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Topic

Integrating Spiritual Care into Healthcare
A Conference Report from Orlando

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From the 20th to the 22nd of April, the second national conference of the HealthCare Chaplaincy Network was held in Orlando (USA) at Walt Disney World Resort. 400 professionals from pastoral care, medical science, nursing, research and education participated. In addition, the live broadcast of the conference was followed worldwide by around 5,000 people on screen. The focus was on the question how Spiritual Care integrates into healthcare - in America and worldwide.

A) Spirituality - an Aspect of Humanity

All speakers referred to an open definition of spirituality, the definition of the American Consensus Conference was often mentioned:
"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."[1]
This definition of 2009, which has recently been further developed in 2014 in Geneva with international participation, is anthropologically founded, not theologically. It is based on the subjective experiences and resources of humans and doesn't conform to any traditional or institutional framework.
This definition is also the basis that spiritual care is understood as an interprofessional task and therefore as a task of healthcare itself. In this connection, different tasks were assigned to different professional groups: the medical health professionals should recognize spiritual needs and also take them into account in their actions. However, they are to call the "specialists" for Spiritual Care, the pastors (chaplaincy) of the institution, in case of complex spiritual needs or at the request of patients.
With the interprofessional profile of Spiritual Care, the central theme of the conference came into focus: How can Spiritual Care be integrated into healthcare?

B) Make Your Chatter Matter!

As a central basis for the integration, a) a proper and understandable language for the interprofessional discourse as well as b) a standardized procedure from the screening up to the interventions and the documentation were named:
So for instance, George Handzo (Director of Health Services, Research and Quality at HealthCare Chaplaincy Network) claimed that the experts, for the most important aspects of Spiritual Care, should agree on definitions that promote clinical communication about Spiritual Care and that help Spiritual Care obtain a greater weight in healthcare. Christina Puchalski, director of the George Washington Institute for Spirituality and Health, aimed at combining the narrative and the medical model, so that the stories of patients would be heard and so that it would be ensured that the interprofessional team really considers their spiritual concerns. In interdisciplinary communication, it needs concepts by which spiritual issues are effectively integrated into the therapeutic process. Many interesting models from medical practice and pastoral care were presented, such as the communication model ISBAR which was standardized in the interprofessional context, the procedural concept "5 Triads Chaplaincy Perspective" by Timothy J. Ledbetter or the indication model "Clinical+Coping Score".

C) Change Healthcare

George Handzo terminated the conference with battlesome words: "The question of, should spirituality be involved in healthcare, has been settled. We are not to discuss it anymore. The evidence is clear and we need to move on. What we have to do now, is to jump ahead of the field. Not playing catch-up like we always do in spiritual care. Spiritual care needs to be leading healthcare! "
Betty Ferrell and Christina Puchalski pointed in the same direction. Betty Ferrell, professor and director of nursing research and education at the City of Hope in Duarte and widely respected expert in the palliative care movement showed to the world's growing acceptance of Spiritual Care in the context of palliative care, and culminated in the statement: "If you're not providing excellent spiritual care, you're not providing palliative care." Christina Puchalski diagnosed some pathological symptoms in American as well as in worldwide healthcare: "Health Care Systems in the US and in many parts of the world - in both developing and high income countries - are broken: poor access, inequality, low patient and provider satisfaction, high rates of medical error, cost driven bottom line." In addition, the relationship between clinicians and patients had deteriorated manifold. She sees spirituality as leading discipline, which, in conjunction with other disciplines in the health facilities, takes charge of a renewed medicine based on a "compassionate relationship". Thereupon, she demanded a global initiative of the implementation of interprofessional Spiritual Care.

D) Slow Down!

Perhaps it is no coincidence that a speaker of this side of the pond (from Scotland) brought in yet another view of integration, in which the tensions between medical and religious ways of thinking are preserved and act creatively. John Swinton, professor of practical theology and pastoral care from Aberdeen, in his humorous speech, brought a biblical-theological perspective into play with which he contrasted the American integration efforts of Spiritual Care into the medical system partly critically.
According to Swinton, the health care system is characterized by an increasingly higher speed and is thus in danger of no longer being able to perceive many needs of patients and augmentedly putting employees under pressure. By contrast „God goes three miles an hour" (Kosuke Koyama), because it takes its own time in which to unfold love and appreciation, a time that cannot be rationalized. It is therefore a duty of pastoral care, to operate slowly itself and to demand slowness in the therapeutic process, so that people can be perceived accurately. It is the task of pastoral care to orient itself on the Sabbath, that is, the potential of interruption, and to look for creative ways to break through the often automated clinical processes and patterns of perception in order that „the sacrament of the present moment" be made tangible. On this sacrament, so Swinton, both live, the helping and those seeking help, and in it, they meet at eye level. The result is a reciprocal rhythm of giving and taking, of "guesting and hosting" which, in its core, is not a one-dimensional aid process, but a process of exchange and touch.

References
[1] The Report of the Consensus Conference. J Palliat Med 2009; 12(10): 885-904

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