals take the time to form SCTs to assess and address the spiritual needs of patients? The rationale is both theoretical and concrete, and relates to the interconnectedness of mind, body, and spirit. First, many patients have spiritual needs related to illness, and addressing those needs affects satisfaction with care, quality of life, and interestingly, healthcare costs [13–15]. Furthermore, clinical trials have reported that when physicians conduct a spiritual assessment, patient outcomes improve, including compliance with clinic visits, reduction of depressive symptoms, increased functional well-being, and improved the doctor-patient relationship (sense of personal caring from the physician) [16,17]. Second, religious beliefs influence coping with illness and may affect the patient's emotional state and motivation towards recovery, affecting their ability to provide self-care [18]. Third, religious beliefs affect important health-related behaviors and likely influence medical outcomes, as is increasingly being documented [19]. Fourth, religious beliefs influence medical decisions made by *both* patients [20,21] *and* physicians [22]; these decisions often involve the use of expensive, high tech treatments, especially towards the end of life [23].

Fifth, the “standard of care” put forth by the Joint Commission for the Accreditation of Hospital Organizations (JCAHO) in the U.S. requires that providers respect patients' cultural and spiritual beliefs [24]. Specifically, the regulations for hospitals (for all patients) say: “The hospital respects the patient's cultural and personal values, beliefs and preferences” (RI.01.01.01 EP 6) and “The hospital accommodates the patient's right to religious and other spiritual services” (RI.01.01.01 EP 9). The regulations are even more specific about respecting the spiritual beliefs of patients in end-of-life care, those being treated for alcohol and substance use, and those receiving treatment for emotional or behavioral disorders (PC.01.02.01 EP 4, PC.01.02.11 EP 5, and PC 01.02.13 EP3, respectively). Assessment is the only way to know the nature of these beliefs.

Sixth, support from a religious community may increase patient monitoring and improve compliance with treatment, resulting in more timely healthcare that is always less expensive than acute emergency care. Finally, addressing spiritual issues may benefit the health professional as well by providing intrinsic rewards associated with delivering whole-person healthcare.

There is also scientific rationale for assessing and addressing patients' spiritual needs. I will briefly review some of that research here. However, for a more detailed examination of these studies, readers are referred to the *Handbook of Religion and Health*, which contains a systematic review of quantitative studies published in academic peer-reviewed journals through 2010 [1]. I begin with mental health, and then move on to social health, health behaviors, and physical health.

First, in some areas of the U.S. and elsewhere in the world, up to 90% of medical patients rely on religion to cope [18]. High levels of stress, such as those experienced after the September 11 terrorist attacks, often cause people to turn to religion for comfort and control during such events [25]. In the

overwhelming majority of over 400 studies that have now examined this (not including most qualitative studies), people say that religion helps them to cope better [1]. Religious beliefs are commonly used to endure the distress caused by health problems, giving meaning to illness, promoting hope for recovery, and providing rituals and behaviors that bring individuals together and settle anxiety (such as prayer). Similarly, beliefs of this kind have been repeatedly linked with better mental health in medical patients [26–28].

How is religious involvement related to mental health more generally and to social health? In brief, religiosity or spirituality is related to less depression in over 60% of 444 quantitative studies; greater well-being and happiness in nearly 80% of 326 studies; greater meaning and purpose in over 90% of 45 studies; greater hope and optimism in over 75% of 72 studies; and because they convey greater meaning, purpose and hope, religious beliefs and activities are related to less suicide, fewer suicide attempts, and more negative attitudes toward suicide in 75% of 141 studies. Religiosity was also found to be related to less alcohol or drug use/abuse in over 85% of nearly 300 studies, and greater social support, marital stability, and prosocial behavior in more than 80% of 257 studies.

What about health behaviors, such as exercise, diet, cigarette smoking, sexual activity, and weight control that are responsible for nearly 80% of all chronic medical illness? The research shows that religious persons were more likely to exercise or be physically active in nearly 70% of 37 studies; eat a better diet in over 60% of 21 studies; have lower cholesterol in over 50% of 23 studies; participate in less extra-marital sex in 86% of 95 studies, and were less likely to smoke cigarettes in 90% of 137 studies. Unfortunately, those who are more religious had lower weight in less than 20% of studies and were heavier than non-religious persons in nearly 40% of studies. Yes, those potluck suppers!

Despite this, however, religious persons have tended to have better physical health than non-religious persons in the majority of studies so far. This includes better immune function in over 50% of 25 studies; better endocrine function in nearly 75% of 31 studies; better cardiovascular functions in close to 70% of 16 studies; less coronary heart disease in nearly two-thirds of 19 studies; lower blood pressure in nearly 60% of 63 studies; less cancer or a better prognosis in more than half of 25 studies, and greater longevity overall in 68% of 121 studies, including over 75% of the most rigorously designed studies. Finally, research indicates that when spiritual needs have not been addressed by the medical team, this not only reduces the patient's quality of life and satisfaction with care, but may *double or triple healthcare costs*, at least towards the end of life [15].

In conclusion, based on this review of the available research, religion is often used to cope with stress in general and medical illness in particular; religious or spiritual involvement is associated with greater well-being, less emotional disorder, less substance abuse, greater social support, and better health behaviors; religiosity is related to less physical illness, better medical outcomes, and greater longevity; spiritual needs are widespread in medical settings, especially in those with serious, life-threatening disease; and assessing and addressing patients' spiritual needs is related to greater satisfaction with care, better QOL, less depression, fewer unnecessary health services, better functioning, and a better doctor-patient relationship. Much more research is needed to better understand relationships between religion and health; determine the underlying biological mechanisms involved; and develop new interventions that harness these effects. However, given the results of research already done, there is *every reason* for health professionals to assess and address the spiritual needs of patients.

4. Structure of the Spiritual Care Team

The members of the SCT and their roles will vary depending on whether the setting of care is outpatient or inpatient. For outpatient settings, the SCT will likely consist of a physician, a spiritual care coordinator (nurse or clinic manager), a chaplain or pastoral counselor, and a receptionist. In hospital settings, the SCT will include a social worker or case manager. The roles of each member of the team are distinct.

Physician. The physician's responsibility on the SCT is to conduct a brief "spiritual assessment" in order to identify spiritual needs. Once spiritual needs are identified, the physician will then arrange for someone to address those needs, follow up to ensure that spiritual needs are met, and be available to discuss this subject with patients as needed. The spiritual assessment done by the physician involves asking a few simple questions to identify spiritual needs related to medical illness. The purpose is to make the physician aware of the patient's religious background; determine if the patient has religious or spiritual support; identify beliefs that might influence medical decisions and affect compliance with the medical care plan; identify unmet spiritual needs related to medical illness; determine if engagement of the "spiritual care team" is necessary; and create an atmosphere where the patient feels comfortable talking with their physician about spiritual needs affecting medical care. The spiritual assessment consists of three questions:

1. Do you have a religious or spiritual support system to help you in times of need?
2. Do you have any religious beliefs that might influence your medical decisions?
3. Do you have any other spiritual concerns that you would like someone to address?

The physician will then document the patient's responses in the medical record, elaborating on any "yes" responses. If spiritual needs are identified, the physician will alert the Spiritual Care Coordinator (see below) so that arrangements can be made to address those needs. Finally, there should be follow-up down the road to determine if spiritual needs have been adequately addressed. The SCT will assist in this regard, although the physician is responsible for ensuring that such follow-up occurs. This is the minimum requirement that we are requesting of physicians. The spiritual assessment, however, is NOT a one-time event. Whenever there is a significant change in the patient's condition, the physician will want to check whether any new spiritual needs have arisen that the patient needs help with. Patients may not disclose a spiritual need or wish to discuss spiritual concerns, especially during a first visit. However, once the patient learns that the physician is receptive to discussing such issues, he or she may bring up the topic if needed during a future visit.

Do all patients need a spiritual assessment? No. There are five categories of patients where a spiritual assessment is indicated: patients with serious, life-threatening conditions; patients with chronic, disabling medical illness; patients with depression or significant anxiety; patients newly admitted to the hospital or to a nursing home; and patients being seen for a well-patient exam when time is available to address social issues. Those who do not need a spiritual assessment are patients seen for an acute problem without long-term implications, such as an upper respiratory infection, minor surgical procedure, routine pelvic exam, or some other specific, well-defined condition; patients seen for follow-up of a time-limited problem where there is no significant disability or challenges to coping; children, teenagers or young adults without chronic illness, life-threatening conditions, or disabling

serious medical problem; and patients who are not religious or spiritual and so this area is not relevant to them.

Spiritual Care Coordinator (SCC). The SCC is often a nurse or a clinic manager. If the physician is the leader of the spiritual care team, then the SCC could be considered the “coach” of the team. The SCC has multiple duties. The first duty is to review the results of the physician’s spiritual assessment, and identify and prioritize the spiritual needs that require addressing. The SCC does not conduct the assessment. The physician’s assessment cannot be deferred to the SCC, since the physician needs to collect this information first hand. Next, the SCC manages each step to ensure that the patients’ spiritual needs are addressed, providing resources as needed (for example, information on local faith communities, spiritual reading materials, information on pastoral care services, and so forth).

If a chaplain or pastoral care referral is necessary, the SCC prepares the patient to see the chaplain, *i.e.*, explains the reasons for the referral, describes the training that a chaplain has, and discusses what the chaplain will do. The SCC also prepares the chaplain (or pastoral counselor) for the referral, informing him or her about the spiritual needs identified and why the physician or SCC is referring the patient. After the chaplain referral is completed, the SCC follows up to obtain feedback from chaplain on the results of the evaluation and information about spiritual care plan, and then communicates this to the physician. The SCC then helps the chaplain follow-up with patient to ensure that spiritual needs identified during the physician’s assessment were adequately addressed by the spiritual care plan. Finally, together with the chaplain, the SCC provides spiritual support to the physician and other members of the team, helping them to provide whole-person care to their patients. If, on the other hand, a patient prefers to address spiritual concerns with their own clergy, other member of their faith community, or other member of the healthcare team, the SCC will make the arrangements for such a meeting to occur.

The Chaplain. The chaplain likewise plays many roles, but there is one that is completely unique. The chaplain is the only person on the SCT *trained* to comprehensively assess and address the spiritual needs of patients. After receiving a referral, the chaplain will do a spiritual assessment that is quite different from physician’s brief “screening” assessment. The chaplain will clarify spiritual needs that are present and will then develop a “spiritual care plan” to address those needs. The chaplain will work with the social worker (if available) to implement the spiritual care plan after discharge from the hospital or from the clinic. He or she will also follow up to ensure that spiritual needs are met and provide feedback to the team. Finally, the chaplain will work with the Spiritual Care Coordinator to address the spiritual needs of team members that are related to patient care. More specifically, what is involved in the chaplain’s assessment and what types of interventions are then implemented?

The chaplain’s assessment will differ depending on her or his individual style. Generally, though, the chaplain will make contact with the patient and spend time forming a relationship. During this time, the chaplain learns the “spiritual language” of the patient, which may or may not be religious. Much of the assessment will be spent listening to the patient talk about his or her struggles. No advice or spiritual counsel is usually offered during this time, which is often called the “ministry of presence”. After that, the chaplain may ask questions about the patient’s religious or spiritual background, and inquire about positive and negative experiences with religion. When the assessment has been completed, the chaplain will develop a spiritual care plan to address the spiritual needs identified.

The spiritual care plan will involve one or more specific interventions by the chaplain. Note that the “ministry of presence”, which involves simply sitting with the patient and listening, is a powerful intervention by itself. The chaplain, however, may do other things besides simply listen. The chaplain may or may not pray with the patient, depending on the patient’s preference. The chaplain may or may not read a Holy Scripture related to the patient’s illness, again depending on the patient’s preference. The chaplain may or may not provide spiritual advice, depending on patient’s request and on the patient’s readiness for such advice. The chaplain may provide religious resources to the patient, by request, such as spiritual reading materials, prayer beads, a prayer rug, *etc.* The chaplain may contact the patient’s clergy or mobilize the patient’s faith community for support, after obtaining explicit consent from the patient. All of this activity is highly patient-centered and focused on the patient’s particular religious tradition or humanistic worldview. Finally, the chaplain will re-contact the patient at some future time to get follow-up on how effective the interventions were in addressing the patient’s spiritual needs.

The chaplain may also engage in other activities, such as listening to, counseling, praying with, or providing spiritual and emotional support to family members. The chaplain may do the same for other members of the SCT. In hospital settings, the chaplain may hold chapel services and administer sacraments or perform other rituals at the bedside. The chaplain may also serve on the ethics committees or the institutional review board at the hospital. Finally, the chaplain works with community clergy, who may be trained to fill in for the chaplain during emergencies or during situations where the chaplain is absent.

Whether in an outpatient or inpatient setting, the chaplain should be fully integrated into the healthcare team. As noted above, the chaplain or pastoral counselor is at the core of the spiritual care team because he or she is the only person fully trained to address spiritual needs. Consequently, the chaplain should be actively involved in hospital rounds and in discussions involving patients in the clinic. Unfortunately, many hospital and outpatient settings do not have enough healthcare chaplains to meet the need. In a survey of 1591 patients at the Mayo Clinic [29], researchers found that 70% of hospitalized patients wanted to see a chaplain, but only 43% were visited by a chaplain, which is over double the national rate in the U.S. (*i.e.*, 20%) [30]. The proportion of outpatients seen by a chaplain or pastoral counselor is probably in the single digits. Note that over 80% of patients visited by a chaplain in the Mayo Clinic study said that the visit was important to them.

If a chaplain is not available, as may be the case in some outpatient settings, the Spiritual Care Coordinator would arrange a visit with a pastoral counselor or other person trained to address the spiritual needs of medical patients. If spiritual needs are urgent and trained clergy are not immediately available, then the SCC or other spiritual care team member might have to do their best to address the spiritual needs of the patient (primarily by listening and providing resources) and then make arrangements for follow-up by a religious professional at a later date. For this reason, all members of the spiritual care team, including the physician, should receive some training on providing “spiritual first aid” in the event that such care is needed.

Social Worker. In hospital settings, chaplains often have a close relationship with the team social worker, and some hospitals have actually combined pastoral care and social services into a single department. The reason is that spiritual needs are often closely linked with social issues. As a result, the social worker may provide important input to the spiritual care plan.

In this regard, the social worker may contact members of the patient's faith community for support after hospital discharge; identify a local faith community for the patient, if desired; identify a pastoral counselor after discharge and set up appointments; or help the chaplain follow-up to determine whether spiritual needs were effectively addressed.

There are many other contributions that the social worker can make to the spiritual care team. These include identifying spiritual needs during routine social assessment (however, this would not replace the physician's assessment); arranging referral to the chaplain or pastoral counselor if the Spiritual Care Coordinator is not available (or may work with the SCC to arrange the referral); and addressing simple spiritual needs if a chaplain is unavailable or is refused by the patient (this applies only to "simple" spiritual needs, since most social workers are not trained to address such needs). The social worker may also connect the patient with a mental health professional trained to integrate spiritual and emotional needs, as might be the case for trauma survivors and others with serious mental health problems.

The Receptionist. The receptionist in the physician's clinic or ward clerk in the hospital plays an important role on the spiritual care team. The duty of the receptionist is to record the patient's religious affiliation (specific denomination or religious group) in the medical record so that the physician can access it easily. This will save the physician time in conducting the spiritual assessment.

5. Spiritual Care

A major goal of the spiritual care team is to provide "spiritual care" to all patients as part of whole-person medicine. What is spiritual care? Although assessing and addressing the spiritual needs of patients is an important part of it, spiritual care goes far beyond that. The way that *ordinary health care* is provided by the physician and other members of the healthcare can be "spiritual". By that, I mean recognizing the sacred nature of the person being cared for and the holy obligation and privilege that health professionals have. More specifically, this means providing care with respect for the individual patient, a person with a unique life story; inquiring about how the patient wishes to be cared for, rather than providing the same care in the same way to everyone; providing care in a kind and gentle manner; providing care in a "competent" manner; and taking extra time with patients who really need it.

Spiritual care is the heart of what whole-person healthcare is really about, and has the potential to bring vitality back into the patient and into the practice of healthcare. However, it is not easy to do. Research indicates that only about 10% of physicians regularly conduct a spiritual assessment (and nearly 50% never do one) [31]. Why is this so? The following are 10 barriers that stand in the way of spiritual care. These barriers are based on research by the Harvard oncology group at the Dana Farber Institute [32]. They asked oncologists and oncology nurses why they did not routinely assess and address the spiritual needs of patients. Here is how they responded. After each barrier, I will suggest how to overcome it:

(1) *Lack of Time.* Spiritual care is just one more thing that health professionals are now being asked to do. They barely have enough time to perform required duties and document the results. Many are concerned about opening Pandora's box and not having adequate time to address the issues uncovered. There is temptation, then, to eliminate this "optional" activity (or defer it to others).

How to overcome: Doing a brief spiritual assessment must be a priority for the physician and addressing those needs a priority for the spiritual care team. This is not an optional activity, but central to providing “whole-person” medical care. The spiritual assessment can actually save time, improve the relationship with the patient, improve compliance, and make the physician’s work more rewarding. The physician, as the director of the spiritual care team, cannot defer the spiritual assessment to anyone else. The spiritual care team, though, must be ready to fully address the patient’s spiritual needs as their part of whole-person care.

(2) *Discomfort.* Many health professionals are not comfortable addressing this topic, particularly if they are not religious or particularly spiritual. Few health professionals have training on how to assess or address the spiritual needs of patients in a sensible and timely manner, or what to do if spiritual needs are identified.

How to overcome: Comfort comes with training and practice. Sometimes health professionals must do things that are not comfortable with to improve the quality of care that patients receive.

(3) *Making Patient Uncomfortable.* Health professionals may fear that asking such questions will make the patient feel uncomfortable, or may not know how to respond if the patient says: “Why are you asking these questions?”

How to overcome: Research shows that most patients, especially when seriously ill, are not offended or made uncomfortable when the physician performs a spiritual assessment, and in fact, the majority would like health professionals to do so [21,33]. If a patient asks why these questions are being asked, an appropriate response would be: “We are doing this routinely as a show of respect for the beliefs and values of patients, which may influence their medical care”.

(4) *Spirituality Not Important.* Because spirituality is not important to the health professional, there is fear that the patient will ask about his or her own beliefs.

How to overcome: First, patients seldom ask health professionals about their personal beliefs. If they do ask, then a brief or general response usually satisfies the patient. The reason why most patients ask is that they are worried about how the clinician will treat their beliefs. Reassuring the patient that their beliefs will always be respected and honored usually allays this concern.

(5) *Topic Too Personal.* Health professionals feel that this topic is too personal to ask about, or they are concerned that they don’t have a private space to discuss it.

How to overcome: Clinicians deal with other sensitive areas related to health much more personal than asking about religious beliefs. Sensitive areas include sexual behavior or personal health habits, such as smoking, drinking, diet, or weight control. Fear that these areas are too personal does not prevent health professionals from thoroughly assessing them.

(6) *Done Better by Others.* The physician believes that the spiritual assessment is done better by others.

How to overcome: Recognize that the physician is the leader of the healthcare team and needs to know about factors that could affect the patient’s health and their compliance with the medical care plan.

(7) *Patients Don’t Want Spiritual Care from Doctors/Nurses.* Health professionals believe that patients don’t want them to address these issues.

How to overcome: As noted above, patient surveys indicate that only a minority of patients show resistance to inquiry about spiritual needs, or wish to keep medicine and religion separate [21,33]. Furthermore, doctors are usually only responsible for *assessment* in this model. Once spiritual needs

are identified, the chaplain or pastoral counselor is the health professional who addresses them. One large study even found that when patients who did not want a visit from a chaplain and received one anyway, actually reported more satisfaction with their overall healthcare than did non-visited patients [34].

(8) *Power Inequality*. There is concern that the power inequality between patient and health professional might lead to coercion.

How to overcome: Realize that coercion in this area is unethical and a violation of civil rights. Thus, it is never appropriate to do so. I will discuss this boundary issue further in the next section.

(9) *Religious Beliefs Differ*. The religious beliefs of the healthcare provider differ from those of the patient.

How to overcome: Realize that in this era of patient-centered medicine, the focus should always be on respecting and supporting the spiritual beliefs of the patient, whether or not the health professional agrees with those beliefs.

(10) *Not Health Professional's Role*. Healthcare providers feel that assessing and addressing spiritual needs related to medical care is not part of their role.

How to overcome: Realize that providing whole-person care *is* part of the health professional's role and whole-person care includes addressing this area.

All of these barriers could be overcome through training and practice. Future research, however, will be needed to determine whether training, careful dividing up tasks among team members, and practice will make health professionals comfortable and fluent in spiritual care. In the Duke-Adventist Health collaborative study, we plan to systematically examine exactly this—whether the forming and training of spiritual care teams to assess and address patients' spiritual needs will affect health professionals' attitudes and behaviors (which will be measured at baseline and then 3 and 12 months afterwards).

6. Boundaries

There are, however, boundaries to providing spiritual care. Sometimes health professionals go beyond their expertise and perform actions that are neither sensible nor ethically justifiable. Here are five behaviors that healthcare providers should almost never do. First, don't prescribe religion to non-religious patients. Even though religious involvement may be good for health, non-believers should not be encouraged to become religious. Furthermore, the spiritual assessment should be conducted in such a way that patients who do not consider themselves spiritual do not feel devalued. As noted above, the spiritual assessment should be framed in such a way that the patient understands that such questions are being asked as a matter of routine in order to provide whole person care to those who do have spiritual needs. Second, and related to the latter, don't force a spiritual assessment if the patient is not religious. In that case, quickly switch to asking about what gives life meaning and purpose in the context of illness and how this can be supported. For these individuals, issues related to demoralization or death anxiety should be dealt with in a broad way using a holistic model grounded on humanistic beliefs and values. Third, don't pray with a patient before doing a spiritual assessment *and* unless the patient asks. While more than two-thirds to three-quarters of patients would like to pray with a health professional and deeply appreciate this [35,36], others might not. Fourth, in general, don't provide spiritual counsel to patients. Instead, always refer the patient to a trained professional

chaplain or a pastoral counselor. As noted earlier, the only exceptions might be if the health professional has pastoral care training, or if addressing spiritual issues is urgent and the patient refuses pastoral care or pastoral care is not available. Finally, don't do any activity that is not patient-centered and patient-directed. Remember, it's about the patient—not the health professional. Addressing spiritual issues is like a ballroom dance. The patient leads and the health professional tries not to step on his or her toes.

Finally, in order for the physician and other team members to deliver whole-person spiritual care to patients, they need to be whole-persons themselves. The difficult task of caring for sick patients day-in and day-out challenges the physical, emotional and spiritual resources of most providers. For that reason, one major task of the spiritual care team is to support each other's spiritual needs that arise during the course of providing healthcare. Part of the role of the spiritual care coordinator and the chaplain is to ensure that the spiritual needs of team members are met. There are numerous spiritual resources that may help in this regard, depending on the provider's faith tradition [37–40].

Models, such as the one proposed here, and similar ones proposed by others [41], will need to be adapted to the unique settings and cultural environments that health professionals find themselves in—particularly as these models begin to be applied in non-Western countries (and in hospital settings that may not reflect the religious values of the Adventist Health System).

7. Conclusions

The following are the main points that this paper has been trying to convey. First, there is every reason to assess and address spiritual needs related to medical care—based on common sense, good clinical practice, and a firm scientific rationale. Second, the *physician* is responsible for a brief spiritual assessment that is designed to identify spiritual needs and create an atmosphere where spiritual needs related to medical care can be discussed. Third, the rest of the spiritual care team, led by the spiritual care coordinator, supports the physician by ensuring that the spiritual needs identified are effectively addressed. Fourth, the chaplain or pastoral counselor is at the core of the spiritual care team, and is responsible for conducting a comprehensive spiritual assessment to clarify spiritual needs and develop a spiritual care plan to address them. Finally, in hospital settings, the social worker helps the chaplain to develop and implement the spiritual care plan, and to arrange for follow-up to ensure that spiritual needs are met. For a more comprehensive resource on assessing and addressing the spiritual needs of patients, readers are referred elsewhere [42,43].

Conflicts of Interest

The author declares no conflicts of interest.

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