

LIT REVIEW: SPIRITUALITY, PALLIATIVE CARE AND THE PROFESSIONAL CAREGIVER

Michael Brown, MSW
Wilfrid Laurier University

Search Terms

A range of terms were used in searching through social science and medical journals on the topic of professional caregivers, spirituality, and palliative care. They included: spiritual needs; spiritual; spiritual counsellors; spiritual caregivers; religion; religious affiliation; life experiences; coping; terminally-ill; death and dying; terminally ill patients; death attitudes; care of the chronically ill and dying; and caregivers.

Themes

“The **inadequacy of words** to express spirituality was a common theme” for professional caregivers. (Boston & Mount, 2006, p. 17).

Caregiver observed patient suddenly noticed how spiritual Yo Yo Ma **music** is (Boston & Mount, 2006).

Caregiver notices how patient suddenly takes up **poetry** (Brayne et al., 2006, p. 20).

Themes include how spiritual and existential needs of patients are identified and interpreted by professional caregivers, how caregivers identify and interpret own experience of spiritual and existential suffering, and how caregivers perceive strengths and barriers to providing spiritual care (Boston & Mount, 2006). Nurses, physicians, a family therapist and volunteers were interviewed in focus groups.

Katz & Genevay (2002) noted from case examples that some professionals may not deal with their relationships at home and fill their intimacy void with clients (p. 333). Katz & Genevay (2002) give example of **psychiatrist** that transferred case to block own difficult feelings stirred up by dying patient (p. 330). In another case, they note how the professional makes assumptions about family's culture and does not explore this particular family's own responses to their loved one dying (p. 332).

Flannelly et al. (2004) note in their study of scholarly articles that there was a tendency for **non-research articles** to be more likely to address spirituality, whereas **research articles** were more likely to address religion. They continue that in the last 20 years or so, spirituality has become differentiated from religion or religiousness, and the concept of spirituality has taken on some of the features of religiousness with the concept of religion narrowed down to its more institutional, doctrinal, or ritualistic features.

There is a need to focus on the knowledge, skills and actions of individual healthcare professionals so that good practice is affirmed, personal skills and limits are recognized, and training and development needs are identified. A four-level competency framework was created by the authors based on knowledge, skills, and actions to specify spiritual and religious care that can be understood and achieved by staff and volunteer caregivers (Gordon & Mitchell, 2004)

Interdisciplinary teams:

Interdisciplinary teams are increasing because spiritual needs not frequently addressed, there is a growing response to family-focused care, and there are broader efforts to improve professional and patient communication (Connor et al., 2002).

According to Abrahm et al. (1996), care of **cancer patients** involves network of hospice services, consultation teams advising on the management of hospitalized cancer patients not residing on the hospital wards, and coordinating with community agencies that provide hospice care to patients in their homes. (p. 24)

Neonatal (1 journal article for this theme) :

When asked what ultimate sense they make of infants suffering, respondents said there was no sense to be made, or this was part of a larger cosmic plan they did not understand, or part of a larger plan that included God or a higher power with degrees of agency over infants' suffering (Cadge & Catlin, 2006).

Nurses (3 journal articles for this theme):

Gilliat-Ray (2003) notes that academics and educators have a much wider definition of spirituality than **nurses**, who tend to define it relation to God or a Deity. She also emphasizes that nurses' stereotypes of non-Christian religions must be overcome.

Doorenbos et al. (2006): **Nurses** that promoted dignified dying in **India** supported patients to find spiritual comfort at end of life, with nurses from the south reporting a greater number of these spiritual related interventions (p. 32). Doorenbos et al. (2006) speculate this may due to **hospitals** in south non-governmental Christian organizations, while government-run hospitals for indigent people have nurses who are paid lower salaries and have less palliative care training, and private hospitals in the north focus on superior technological care options and do not place value on palliative care (p. 32).

Interviews with **hospice nurses**: The need for comfort is highly individualized and a person who is spiritually troubled but not in pain physically will seek psycho-spiritual comfort. It therefore takes time to develop trust with patient and their family, time for beneficial communication and understanding, and time enough to make person feel they matter (Evans & Hallett, 2007).

Physicians (5 journal articles for this theme):

Themes for **physicians** with regard to end-of-life care include: Physician training marginalizes aspects of care, doctors overwhelmed by the busyness of their days, some doctors self-impose busyness as an involuntary excuse, and there is difficulty communicating subjective views between patient and physicians (Chibnall et al., 2004).

According to Chibnall et al. (2004), **physician training** was detrimental to providing PSS to patients in St. Louis, Missouri: physicians had to process their first existential crisis alone, lack of empathy from supervisors, lack of time and place to discuss event, use denial as coping mechanism, training instilled message that death is enemy to be defeated or denied, as well as distancing effects of technology and emotional desensitization (p. 421).

Patients find it difficult to approach **physicians** to talk about spiritual and existential matters (Brayne et al., 2006).

Ellis & Campbell (2004): "... **physician and patient** respondents believed that holding or expressing **dogmatic religious views** may create a barrier to fruitful spiritual discussions (p. 49).

Hart et al. (2003): Four themes were identified in patient interviews when talking about relationship with their **physicians**: treat the whole person, treat with sensitivity, favourable attitudes toward religious and spiritual discussions, and no preaching.

Hebert (2001)

Social Work:

Operational Definitions of Spirituality in Relation to Palliative Care

Boston & Mount (2006) highlight how the boundaries between psychological, existential, and spiritual issues were not clearly drawn for participants in the interviews (p. 15). “Spirituality was equated with a sense of meaning” (e.g., did not believe in life after death but believed in the goodness of his wife) (Boston and Mount, 2006, p. 15).

Boston & Mount (2006) note how the terms “spiritual” and “psychological” were sometimes difficult to distinguish for caregivers (p. 17).

Spirituality: individuals who believe their life have a purpose but do not necessarily participate in established organized belief practices Brown et al., 2006).

Evans & Hallett (2007) did not provide operational definition of spirituality, but discussed aspects of how the spiritual needs of terminally ill incorporate a search for meaning and a sense of forgiveness and is not wholly about specific religious or agnostic issues.

Flannelly et al. (2004) note that spirituality typically was mentioned in the context of spiritual care, needs, awareness, or well-being in the scholarly articles that they studied.

Spiritual care is usually given one-to-one, person-centered, makes no assumptions about personal convictions or life orientation, and not necessarily religious (Gordon & Mitchell, 2004).

Hebert et al. (2001): Spirituality was described in broad terms such as faith, reflection, healing, meaning, hope and purpose.

Operational Definitions of Religion in Relation to Palliative Care

Religion defined as a way of perceiving life meaning and higher purpose through a codified philosophy, shared doctrine, and community worship (Brown et al., 2006, adapting definitions from McKee & Cheppel, 1992, and Bessinger & Kuhne, 2002).

Flannelly et al. (2004) note that mention of religion typically included religious affiliation/denomination and/or religious beliefs, practices, services, traditions in general, or traditions in relation to specific religious faiths in the scholarly articles that they studied.

Religious care is given in the context of shared religious beliefs, values, liturgies, and lifestyle of a faith community (Gordon & Mitchell, 2004).

Hebert et al. (2001): Participants describe religion in terms of church attendance, ideologic involvement, and fellowship.

Overview of Methods

Abrahm et al. (1996) used all **data collection forms** which included demographic and medical information, and assessment of medical, nursing, psychosocial, and spiritual needs of patients and families. Team meetings were held weekly or more if clinically indicated. A medical oncologist, nurse coordinator, oncology social worker, and hospital chaplain were on the team.

Boston and Mount (2006) highlight **publications** from last ten years that present systematic reviews of research about religion and health, and double blind studies on intercessory prayer suggesting better clinical outcomes among prayed for victims. Boston and Mount (2006) in their

study used a qualitative focus group to investigate issues from perspective of highly experienced palliative care providers. Two authors are a palliative care physician and nurse educator experienced in qualitative research.

Brayne et al. (2006) used a **questionnaire** that provided demographic information, asked about interviewee's professional observations, and questioned the impact death bed phenomenon had on spiritual and religious beliefs of the interviewee. Brayne et al. (2006) also conducted semi-structured interviews that were tape recorded.

Cadge & Catlin (2006) used data from an anonymous **survey** which included 45 questions, two-thirds were close-ended. The data was collected by Catlin, MD, in the neonatal intensive care unit at Massachusetts General Hospital for Children.

Chibnall et al. (2004) conducted two **discussion groups** to talk with physicians about end-of-life care.

A **questionnaire** was filled out by people who left religious communities and subsequently chose to work in mental health care. The questions sought to elicit information on why people entered the religious communities, their experiences while there, reasons for leaving, their subsequent employment, and the impact their religious experience had on their work in caring professions. Very little else about the questionnaire was provided in this article by the authors (Crawford et al., 1998).

Conversational **interviews** and semi-structured interviews were conducted by Evans & Hallett (2007) using a sampling strategy to explore the meaning of comfort care for hospice nurses, understand how they pursue this work, and examine the means by which they provide comfort to hospice patients. An interview guide with issues was used, and Evans maintained a reflective journal throughout the study. Hallett is a senior lecturer and has Phd in nursing, and Evans is nurse and lecturer with MPhil degree.

Flannelly et al. (2004) read **articles** published in three journals from 1990 to 1999 to see if they explicitly mentioned religion and spirituality. They included statistical and thematic analyses.

Gilliat-Ray (2003) examines definitions of spirituality in nursing **literature** and compares them to ways in which spirituality is defined or not defined in field of theology and religious studies.

Interviews with 15 patients were audiotaped and transcribed (Hart et al. 2003).

Focus groups were facilitated, audiotaped and transcribed (Hebert et al., 2000).

Measurement Tools

Brown et al. (2006) present some clinical tools that physicians can use a structured approach to assessing and treating spiritual distress, such as the practical guide JAMA, the 10-item instrument called the "Living Well Interview," and interventions including psycho-social-spiritual group discussions (p. 84).

Katz & Genevay (2002) present an Early Behavioral Indicators table, a Feeling Self-Reflection Survey, and a Self-Awareness Exploration Questions form to assist professionals in coping with their emotional responses.

Doorenbos et al. (2006): The International Classification for Nursing Practice (ICNP) classifies nursing phenomena, actions, and outcomes that can be classified and enable intercultural and international comparison of nursing data. "Results from the factor analysis indicate that 11 items

can be used to provide a valid assessment of dignified dying among Indian nurses. Further studies are needed to validate these items in other cross-cultural nursing samples.”

Research Conclusions

“Data presented indicate the Philadelphia VAMC Hospice Consultation Team was able to provide significant service to its veterans and, probably, also provided cost savings to the VA...” (Abrahm et al., 1996, p. 30). A hospice consultation team made up of a medical oncologist, nurse coordinator, oncology social worker, and hospital chaplain. The hospice consultation team was very effective in identifying and resolving medical, psychosocial, and spiritual problems. However, they discovered that they needed a psychologist or psychiatrist on their team to resolve “psychological problems of anxiety, depression, or anger” (Abrahm et al., 1996, p. 29).

“The caregiver who brings awareness of personal vulnerability to the bedside, yet is willing to accompany the patient, effectively lights a fire of possibility that otherwise lies dormant, by activating the patient’s inner capacity to heal himself” (Boston & Mount, 2006, p. 25). Participants in this study suggest that spiritual discussions may be facilitated by the caregiver’s personal experience of suffering and by the imminence of the patient’s death. There is also a need for continuous reflective assessment of the personal emotional cost of being a palliative caregiver and for the provision of informal and formal opportunities for personnel support (Boston & Mount, 2006, p. 24).

“This survey supported the findings of other studies that patients tend to talk to nurses more than doctors” (Brayne et al., 2006, p. 23). Recommendations included caregiver support by teaching them therapeutic skills, learning language of the dying, providing educational booklets, forming a group with community and inpatient caregivers to discuss spirituality issues, have therapy in unit available for caregivers, have awareness and open discussion built into team structure, annual workshops and supervision specific to spirituality and dying (Brayne et al., 2006, pp. 23-24).

The results of Chibnall et al.’s (2004) study suggest that the **culture** that selects and trains technically competent physicians does not value PSS and creates a work environment hostile to PSS concerns, thus it seems interventions designed to improve end-of-life care must address barriers at the cultural, organizational, and clinical levels to be effective (p.423).

Connor et al. (2002): “The education of all health care professionals needs to value true **interdisciplinary** collaboration...no individual team member alone can meet the needs of these highly complex patients and families facing the most difficult passage of a lifetime.” (p. 354)

Crawford et al. (1998) observed that respondents in prior pastoral role cared for mentally ill, switched from religious life to mental health life in secular work, and were disappointed with previous religious life. Respondents’ journey involved self-healing, understanding self, and to be understood – a kind of **wounded healer** journey.

Ellis & Campbell (2004): "...patients may be more influenced by physicians’ manner of approach than by their use of spiritual health screening questions is consistent with a substantial body of literature about sensitive subjects in the doctor–patient interaction...physician spiritual assessment is neither a marker for physician sensitivity nor a guarantee for successful spiritual dialogue" (p. 50).

Flannelly et al. (2004): “Since our scientific understanding is constrained by the definitions we use to measure concepts, more **explicit operational definitions** are needed to help to clarify the relationship between the concepts of religion and spirituality, and their influence on health and well-being.”

Hall et al. (2006): It is possible to introduce meaningful interprofessional education to medical, nursing, and spiritual care students early in their training which includes fostering professional collaboration.

Hebert (2001): Patients wanted physicians to inquire about social support and coping, and this study's findings provide some insight into why or why not patients want spiritual dialogue with physicians. Also, communication and the strength of the patient-physician relationship are important to measure.

Future Research

Cadge & Catlin (2006) note that few people who work in neonatal intensive care units have strictly scientific responses to the existential dilemmas of their work. They continue that the majority of providers referred to otherworldly plans including God or other higher power. "While these themes are largely invisible in the seemingly secular day-to-day work on the unit, their presence begs for further investigation and explanation" (Cadge & Catlin, 2006, p. 257).

Patterns by religious tradition, occupation, gender, and other demographic factors known to influence religious belief and practice might be evident within individual neonatal intensive care units, but demands further research (Cadge & Catlin, 2006).

The role of institutional factors in the shape of the religious affiliation of the hospital or the religious interest or sympathy of hospital and unit leaders are important contextual influences to investigate in studies comparing more than one unit (Cadge & Catlin, 2006).

Investigate how and in what context spirituality and religion come up and are addressed by physicians, nurses, and chaplains in neonatal intensive care units and other medical settings (Cadge & Catlin, 2006).

Little recent research considers how religion and spirituality are present in institutions among physicians, nurses, patients, social workers, administrators, and other employees (Cadge & Catlin, 2006).

Chibnall et al. (2004) conclude that organizational interventions, such as recognition, feedback, and remediation, combined with a method for quality improvement as espoused by Lynn and colleagues, are particularly unexplored in the current literature. Chibnall et al. also note that recent literature offers a variety of models, but "mostly unresearched," for initiating and managing PSS communication at the end of life (p. 423). They also note that future research needs a larger sample size from all medical specialties, as well as broader age, gender, racial, and religious affiliation distributions to provide a wider range of opinions, attitudes, experiences and values (p. 424).

Connor et al. (2002): "Interdisciplinary care is especially valuable for people who are chronically ill and dying; however, this care is not necessary for all patients. We need clearer knowledge concerning how to apply what kinds of interdisciplinary care to which populations."

Doorenbos et al. (2006): "Investigate the disparities inherent in different religious affiliations within the cross cultural sample of Indian nurses. As well, "A unifying language framework is necessary to promote scholarly exchange among nurses cross-culturally, and the ICNP® provides such a framework for nursing phenomena and actions. Results of this study contribute to the ongoing development of the ICNP®."

Respondents may have important different, modifying, or secular viewpoints which are not represented here and need to be explored in future study (Cadge & Catlin, 2006).

Gilliat-Ray (2003) suggests the need for more research on spiritual needs be carried out among patients, especially those who have spiritual needs and those who do not belong to any particular faith group. This may help close the gap between what patients really want, and the needs nurses think they are fulfilling for patients.

Hebert (2001): More research is necessary to determine how physicians may best address issues such as organ donation, end-of-life care or advance directives.

Bibliography

- Abraham, J. L., Callahan, J., Rossetti, K., & Pierre, L. (1996). The impact of a hospice consultation team on the care of veterans with advanced cancer. *Journal of pain and symptom management*, 12(1), 23-31. Abstract: To address the needs of patients with advanced cancer, all Veterans' Affairs hospitals were asked to establish teams of clinicians whose focus was to deliver expert palliative care. At the Philadelphia Veteran's Affairs Medical Center, our Hospice Consultation Team brought together professionals who had worked together informally in some of the outpatient oncology clinics. We conducted a prospective study of all consults received during the first year of the team's operation to determine whether or not the team approach would duplicate already available services or provide improved care. We identified 164 new medical/nursing problems in 75 patients, 85% of which we were able to resolve. There were 152 new psychosocial/spiritual problems, but only 40%–61% were resolved. Of 222 patients followed in oncology clinics, new problems were identified resolved in 21. We conclude that the expertise of the Hospice Consultation Team members along with the team process provided improved care to these patients. Keywords: Hospice; pain; psychosocial.
- Boston, P. H., & Mount, B. M. (2006). The caregiver's perspective on existential and spiritual distress in palliative care. *Journal of pain and symptom management*, 32(1), 13-26. Abstract: There is a paucity of research relating to how palliative caregivers conceptualize, identify, and provide for spiritual and existential domains of care. Focus groups comprising experienced palliative care providers participated in three semistructured 2--2.5 hour interviews, which were transcribed and subjected to thematic analysis. Eight themes were revealed: conceptualization of spirituality; creating openings; issues of transference and countertransference; cumulative grief; healing connections; the wounded healer; sustaining a healing environment for the caregiver; and challenges and strengths for the spiritual and existential domains of palliative care. While the spiritual and existential domains were variously conceived by experienced care providers, their significance for both patient and caregiver was affirmed. Transference and countertransference issues and the "wounded healer" concept were considered fundamental to effective care. Strategies for promoting therapeutic depth discussion were suggested and the importance of self-awareness and staff support emphasized. *J Pain Symptom Manage* 2006;32:13--26. 2006 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved. Key Words: Palliative care, existential suffering, healing, caregivers, spiritual care.
- Brayne, S., Farnham, C., & Fenwick, P. (2006). Deathbed phenomena and their effect on a palliative care team: A pilot study. *American Journal of Hospice & Palliative Medicine*, 23(1), 17-24. Abstract: Anecdotal evidence suggests that death may be heralded by deathbed phenomena (DBP) such as visions that comfort the dying and prepare them spiritually for death. Medical practitioners have been slow to recognize DBP, and there has been little research into the spiritual effect that DBP have on caregivers or on how these phenomena influence their work. A pilot study looking into the occurrence of DBP was conducted by

the palliative care team at Camden Primary Care Trust. Interviews revealed that patients regularly report these phenomena as an important part of their dying process, and that DBP are far broader than the traditional image of an apparition at the end of the bed. Results of the interviews raise concerns about the lack of education or training to help palliative care teams recognize the wider implications of DBP and deal with difficult questions or situations associated with them. Many DBP may go unreported because of this. Results of this pilot study also suggest that DBP are not drug-induced, and that patients would rather talk to nurses than doctors about their experiences. Key words: end of life, palliative care, deathbed phenomena, spirituality.

Brown, A. E., Whitney, S. N., & Duffy, J. D. (2006). The physician's role in the assessment and treatment of spiritual distress at the end of life. *Palliative & Supportive Care*, 4(1), 81-86. ABSTRACT: Objective: Patients at the end of their life typically endure physical, emotional, interpersonal, and spiritual challenges. Although physicians assume a clearly defined role in approaching the physical aspects of terminal illness, the responsibility for helping their patients' spiritual adaptation is also important. Methods: This article ~1! describes the terms and definitions that have clinical utility in assessing the spiritual needs of dying patients, ~2! reviews the justifications that support physicians assuming an active role in addressing the spiritual needs of their patients, and ~3! reviews clinical tools that provide physicians with a structured approach to the assessment and treatment of spiritual distress. Results: This review suggests that physicians can and should be equipped to play a key role in relieving suffering at the end of life. Significance of results: Physicians can help their patients achieve a sense of completed purpose and peace. KEYWORDS: Spirituality, Religion, End of life, Palliative care, Quality of life.

Cadge, W., & Catlin, E. A. (2006). Making sense of suffering and death: How health care providers' construct meanings in a neonatal intensive care unit. *Journal of Religion and Health*, 45(2), 248-263. ABSTRACT: Biomedical technology has progressed at a pace that has created a new set of patient care dilemmas. Health care providers in intensive care units where life-sustaining therapies are both initiated and withdrawn encounter clinical scenarios that raise new existential, theological, and moral questions. We hypothesized that there might be broad patterns in how such staff understand these questions and make sense and meaning from their work. Such meaning making might be the key to working with the critically ill and dying while helping to create and sustain a meaningful context for personal living. This article presents themes evident in an in depth analysis of open-text responses to a spiritual and religious questionnaire survey completed by staff in one neonatal intensive care unit. The data reveal the central roles of perceived infant suffering and death in these providers' work experience and details how they understand the ultimate meaning of the suffering and death. We investigate patterns in how different providers articulate their individual attributes and motivations for working in intensive care. We found a surprising range of religious, spiritual, existential, and other meaning-making systems that underpin how staffs understand their work and how, certain of them, even define their purpose in life as caring for critically ill infants and their families. KEY WORDS: neonatology; health care providers; religion and spirituality; suffering; death.

Chibnall, J. T., Bennett, M. L., Videen, S. D., Duckro, P. N., & Miller, D. K. (2004). Identifying barriers to psychosocial spiritual care at the end of life: A physician group study. *American Journal of Hospice & Palliative Medicine*, 21(6), 419-425. Abstract: Objective. The recent literature addresses the need to improve care for dying patients. The purpose of this study was to identify barriers to the psychosocial spiritual care of these patients by their physicians. Psychosocial spiritual care is defined as aspects of care concerning patient emotional state, social support and relationships, and spiritual wellbeing. The study was an exploratory means for generating hypotheses and identifying directions for interventions,

research, and training in care for the dying. Design and participants. The study used a qualitative group discussion format. Seventeen physicians at a university-based health sciences center representing 10 areas of medical specialty—including internal medicine, oncology, pediatrics, and geriatrics—met in two groups for 20 75-minute discussion sessions over the course of one year. Discussions were recorded, analyzed, and categorized. Results. Barriers to psychosocial spiritual care were grouped into three domains and seven themes. The cultural domain included the themes of training, selection, medical practice environment, and debt/delay. Participants believed that medical selection and training combine to marginalize psychosocial spiritual approaches to patient care, while the practice environment and debt/delay augment emotional isolation and dampen idealism. The organizational domain included the themes of dissatisfaction and time/busyness. Physicians indicated that the current reimbursement climate and time pressures contribute to dissatisfaction and the tendency to avoid patient psychosocial spiritual issues. The clinical domain included the theme of communication. Physicians were concerned about their ability to communicate nonmedical issues effectively and manage the patient's reactions and needs in the psychosocial spiritual arena. Conclusions. This study suggests that research and educational approaches to improving the psychosocial spiritual care of the dying by physicians should address barriers at the cultural, organizational, and clinical levels. Suggestions for interventions at various levels are offered. Key words: end-of-life care, spiritual care, psychosocial care.

Claxton-Oldfield, S., Crain, M., & Claxton-Oldfield, J. (2007). Death anxiety and death competency: The impact of a palliative care volunteer training program. *American Journal of Hospice & Palliative Medicine*, 23(6), 464-468. Before and immediately after the 2 most recent offerings of a local palliative care volunteer training program, 17 participants completed the Collett-Lester Fear of Death Scale and Bugen's Coping with Death Scale. The training program consisted of approximately 27 hours of training presented in 3-hour blocks during a 9-week period. Topics included the philosophy and goals of palliative care, spiritual issues from a multicultural and multifaith perspective, communication, the dying process, grief and bereavement, and the role of the volunteer. The results showed no differences in participants' pretraining and posttraining scores on the 4 subscales of the Fear of Death Scale. However, participants felt significantly more able to cope with death and dying after the training program than before. With proper training, volunteers will feel more prepared to handle situations involving terminal illness and death. In short, they will be more effective in their work with dying patients and their families. Keywords: death anxiety; death competency; palliative care volunteers.

Connor, S. R., Egan, K. A., Kwilosz, D. M., Larson, D. G., & Reese, D. J. (2002). Interdisciplinary approaches to assisting with end-of-life care and decision making. *American Behavioral Scientist*, 46(3), 340-356. Abstract: The importance of interdisciplinary care for patients and families facing the end of life is examined. Descriptions of varying forms of team functioning are provided with an emphasis on the characteristics of high-functioning interdisciplinary teams. The value of empowering the patient and family to direct the care they receive from their team is emphasized. Interdisciplinary team interventions in end-of-life care focus on the biopsychosocial and spiritual dimensions of human experience and facilitate growth and development in the last phase of life. Despite its great promise for improving patient care, the interdisciplinary model is not—with the exception of hospice care—widely implemented in today's health care system. The contributions of interdisciplinary teams to end-of-life care can be enhanced through the development of interdisciplinary team training programs, the creation of payment structures that support the interdisciplinary team model, and continuing research assessing the dynamics of team functioning and the benefits that interdisciplinary team care provides to patients and families near the end of life.

Crawford, P., Nolan, P. W., & Brown, B. (1998). Ministering to madness: The narratives of people who have left religious orders to work in the caring professions. *Journal of Advanced Nursing*, 28(1), 212-220. This paper examines the life stories of 14 men and women who spent time in religious communities and who subsequently took up work in the caring professions. Their accounts reflect the alignment between the ethics of care and those of religious life, the centrality of contemplation and self-examination to both Christianity and psychotherapy. There are further correspondences between their narratives and recent academic interest in the spiritual aspects of health care. They also describe profound changes and moments of uncertainty which parallel other transitional experiences like grieving or unemployment. For many respondents also, caring for others is part of caring for oneself. Disappointment with the religious life and isolation on leaving it appear to have brought the respondents into a close relationship with those who suffer mental illness. It is almost as if they seek to heal the distress in their own lives by proxy.

Doorenbos, A. Z., Wilson, S. A., Coenen, A., & Borse, N. N. (2006). Dignified dying: Phenomenon and actions among nurses in India. *International nursing review*, 53(1), 28-33. Purpose: This study contributes to the ongoing efforts of the International Classification for Nursing Practice (ICNP®) to describe the phenomenon of dignified dying, to describe nursing actions used to promote dignified dying, and to evaluate the validity of a dignified dying scale among practising nurses in India. Design and sample: This descriptive study surveyed 229 nurses who had cared for dying patients and were currently practising in government and private hospitals in India. Methods: Nurses were recruited to complete a survey in either Hindi or English. The survey included demographic, open-ended questions, and a dignified dying scale of Likert-like items. Nurses also identified nursing interventions used in practice to promote dignified dying. Findings: The descriptions of dignified dying phenomenon fit within the three major areas of the Dignity-Conserving Model of Care. A variety of interventions were reported, with more focusing on spiritual than physical factors. The 14 items selected reliably measured dignified dying, with a Cronbach's alpha of 0.79. Factor analysis yielded a 4-factor solution, with 11 items accounting for 56% of the variance. Conclusions: Nurses in India endorsed spirituality as an essential aspect of the phenomenon of dignified dying. Nursing actions to promote dignified dying supported finding spiritual comfort at end of life. These results contribute to an understanding of nursing phenomena and actions worldwide. Keywords: Dignified Dying, (ICNP®), India, Nurses, Nursing Actions.

Ellis, M. R., & Campbell, J. D. (2005). Concordant spiritual orientations as a factor in physician-patient spiritual discussions: A qualitative study. *Journal of Religion and Health*, 44(1), 39-53. ABSTRACT: Objectives: To understand the impact of physicians' and patients' religious/spiritual orientation on discussions of spiritual issues. Methods: We performed semi-structured interviews of 10 Missouri family physicians and 10 patients of these physicians, selecting subjects nonrandomly to represent a range of demographic factors, practice types, and chronic or terminal illness. We coded and evaluated transcribed interviews for themes. Results: Respondents expressed that similar belief systems facilitate patient-physician spiritual interactions and bring confidence to their relationships. Those holding dissimilar faiths noted limited ability to address spiritual questions directly. They cited significant barriers to spiritual interaction but considered that ecumenism, use of patient-centered care, and negotiation skills lessen these barriers. Conclusions: Our respondents view spirituality similarly to other aspects of the physician-patient relationship involving differing viewpoints. Where discordance exists, cross-cultural, patient-centered, diplomatic approaches facilitate spiritual discussions. KEY WORDS: cross-cultural medicine; family medicine; patient-centered care; religion and medicine; spirituality and medicine.

Evans, M. J., & Hallett, C. E. (2007). Living with dying: A hermeneutic phenomenological study of the work of hospice nurses. *Journal of Clinical Nursing*, 16(4), 742-751. Aims. (i) Explore the meaning of comfort care for hospice nurses. (ii) Provide an understanding of how this work is pursued in the hospice setting. (iii) Examine the means by which hospice nurses provide comfort to hospice patients. Background. The concepts of 'comfort' and 'comfort care' have long been a subject for examination by nurse researchers. The paper provides an overview of selected, relevant literature in this area. The methods used by nurse researchers have almost always been qualitative, and have focused on the meaning of nursing care for dying patients, from both nurses' and patients' perspectives. Design and methods. The paper reports a hermeneutic phenomenological study of the work of 15 hospice nurses based in one hospice in the north of England. Sampling was purposive, and data were collected by means of semi-structured interviews. A reflective diary was also kept. The interpretation of data was guided by phenomenological and hermeneutic methodology. Results. The nurses interviewed spoke openly about their experiences of working with hospice patients. They saw the relief of suffering through 'comfort care' as an important element of their work. The findings are presented under three thematic headings: 'Comfort and relief', 'Peace and ease' and 'Spirituality and meaning'. Conclusion. Hermeneutic phenomenology is an important method for uncovering the complex realities of nursing work. The nurses' perspectives on 'comfort care' they offer to patients were revealed by the data presented here, which were interpreted to offer a unique perspective on this type of nursing work. Relevance to clinical practice. These findings offer insights to nurses in both hospice and other settings; they give a number of perspectives on the nature of 'comfort care' and the meanings attached to it by experienced hospice nurses'. Key words: comfort care, dying, nurses, nursing, palliative care, phenomenology.

Flannelly, K. J., Weaver, A. J., & Costa, K. G. (2004). A systematic review of religion and spirituality in three palliative care journals, 1990-1999. *Journal of palliative care*, 20(1), 50-56.

Gilliat-Ray, S. (2003). Nursing, professionalism, and spirituality. *Journal of Contemporary Religion*, 18(3), 335-349. ABSTRACT The first of the nine National Charter Standards stated in the Patient's Charter, launched in 1991 by the UK Department of Health, specifies 'respect for privacy, dignity and religious and cultural beliefs'. Over the past decade, partly as a consequence of this dimension of the Charter, articles about 'spirituality' have become commonplace in nursing journals and several specialist books have been written on the role of nurses and the delivery of spiritual care. However, some of the assumptions that lie behind the use of the word 'spirituality' in nursing are highly questionable and this paper critically evaluates its use and abuse. Tony Walter (2002) offered a critique of the term (particularly in relation to nursing and palliative care) and this paper develops his discussion by arguing that the appropriation of 'spirituality'—by nursing educators and academics in particular—reflects a deliberate effort to professionalise the nursing occupation. This is often at the expense of patients, especially those from minority faith traditions and indeed 'ordinary' nurses.

Gordon, T., & Mitchell, D. (2004). A competency model for the assessment and delivery of spiritual care. *Palliative medicine*, 18(7), 646-651. The delivery of spiritual and religious care has received a high profile in national reports, guidelines and standards since the start of the millennium, yet there is, to date, no recognized definition of spirituality or spiritual care nor a validated assessment tool. This article suggests an alternative to the search for a definition and assessment tool, and seeks to set spiritual care in a practical context by offering a model for spiritual assessment and care based on the individual competence of all healthcare professionals to deliver spiritual and religious care. Through-the evaluation of a pilot study to familiarize staff with the Spiritual and Religious Care Competencies for

Specialist Palliative Care developed by Marie Curie Cancer Care, the authors conclude that competencies are a viable and crucial first step in 'earthing' spiritual care in practice, and evidencing this illusive area of care. *Palliative Medicine* 2004; 18: 646-651. Key words: assessment; competency; hospice; multidisciplinary; religious care; spiritual care.

Hall, P., Weaver, L., Fothergill-Bourbonnais, F., Amos, S., Whiting, N., Barnes, P., et al. (2006). Interprofessional education in palliative care: A pilot project using popular literature. *Journal of Interprofessional Care. Special Issue: Framing and reframing*, 20(1), 51-59. Summary: A need to introduce the concepts of death and dying to the medical and health sciences undergraduate curriculum was identified at the University of Ottawa, Ontario, Canada. As care of the terminally ill is complex and requires the collaborative involvement of a diverse group of health care professionals, an interprofessional educational approach was utilized to address this need. A seminar course was developed using popular literature as the basis for learning, and offered to first and second year medical students, fourth year nursing students and graduate students in spiritual care. The discussion of roles and the provision of care within the context of works of selected literature provided a focus that enabled the students to transcend their disciplinary barriers, and to better understand the perspectives and contributions that other team members bring to patient care. Evaluation findings suggest that meaningful interprofessional education can be introduced effectively to students either prior to or while they are maturing in their professional roles. Keywords: Interprofessional education, medicine, nursing, literature, spiritual care, palliative care.

Hart, A., Kohlwes, R. J., Deyo, R., Rhodes, L. A., & Bowen, D. J. (2003). Hospice patients' attitudes regarding spiritual discussions with their doctors. *American Journal of Hospice and Palliative Medicine*, 20(2), 135-139. Abstract: The purpose of this study was to assess hospice patients' attitudes regarding the discussion of spiritual issues with their physicians. We conducted in-depth interviews using open-ended questions on living with illness, spirituality and religion, and physician-patient relationships. The interviews were audiotaped, transcribed, and analyzed for dominant themes. The following dominant themes were identified: (1) treating the whole person, (2) treating with sensitivity, (3) favorable attitudes toward religious or spiritual discussions with doctors, and (4) no "preaching." Our findings suggest that patients do not expect physicians to be their primary spiritual advisors; however, physicians should be aware of and comfortable communicating with patients about religious or spiritual issues. More training in this topic may enhance the care physicians provide to patients near the end of life. Key words: spiritual, religion, hospice patients, physician-patient relationships

Hebert, R. S., Jenckes, M. W., Ford, D. E., O'Connor, D. R., & Cooper, L. A. (2001). Patient perspectives on spirituality and the patient-physician relationship. *Journal of General Internal Medicine*, 16(10), 685-692. OBJECTIVE: To identify the preferences and concerns of seriously ill patients about discussing religious and spiritual beliefs with physicians. DESIGN: Three focus group discussions with patients who had experienced a recent life-threatening illness. Discussions were audiotaped, transcribed verbatim, and reviewed independently by two investigators to identify discrete comments for grouping into domains. A third investigator adjudicated differences in opinion. Comments were then independently reviewed for relevance and consistency by a health services researcher and a pastoral counselor. SETTING: Academic medical center. PARTICIPANTS: Referred sample of 22 patients hospitalized with a recent life-threatening illness. MEASUREMENTS AND MAIN RESULTS: Almost all of the 562 comments could be grouped into one of five broad domains: 1) religiosity/spirituality, 2) prayer, 3) patient-physician relationship, 4) religious/spiritual conversations, and 5) recommendations to physicians. God, prayer, and

spiritual beliefs were often mentioned as sources of comfort, support, and healing. All participants stressed the importance of physician empathy. Willingness to participate in spiritual discussions with doctors was closely tied to the patient-physician relationship. Although divided on the proper context, patients agreed that physicians must have strong interpersonal skills for discussions to be fruitful. Physician-initiated conversation without a strong patient-physician relationship was viewed as inappropriate and as implying a poor prognosis. CONCLUSION: Religion and spirituality are a source of comfort for many patients. Although not necessarily expecting physicians to discuss spirituality, patients want physicians to ask about coping and support mechanisms. This exploratory study suggests that if patients then disclose the importance of spiritual beliefs in their lives, they would like physicians to respect these values.

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