

Integrating Spiritual Care in Healthcare—A Global Imperative

Christina M. Puchalski, MD, FACP



Improving the Spiritual Domain of Whole Person Care: Reaching National and International Consensus

Christina M. Puchalski, MD, FACP

The George Washington Institute for Spirituality and Health
(GWish)

The George Washington University
HCCN 2015



Healthcare: Journeying In Community

- Form deeply meaningful relationships with our patients and their families
- Witness to suffering, to joy, to disappointment, to aspirations
- Transformation that can occur between healthcare professionals and patients/families if we are open to relationship-to the sacred in that professional relationship



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A clinical encounter in today's health system

- Ms. CM is an 88 year old patient coming to physicians' office to discuss the results of a breast biopsy– est/pr/ Her-2 negative. Options for treatment are surgery then chemotherapy. Breast surgeon asking her PMD to discuss findings and goals of care regarding medical decisions.



Typical A/P

- CM is an 88 year female with newly diagnosed triple receptor negative breast cancer right breast, mild cognitive impairment, h/o HTN, hypothyroidism. Goals of care are to have surgery and remove the tumor. Explained limited treatment options of triple negative breast c. Risks of procedures explained with prognosis. Will proceed with metastatic work-up and plan for right mastectomy and sentinel node biopsy.



An alternative view

- Ms.CM is a lovely 88 year old woman with a very supportive family. She grew up in Ghana and came to the US when she was 35 years of age with her son who at that time was 10 years old and her husband. In her country she was a nurse but in the US she worked in nursing homes cleaning rooms. She talks of times when she listened to residents cries at night and just sat at their bedside silently praying for them.



Ms. CM

- She loved helping people and thinks the world of her son and his family though she does not really like having him take care of her now. “I don’t want to be a burden ”She says that she remembers enough of her nursing to know “this is a serious illness” referring to her breast cancer.
- Her faith (She is catholic, active in her church, faith guides her decisions)



Ms. CM

- She wants to take care of things that can be taken care but does not want to be so sick that she cannot enjoy her family
- She also loves to sing and sings in her church choir. It reminds her of the time she sang gentle lullabies to the residents in the nursing home.
- She is not afraid of dying but not quite ready to "go to Him" yet. But "if He calls I will go to Him". She wonders a bit why god would do this now? "there must be a reason...but what is that reason?"



Ms. CM's Issues

- What do I do--- surgery, more tests” referrals, etc. Overwhelmingly complicated health system
- Symptom management—none now but concern for post op and chemo if she choses that
- Worried about being a burden to her family
- Struggling with loss of independence and being the “parent”



Ms. CM's Spiritual History

- F: Catholic, has deep personal relationship with God; meaning in helping others and her family
- I: central to her life, has gotten her through many challenges in her life
- C: Church regular attendance, sings in choir, supportive community
- A: Deep faith, some why me? Why god doing this? What is purpose? Many issues about independence being threatened and being a burden to her family? Great meaning in helping family and others and now wondering what that will mean for her in the setting of a big surgery and having cancer



“You don’t really know who this human being is —the full depth of the person... the soul.... You don’t know who that person really is..... and so you listen.”

Rev. Margaret, Guenther, PhD



Narrative Model and the Medical Model:

How do we really listen to the patient's story **AND** make sure everyone on the team is doing that..



Reductionism: language of
medicine

Sharing stories: language of
chaplains

The Challenge: how to blend the
two....



The Whole Person Assessment and Plan

Ms. CM is an ** yo female with newly diagnosed breast cancer, (triple neg), HTN, hypothyroidism, supportive family, though she is concerned about loss of independence as son takes more caregiver role, deep faith and some questioning as to reason, also expresses some concern re loss of meaning. Goals of care include being present for family and continue to care for them, trying to do the next right things and treat the cancer without a lot of aggressive chemo and side effects that would affect her QOL

Physical

Discuss referrals to oncology, surgery and potential treatment options and help navigate Those appts. Education on differences in treatment options with prognosis

Emotional

No depression no anxiety

Social

Discuss with family and patient ways for her to maintain her independence

Spiritual

Continued presence, referral to chaplain on team, offer sacraments,



Whole person care

- Attention to pain and suffering---
physical as well as psychosocial
and spiritual suffering WHO Pall Care
Resolution, 2014



Creating Standards, Improving Care: A Consensus Approach

- Improving the Spiritual Domain of Palliative Care (US, 2009)
- Creating More Compassionate Systems of care (US, 2012)
- International Consensus Conference on Spiritual Domain of Compassionate Care (Geneva, Switzerland, 2013)
- Global Network In Improving the Spiritual Domain of Compassionate Care (2014)



2009: Improving the Quality of Spiritual Care in Palliative Care: An Integrated Model

Recommendations:

- Integral to any patient-centered healthcare system
- ***Based on honoring dignity, attending to suffering***
- ***Spiritual distress treated the same as any other medical problem***
- Spirituality should be considered a “vital sign”
- ***Interdisciplinary (including Chaplains)***
- ***All patients get a spiritual history or screening***
- ***Integrated into a whole person treatment plan***

- Puchalski, Ferrell, Virani et.al. JPM, 2009



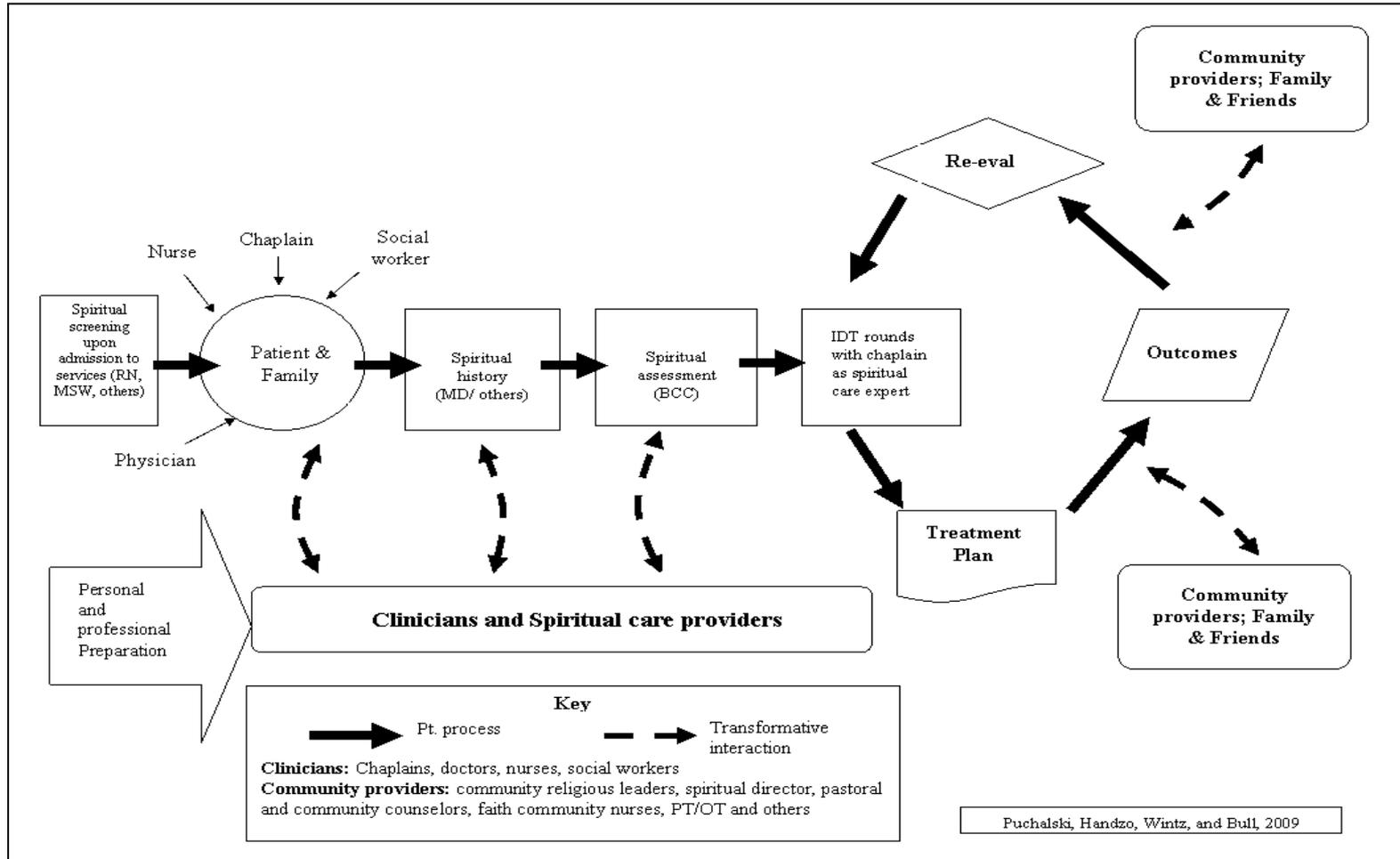
Spirituality: Meaning and Connection

Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred.

Puchalski CM, Ferrell B, Virani R, Otis-Green S, Baird P, Bull J, et. al.: Improving the quality of spiritual care as a dimension of palliative care: The Report of the Consensus Conference. *J Palliate Med* 2009; 12(10):885-904.



Consensus Conference: Spiritual Care Models





The Whole Person Assessment and Plan

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Clinical Spiritual Care

(Puchalski, Ferrell, Virani, et al. Improving the Quality of Spiritual Care as a Dimension of Palliative Care, JPM 2009)

- Assessment and treatment of spiritual distress—include spiritual distress in symptom management
- Identification and support of spiritual resources of strength
- Generalist-Specialist Spiritual care
- Provision of compassionate care
- Training of above commensurate to scope of practice of healthcare workers



Spiritual Distress Diagnosis

(NCCN Distress Guidelines; Puchalski, Ferrell, Virani et al JPM,2009)

- Existential
- Conflicted or challenged belief systems
- Anger at God/others
- Abandonment by God/others
- Concerns about relationship with significant or sacred (inner life)
- Despair
- Hopelessness
- Grief/Loss
- Reconciliation
- Ritual needs



Policy Consensus Conferences

- **Creating More Compassionate Systems of Care**
GWish-AVD
 - Christina Puchalski, MD, Chair
 - Sharon Hull, MD, MPH, Facilitator
- **International Consensus Conference**
“On Improving the Spiritual Dimension of Whole Person Care: The Transformational Role of Compassion, Love and Forgiveness in Health Care”
GWish-Caritas-Fetzer
 - Christina Puchalski, MD, MS, Co-Chair
 - Msgr. Robert Vitillo, MSW, Co-Chair
 - Sharon Hull, MD, MPH, Facilitator



Background of Conferences

- Built on the work of the 2009 consensus conference, *Improving Spiritual Care as a Dimension of Palliative Care*
- Broadened the scope of care in general
- Built upon two Fetzner Institute initiatives that linked spirituality to compassionate care



The Problem

- Healthcare systems in the US and in many parts of the world— in both developing and high income countries-- are broken: poor access, inequality, low patient and provider satisfaction, high rates of medical error, cost driven bottom line.
- The relationship between the clinician and patient is being eroded by many factors
- Healing can only occur in the context of compassionate relationship based care

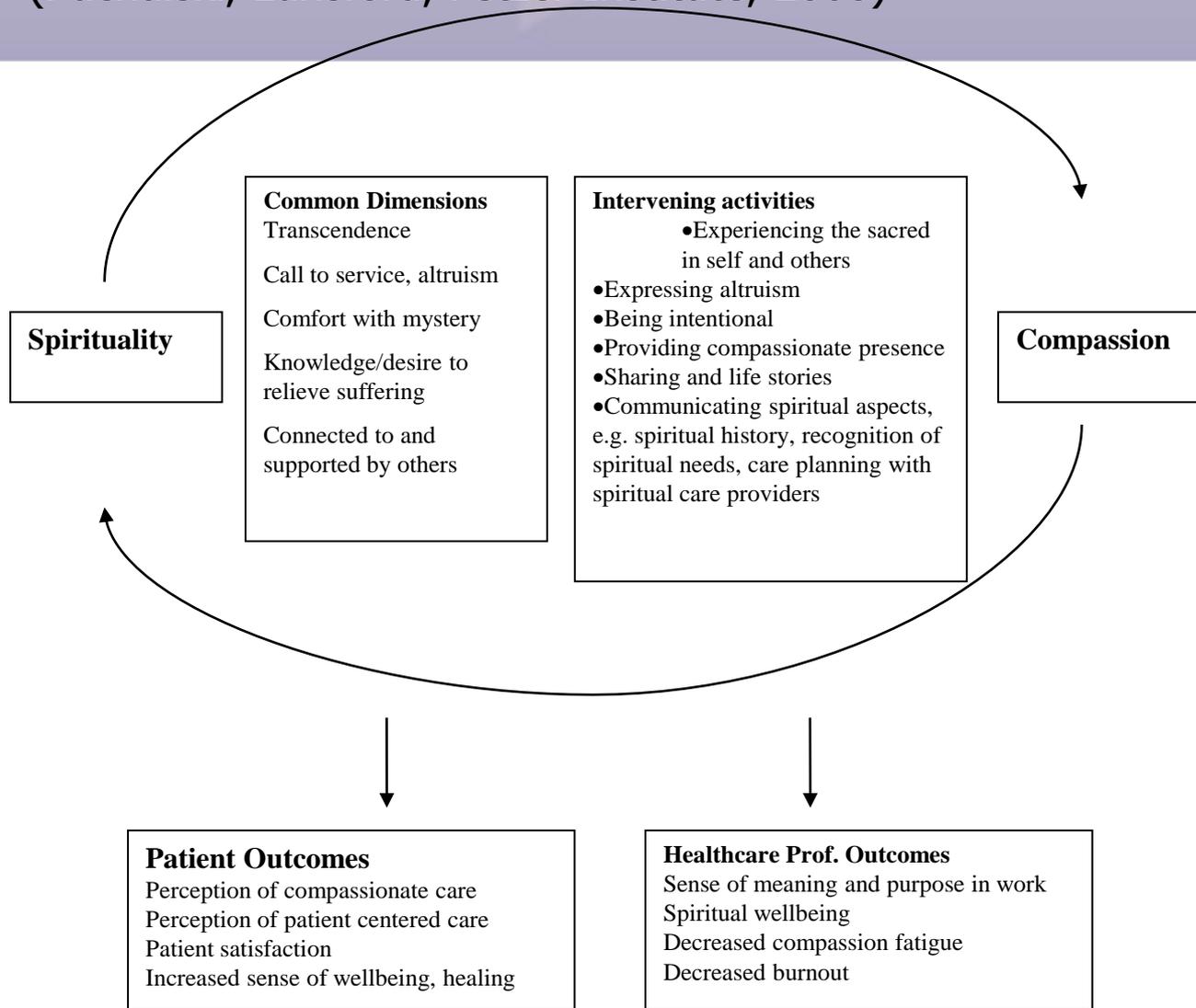


The Solution

- Building on the work of many within the field of spirituality and health and related initiatives – humanities, ethics, whole-person care, CAM – the working group will review existing guidelines, add others and develop strategies to move the field forward toward a more compassionate systems of care.



Model of Spirituality and Compassionate Healthcare (Puchalski, Lunsford, Fetzer Institute, 2008)





US Conference Design and Organization

- **Members:**

42 national leaders subject matter experts from the fields of medicine, nursing, social work, chaplaincy, healthcare administration, clinical research, health economics, ethics, law, policy, insurance, workforce, and education with healthcare professionals
- **Policy Delphi:** with NCC recommendations and new recommendation preconference
- Two day conference in Washington, DC



ICC-Conference Design and Organization

- 36 healthcare professionals and those involved in policy representing 27 countries
- Policy Delphi with NCC recommendations and new recommendation pre conference
- Three day conference in Geneva, Switzerland



ICC Members





Goals of Consensus Conferences

- Develop proposed standards of care for spiritually centered compassionate care.
- Develop a broad framework for the proposed strategic plan to improve the quality of spiritual care in healthcare
 - Identify and recommend specific strategies for implementation within research, education, clinical care, policy and advocacy, communication and community
 - Identify barriers and assess opportunities for implementation of the standards of care



Goals of Consensus Conference

- Build a coalition for change
 - Convene a working group to build a sense of community and enthusiasm for agenda-setting
- Develop a **Call to Action** that represents the values of the participants



Long range vision

- To ensure that healthcare systems honor, respect and dignify the personhood of those who give and receive care is standardized across the national and other healthcare systems
- Measures that would reflect this include the proposed guidelines of care are reflected in licensing and professional examinations, in educational certifications, in accrediting standards of clinical settings etc.



Global Consensus-Derived Definition of 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.*

Puchalski, Vitillo, Hull, Reller, Improving the Spiritual Dimension of Whole Person Care: Reaching National and International Consensus, Journal of Palliative Medicine

June, 2014

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Recommended Standards for Spiritual Care

(Puchalski, Vitillo, Hull, Reller JPM 2014)

- 1. Spiritual care is ***integral to compassionate***, person-centered health care and is a standard for all health settings.
- 2. Spiritual care is a ***part of routine care*** and ***integrated into policies*** for intake and ongoing assessment of spiritual distress and spiritual well-being.
- 3. All health care providers are ***knowledgeable about the options for addressing patients' spiritual distress and needs***, including spiritual resources and information
- 4. Development of spiritual care is supported ***by evidence-based research***.
- 5. Spirituality in health care is developed in ***partnership with faith traditions and belief groups***.
- 6. Throughout their ***training***, health care providers are educated on the spiritual aspects of health and how this ***relates to themselves, to others, and to the delivery of compassionate care***.



Recommended Standards for Spiritual Care

(Puchalski, Vitillo, Hull, Reller JPM 2014)

- 7. Health care professionals are ***trained in conducting spiritual*** screening or spiritual history as part of routine patient assessment.
- 8. All health care providers are ***trained in compassionate presence, active listening, and cultural sensitivity, and practice these*** competencies as part of an interprofessional team.
- 9. All health care providers are trained in spiritual care ***commensurate with their scope of practice***, with reference to a spiritual care model, and tailored to different contexts and settings.
- 10. Health care systems and settings provide opportunities to develop and sustain ***a sense of connectedness with the community they serve***; healthcare providers work to create healing environments in their workplace and community.
- 11. Health care systems and settings support and encourage health care providers' attention to ***self-care, reflective practice, retreat, and attention to stress management***.
- 12. Health care systems and settings focus on ***health and wellness and not just on disease***.



Examples of Group Goals/Action Plans

- **Clinical Practice**
 - Develop spiritual screening history and assessment tools and protocols – Intermediate Term; ACTIONS:
 - Describe existing tools, do a gap analysis and the pilot tools
- **Communication**
 - Short-term: To build up an on-line community
 - Facebook, twitter, online conferences, papers for download, webinars
- **Community Engagement**
 - To determine the mode and level of engagement with spiritual of engagement with spiritual care in health care
 - Evaluate the needs and assets/ resources of communities



Examples of Group Goals/Action Plans

- **Education**

- Evidence-based, culturally appropriate curriculum across disciplines
 - Research and Assessment of the State of the Art – globally and at institutional level

- **Research**

- Establish Research Network
 - Identify and link individuals and existing network
 - Establish platform for database/forum and information required

- **Policy**

- Evidence -based spiritual care is integrated within different settings
 - WHO Member States adopt a resolution with their respective Regional Committees to strengthen spiritual care within country' s health systems.



Education



Spirituality and Health Education: Whole Person Care

- Patient care
 - Spiritual history
 - Spiritual distress diagnosis and treatment
 - Biopsychosocialspiritual Assessment and treatment plan
 - Compassionate presence to persons' suffering
- Student/resident/clinician formation
 - Inner life focus
 - Meaning, purpose, call to serve
 - Authenticity
 - Compassionate presence— to self



National Competencies in Spirituality and Health (Puchalski ,Blatt, Kogan, Butler, Acad. Med, 2014)

- ACGME to frame; added Compassionate Presence
- Key concepts
 - Clinical
 - Spiritual care in clinical care (spiritual history, assessment and plan)
 - Diagnosis: (NCCN, NCC 09)
 - Whole person care, spirituality broadly defined, interprofessional spiritual care
 - Based in part Guidelines from National Consensus Conference in Spiritual Care in Palliative Care
 - Basis of compassionate care– Dignity, respect, integrity, presence to suffering, outgrowth of one's spirituality
 - Healthy relationships are crucial in medicine; transformation of patient and physician in the encounter
 - Compassion is core to clinical care and healing
 - Awareness of the sacred in clinical practice
 - Professional development should include focus on student and physician wellbeing, on spirituality as core to the way we understand our vocation to serve other who suffer (MSOP, Report III, 1999)



Educational Initiatives outside US

- **Brazil– Survey of Medical Schools** (Lucetti et al 2012), 10% courses, required, 40% with topics
 - 54% med directors say important
- **U of Alberta, Canada--GTTR**
- **Korea– Spirituality in Nursing Formation**
(Sr. Julianna Yong, PhD, RN)



Educational Initiatives outside US

- Nambia Windhoek School of Medicine (Fr, Rick Bauer, MM, LCSW)
 - FICA- 3rd med students, very receptive , hungry for more
 - One week training in Palliative Care for Cancer Center Staff.
 - Radiology aids most excited
 - “Is it ok if we talk to patients like Fr Rick is teaching?”
 - Fully present to the clients
- India
 - Feb 2015 Conference on Education and Clinical Care in Spirituality and Health
 - Active Curricular developments in many parts of the country (Nagesh Simha, MD)



Education for Clinicians

- Marie Curie Cancer Center Spiritual and Religious Competencies for all healthcare workers (Great Britain)
- Outcomes
 - Pre-post knowledge, skill, attitudes and behaviors
 - No systematic patient care outcomes of training
 - Some anecdotal evidence in patient care



Recommendations of Global Consensus Conference (Puchalski, Vitillo, Hull and Reller JPM 2014)

- Conduct research and assessment of current body of knowledge
- Conduct needs assessment to identify best training practices
- Focus assessment of needed skill sets
- Develop evaluation tools to accompany standards



Clinical Care



Bring Pieces Together: Outpatient Supportive & Palliative Care Clinic (SAPC) at the Medical Faculty Associates- George Washington University





SAPC- Oncology

- Co-Directors
- Christina Puchalski, MD, Jen Bires, MSW
- Katalin Roth, MD
- Sam Lolak MD (psychiatry and CL fellows)
- Susan Donham, BCC
- Monica Dreyer, MA
- Safyia Stewart, NP

- Assessment: 38 yo female with metastatic breast cancer with severe fatigue, shortness of breath from ascites and deconditioning, lymphedema not well managed by her at home, acute end of life issues– deep existential distress, isolation from husband and friends, bereavement of her own family and facing her own dying
 - Plan:
 - Referral to lymphedema clinic at MFA
 - PT—pool exercise
 - Yoga (Jen Bires)
 - Nutrition support –increased hydration, nutrition
 - Art therapy referral
 - Invite husband to next visit to discuss end of life issues
- (note patient improved at follow-up, decided with husband on home hospice and died 10 days after the follow up visit at home)





Clinical Care

- Hospital based training programs
 - Based on NCC model and guidelines
 - Piloted in 9 sites in S.Calif,(Ferrell and colleagues—COH)
 - Pace, NY, VA-DC, Florida (St Anthony's)
 - Spain: Interprofessional training model, tested in over 30 sites in Spain.
Psychosocial and spiritual training for psychologists, counselors who work with the chronically ill



Research



Research networks For Spirituality and Health

- Duke University (Karen Steinhauser, PhD and Tracy Balboni, MD)
- EAPC Spirituality Task Force, Carlo Leget, PhD, Lucy Selman, MD
 - Selman et al: Research Priorities
- HCCN– Chaplaincy Research
- GNSAH Two projects
 - Lucy Selman, PhD—spirituality and caregivers multicountry effort
 - Suzette Bremault-Phillips, PhD, OT- FiCA in Edmonton, Canada



Policy : WHO resolution in Palliative Care



WHO Palliative Care Resolution

Strengthening of palliative care as a component of integrated treatment within the continuum of care, Jan. 23, 2014

- Bearing in mind that palliative care is an approach that improves the quality of life of patients (adults and children) and their families facing the problems associated with life-threatening illness, ***through the prevention and relief of suffering by means of early identification and correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual;***



WHO Palliative Care Resolution

Strengthening of palliative care as a component of integrated treatment within the continuum of care, Jan. 23, 2014

- :Acknowledging that palliative care is an ***ethical responsibility of health systems, and that it is the ethical duty of health care professionals*** to alleviate pain and suffering, whether physical, psychosocial or spiritual...”



WHO Palliative Care Resolution

Strengthening of palliative care as a component of integrated treatment within the continuum of care, Jan. 23, 2014

- ...the delivery of quality palliative care is most likely to be realized where strong networks exist between professional palliative care providers, support care providers (***including spiritual support and counseling***, as needed)...



GNSAH: Advisory to WHO for Spiritual Issues

- Manual for Palliative Care Resolution
- Demonstration Sites
 - PAHO
 - India
 - Africa
- May 7, 2015 Third Convening of Members of GNSAH , Copenhagen, Denmark
 - Chapter on Policy for Spiritual Care
 - Chapter on Spiritual Care

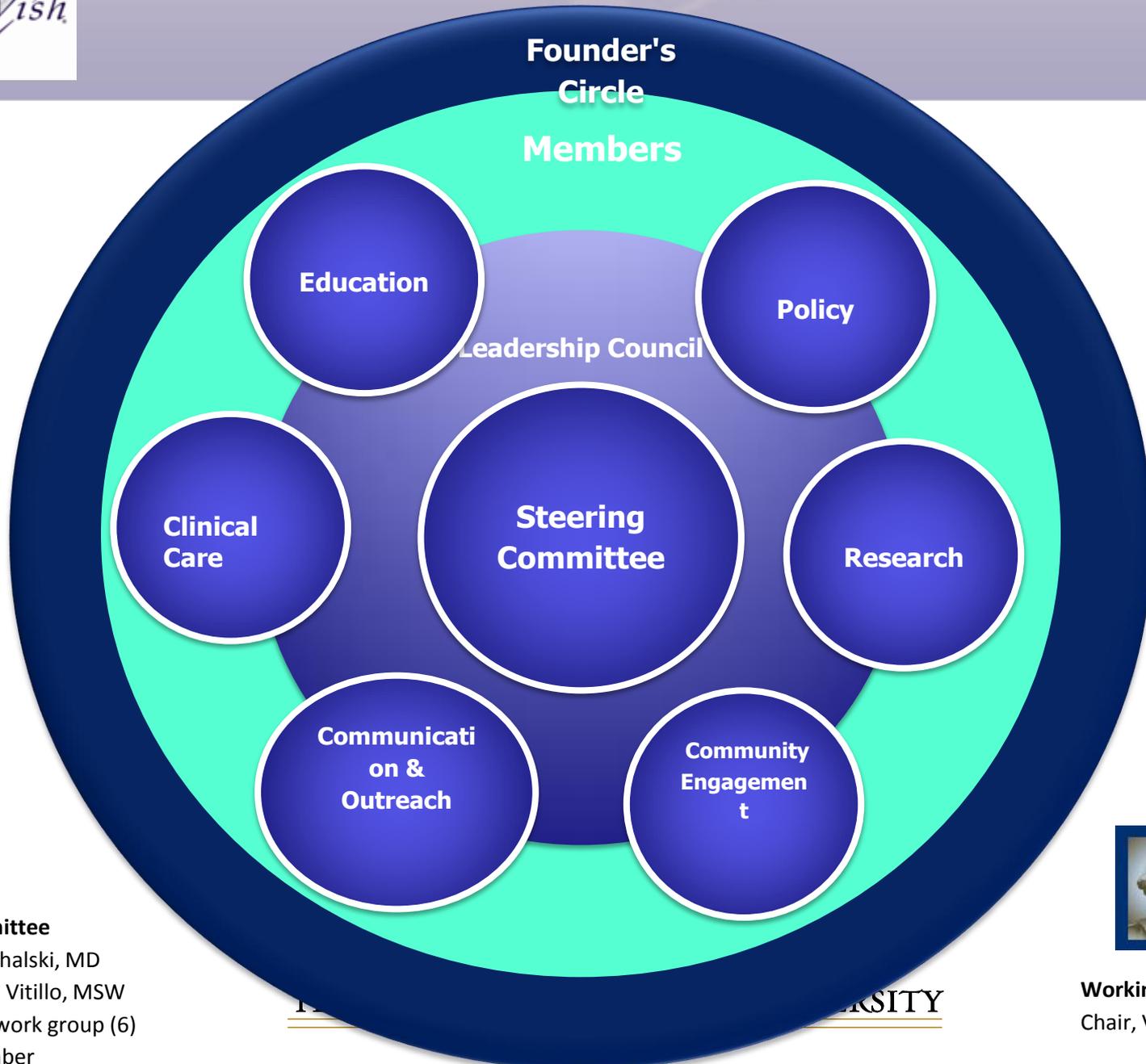


Members of GNSAH –May 7 Convening

- Xavier Gomez-Baptiste, MD, PhD Spain
- Fr. Rick Bauer, MM, LCSW Namibia, Africa
- Marie-Charlotte Bousseau, PhD Geneva, Switzerland
- Bruce Feldstein, MD, BCC USA
- George Handzo, Mdiv, BCC USA
- Sharon Hull, MD, MPH USA
- Fr. Jan Jaworski, MD, Mdiv Papua New Guinea
- Ikali Karvinen, PhD, RN Finland
- Fr. Piotr Krakowiak, PhD Poland
- Carlo Leget, PhD The Netherlands
- Roderick, MacLeod, MD Australia
- Joan Marsten South Africa
- Nagesh Simha, MD India
- Shane Sinclair, PhD, BCC Canada
- Rev Peter Speck, PhD England
- John Swinton, PhD, RN Scotland
- Anne Vanenhock, PhD, BCC Belgium
- Mieke Vermandere, MD, PhD Belgium
- Fr. Robert Vitillo, MSW Geneva Switzerland



Integrating Spirituality into Health A Global Movement



Steering Committee

Co-Chair, C Puchalski, MD
 Co-Chair, Rev R Vitillo, MSW
 Chairs of each work group (6)
 Ex-Officio Member



Working Groups

Chair, Vice Chair and members



Global Network

- GW hosted meeting of advisor approved forming GNSAH
- Leaders' Summit, Fetzer Institute April 22-24, 2014
- Formation of Strategic Plan
- Advisory Council
- Call to World dvd
- Hosted on GWish website
- Launch Summer 2014



GNSAH Steering Committee

- Co-chairs
 - Christina Puchalski, MD and Msgr Robert Vitillo, MS
- Members
 - Carlo Leget, PhD
 - Richard Bauer, MM, LCSW
 - Noreen Chan, MD
 - Manuel Dayrit, MD, MPH
 - Liliana De Lima, MHA
 - Xavier Gomex, MD, PhD
 - George Handzo, MDiv, BCC
 - Ikali Karvinen, PhD, RN
 - Piotr Krakowiak, SAC, PHD
 - Katherine McOwen, MEd
 - Shane Sinclair, PhD, Mdiv
 - John Swinton, PhD, RN
 - Virginia Stallings, MD
 - Deane Wolcott, MD
- GWish Staff
 - Najmeh Jafari, MD
 - Susan Donham, BCC



Aim of GNSAH

- The Global Network for Spirituality and Health has been established to promote the transformation of health systems by integrating interprofessional spiritual care as an essential aspect of health, healing and compassionate, person-centered care.



Goal 1

- Goal 1: To convene an inclusive, diverse and multidisciplinary network of clinicians, researchers, educators, policy makers, and health communities including patients and caregivers.
- Objective 1.1: To invite participants to advance the field of spirituality and health by collaborating and sharing resources and ideas;
- Objective 1.2: To promote dissemination of research findings, curricula, policies and clinical models and guidelines, and engaging in ongoing dialogue to help empower passionate people to transform healthcare systems globally.



Goal 2

- Goal 2: To catalyze innovative thinking and action related to health care that addresses the comprehensive needs of both patients and professional and family caregivers, including their spiritual needs,
- Objective 2.1: to raise awareness of the significant or sacred as a relevant dimension in clinical, psycho-social, and spiritual care;
- Objective 2.2: to bridge disciplines, worldviews and cultures, while building up the knowledge and evidence base related to spirituality and health.



How can you get involved?

- Sign up as individual or organization
- Participate in future meetings
- Spread the word of GNSAH activities to people you know in policy, research , education, clinical care, community
- Get involve in Call to World discussion groups
- Utilize resources as they build on the web



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We call for a health care system that provides caregivers – professional and family – and care receivers the **opportunity to realize their full selves** – physically, emotionally, socially and spiritually; that emphasizes health and healing; and that honors the health of the community.

We seek a system that promotes **compassionate** care, **respects** the **dignity** of those who give and receive care, and promotes **love** and **forgiveness** through **relationship-centered care**.

Fetzer Health Advisory Council, 2012



We are bold enough to say that we want a health care system that is **spiritual, even awe inspiring!**

A health care system that will **transform the hearts** of those who give, receive, teach, and learn care – the culture of care and the language of care;

A system that will be **other regarding, moving toward justice by** encouraging practitioners to work as a team to deliver service grounded in benevolence and altruism;

A system that encourages **self-compassion and self-care**, which says to a practitioner “you don’t have to take it all on yourself”;

A system that strives for **equity**, removing barriers due to finances, culture and individual status.



GNSAH: Global Network in Spirituality and Health

- www.gnash.org
- Sign up for membership!



GWish, www.gwish.org

- Education resources (SOERCE, National Competencies)
- Interprofessional Initiative in Spirituality Education (nursing, medicine, social work, pharm, psychology)
- Retreats for healthcare professionals (Assisi, U.S.)
- Time for Listening and Caring: Oxford University Press
- Making Healthcare Whole, Templeton Press
- FICA Assessment Tool—online DVD
- Spiritual and Health Summer Institute, July, GW campus
- INSPIR
- Christina Puchalski, MD, 202-994-6220,
cpuchals@gwu.edu