

Creating Healing Environments

An Initiative
Seeks to
Restore "Heart
and Humanity" to
Depersonalized
Health Care

Today's health care system is in crisis. Due to increasing insurance limitations on reimbursements and rising malpractice costs, physicians are pushed to see more patients each day and to shorten the length of their visits. Some hospitals attempt to contain costs by cutting their nursing staffs. Many social work departments are also short-staffed because of rising health care costs. Although many social workers and nurses would like to spend more time on direct patient care, they are forced by staffing issues to use it on documentation, such as discharge planning. Physicians also know that excellent patient-centered care requires time, but many find that they do not have that time.



**BY CHRISTINA M. PUCHALSKI, MD, MS;
& SYLVIA MCSKIMMING, PHD, RN**

Dr. Puchalski is associate professor, medicine and health management leadership, George Washington University School of Medicine and Health Sciences, Washington, DC, and director of the school's Institute for Spirituality and Health. Dr. McSkimming is former executive director, Supportive Care Coalition: Pursuing Excellence in Palliative Care, Portland, OR. Their article is reprinted with permission from Supportive Voice, May 2006.



Many health care professionals note that their own spirituality supports them in finding meaning in their profession. In addressing patients' spirituality, such caregivers realize, they also trigger questions in themselves about their own spirituality. Given the current stresses in the health care system, caregivers find it a challenge to tap into their own spirituality in a way that nurtures their clinical practice. Consequently, physician and other clinician burnout is often high.

Spirituality is the source of life's meaning. It is the individual's continuous search for meaning and transcendence in life, especially during times of illness and pain. For some people, spirituality includes religious practices; for others, it may include nature, art, music, family, or community. Spirituality is the lifeline that sustains people through stress and challenging times, an essential aspect of one's humanness.

Today, however, health care providers are ill-equipped to care for the spiritual dimension in patients. Many patients complain about the increasingly impersonal approach they encounter in hospitals and other health care organizations. And, ironically, they often experience this sense of alienation at precisely the time when they most need human interaction and spiritual support. People facing challenges in their health and well-being often turn inward to reflect on the meaning of their illnesses and their lives and to search for purpose and hope. This search for meaning and purpose is integral to each individual and influences the impact of illness on the patient and his or her family.

The U.S. health care system itself is frequently perceived as lacking in personalized and compassionate health care services. One often hears medical students say that, although they are learning important values and practices, they find that the organizations in which they will practice—hospitals, nursing homes, outpatient offices, and others—do not reflect the material taught concerning the importance of spirituality to good health.

Care providers who learn more about the spiritual lives of their patients find they are able to provide more personalized care while, at the same time, nurturing their own spiritual awareness and growth.

In 2004 two organizations, the George Washington Institute for Spirituality and Health, Washington, DC, and the Supportive Care Coalition: Pursuing Excellence in Palliative Care, Portland, OR (formerly Supportive Care of the Dying: A Coalition for Compassionate Care), collaborated in developing a solution to the depersonalization of health care. To this end, they created the "Hospital-Based Spirituality Initiative: Creating Healing Environments," an innovative demonstration project designed to test ways of restoring heart and humanity to health care by reintegrating an awareness of spirituality and spiritual care into the role of each care provider.

THE INITIATIVE'S GOALS

Specifically, the initiative was intended to achieve two objectives: First, to develop and test strategies that encourage ownership of the professional responsibility to attend to spiritual concerns among caregivers; and, second, to better understand the organizational values and infrastructure that support increasing the spiritual care that caregivers provide. Integral to this process was developing programs that address caregivers' own spirituality, as well as that of patients. The goals were to:

- Develop a process that is reproducible, effective, and respectful of available resources within the hospital system
- Foster awareness of personal spirituality in direct caregivers and indirect care providers as an aspect of their professional lives
- Foster development of enhanced individual competencies for delivering patient-centered, interdisciplinary, spiritual care
- Develop structured patient spiritual assessment and a model of integrating patients' spiritu-

al values into treatment plans

- Develop and test strategies for applying those competencies in the work environment in which care is delivered for people with progressive chronic or life-threatening illness and injury
- Develop and provide peer mentoring and coaching so that participants can "model, teach, and encourage" others in developing skills that facilitate the provision of "fully present" care (that is, attending to the patient's psychosocial and spiritual dimensions as well as the physical dimension, the goal being to develop a caring, supportive, trusting relationship with him or her)
- Demonstrate effectiveness in supporting staff and improving patient/family experiences
- Increase the integration of chaplains as key members of interdisciplinary teams
- Develop work environment structures and institutional competencies that encourage caregivers to be a consistent, compassionate presence to the "whole person"

SITES, TEAMS, AND A RETREAT

The pilot project was conducted in five faith-based hospitals and two secular hospitals that had volunteered to participate. The hospitals were:

- MountainView Regional Medical Center, Las Cruces, NM
- Providence St. Vincent Medical Center, Portland, OR
- St. Agnes Hospital, Baltimore
- St. Elizabeth Health Center, Youngstown, OH
- St. Patrick Hospital and Health Sciences Center, Missoula, MT
- St. Vincent Indianapolis Hospital, Indianapolis
- George Washington University—UHS Medical Center, Washington, DC

The initiative addressed caregivers' spirituality as well as that of patients.

SUMMARY

In 2004 two organizations, the George Washington Institute for Spirituality and Health, Washington, DC, and the Supportive Care Coalition: Pursuing Excellence in Palliative Care, Portland, OR, collaborated in an experiment seeking antidotes to the depersonalization of health care.

Their "Hospital-Based Spirituality Initiative: Creating Healing Environments" was intended to achieve two objectives: First, to develop and test strategies that encourage

clinical caregivers to attend to patients' spiritual concerns; and, second, to better understand the organizational values and infrastructure that support increasing the spiritual care that caregivers provide.

The initiative was conducted in five faith-based hospitals and two secular hospitals. Evaluation of the data indicated that the initiative was success for patients and caregivers.



Creating Healing Environments

Each hospital selected one clinical unit to participate in the initiative. The units were typically those in which patients with cancer, cardiac disease, and other complex medical conditions were likely to receive care. These units thus became initiative "sites."

THE RESEARCH TEAM

The members of the initiative's research leadership team are:

Christina Puchalski, MD, MS, principal investigator

Sylvia McSkimming, RN, PhD, co-investigator and project coordinator

Sr. Carol Taylor, CSFN, RN, PhD, coinvestigator; Sr. Carol is director, Center for Clinical Bioethics, Georgetown University Medical Center, Washington, DC

Thomas J. Butler, MDiv, coinvestigator; Mr. Butler is executive director, Lilly Endowment Grant, Mount St. Mary's University, Emmitsburg, MD

Sean Cleary, PhD, MPH, coinvestigator; Dr. Cleary is associate professor, Department of Epidemiology and Biostatistics, School of Public Health and Health Services, George Washington University, Washington, DC

Each site selected five or six people to be members of its interdisciplinary team: the facility's medical director, its director of nursing (or a unit manager), its director of pastoral care, a social worker, and a clinical leader. The teams were charged with developing training programs to teach staff how to address spiritual issues with patients; how to care for themselves and manage their own stress; and how to make institutional changes that would support a more caring, relationship-centered approach to care (see **Diagram A**).

In October 2004, to prepare for the initiative's implementation at their facilities, the teams participated in a two-day retreat at St. Mary's Seminary and University retreat center, Baltimore. The retreat's facilitators were this article's authors; Thomas J. Butler, MDiv (see **Box**); Mary Matthiesen, founder, Courage to Choose, Courage to Care, Sausalito, CA; Edward

McConmack, PhD, director, Continuing Education, Washington Theological Union, Washington, DC; Michael Stillwater, founder and director, Companion Arts, Novato, CA; Sr. Carol Taylor, CSFN, RN, PhD (see **Box**); and Paul Tschudi, director, End of Life Care Programs, George Washington University School of Medicine.

During the retreat, team members worked to:

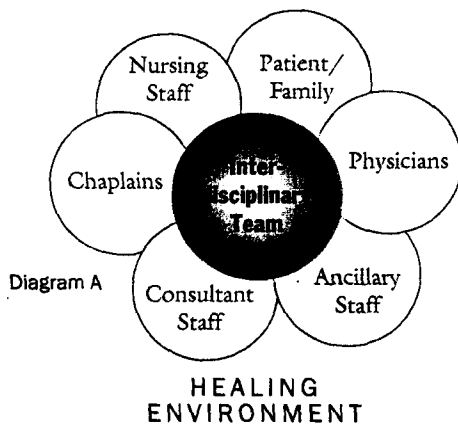
- Develop a common understanding of spirituality
- Explore personal spiritual issues
- Experience spiritual care and "presence" (focusing on the patient as a whole person)
- Understand the importance of spiritual care for patients and families
- Acknowledge the interdisciplinary responsibility for spiritual care
- Foster development of the interdisciplinary team
- Discuss how to create a care environment for patients and colleagues that fosters relationship-centered spiritual care
- Describe the pilot project and expectations for site participation
- Design interventions to be implemented at each site

METHODS USED

It was important that each hospital develop a program suited to its particular environment. Only thus could it instill in all stakeholders—every staff member likely to interact with a patient or her or his family—a sense of ownership of, and commitment to, the initiative. A "boilerplate program" could not work at sites that were diverse and had their own unique needs (see **Diagram B**, page 33).

It was vital that each site develop educational and organizational change strategies and implement a systematic spiritual screening tool for patients, both of which would encourage a person-centered approach to care.

Each site was encouraged to assess the hospital's expectations (as delineated in job descriptions, care standards, and performance reviews) concerning the way staff members address patients' spiritual concerns. Sites were also advised to ensure that all interdisciplinary team members consider their role—being sensitive to patients', families', and caregivers' spiritual concerns—important. Such sensitivity integrates all who interact in a care environment—even those (such as custodians, housekeepers, and dietary workers) who are not typically considered care-



HEALING ENVIRONMENT

Hospital-Based Spirituality Initiative
George Washington Institute for Spirituality in Health
Supportive Care Coalition: Pursuing Excellence in Palliative Care

givers. On the other hand, it was also essential that everyone involved recognize chaplains as the expert spiritual care providers who would work with patients and staff on in-depth spiritual issues and distress (see Diagram C).

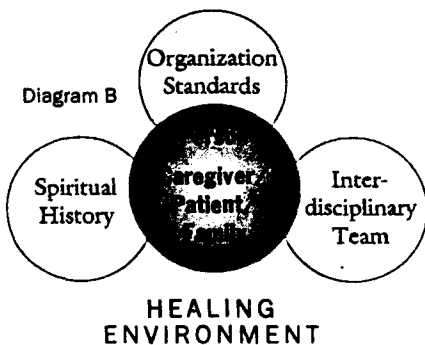
The coauthors of this article, who were the initiative's principal investigator and project coordinator, supported the teams by conducting an on-site, one-day visit to each site. The investigator and coordinator also arranged cross-site conference calls, enabling the teams to share insights with each other.

Although the sites differed from each other in various ways, each of them:

- Conducted physician and staff education regarding spirituality
- Held rituals during work shifts to remind staff members to focus on their calling to a service profession
- Posted inspirational messages
- Shared positive practices and examples of spiritual care
- Used symbolic reminders of the spirituality initiative
- Posted photos of the staff to strengthen the interdisciplinary team
- Acknowledged team members who provided excellent spiritual care
- Conducted spiritual screenings or assessments using a standardized format such as the FICA tool (see below)

THE FICA TOOL

Obtaining a spiritual history is one way a caregiver can learn what is deeply important to a patient.



In discussing the patient's spirituality, the caregiver enters the domain of what gives the patient meaning and purpose in life and how he or she copes with stress, illness, and dying. The spiritual history affords the patient the space and opportunity to address his or her suffering and hopes. A spiritual history validates the importance of a patient's spirituality, giving the patient "permission" to discuss his or her spirituality, assuming he or she desires to do so.

The FICA tool, developed in 1996 by Christina Puchalski, MD, one of this article's coauthors, can help a caregiver structure the questions he or she will ask in taking a spiritual history.

F: Faith, Belief, Meaning The caregiver begins by asking the patient, "Do you consider yourself spiritual or religious?" or "Do you have spiritual beliefs that help you cope with stress?" If the patient says no, the caregiver might ask, "What gives your life meaning?" Sometimes patients respond, "My family," "my career," or "nature."

I: Importance and Influence The caregiver may then ask, "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 The caregiver can ask, "Are you part of a spiritual or religious community? Do you find this community supportive? If so, in what way? Is there a group of people you really love or who are important to you?" Communities such as the members of churches, temples, and mosques, or even a group of like-minded friends, can serve as strong support systems for some patients.



Creating Healing Environments

FICA is a guide that helps the caregiver start a spiritual history.

A: Address/Action in Care Finally, the caregiver may ask, "How would you like me, your health care provider, to address these issues in *your* health care?"

FICA is not meant to be used as a checklist, but, rather, as a guide that helps the caregiver start spiritual histories, indicating what he or she should listen for as patients talk about their beliefs. Above all, FICA shows physicians and other caregivers how to steer a conversation toward spiritual issues, issues involving meaning and value. During such a history, a patient may relate to the caregiver his or her spiritual or religious beliefs, fears, dreams, and hopes. The spiritual history can be done in the context of a routine history, or at any time in the patient interview, usually as a part of the social history.

EVALUATION

Overall, the initiative was designed to answer, through narratives and questionnaire data, the following questions:

- Can interventions be designed that alleviate staff burnout, turnover, and depression and improve staff members' awareness of their own spirituality?
- Can interventions be designed that improve staff response to the spiritual needs of patients in hospital settings?
- Will such interventions improve such outcomes as patient satisfaction, trust in providers, and spiritual care?

Both caregivers and patients were surveyed about the initiative's effectiveness. Patients and staff were asked to fill out questionnaires at the initiative's beginning, after three months, after six months, and at the one-year mark. At each site, after the initiative had been approved, either by the hospital's institutional review board or a committee responsible for research there, a research nurse collected the data. The data were then evaluated by Sean Cleary, PhD (see **Box**, p. 32), and research team members at George Washington University.

The questionnaires, designed for the project, inquired about:

- Attitudes about spiritual care in the clinical setting
- Attitudes about the importance of spiritually and spiritual practices of the health care professional in the context of the work environment
- The stress level of health care professionals
- Caregivers' satisfaction with their work and

their workplace environments

- Patients' satisfaction with their encounters with physicians and other health care professionals
- Staff vacancy and turnover rates
- Trust in providers

NARRATIVE RESULTS

Evaluation of the data indicated the initiative's success for both team members and patients. The pilot units involved reported a "culture change" resulting in more positive cultures and a stronger sense of teamwork and community. As one participant said, "It's as if we have permission to be present to spiritual issues for ourselves and each other." Managers perceived improved staff satisfaction and have noted a reduction in days taken off because of illness.

Several sites have reported improved interdisciplinary relationships in pilot units. A leader at one site says that, during periods when the unit is shorthanded, staff members have begun calling on their days off to see if more staffing or help is needed. In addition, sites have described a variety of ways that staff members now include spiritual care in the overall care they provide to patients. Among these examples are:

- Arranging for a patient approaching the end of life to be visited by a pet
- Celebrating an anniversary with a patient prior to surgery
- Praying with a patient who is fearful about undergoing a therapeutic procedure
- Taking patients' spiritual histories

Sites report that staff members increasingly extend such thoughtfulness to each other as well. For example, the staff at one site volunteered to work on another unit so that all staff members on that unit could attend a memorial service for a recently deceased nurse.

CHALLENGES

A challenge reported by several sites involves developing strategies to help staff differentiate spiritual care from good "customer service." Many sites initiated discussions about customer-service approaches and meeting the social needs of patients and families. While those activities are often kind and service-oriented, and part of spiritual care, they are not true spiritual care. Site leaders found that using narratives of care and having the chaplain make the spiritual components of care more overt worked well to help dis-

tinguish between customer service and spiritual care. One project coordinator said that the "challenge [was] to help all understand how to care for the patient with a focus on the spirit of ourselves and the patient regardless of other care needs."

Another challenge involved finding the right time and focus for ongoing staff education sessions. The lunch hour seemed to be difficult for many busy units. Staff members were often unable to get away for education sessions during lunch, and therefore attendance waned. One successful site integrated the staff education sessions within the mandatory unit meeting time. Doing that helped contain costs and increase team members' participation. It did require the inclusion of other caregivers in what had been traditionally the nurse unit meetings. This was perceived as strengthening the interdisciplinary nature of the care team.

Each team developed interventions aimed at increasing awareness of the importance of spiritual care. Not all were well received at first. For example, one site rang chimes from time to time during the day to remind staff members of their calling and the importance of integrating spiritual care. However, some staff members said they were confused by this because they didn't know whether the sound indicated the birth of a baby—as had previously been the practice—or was intended to remind them to focus on spiritual care for themselves and others. It is clearly important to be flexible with interventions and to have ongoing communication concerning their development.

LESSONS AND RECOMMENDATIONS

Sites reported that the cross-site leadership team retreat had been essential to success. The retreat fostered a common understanding of spirituality and a sense of responsibility for attending to the spiritual concerns of both patients and caregivers. It also provided reflective time so that participants could, with guidance from the retreat leaders, begin to develop strategies for implementation of interventions in the pilot units.

In order to make the initiative successful, each site was encouraged to develop its own interven-

tions. This autonomy, and the interventions created through it, helped each hospital enlarge its expertise in spiritual care. Site leaders found that developing educational strategies and organizational expectations for the integration of spiritual care was necessary for nurturing and sustaining the initiative.

Sites also gave credit for the initiative's success to the strong support received from administrators, and to its strong leadership teams and its interdisciplinary approach, and to the ongoing advice from the leaders of the George Washington Institute for Spirituality and Health and the Supportive Care Coalition: Pursuing Excellence in Palliative Care.

RESPECT MADE VISIBLE

Many health care organizations emphasize the importance they place on respect for patients, family members, and caregivers. Such respect has historically been the foundation of health care in the United States, especially that of Catholic health care. The spirituality initiative described in this article made such respect visible. The sites report perceived increases in patient and staff satisfaction, reduced staff turnover, and waiting lists of staff members seeking to work in the pilot units. Sites also report strategies for continuing the work locally and for extending the initiative within the hospital. ■

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Funding for the initiative was provided by Supportive Care Coalition: Pursuing Excellence in Palliative Care, Portland, OR; the Catholic Health Association, St. Louis; and a continuation grant from the Spirituality in Health and Healing research, Sr. Diana Bader, OP, PhD, principal investigator.

For further information, contact the George Washington Institute for Spirituality and Health at 202-496-6409 or hcscea@gwumc.edu (www.gwish.org is the institute's website); or Sr. Karin Dufault, SP, RN, PhD, executive director, Supportive Care Coalition: Pursuing Excellence in Palliative Care at 503-215-5053 or karin.dufault@providence.org.

The retreat fostered a common understanding of spirituality.