REVIEW ARTICLE

Integrating spirituality into patient care: an essential element of person-centered care

Christina M. Puchalski

George Washington Institute for Spirituality and Health, The George Washington University, Washington DC, United States

KEY WORDS

medical education, person-centered care, spirituality and health, spiritual care

ABSTRACT

Spirituality and health is a growing field of healthcare. It grew out of courses in spirituality and health developed for medical students in the United States. Research in this area over the last 30 years has also formed an evidence base for spirituality and health. Studies have demonstrated an association between spiritual beliefs and values and a variety of healthcare outcomes. More recent research has also shown a strong desire on the part of patients to have their spirituality addressed as part of their care. Studies also show that spiritual care has an impact on patient decision making, particularly in end-of-life care. The Association of American Medical Colleges developed a broad definition of spirituality as well as learning objectives and guidelines for teaching. Standards in organizations such as the American College of Physicians support physicians treating the whole person, that is, the body, mind, and spirit. In 2009, National Competencies in Spirituality and Health education were developed in the United States with schools currently working on curriculum projects based on these competencies. Models are being developed for all members of the healthcare team to address patient distress, in cooperation with chaplains as spiritual care experts. The goals are to develop a biopsychosocial and spiritual assessment and treatment as part of compassionate whole-person care of all patients.

Correspondence to:
Christina M. Puchalski, MD, MS, FACP, George Washington Institute for Spirituality and Health, 2030 M Street NW Suite 4014 Washington DC, 20036, United States, phone: +1-202-994-62-20, fax: +1-202-994-64-13, e-mail: cpuchals@gwu.edu
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Introduction Spirituality and health is a growing new field of healthcare, with the first textbook in spirituality and health recently published by Oxford University Press.[1] This relatively new field began with courses on spirituality and health for medical students in the United States[2] and with research that demonstrated the association between religious and/or spiritual beliefs and values and a variety of healthcare outcomes including coping with illness, overall quality of life, recovery from surgery or depression, and positive reframing of a difficult clinical situation.[3-12] Surveys also demonstrated that patients would like their spirituality to be addressed in their medical care.[13] As the courses and research evolved, ethical questions began to arise as to the definition of spirituality within clinical care, its role in patient care, and the implementation of spiritual care in the clinical setting.

One of the earliest consensus conferences in this area was convened by the Association of American Medical Colleges (AAMC), which addressed the question of the clinical relevance of spirituality and health. The definition of spirituality developed from this meeting focused on spirituality broadly defined as "an individual's search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism, and the arts. All of these factors can influence how patients and healthcare professionals perceive health and illness and how they interact with one another."[14]

The participants, which included deans and medical educators, discussed spirituality and health as the basis for a more holistic and person-centered approach to care, grounded in values of compassion and service. Such care, often called "whole-person care", is based on the biopsychosocial and spiritual model of care,[7] which defines care as encompassing not only the physical but also psychological, social, and spiritual domains of care.[3-6] Whole-person care is premised on the core values of altruism and service to others, recognizing that clinical care is a vocation and not just a job, which places emphasis on the care of the whole person and describes suffering as psychosocial spiritual as well as physical.

The AAMC definition of spirituality and the resulting ethical principles aligned with the ethical standards for physicians as set by the AAMC and the American College of Physicians (ACP). The American Medical Association (AMA) developed the "Code of Medical Ethics" stating that physicians should provide competent care based on respect and compassion, the core values of spirituality, and the ACP noted that physicians should extend their care for those with serious medical illness by attentiveness not only to physical pain but also to psychosocial, existential, or spiritual suffering.[8] Attending to patients' spiritual distress is the medical approach to attending to patient suffering. It includes formal assessment of spiritual distress and also the provision of compassionate care.

In addition to the recommended standards for physicians to attend to the whole person, including the patient's spirituality, surveys have demonstrated that patients value a more whole-person focus on care and appreciate physician inquiry into their spiritual beliefs.[10,15] Studies have also showed that patients value clinicians who are compassionate.[16] Balboni et al.,[17] in a study of patients with advanced cancer, found that the majority of patients welcome clinicians addressing spirituality and providing spiritual care but that only a small percentage of clinicians actually do that. McCord et al.[13] found that 85% of primary care physicians acknowledged that they should be aware of their patients' spiritual beliefs. However, only 31% said that they should ask about these beliefs during a routine office visit, though this percentage increased to 74% when the person was dying. Clinicians describe their desire to attend to patients suffering and a sense of lack of meaning in their work when they are unable to do that.[18]

Despite those studies, clinician inquiries about patient spirituality and the practice of compassionate care are lacking.[17] Studies show that the reason clinicians do not integrate spirituality into their practice or do not practice compassionate presence is due to a number of factors including limited healthcare professional education and training, design of clinical practices, time within an already limited office visit, and payment constraints.[19,20] Also, until recent models in interprofessional spiritual care,[5] there has been lack of clarity of the role of spiritual care professionals and the rest of the medical team. This paper describes the development of the field of spirituality and health, and the clinical models and guidelines for integrating spirituality more fully into clinical care.

Integrating spirituality into healthcare: creation of a movement Spirituality has played a role in health care for centuries but became overshadowed by technological advances in diagnosis and treatment that occurred in the early 20th century. Though these advances were dramatic and resulted in the saving of countless lives, the scientific focus moved the culture of medicine away from a holistic, service-oriented model to a technological reductionist model. In response, a core group of medical academics and practitioners launched a movement to reclaim the spiritual roots of medicine, helping define spirituality beyond religion and ethics and build acceptance for its essential relevance to patient care.

The efforts in the United States, and now internationally, to reclaim the spiritual roots of medicine and healthcare started with courses on spirituality and health. In 1992, the George Washington University School of Medicine developed the first course on spirituality and health, which, in 1996, became part of the required curriculum for the medical school and continues to date. The George Washington University's Institute for Spirituality and Health (GWISH) ran an awards program for medical schools to develop courses in this area. As a result of this program, 75% of the medical schools in the United States have developed courses in spirituality and health.

The AAMC consensus conference on spirituality and health education developed outcome goals and learning objectives for the course in spirituality and health. The report of this conference identified seven learning objectives and three outcome goals. These outcome goals reflect the consensus group's recommendation that spirituality be recognized across the lifespan of patients, as part of students' professional development, and as part of whole-person care.[14]

In 2009, the GWISH convened expert physician, chaplain, and medical educator teams from American medical schools awarded for excellence in spirituality and health education. These schools developed national competencies and behaviors for courses in spirituality and health to develop a more standardized approach to teaching this subject.[21]

As these courses expanded, many questions arose in the field. Most of these questions had to do with how spirituality can and should be integrated into care. Who should provide spiritual care? Chaplains? Clergy? Physicians? Nurses? What would it mean to provide such care? What are the ethical issues involved? Over the years, standards and models have been developed which are enabling an integration of spirituality as part of healthcare systems.

Theoretical and ethical framework The courses on spirituality and health are built on theoretical and ethical frameworks. First, as cited above, standards from the AMA, AAMC, ACP, and Code of Nursing state that compassionate care is grounded in the attention to the suffering of the patient and that spirituality is key to relationship-centered care. The Picker Institute noted that a key element of patient-centered care includes shared decision making, respect for patients' values and beliefs, and involvement of a larger community of caregivers. Values and beliefs include spiritual and religious values; community could include

TABLE 1 Biopsychosocial and spiritual model of care

physical dimension
pain and other physical symptoms
emotional dimension
depression
anxiety
psychosis
personality disorders
social dimension
financial
relationships
community support
spiritual dimension
meaning, purpose
hope, faith
connection, love
forgiveness, reconciliation
relationship with a transcendent/holy/divine
demoralization
despair, spiritual doubt
isolation
inability to forgive, resentment
no sense of transcendence

faith-based and other communities. The biopsychosocial and spiritual model[7,22] forms the basis of holistic care with spirituality being central to such care (TABLE 1).

There is recognition that spiritual or existential or religious questions can be triggered by the diagnosis of illness or experience of loss. The narrative/hermeneutical model of pastoral care describes the movement toward meaningful, integrative structures of a life being lived.[23] Illness can disrupt the integration of one's life and provoke a spiritual crisis around meaning, purpose, and connectedness.

In the clinical setting, spirituality may be dynamic in the patient's understanding of illness and it may affect coping (both patients and caregivers), healthcare outcomes, and healthcare decision making. Data also demonstrated that spirituality is a patient's need in many cases and may also impact stress management and resiliency.

Ethical guidelines have been developed in terms of what is appropriate in the delivery of spiritual care. These include: 1) spiritual history: noncoercive, patient-centered; 2) professional boundaries: no abuse of patient's trust; 3) broad definition of spirituality; 4) avoidance of trying to answer unanswerable questions ("Why me?"; "Why now?"); 5) not going beyond one's level of expertise; 6) recognition of pastoral care professionals as experts; 7) proselytization is not acceptable in professional settings; 8) more in-depth spiritual counseling should be under the direction of chaplains and other spiritual leaders; and 9) praying with patients: a controversial area; general guidelines recommend to hold respect for the patient as primary and be mindful that patients' needs come before healthcare professionals' needs.

Standards and guidelines Triggered by the increased interest in spirituality as a part of healthcare, there have been several significant developments that have helped expand the field beyond the courses on spirituality and health. In 2004, clinical practice guidelines for Quality Palliative Care were developed in the United States, with palliative care being defined broadly as starting from diagnosis of a serious illness. Spiritual, religious, and existential issues were identified as a required domain of care. However, the details of how spirituality should be addressed were not specified. Should the clinicians address spirituality or should that be left to clergy and chaplains? If clinicians are to address spiritual issues, then what tools are available to do that?

In 2009, the National Consensus Conference was held in the United States where clinicians, researchers, chaplains, clergy, and other healthcare professionals met to develop recommendations and an interdisciplinary model of care. The attendees also reached full consensus on a definition of spirituality: "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."[5] Based on this definition, clinicians can inquire about meaning and connection in a patient's life. They can identify resources of spiritual strength, which might be values, beliefs, practices, or communities. Clinicians who develop treatment or care plans also would identify and diagnose spiritual distress, which, in general terms, would be lack of meaning and/or connection as per the definition.

There are tools used to identify spiritual distress or spiritual resources of strength. All patients receive spiritual screening, history, and assessment by the appropriate healthcare professional. The goal of the screening is to identify a need for an immediate referral to a chaplain. The goal of the spiritual history is to learn more about the person spiritual or inmost story, to identify spiritual resources of strength, and to diagnose spiritual distress. Spiritual assessments are done by chaplains in a narrative–reflective process. The assessment is used to further delineate the spiritual issues, confirm or change the diagnosis made initially by the clinician, and to help determine an appropriate plan of care with regard to the patients and family's care plan.

Spiritual screenings are admission questions to screen for spiritual distress; screening is usually limited to one or two questions: 1) Is spirituality or religion important for you and are your spiritual or religious beliefs helping you right now? A yes/no combination to these questions triggers a referral to a board-certified chaplain[24]; and 2)

TABLE 2 Components of the FICA tool

F – Faith and Belief
Do you consider yourself spiritual or religious? Do you have spiritual beliefs that help you cope with stress? If the patient responds "No", the healthcare provider might ask, "What gives your life meaning?" Sometimes patients respond with answers such as family, career, or nature.
I – Importance
What importance does your faith or belief have in your life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?
C – Community
Are you part of a spiritual or religious community? Is this of support to you and how? Is there a group of people you really love or who are important to you? Communities such as churches, temples, and mosques, or a group of like-minded friends can serve as strong support systems for some patients.
A – Address in Care
How would you like me, your healthcare provider, to address these issues in your healthcare?

Do you have any spiritual beliefs, practices, or values that you want integrated into your care?

Spiritual histories are more detailed and to be done by clinicians who determine treatment or care plans; the spiritual history can be done by special tools developed for clinicians, such as the FICA.[25-28]

The FICA tool, which has been validated, is designed for beginning the spiritual history and the conversation with the patient and family about spirituality.[29] The key elements of the tool are to start with a broad opening question about spirituality and then meaning. Some people may not relate to the word "spirituality", and the clinician may need to clarify that it is not only about religion. The second question is about meaning in life for the person. The next element has to do with importance of the belief system of the patient as well as impact on healthcare decision making. The third question asks about a spiritual community for patients and families which could be church, temple or mosque, like-minded friends, yoga group, family, etc. Finally the information gathered should be integrated into the assessment of the patient. One can also ask patients how they might like the information gathered in the history to be integrated into their care (TABLE 2).

Identifying spiritual distress The general algorithm for the process of identifying spiritual distress is first to ask if the patient has any source of distress and then, through a logical clinical discernment process, decide the source of distress: physical, emotional, social, or spiritual, or combinations of these. Once a diagnosis or possible diagnosis is made, the clinician needs to refer to the appropriate person that would need to be involved in the care of the patient. For emotional or psychological care, one would consider a mental health professional, for physical a physician or nurse, for social a social worker, and for spiritual a chaplain or other spiritual care professional such as a spiritual director or pastoral counselor. TABLE 3 presents potential

TABLE 3 Potential spiritual diagnoses

Diagnosis (primary)	Key feature from history	Example statements
existential	lack of meaning; questions meaning about one's own existence; concern about afterlife; questions the meaning of suffering; seeks spiritual assistance	"My life is meaningless." "I feel useless."
abandonment (God or others)	lack of love; loneliness; not being remembered; no sense of relatedness	"God has abandoned me." "No one comes by anymore."
anger at God or others	displaces anger toward religious representatives; inability to forgive	"Why would God take my child…it's not fair."
concerns about relationship with deity	closeness to God, deepening relationship	"I want to have a deeper relationship with God."
conflicted or challenged belief system	verbalizes inner conflicts or questions about beliefs or faith conflicts between religious beliefs and recommended treatments; questions moral or ethical implications of therapeutic regimen; express concern with life/death and/or belief system	"I am not sure if God is with me anymore."
despair/hopelessness	hopelessness about future health, life; despair as absolute hopelessness; no hope for value in life	"Life is being cut short." "There is nothing left for me to live for."
grief/loss	grief is a feeling and process associated with a loss of person, health, etc.	"I miss my loved one so much." "I wish I could run again."
guilt/shame	guilt is a feeling that the person has done something wrong or evil; shame is a feeling that the person is bad or evil	"I do not deserve to die pain-free."
reconciliation	need for forgiveness and/or reconciliation of self or others	"I need to be forgiven for what I did." "I would like my wife to forgive me."
isolation	from religious community or other	"Since moving to the assisted living, I am not able to go to my church anymore."
religious specific	ritual needs; unable to follow usual religious practices	"I just can't pray anymore."
religious/spiritual struggle	loss of faith and/or meaning; religious or spiritual beliefs and/or community not helping with coping	"What if all that I believe is not true."

TABLE 4 Biopsychosocial and spiritual assessment and plan in a 52-year-old patient with end-stage ovarian cancer

physical dimension
pain is well controlled; continue with current medication regime
nausea; still has episodes of nausea and vomiting, likely secondary to partial small bowel obstruction; add octreotide to the current regimen
emotional dimension
grief reaction that "fight is over"
tearful, difficulty sleeping
supportive counseling, presence
social dimension
concerned about how to tell them she is dying
work with social work to arrange family meeting
spiritual dimension
hopelessness, main source of meaning in "winning the fight"
active in the Ovarian Cancer Alliance and seen as inspiration
not religious but now wants to learn how "Jewish patients die"
dream list, legacy building, encourage talking with the Ovarian Cancer Alliance, referral to a chaplain and to a rabbi

spiritual diagnoses. This list is based on work from the National Comprehensive Cancer Network[30] as well as the literature in spirituality and health. It should be recognized that this is a preliminary attempt to create taxonomy of spiritual distress and that more research is needed in this field.

Treatment plan There are two possible pathways once a diagnosis is made: the simple and complex. For simple spiritual issues, a clinician might be able to continue to be present and listen to the patient's story. Oftentimes the patient might come to some understanding on their own in the context of being heard. Other types of interventions might include dignity-based therapy, meaning-oriented therapy, art therapy, journaling, and yoga, and mindfulness or the patient's own self-identified resources such as meditation, prayer, or self-care.

For the more complex spiritual issues, such as the need for forgiveness and/or reconciliation of self or others, severe existential distress, or lack of connection or love of others or God, referral to chaplains or other spiritual care professional is critical.

Each of these elements is discussed in depth in the title report of the consensus conference, which includes decision tree algorithms.[5]

Integrating spirituality into the patient treatment plan Once the clinician obtains the information from the history, he or she integrates it into the treatment plan. This includes making a diagnosis of spiritual distress or pain, identifying spiritual issues or spiritual goals if appropriate, and determining and implementing the appropriate spiritual interventions.

A more holistic assessment and treatment plan addresses all dimensions of the patient, not just the physical. Therefore, the biospychosocial and spiritual assessment and plan is the model recommended. This model emphasizes the need for all clinicians to address all dimension of the patient and document those in the chart. Treatments are then targeted to the dimensions that have active issues; resources of strength are also noted. There is an ongoing follow-up and modification of the plan, as needed (TABLE 4).

Discussion Spirituality is an integral part of all our patients and their families as well as of our lives. It is a component of the quality of life of patients and families and a need that is recognized by patients and supported by the evidence. Suffering, illness, and loss trigger deep issues related to meaning, purpose, and often to the finality of life. These issues, if ignored, can cause deep suffering in people's lives. It is often in the context of healthcare systems that patients, families, and clinicians become aware of these spiritual issues. Suffering, if supported, may be transformed in a person's life where healing as a restoration of meaning, purpose, coherence, and inner peace might be possible. Therefore, spirituality is foundational to the provision of whole-person care.

This paper describes the evolution of courses, tools, guidelines, and ways to attend to the spiritual distress of patients and families as well as support the positive spiritual resources in patients in their own healing process. While more research and investigation is needed to further develop these models, the theoretical underpinnings of integration of spirituality into patient care support the implementation of this work to better provide person-centered care.

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ARTYKUŁ POGLĄDOWY

Uwzględnienie duchowości w opiece zdrowotnej: niezbędny element opieki zorientowanej na pacjenta

Christina M. Puchalski

George Washington Institute for Spirituality and Health, The George Washington University, Washington DC, Stany Zjednoczone

SŁOWA KLUCZOWE

duchowość i zdrowie, edukacja medyczna, opieka duchowa, opieka zorientowana na pacjenta

STRESZCZENIE

Duchowość i zdrowie to rozwijający się obszar opieki zdrowotnej. Został on zapoczątkowany przez zajęcia z duchowości i zdrowia opracowane dla studentów medycyny w Stanach Zjednoczonych. Dane naukowe dotyczące obszaru duchowości i zdrowia zgromadzono w wyniku badań prowadzonych przez ostatnie 30 lat. Wyniki badań wskazują na zależność między przekonaniami religijnymi i wartościami duchowymi a osiąganiem różnorodnych celów terapeutycznych. Niedawno przeprowadzone badania wskazują na ogromną potrzebę pacjentów, aby uwzględniać sferę duchową w opiece medycznej. Badania dowodzą także, że opieka duchowa wpływa na podejmowane przez pacjentów decyzje, zwłaszcza w kontekście opieki u schyłku życia. Association of American Medical Colleges opracowało definicję duchowości, a także cele edukacyjne oraz wytyczne nauczania przedmiotu. Standardy opracowane przez takie organizacje jak American College of Physicians wspierają lekarzy, którzy podchodzą do pacjenta całościowo, lecząc ciało, umysł oraz duszę. W 2009 r. w Stanach Zjednoczonych opracowano kompetencje wymagane do nauczania przedmiotu oraz program zajęć, z którego obecnie korzystają uczelnie amerykańskie. Obecnie opracowywane są schematy postępowania we współpracy z kapelanami jako ekspertami ds. opieki duchowej, które umożliwią wszystkim pracownikom opieki zdrowotnej rozpoznanie i odpowiednie reagowanie na cierpienie duchowe pacjentów. Prace te mają na celu rozwój modelu bio-psycho-społeczno-duchowego do oceny stanu pacjenta oraz leczenia jako podstawy opieki całościowej.

Adres do korespondencji:
Christina M. Puchalski, MD, MS, FACP, George Washington Institute for Spirituality and Health, 2030 M Street NW Suite 4014, Washington DC, 20 036, United States, phone: +1-202-994-62-20, fax: +1-202-994-64-13, e-mail: cpuchals@gwu.edu
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