Can we Judge a Book by its Cover? Hospital Admission Religious Identifiers and Personal Spirituality

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Abstract

This paper compares the religious identifiers patients choose on admission with their spirituality during the course of their care. Informed by George Fitchett's recent Making Our Case(s) case study project, this project utilizes transcripts of case notes by pastoral practitioners to demonstrate how spiritual assessment can clarify the congruence or incongruence between these labels and individual spirituality. These case vignettes illustrate ways in which careful spiritual assessment can ascertain the importance and helpfulness - or not -of the religious tradition, and discern individual (and often unique) spiritual practice within or without that label. The aim is to highlight the necessity of ongoing assessment over the course of treatment, so that patients receive the spiritual care they need, and aren't merely 'judged by their cover.' The objective is to inform strategies for future provision of spiritual care.

Keywords: Palliative care; Spirituality; Spiritual assessment

Introduction

This article is the result of a quality improvement project, which compared the religious identifiers patients choose on admission with their spirituality during the course of their care. Informed by George Fitchett's recent Making Our Case(s) case study project, this article utilises transcripts of patient case notes by Pastoral Care Practitioners to demonstrate how spiritual assessment can clarify the congruence or incongruence between these labels and individual spirituality [1]. The aim is to highlight the necessity of ongoing spiritual assessment over the course of treatment, so that patients receive the spiritual care they need, and aren't merely 'judged by their cover.' The objective is to inform strategies for future provision of spiritual care. Most case vignettes occurred within the palliative and oncologic patient populations.

For the purposes of this article, the term *congruence* refers to some direct correlation, more or less, between a patient's religious identifier and their worldview and spiritual practice. Similarly incongruence refers to a disparity between the patient's religious identifier and their actual worldview and spiritual practice.

Religious Identifiers

Upon admission to our major Melbourne public hospital, as in most medical facilities, each patient is asked to identify a *'religion'* which, along with demographic details, is included on their file admission criteria, on labels affixed to each page of their file progress notes, and - critically when medication is administered - on their personal wrist band. In our hospital, on any given day the "by religion" list will yield a majority of *Christian*s from various denominations, a rising quota of Muslims and Buddhists, scaling down through a multitude of other faiths including humanist and Wiccan, to less than 1% agnostic or atheist. (Other Melbourne hospitals have greater concentrations of particular faith populations, i.e. Jewish). Not surprisingly, in our reputedly secular society, the second largest group, between 15% and 20%, are listed as no *religion,* but as will later be indicated, this negative identifier can be ambiguous.

All the case vignettes in this article occurred over 3 months, between June and September 2012, at St Vincent's public hospital, Melbourne, which includes Caritas Christi Hospice. All are transcripts from notes written in patient files: for de-identification purposes, pseudonyms have been used for patient names and authorship of individual notes is anonymous. To begin with review the ongoing discussion in the literature on spiritual assessment.

Spiritual assessment

Articles which attempt to define spirituality, stress its importance and the necessity of assessment, or to develop formal therapies that address it, are more prevalent in the palliative care -and associated aged and cancer care- literature than any other sector of health care, and the consequent debate can seem recursive. For example, in 2011 Guijsberts et al. [2] criticised Vachon et al. [3] review (formerly criticised for its 'psychological' definition excluding those with cognitive deficits [4]) for not resolving into a conceptual model that can be clinically utilised [3]. They suggested their own "three dimensional" definition (Spiritual well-being, Spiritual Cognitive Behavioral Context, and Spiritual Coping) is more useful for distinguishing how each dimension actually operates [2]. Their model, which the authors believe incorporates and broadens past definitions (including Puchalski et al's Consensus Conference definition), despite different terminology is strikingly similar to Allan Kellehear's *Spiritualty and palliative care: a model of needs*, published over a decade earlier [5,6]. This similarity highlights the circular nature of the ongoing debate, despite input from various disciplinary stakeholders, and continuing confusion in regard to terminologies [7].

For the purposes of this article it may be helpful to consider working definitions of the terms religion and *spirituality*. In the recent *Oxford Textbook of Spirituality in Healthcare,* John Swinton emphasises the varying interpretations and definitions of these slippery terms, and offers inclusively elastic definitions of both. He suggests religion is generally perceived as a formal system of beliefs incorporating "shared narratives, practices, beliefs and rituals that, taken together, create particular worldviews." *Spirituality*, he suggests, is a "subjective experience that exists both within and outside traditional religious systems", which can comprise elements of "meaning, purpose, value,

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hope, relationships, love, and for some, a connection to a higher power or something greater than self [8]."

Many articles addressing the importance of spiritual assessment and therapeutic interactions owe a methodological debt to Fitchett's 7×7 model of spiritual assessment, devised to define his role as chaplain in St Elizabeth's psychiatric hospital in Washington from that of other disciplines [9]. Systematic reviews of this kind of literature appear semi-regularly, incorporating and criticising their predecessors and offering updated definitions of spirituality [10]. The most recent review (at time of writing) by UK Chaplain Cobb et al. concluded with a caveat touched upon by Guijsberts et al [2]: they suggest the epistemological origins of most of the research articles they examined limit their worth in producing reliable data for actual clinical practice [11]. This is due, they suggest, to a tendency towards reductionism, unexamined assumptions upon which research is based, and lack of collaboration with "disciplines and interpretive traditions of spirituality." This last important criticism is implicit in other recent articles focussed on spiritual care. For example, Buddhist palliative physicians not only recommend mindfulness for anxiety but Dharma to address underlying spiritual suffering; and psychologist and chaplain Bisschops– also citing Puchalski et al. definition- suggests the healing process of "self-observation, presence and contemplation" in "classic spiritual stages" can also be present in the process of clinical psychotherapy, provided the therapist is not only spiritually informed but integrated [12,13]. Both articles emphasise the importance of practitioners being grounded in a particular spiritual tradition. With this argument in mind, we frame our argument for the importance of ongoing spiritual assessment within transcripts of actual case notes, to illustrate how assessment can be clinically utilised.

To begin, we offer examples of congruence between patient religious identifiers and personal spirituality.

Congruence between religious ID and spirituality

It might be reasonably assumed that the beliefs and practices associated with those identifying with a major *religion,* such as *Catholic or Muslim,* would be fairly similar, and for many this assumption is valid, but as will be demonstrated there are dangers in generalising.

The following three vignettes are examples where the patient's religious identifier was congruent with their active spirituality, and the Pastoral Practitioner was able to ascertain its helpfulness in their treatment trajectory. In this first case a referral was made, via palliative consult team, for a middle aged man with rapidly progressing testicular cancer:

Kevin identified as *Catholic* upon admission, and I reflected this to him – this opened conversation to exploring the place of faith in his life and wish to see a priest. This became a means to engagement around the spiritual at considerable depth, enabling him to both identify practical resources and assist in the processing and making sense of the news he had been given.

Similarly, another younger patient in the Cancer Services unit initiated a pastoral visit through her nurse following new ovarian cancer diagnosis:

Lina identified as *Muslim* on admission and in conversation I asked if there were any specific religious needs we needed to be aware of. Lina shared what her faith means to her and explored how it shaped the way she was coping with her diagnosis.

In this third example, a 75 year old woman, identified *Greek Orthodox,* was admitted to ICU following a cerebral haemorrhage. Prior to this she was primary caregiver for her husband with Parkinson's disease. Pastoral care was alerted by the ICU treating team, to support him and son at the bedside, explain and normalise procedures, and prepare for probable end-of-life:

Whilst a priest was not required at this time, I offered a picture of a Greek Orthodox icon. Pt husband Chris accepted it, kissed the picture and indicated that I should place it on the bed head. This enabled further interaction and support and Chris and son were able to express their own fears and distress.

This encounter again illustrates congruence– the intervention a offering solace and the icon's complex symbols providing a window into and connection with, extramundane experience.

Each of these three examples clearly identified with a particular faith tradition, and the practitioner was quickly able to assess the congruence and respond accordingly. In these cases initial spiritual screening as part of admission criteria would substantially suffice as spiritual assessment. However, in cases where there is incongruence, more subtle and protracted assessment may be required in order for the person to receive appropriate spiritual care, as these next case examples illustrate.

Incongruence of religious labels with spirituality

A 'major religion' label carries many assumptions about content –dogma and ritual- but these assumptions may not be entirely congruent with individual spirituality. Care needs to be taken in assessing spiritual needs, exemplified in sensitive assessment, in which the patient's beliefs, practices, hopes and wishes, are recorded, to alert the wider multidisciplinary team to any spiritual needs, and potential interventions, and just as importantly, to simply inform as an aid in holistic understanding. This next case is an example of marked incongruence between religious label and spirituality.

A palliative patient with end-stage breast cancer has identified as *Catholic,* but is no longer 'practising' and expresses ambivalence towards the church. The practitioner had clarified that the patient did not wish to receive the sacraments of communion or anointing – a ritual once referred to as 'last rites' but now 'sacrament of the sick'- and ended up in the difficult situation of advocating for her against the wishes of her family:

As Cathy became less respondent, drawing closer to death, a family member asked that I arrange for her to be anointed. I explained that I had checked with Cathy when she was coherent and she was definite about NOT wanting this ritual. The relative visibly struggled in knowing that her loved one's wishes had to be carried out against her deep belief that anointing prior to death is crucial for eternal assurance.

This case illustrates the fairly common situation where a patient chooses *Catholic* as an indicator of heritage or identity, but no longer retains beliefs or belongs to a faith community. This counter-intuitive scenario also indicates the importance of spiritual assessment. To make an assumption purely on the basis of label may have caused violation of the patient's integrity, and perhaps compounded her existential distress (a notion understood to include conscious reflection on loss of life affirming and/or transcending purpose) [13].

A less extreme example illustrates the importance of assessment in identifying the renewed importance of religious heritage to a patient's spiritual coping. The Pastoral Practitioner initiated a visit to a *Christian* in her 50s following new breast cancer diagnosis:

Sue yearned for a reconnection with the church but did not know

how to initiate this and was still wary following her experience of hurt and suffering. She said that when she was asked about religious affiliation on admission, she had deliberately said 'Christian', something she had not identified as for many years prior. Ongoing pastoral care has explored issues of faith, meaning and reconnection.

This case illustrates another fairly common situation, where a health crisis causes patients to actively question the congruence between their religious affiliation and spirituality. The presence of a clinician with knowledge, experience and sensitivity can enhance patient reflectivity; allow reframing of events and transitions from their life narratives, and promote reconnection, as in the above case, or validate disconnection in favour of alternative expressions.

The following case sits between reconnection and disconnection: rather the practitioner provided a safe conversational space for the patient to express his disaffection with the church and anger at God. The patient, recovering from radiation therapy, identified as *Anglican*:

Phillip, recently retired, shared his fear of losing all ability, becoming bed-ridden and unable to communicate, and "dying alone". Phillip reflected on youthful experiences of rejection because of his sexuality, and the early death of his partner, which continue to inform his image of God. Faith and community are important, but the experience of illness has caused Phillip to wonder "where is God in all of this."

In this case, where illness evokes past trauma, spiritual assessment, garnered implicitly from the interaction rather than in explicit questioning, ascertained the patient's ambivalence towards his religious tradition and the inadequacy of his theological constructs to frame his experience of suffering. This assessment enabled ongoing therapeutic interaction.

Similarly, in this next case, a woman in her 40s with a brain tumour and associated confusion and anxiety expressed ambivalence towards her religious community and a crisis of faith:

Serena identifies as Orthodox but actually attends a charismatic Christian community, and believes she had not received a miraculous cure because of unworthiness. Ongoing theological exploration is addressing this belief.

Accurate assessment, along with a more nuanced understanding of 'cure' and 'healing,' enabled the practitioner to work with her over many months and enable greater spiritual coherence, and in the process possibly adjusting her insecure 'attachment style' [14].

In these examples the religious identifier was chosen intentionally, important to each though not in immediately obvious ways. Spiritual assessment was required to ascertain the helpfulness or non-helpfulness of the identified tradition in coping with their illness/treatment trajectory. Other patients identify a religion less intentionally –"it's just what I am"- attached to a tradition because of cultural reasons: i.e. they were baptised as a child, or they were married in a particular church, but they have no real affinity with the tradition. In these cases, the chosen religion may not impact positively or negatively on their coping, although engagement may lead into conversation about beliefs and/or practices that are actually meaningful to them.

These 'incongruent' case examples illustrate the importance of ongoing spiritual assessment throughout a patient's treatment trajectory so that clinicians can "avoid thinking of spiritual well-being as a static concept" [15].

In this next section, we review the ongoing discussion in the literature on spiritual assessment, and then present several case vignettes featuring patients who identified as *no religion*.

Spiritual assessment through pastoral conversation

"Is spiritual discernment possible without roots in a religious tradition?" is an ongoing question that can provoke misunderstanding and conflict [16]. Psychiatrist and grief expert David Kissane expresses reserve, advising that education in existential distress typologies and the humanities may help palliative physicians deal with distress in terminal patients -making an important distinction between clinical depression and demoralisation- but suggests referral to "rabbi, minister or chaplain" when spiritual assessment is required [17]. Similarly, psychiatrists involved in an interdisciplinary workshop with chaplains at The University of Texas Cancer Centre suggest the latter may be able to function as psychotherapists more "appropriately than psychiatrists can or should function as chaplains" [18]. Others have recommended more extensive education in spiritual and religious care competencies in formal training for all clinicians [19].

The epistemological underpinning of clinical pastoral training and spiritual counselling, which began in the mental health milieu in the early twentieth century, emphasises patient-centred openness to the ontological claims inherent in spiritual narratives, without reductive rationalising. Anton Boisen, one of the founders of Clinical Pastoral Education (CPE) in his clinical work as a psychiatric chaplain, considered each person he encountered as a "living human document" or unique theological text he could learn from [20]. This attitude remains integral to clinical pastoral training, in order to ensure that the contents of an interaction derive from patient experience and not from the practitioner/chaplain's agenda, in order to hear the internal coherence (or incoherence) and intrinsic value of each individual's narrative. Pastoral Practitioner Anne Collopy describes "pastoral conversation" as her "primary tool" which enables exploration and assessment of patient's "inner worlds":

Pastoral conversation is not necessarily driven by the need to identify issues that require action, but rather involves listening for spiritual themes such as meaning in the context of suffering, dealing with grief/loss or search for hope. Such intentional listening enables the person to give expression to the stuff of their soul, their inner self that only they can know. It may transpire that spiritual needs are identified in the conversation and a plan or intervention devised for meeting these needs. A skilled practitioner is able to incorporate assessment unobtrusively into the conversation as it unfolds organically. Assessment tools may even impede engagement if the conversation becomes driven by that agenda. The focus is on the process rather than striving to meet set outcomes, and it is the process itself that may in part address need.

Collopy's final sentence highlights the fact that the process of interaction leading to assessment is often as not the intervention. The process of discernment, recognition and validation of unique spirituality, and its contextual relationship to suffering and growth, is often all that is required. This process has been identified by discourse analysts as an "interactional hybridity" (contrasting with more stratified physician/patient interaction) blending "features of counselling and religious discourse, as well as informal conversation… flexible and responsive, shaped as it is by the personal, spiritual, and social needs of the patient" [21]. As Bruce Rumbold points out, pastoral interactions and assessments take place within a continuum of patient narratives, which may incorporate their past, their illness experience (including the clinicians) and suffering, and their hopes of transcendence [22].

It is understood that accurate spiritual assessment may not arise

from formal 'spiritual' screening in admission forms, but need to be elicited from the metaphors employed in patient narratives [23], which can then be subject to assessment tools such as FICA or FACT [24]. FICA in particular is utilised by our team for its simplicity and inclusiveness, allowing the user to quickly ascertain a person's Faith identity, its Importance to them, their sense of belonging to a faith Community, and any further Action (referral to faith representative, ongoing pastoral counselling etc.) that needs to be undertaken as a result of the assessment [25].

For example, in the following case we see a situation where the palliated patient's seemingly innocuous Christian label is revealed in pastoral conversation to conceal an intense spiritual history that impacts on his physical and psychosocial health:

Emotional support, life-review: Bill used occasion to narrate wife's recent traumatic RIP and his continuing grief at loss. Bill reflected on significant transitions in their relationship, and her "goodness and hospitality" which he described as a "gift from God."

Spiritual AX: Bill still retains personal faith, despite conflict with formative faith community who he believes betrayed he and his wife's trust. I validated Bill's anger and his internalised faith, and responded to his request for prayer.

In this case, initial spiritual screening upon admission did not include any of the information contained in this file excerpt, except a generic Christian identifier. Assessment emerged from the patient's narrative, after a pastoral 'cold-call', allowing understanding and intervention. Given the value of formal therapies, most spiritual care in hospitals arises out of such informal encounters. Pastoral conversations can contain similar features to more formal biographical therapies -such as "life lessons…unfinished business, hopes and dreams" and so on, but with a central focus on meaning and purpose [26].

In this next section, we present several case vignettes of patients who choose *no religion* and the importance of spiritual assessment in enabling their holistic care.

No religion

As indicated, on any given day, patients with *no religion* labels form the second largest group (a significant number of these are ED patients unable to answer triage questions). This identifier may indicate no religious affiliation or beliefs, although this does not preclude any interest in the subject. For example, a palliated male, listed *no religion,* revealed he had been a soldier in the Vietnam War and considerably affected by witnessing Buddhist devotion and resilience there:

Ian spoke of acceptance of 'otherness' of Vietnamese Buddhists – both allies and enemies - and we explored the importance of contemplation on the nature of suffering for finding inner peace

In many instances a patient will choose one of these negative identifiers simply because they no longer participate formally – attend synagogue, mosque, church or temple, belong to a faith community-although they may still retain some form of associated beliefs and practice.

For example, a man in his mid-30s is in palliative respite/rehabilitation after prostate surgery, his treatment complex due to co-morbid obesity. Listed no *religion,* he consents to engagement with Pastoral Care, and during their third interaction, after trust established, admits to a "strange" spiritual practice important to his coping during post-surgery demoralisation:

With a Calvinist minister father, Tom was raised in the church but although respectful now feels some ambivalence about its patriarchal structure. No longer a churchgoer, he believes he has internalized its ethos ('signs of grace' manifest as community concern) and prays daily to a deity whom he has attributed the image and qualities of his grandmother, whom he was very close to and accepted his size and "feminine" traits unconditionally.

The multi-disciplinary team was strongly advocating a life-style change to recover his ambulatory ability and Quality of Life (QOL), and this caused some resurfacing of anxiety about body image and acceptance. Validation and acceptance of his "strange" practice, and normalisation through theological exploration of the feminine divine, became of particular importance to his psycho-spiritual well-being.

The above case illustrates the common situation where patients are reluctant to reveal their spiritual beliefs and practices until a trusting clinical relationship is established.

In this next case, Lei, a young woman with co-morbid MS and scleroderma, was referred to the palliative consult team and then psychiatry liaison after a severe depressive episode. Listed no religion she self-referred through her nurse to pastoral care:

Lei has a Buddhist background but is not practising. She has a long-held commitment to eco-activism, and more recent attendance at Quaker meeting. She requested exploration of Christian concepts of forgiveness and healing. We reflected upon a story of forgiveness – *Who will cast the first stone.*

These are examples of a fairly common phenomenon, where patients choose no religion because they cannot conceive of an identifier that adequately describes their condition of feeling betwixt and between. In some cases, significant spiritual pain underlies the choice, and as the examples indicate, elicitation and validation are usually predicated on the development of a trusting relationship. In some cases, too, an interaction with clinical pastoral care is the first time the patient has been able to voice their disaffection and their self-agency in finding new (often seemingly casual or unusual) forms of spiritual expression.

Conclusion

Our postmodern spiritual landscape has been described as a "fundamentally multivalent, constantly changing complex of many-levelled meaning" [26]. This could be an apt description of the patient population in any contemporary hospital or hospice. As we have demonstrated, an admission-label religious identifier may not be a reliable indicator of patient spirituality. In addition, initial spiritual screening is often done in an ad-hoc way by health professionals who don't identify as skilled in this area. This project and article highlights the necessity for careful spiritual assessment, to ascertain the importance and helpfulness - or not - of the religious tradition to patients, and discern individual (and often unique) spiritual practice within or without that label. Chaplains and Pastoral Care Practitioners are trained in the kind of spiritual assessment we have described and illustrated throughout this article, and we recommend (as Fitchett also recommends in his case study project) properly trained and certified professionals be included in multidisciplinary care to ensure patients' spiritual selves are recognised and attended to. In addition we recommend further, more formal, research in this area, particularly around the phenomenology of clinical interactions and outcomes in light of the varied hermeneutics of multidisciplinary clinical practice. We expect to follow this project and article up with a more formally realised research project.

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