SPIRITUAL CAREGIVING BY HEALTH CARE PROFESSIONALS

Physicians, Nurses, and Others Also Have Important Contributions to Make

BY FREDERIC C. CRAIGIE, JR., PhD

"We may think of spirituality as the vital center of a person; that which is held sacred."
—Former U.S. Surgeon General C. Everett Koop, MD[1]

In the United States in recent decades, an ongoing conversation about spirituality and health care has featured a lively dialogue concerning the role of various professionals in providing spiritual care. Last year, two journals in which articles about spirituality and health care often appear offered special sections on spiritual caregiving. The topic "Physicians and Spirituality" was explored in a special section of *Health Progress's* May-June 2006 issue. An introduction to the section emphasized the importance of physicians' personal spirituality "as a way of coping with the challenges [that] the current medical climate presents,"[2] and the section's articles discussed various approaches to cultivating spiritual balance and skills in both individuals and health care teams.

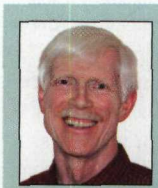
The June 2006 issue of the *Southern Medical Journal* featured a series of articles (arising out of that journal's "Spirituality/Medicine Interface Project") highlighting the contribution of pastoral care professionals to the healing process. Describing chaplains as "hidden assets," the introduction to this special section emphasized the specific training, knowledge, and expertise of chaplains, noting, however, that it was "not our intention to advocate that clinicians attend to the spiritual needs of patients under their care."[3]

I have been involved for many years in the general discussion of professionals and their role in spiritual caregiving. I have worked with dozens of physicians through the Program in Integrative Medicine at the University of Arizona School of Medicine, since 1987 directed an annual symposium in Maine on spirituality and health care, and written articles (for *Health Progress* and other journals),[4] besides keeping up my "day job" as an educator and clinician in a family-practice residency. As an originator of the pastoral care department at the hospital affiliated with our residency, I have also long been an advocate of clinical integration and the professional recognition of chaplains in medical settings.

When invited to speak, I find that I often address two topics concerning the roles of health care professionals—particularly physicians—and their partnership with pastoral care professionals in incorporating spirituality in medical practice. One topic is my belief that spiritual care—the incorporation of spirituality in the care of patients—is ultimately grounded in the "embodiment" of spirit in the life and presence of health care professionals. The second topic is my belief that although medical professionals defer appropriately to their chaplain colleagues in conversations about *spiritual issues and struggles,* they play a vital role in understanding and affirming patients' spiritual *values and resources* in the day-to-day practice of whole-person medicine.

Two Models of Spiritual Care

As I work with physicians, I frequently find them hesitant to engage spirituality in clinical care. I suspect that this hesitance arises out of their belief that spiritual care is fundamentally profound, complicated, theological, and time-consuming,



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and that it requires a facility with sophisticated assessment and intervention techniques. Indeed, a number of perceived barriers to physician engagement with spirituality in medical practice, particularly concerns about time and training, have been reported in the literature in recent years.[5]

Of course, such beliefs about spiritual care are partly true. Our pastoral care colleagues engage in very sophisticated professional practice, spend substantial time with patients and families, and offer facility with a range of approaches—spiritual assessment techniques, taxonomies of spiritual issues and needs, devotional practices, and relationships with sacred texts, among many others.

I believe that our own inner lives show through in our interactions with patients and colleagues. There is always a "spirit in the room," which we might describe in a variety of ways—"calm," "compassionate," "anxious," "businesslike," "welcoming," "respectful," "detached."

Having said this, I must add that my continuing efforts with physicians and other health care professionals are intended to affirm with them the ways in which *they* are—and historically have been—vital participants in the larger picture of the spiritual care of patients. In these conversations, I often contrast what I call the "specialty" and "embodiment" models of spiritual care.

The Specialty Model A "specialty" perspective on spiritual care has two features. First, spiritual care is fundamentally defined by a specific content area, or area of technical expertise, paralleling other content areas (such as cardiology and ENT) that health care practitioners make a part of their repertoire. Second, sometimes you "do it," and sometimes you don't.

In the biomedical realm, for instance, primary care physicians operate from one of a variety of specialty areas as the clinical situation warrants. Sometimes they "do" cardiology and engage that body of technical content in working with a patient with heart disease. Sometimes they "do" neurology, or gastroenterology, or orthopedics. At other times, they do not engage these specialty areas. There is not much need for a copy of *Harrison's Textbook of Internal Medicine* when one is conducting a well-child exam, for example.

In the realm of spiritual care, according to the "specialty" model, spirituality is incorporated in the process of health care in the same way as any other specialty content area is incorporated; sometimes you "do it" and sometimes you don't. In this model, certain clinical situations (such as death and dying or profound disability) lead physicians to shift into a "spirituality mode" and engage this particular content area with specific techniques and approaches. In such a case, physicians may conduct a brief spiritual assessment, recommend prayer, provide resources on meditation, refer the patient to chaplains, and so forth. Apart from clinical situations that trigger the spirituality mode, spirituality content is put away, just as one keeps *Harrison's* on the shelf during the pediatric exam.

The Embodiment Model I believe that the foundation of spiritual care has to do with intention and presence, rather than specific content. Qualities of spirit are, for better or worse, "embodied" in us people and professionals in every interaction we have with our patients and colleagues.

A colleague of mine sometimes refers to a British comedy routine to make the point that our inner lives—which we think are hidden—actually show through and touch the lives of people around us. In the routine, which is set in a restaurant, a strident clatter of pots and pans is heard from the kitchen as the waiter, adjusting his tie as he approaches the patrons' table, tries to give an appearance of calm. The worried patrons know otherwise.

I believe that our own inner lives show through in this way in our interactions with patients and colleagues. There is always a "spirit in the room," which we might describe in a variety of ways—"calm," "compassionate," "anxious," "businesslike," "welcoming," "respectful," "detached," and so forth. And this spirit is often palpable.

The spirit in the room matters. A growing body of health care literature attests to the substantial role played in the healing process by the personal qualities and states of mind of the health care professionals involved. These qualities and states have been variously described as "healing presence,"[6] "intention,"[7] "mindfulness,"[8] "intuition,"[9] and even "love."[10] In my own research interviews, family physicians indicated that their own centeredness and groundedness was critical to their practice because it helped them to have a more peaceful presence and it made them more available as instruments of healing in other people's lives.[11]

A primary care internist described a touching relationship with one of her patients:

> I have an elderly patient who has struggled for many months with the impending death of her sister from end stage cancer. She always included a description (usually tearful) of how her sister was doing at her visits with me, as well as what it was like for her to experience her sister's decline. She was especially feeling helpless and guilty as the oldest sibling who'd been the one that others would always look to for help in the past. At first I was uncomfortable as I felt something more was expected of me besides listening. However at subsequent visits I realized she just needed to tell her story. Even though the telling was not easy she always seemed lifted after and I could sense a deepening spiritual connection between us.[12]

The term "spiritual connection" signifies to me that a spirit of healing is embodied in the person and presence of this practitioner. Although an observer of these interactions might or might not recognize any particular techniques of organized spiritual assessment or intervention, the practitioner is clearly honoring the experience of her patient and relating to her with an open heart. I think this is a fine example of spiritual caregiving by a health care professional.

The idea of "embodiment" was well captured in an article that appeared in *Health Progress* a year ago.[13] Christina M. Puchalski, MD, and Sylvia McSkimming, PhD (echoing Puchalski's earlier writing about "aspects of spiritual care"),[14] wrote about the importance of "fully present" care and argued that compassionate presence and spiritual care are the responsibility of everyone who interacts with patients in a health care environment.

Comparing and Contrasting the Models

Why does the specialty/embodiment distinction matter? The main reason, I believe, is that an embodiment perspective presents spiritual care as an opportunity—and a responsibility—for all health caregivers, at all times. Even in encounters involving no explicit spiritual language, content, or techniques, health care professionals may bring to other people an intention and presence projecting what Parker Palmer calls a "spirit of light or a spirit of shadow."[15]

I believe that the difference between these models also speaks in a significant way to the hesitance with which physicians engage the spiritual dimension of patients' lives. My experience with primary care physicians is that when they reflect on spiritual care as a specialty area with a distinct and unfamiliar body of content, they often display a great sighing weariness about seeing *yet additional* skills to develop. The operational word for the embodiment model, in contrast, is "already." Health care practitioners have *already* experienced "vital and sacred" connections with other people.

At some point, all of us as health care professionals stop to recall why we went into health care in the first place, what it means to be a healer, and how we are enriched by the struggles and triumphs and life experience of the patients and the colleagues with whom we work. I suggest that incorporating spirituality in health care is not fundamentally a matter of "being introduced to" or "learning" things previously unknown. It is more a matter of remembering the times when we have been witness to something meaningful and sacred in people's lives, exploring those times with an open heart, telling each other stories about those times, and allowing those times to nourish our own souls.

Spiritual Resources and Issues

The second topic in the ongoing conversation about the role of health care professionals in spiritual care concerns spiritual resources and issues. To the extent that "attending to the spiritual needs of patients" pertains to spiritual *issues or struggles,* I believe that the professional expertise of chaplains and other pastoral caregivers can be uniquely beneficial. The dying man who needs to reconcile his homosexuality with his lifetime devotion to his church would be such an instance. The family anguishing over why a loving God would visit their child with cancer would be another. A third such example would be the mid-

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about her sexually abusive father but also needs to somehow forgive him. Our pastoral care colleagues can often be extraordinarily helpful with issues such as these.

However, I believe that the *resources* side of spirituality is a matter for the attention of all of us who provide clinical care. The organizational consultant Margaret Wheatley observes that "real change begins with the simple act of people talking about what they care about."[16] There is both power and empowerment, she argues, in people giving voice to the things that really matter to them.

There are countless ways of framing this conversation. My personal approach is to begin with the language of meaning, purpose, and passion. "What are the things that are really important to you?" I ask patients. "What do you take pride in?" "What do you hope for?" "Where do you find strength—what sustains you—what helps you to keep going?" "What helps you to be more peaceful and centered?" "What do you hope the legacy of your life will be?" "What are you really passionate about?" "When do you feel most alive?"

My experience is that patients frequently respond to such questions with spiritual and religious language. "My spirituality," one will reply. "My relationship with my higher power," says another. "The Lord sustained me," says a third. In answering my question about a legacy, a patient may say: "I want to be the kind of person that makes a difference in the world." Patients often experience an affirming and energizing effect when they have an opportunity to speak even briefly to somebody else about these personal and sacred things. That which you focus your mind and heart on becomes your reality.

There are a variety of occasions on which touching on such resource-related subjects may be viable and helpful. Such occasions include both general conversations (during well-woman exams, for instance) and conversations about specific topics—for example, lifestyle changes (e.g., stopping alcohol use, becoming more intentional about eating), life transitions (e.g., the death of a parent, the birth of a child, a career change), or the onset or progression of serious illness.

Although I lack the space to describe it here, there is a considerable and growing empirical basis for the importance of nurturing people's values, character strengths, and spiritual beliefs. In particular, I recommend readers to work being done in the arenas of positive psychology[17] and acceptance and commitment therapy.[18]

My point here is that these are conversations that a) matter clinically, and b) arise less out of specialized spiritual care skills than they do out of genuine curiosity and an open heart. They are the kinds of conversations that doctors have always had with patients, and I believe that they represent a significant piece of the overall picture of good spiritual care.

So What?

To the extent that the views expressed here have some merit, what difference might they make for health care administrators, clinicians, and educators?

As I suggested in my earlier *Health Progress* article, staff members must decide for themselves—perhaps in small group discussions—what spiritual care means to them and how they can best make it a part of their healing work. I recommend:

- Arranging programs (retreats, celebrations, mentoring) that support staff spiritual wellness and "groundedness."
- Creating opportunities for storytelling about how spiritual vitality is embodied in the compassionate presence and intention of medical staff.
- Conducting staff conversations about spiritual care, involving representatives from both pastoral and clinical care teams.
- Supporting an institutional/organizational culture (as Puchalski and McSkimming describe in their *Health Progress* article) that values the contributions to spiritual care of everyone on the team.
- Educating staff about the idea of spiritual resources and strengths. (Positive psychology websites, such as www.authentichappiness.sas.upenn.edu, offer good educational and self-assessment material on personal character strengths and virtues.)
- Encouraging staff discussions about approaches that encourage the expression of patients' spiritual resources.
- Encouraging staff discussions about discerning the personal/spiritual values of particularly "difficult" or marginalized patients.

Spiritual Care Is Relevant to All

I want to affirm the significant contribution made to health care by pastoral care professionals, and, at the same time, suggest that "spiritual care" is a matter for *all* health caregivers. Health care professionals may provide good spiritual care through their presence and intention—through the embodiment of spirit—as well as through their understanding of and support for people's spiritual values and resources. In health care, "the vital and sacred" is relevant to all, patients and clinicians alike. ■

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