Religion, Spirituality and Health

Clinical Applications

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1:30-2:30

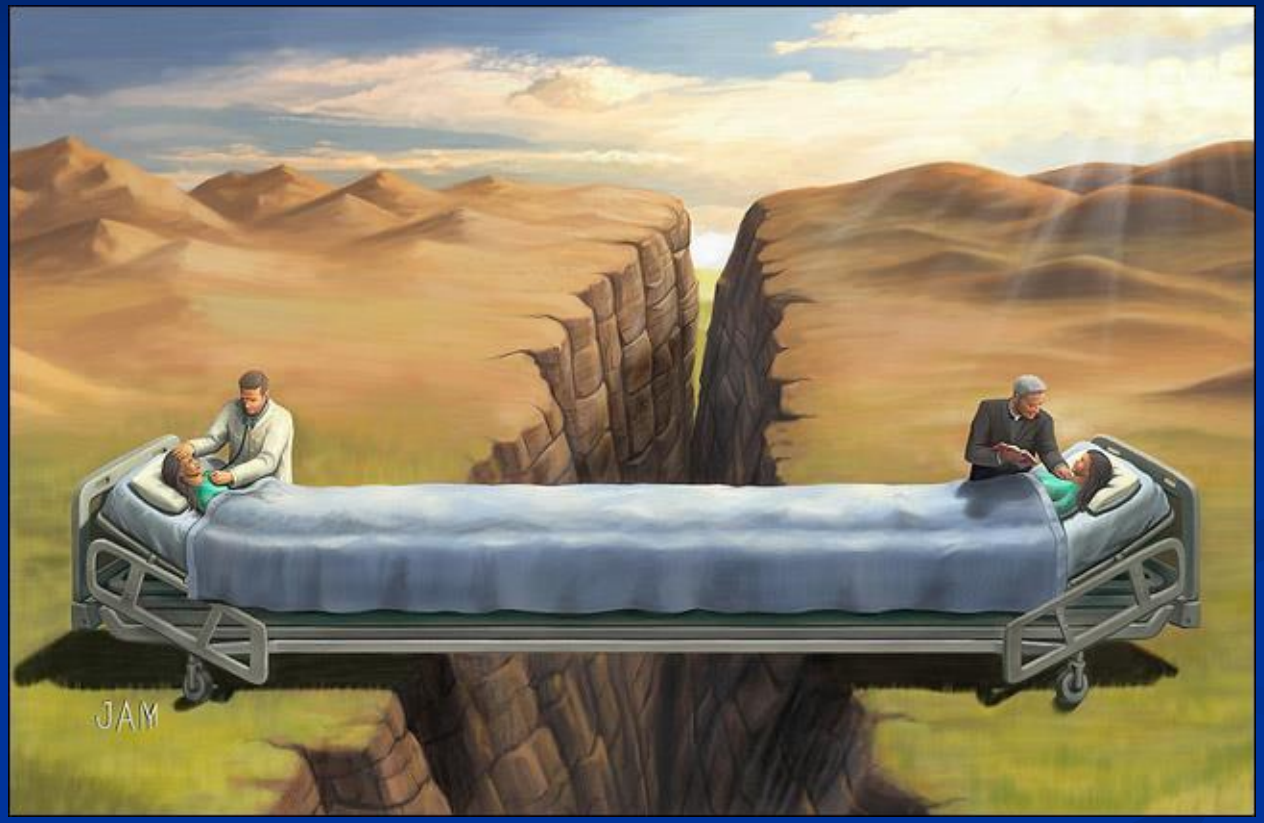
Overview

(1) Applying the results from research into clinical practice

(2) Reasons for doing so

(3) How to do so
- (a) The spiritual history
- (b) Types of patients who need a SH
- (c) Besides the SH, what other activities are appropriate
- (d) Barriers to integrating spirituality
- (e) How to overcome the barriers
- (f) Boundaries

(4) Conclusions and further resources


JAM

"Integrating Spirituality into Patient Care": What does this mean?

(1) Conducting a brief "spiritual assessment"

(2) Identifying spiritual needs related to illness

(3) Ensuring that someone meets those needs

(4) Being willing to discuss this subject with patients

Why integrate spirituality into clinical practice?

(1) Health professionals are interested in factors that influence health; there is now a vast and growing research literature indicating religion is one of those factors

(2) Spiritual needs are common among those with mental or psychiatric illness

(3) Addressing spiritual needs increases satisfaction with care and reduces costs

(4) Addressing spiritual needs improves emotional state and increases motivation towards recovery

(5) Supporting one's religious beliefs and practices may influence mental health, social health, behavioral health, and physical health outcomes

(6) Medical decisions made at critical times are often based on religious beliefs

(7) Almost all major health professional organizations (JCAHO, American Psychological Association, American Psychiatric Association, Royal College of Psychiatrists, World Psychiatric Association) have practice guidelines that recommend a spiritual history, respect for patients' religious beliefs, and provision of healthcare in light of those beliefs.

Spiritual Needs are Widespread and Affect Patient Satisfaction and Health

Although most research on spiritual needs has been done in terminally ill patients, spiritual needs are widespread among persons with any acute serious medical problem and almost all those grappling with chronic health problems

Many Patients Have Spiritual Needs Related to Illness

In a multi-site study by Harvard investigators, 230 patients with advanced cancer were surveyed. Most (88%) considered religious to be at least somewhat important. However, 47% reported that their spiritual needs were minimally or not at all supported by their religious community and 72% said their spiritual needs were minimally or not at all supported by the medical system (doctors, nurses or chaplains). Furthermore, spiritual support provided by their medical team or religious communities was associated with significantly higher quality of life ($p=0.0003$) (Balboni et al, 2007).

Balboni et al. (2007). Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. Journal of Clinical Oncology 25:555-560

Not Addressing Spiritual Needs is *Expensive*

Multi-site, prospective study of 345 patients with advanced cancer who were followed to their death. They found that **intensive, expensive, futile life-prolonging care (mechanical ventilation or resuscitation in last week of life) was more common among those with high levels of religious coping** (Phelps et al, 2009).

Phelps et al. (2009). Religious coping and use of intensive life-prolonging care near death in patients with advanced cancer JAMA 301 (11), 1140-1147

When these investigators examined who among those using religion to cope were using more expensive health services, they found that this was primarily among those whose spiritual needs were not being addressed by the medical team. **Among high religious copers whose spiritual needs were to a large extent or completely supported (vs. not supported), the likelihood of receiving hospice increased 5-fold ($p<0.005$) and of receiving aggressive care towards the end of life decreased by 72%** (range 21% to 96%) ($p=0.02$)

Balboni et al (2010). Provision of spiritual care to patients with advanced cancer: associations with medical care and quality of life near death. Journal of Clinical Oncology 28:445-452

Very Expensive

Patients reporting that their religious/spiritual needs were inadequately supported by clinic staff were less likely to receive a week or more of hospice (54% vs 72.8%; P = .01) and more likely to die in an intensive care unit (ICU) (5.1% vs 1.0%, P = .03).

Among minorities and high religious coping patients, those reporting poorly supported religious/spiritual needs received more ICU care (11.3% vs 1.2%, P = .03 and 13.1% vs 1.6%, P = .02, respectively), received less hospice (43.% vs 75.3% ≥1 week of hospice, P = .01 and 45.3% vs 73.1%, P = .007, respectively), and had increased ICU deaths (11.2% vs 1.2%, P = .03 and 7.7% vs 0.6%, P = .009, respectively).

EOL costs were higher when patients reported that their spiritual needs were inadequately supported ($4947 vs $2833), particularly among minorities ($6533 vs $2276) and high religious copers ($6344 vs $2431).

Balboni et al. (2011). Support of cancer patients' spiritual needs and associations with medical care costs at the end of life. Cancer 117(23): 5383-5391

What are we asking health professionals to do?

(1) Conduct a brief "spiritual assessment"

(2) Identify spiritual needs related to medical illness or health care

(3) Ensure that someone meets those needs

(4) Be willing to discuss the subject in a supportive manner

(5) Be aware of the health benefits of doing so

The Spiritual History

(1) What is a "spiritual history," who should do it, and what should be done with this information?

(2) What types of patients need a spiritual history?

(3) What else might health professionals do to address the patient's spiritual needs?

(4) What are the barriers to taking a spiritual history and how can they be overcome ?

(5) Boundaries the health professionals should not cross

(6) When should training be done?

Purpose of the Spiritual History

(taken by **the physician** or leader of the healthcare team)

(1) Become aware of the patient's religious background

(2) Determine if patient has religious or spiritual support

(3) Identify beliefs influencing decisions about healthcare and compliance with treatment

(4) Identify unmet spiritual needs related to the patient's medical or mental health condition for which they are seeking help

(5) Create atmosphere where patient feels comfortable talking with their health professional about spiritual needs related to their health condition

Adventist Health Study

What is your religious affiliation, if any?

_____ (specify beforehand in waiting room)

Physician asks:

1. Do you have a faith-based 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?

Adventist Health Study

Less than 50% of outpatient physicians said a SH was necessary

More than 50% (55%) never or only rarely took a SH.

Only 17% often take a SH (compared to 10% nationally)

These are physicians in the Adventist Health System!

Who Needs a Spiritual History

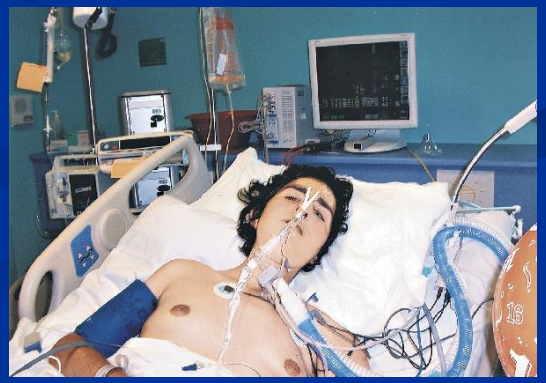
(1) Patients with serious, life-threatening conditions

(2) Patients with chronic, disabling medical illness

(3) Patients with depression or significant anxiety

(4) Patients newly admitted to the hospital or a nursing home

(5) Patients seen for a well-patient exam



Who does NOT need a Spiritual History

(1) Patients seen for an acute problem without long-term complications

(2) Patients seen for follow-up of a time-limited problem without significant disability or challenges to coping

(3) Children, teenagers or young adults without chronic illness, life-threatening or disabling medical conditions

(4) Patients who are not religious or spiritual, and have indicated this area is not relevant to them

Journal of Pain and Symptom Management

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Original Article

Nurse and Physician Barriers to Spiritual Care Provision at the End of Life

Michael J. Balboni, PhD[a, b, e, f, g], Adam Sullivan, MS[h], Andrea C. Enzinger, MD[c, e, f], Zachary D. Epstein-Peterson, BA[a], Yolanda D. Tseng, MD[d, j], Christine Mitchell, MDiv[b], Joshua Niska, BA[a], Angelika Zollfrank, MDiv, BCC[k], Tyler J. VanderWeele, PhD[h, i], Tracy A. Balboni, MD, MPH[a, b, d, e, f]

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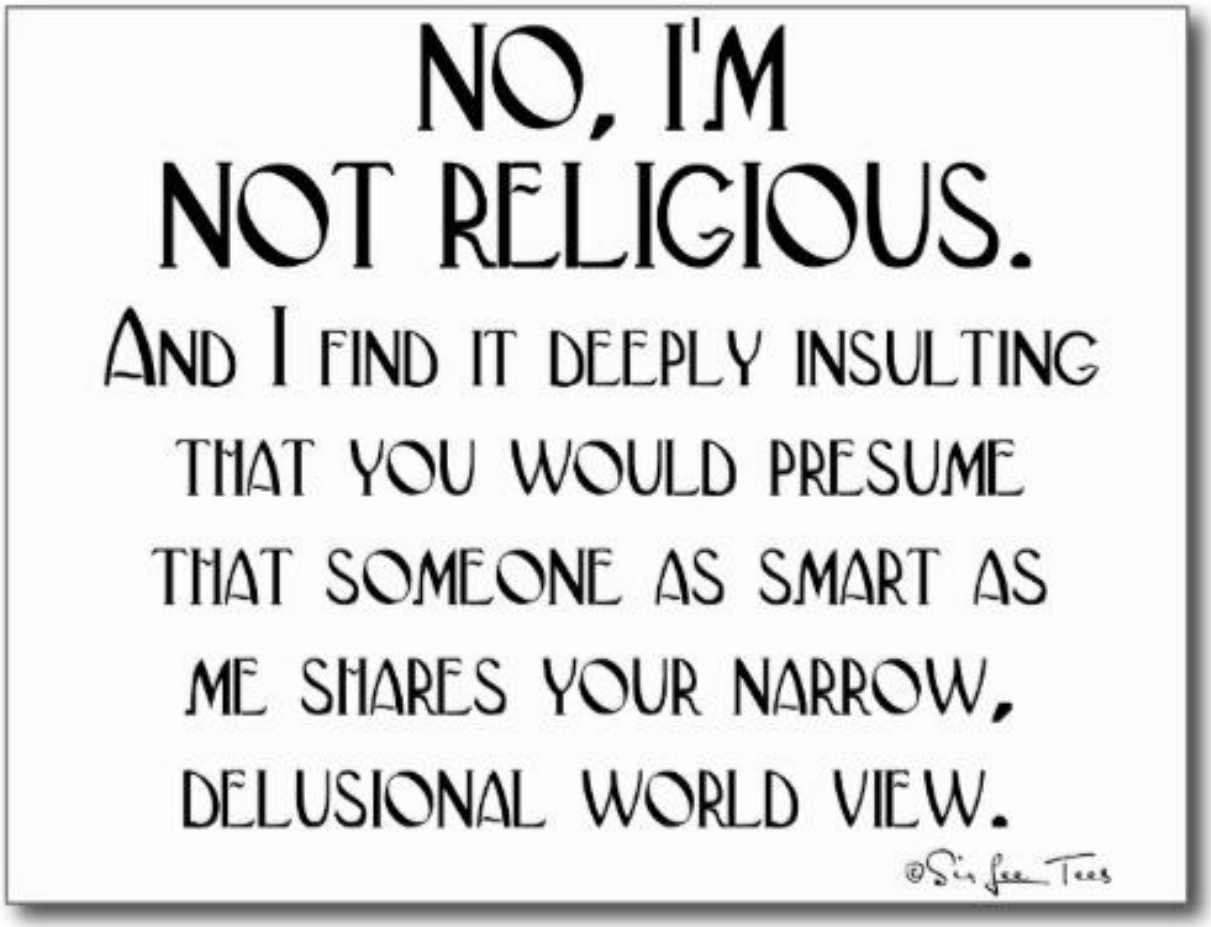
Abstract

Context

Spiritual care (SC) from medical practitioners is infrequent at the end of life (EOL) despite national standards.

Barriers

(1) Lack of Time
(2) Discomfort
(3) Fear of making patient uncomfortable
(4) Spirituality not important to physician personally
(5) Topic too personal
(6) Belief that spiritual assessment done better by others
(7) Belief that patients don't want physician to address spirituality
(8) Concern about power inequality
(9) Religious beliefs of the physician differ from those of patient
(10) Spiritual assessment not part of physician's role


NO, I'M
NOT RELIGIOUS.
AND I FIND IT DEEPLY INSULTING
THAT YOU WOULD PRESUME
THAT SOMEONE AS SMART AS
ME SHARES YOUR NARROW,
DELUSIONAL WORLD VIEW.


HOW PERSONAL IS
TOO PERSONAL?

How do you overcome these barriers?

(1) Training

(2) Training

(3) Training

(4) Persistent training

(5) Training at the very beginning in professional schools (medicine, nursing, social work, allied health professionals)

(6) Ongoing training (CME, CEU, etc.)

(7) Training together with chaplains (during chaplain training)

What Else Can Health Professionals Do

(besides taking a spiritual history)

- Respect, value, support the religious beliefs and practices of **the patient**
- Ensure that someone meets patients' spiritual needs (pastoral care)
- Pray with patients if **patient requests**
- Share their religious beliefs with patients? Only if patient asks.
- Accommodate the environment to ensure that patients may practice their faith
- Work with the faith community, if patient consents

From: Spirituality in Patient Care (Templeton Foundation Press, 2013)

Spiritual Care Team

(1) The physician conducts the spiritual assessment

(2) The spiritual care coordinator (nurse or clinic manager) coordinates the addressing of spiritual needs

(3) The chaplain or pastoral counselor addresses the spiritual needs

(4) In hospital settings, the social worker works with the chaplain to develop a spiritual care plan for after discharge

(5) The receptionist ensures the patient's religious affiliation is recorded in the EMR

Boundaries

1) Prescribe religion

2) Force spiritual assessment

3) Pray with patient unless…

4) Spiritually counsel

5) Any activity not patient-centered

Training of health professionals after they are out in practice works, but not without a major effort and not always successfully

Intervention Outcomes

(Physicians and MLPs separately)

BEHAVIORS

Physicians	B (SE) (d)	MLPs	B (SE) (d)
Frequency of *Currently* Taking a SH			
Time	0.33 (0.03) (1.16) ****		0.36 (0.06) (1.30)****
Frequency of *Currently* Praying with patients?			
Time	0.12 (0.02) (0.57) **		0.17 (0.05) (0.80)****
Frequency of *Currently* Sharing your Own Faith with patients?			
Time	0.08 (0.03) (0.33) ***		-0.14 (0.05) (-0.07)

Intervention Outcomes

BEHAVIORS (continued)

Physicians	B (SE) (d)	MLPs	B (SE) (d)
Frequency of *Currently* Sharing your Religious Faith with patients?			
Time	0.08 (0.03) (0.33) ***		-0.01 (0.05) (-0.07)
Frequency of *Currently* Encouraging patient's Own Faith?			
Time	0.10 (0.03) (0.38) ****		0.17 (0.05) (0.79) ****
Frequency of *Currently* Referring patients to Chaplains?			
Time	0.14 (0.03) (0.58) **		0.21 (0.06) (0.76) ****

All Clinicians (MD's and MLP's)

@@ Interaction between base Religiosity & Time was Not Significant @@ (B=-0.01, SE 0.02, p=0.587)

Change in Practice and Attitude During Adventist Health Study (2016-2017)

Practice

Percentage of Physicians and Mid-Level Practitioners who often or very often take a spiritual history before and after a 12-month intensive intervention:

Baseline	1 month	12 months (end)
16.7% (86)	24.4% (105)	34.8% (149)

Attitude

Percentage of Physicians and Mid-Level Practitioners who indicated quite a bit or very much to the question: “Should a HP take a screening spiritual history?”

Baseline	1 month	12 months (end)
46.5% (240)	51.5% (224)	47.2% (203)

Conclusions

(1) There are many reasons to identify spiritual needs related to medical illness, and to integrate spirituality into patient care

(2) Research, common sense, and good clinical practice justify taking the time to do so

(3) Many patients have spiritual needs related to medical illness and not addressing those needs increases the costs of healthcare, reduces QOL, and adversely affects the clinician-patient relationship

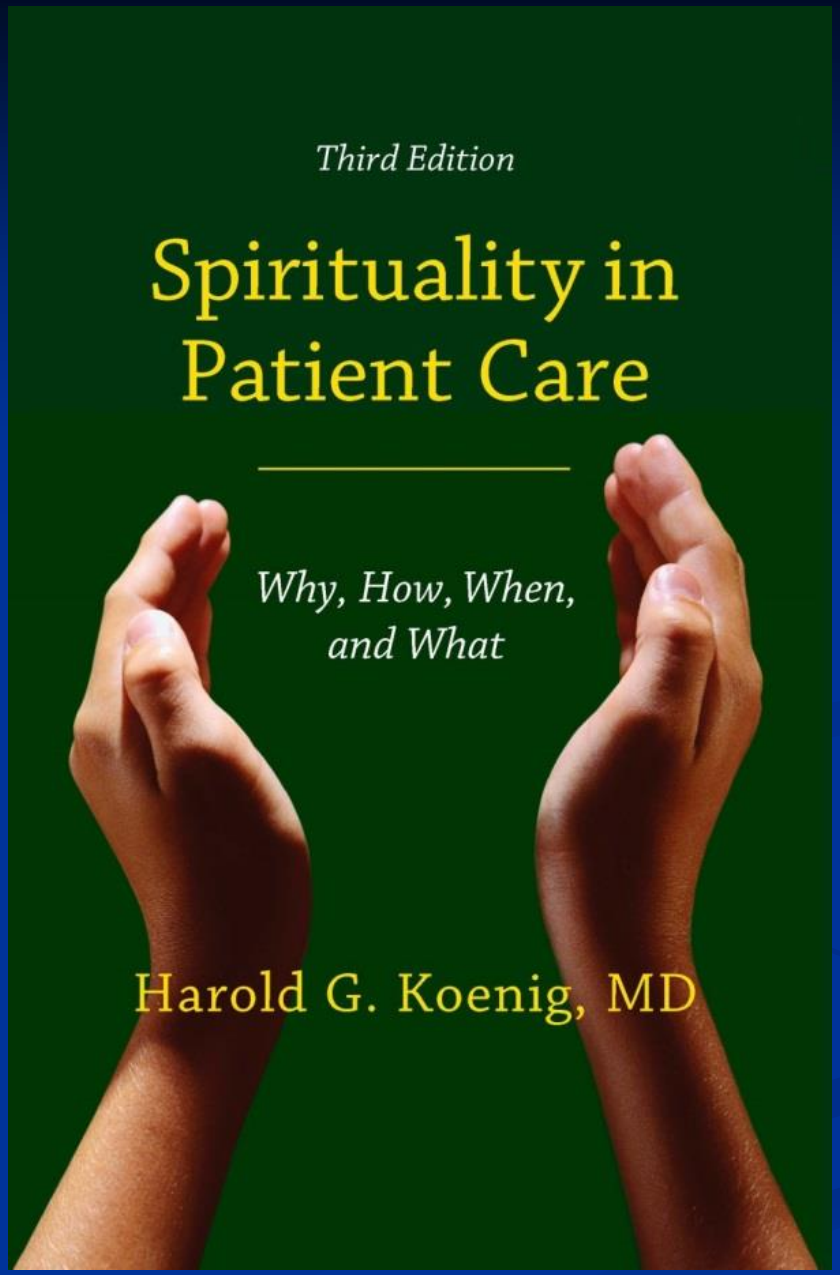
(4) The physician is responsible for conducting the spiritual assessment and following up; if the physician does not take on this responsibility, then it falls to the nurse or other health professionals providing direct care to the patient (social workers, allied health)

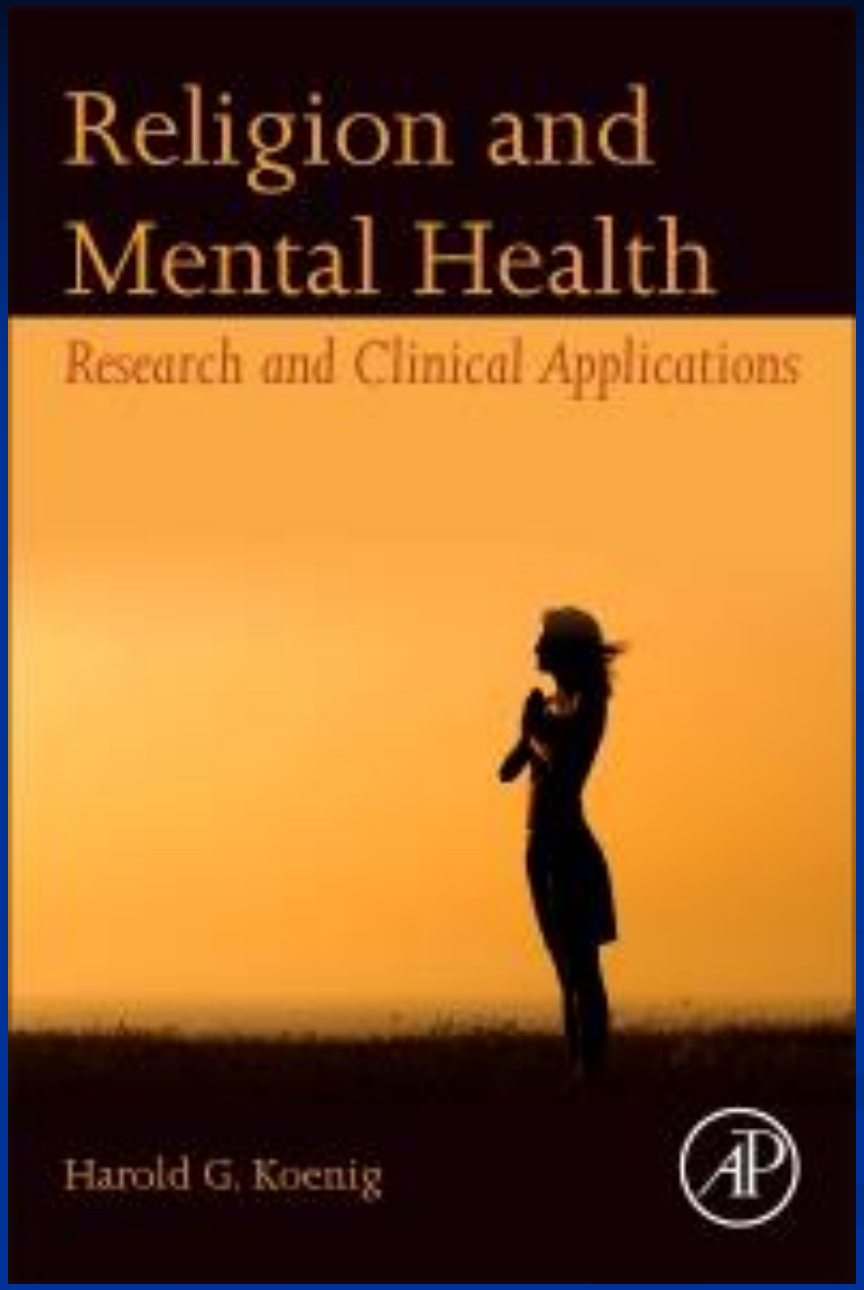
(5) There are boundaries that health professionals should not cross.

(6) If spiritual issues become too complex, or the health professional feels uncomfortable dealing with them, then referral should be made to chaplains or other religious professionals in the patient's tradition who are trained to address these issues

(7) Exposure to these issues needs to begin early on in training, and not wait until after the health professional is out in practice. Habits are hard to change.

Further Resources


Third Edition
Spirituality in Patient Care
Why, How, When, and What
Harold G. Koenig, MD


Religion and
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2017 Religion and Mental Health Book Series

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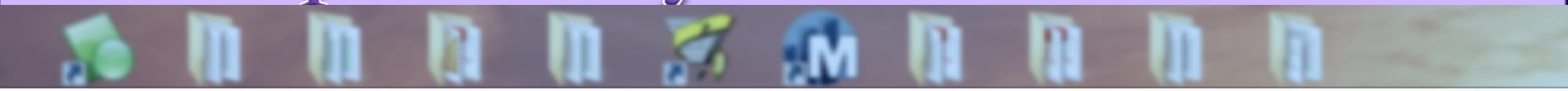

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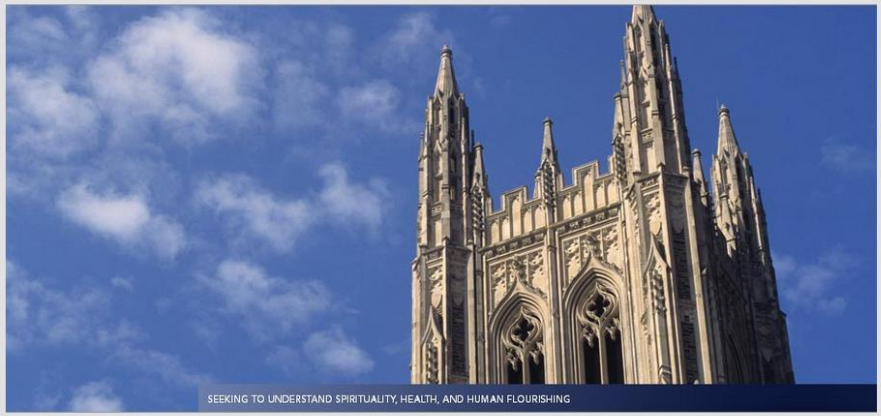
Welcome

The Center was founded in 1998, and is focused on conducting research, training others to conduct research, and promoting scholarly field-building activities related to religion, spirituality, and health. The Center serves as a clearinghouse for information on this topic, and seeks to support and encourage dialogue between researchers, clinicians, theologians, clergy, and others interested in the intersection.



Mission

The five main goals of the Center are to:

- Conduct research on religion, spirituality and health
- Train those wishing to do research on this topic
- Interpret the research for clinical and societal applications
- Explore the meaning of the research for pastors and theologians
- Discuss how theological input can advance the research

Upcoming Events

16th Annual 5-day Spirituality and Health Research Workshop (August 12-16, 2019)

Monthly Research Seminars

Recent News

Religion and Mental Health Review (new)

Resources on Moral Injury

Special Issue on Moral Injury in *Frontiers in Psychiatry*

2017 Mental Health and Religion Book Series

Health and Well-being in Islamic Societies

Latest Research on Spirituality

Questions and Discussion