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FROM THE EDITOR

The spiritual domain of palliative care: Who should be "spiritual care professionals"?

This journal, *Palliative & Supportive Care*, has described itself as the first international palliative care journal that focuses on the psychiatric, psychosocial, *spiritual*, existential, ethical, and philosophical aspects of palliative care. Over the past 7 years, I believe we have been true to that mission; however, we have, perhaps, skirted around the issue of religious aspects of palliative care and how they may overlap or intersect or, some might say, transcend the issues we have identified as *spiritual*, existential, and even perhaps psychological. Some of you may recall an editorial from Volume 5, Number 2, in 2007 entitled "Who Needs the Concept of Spirituality? Human Beings Seem To!" (Breitbart, 2007), in which I argued that there was the need for the term or concept of *spirituality*, independent of the terms *existential*, *meaning*, *purpose*, or *religious*.

Salander (2006) pointed out the many problems with the term *spirituality*, including the following: (1) *Spirituality* as a "concept" is poorly defined or operationalized, (2) the concept of *spirituality* is not linked to any theory and lacks a systemic meaning, (3) the term *spiritual* is unnecessarily and inaccurately being used to describe what are essentially *existential* issues, and, finally, (4) the universality of the term *spiritual* is challenged, pointing out that it may be acceptable and reasonable to ask an American if he or she is a "spiritual person," but that such a question would be quite irrelevant and alien to a Swede or a "non-English speaking secular European." Salander correctly pointed out examples of papers where the term *spiritual* was used inconsistently: some papers in which it is alternately used to describe religious beliefs or religiosity, papers in which the term is used to describe existential concepts of meaning and purpose, and finally papers in which the concept is used to refer to general psychosocial issues (Breitbart, 2002; Meraviglia, 2004; Murray et al., 2004; Krupski et al., 2006). Salander asked us to use the terms *religion* or *religious*, rather than *spiritual*, when we mean *religious* and to use the terms *meaning*, *purpose*, or *existential*, rather than *spiritual*, when we mean *meaning* and so on. My defense of the term *spirituality* was based on the argument that *spirituality* was necessary as a term or concept because it was a concept that was shared by both the religious and the secular to describe a dimension of human experience that was not captured completely by the terms *existential* or *religious*. The term *spirituality* allowed for multiple options and permutations and interpretations of the religious or existential that still spoke to some basic human pursuit of understanding one's place and purpose in the universe. Clearly the debate continues and has been brought into more acute focus by a variety of endeavors in the palliative care field to define and improve the quality of the spiritual domain of palliative care.

The question that I have been struggling with and discussing with colleagues these days is "Who in an interdisciplinary palliative care team should be considered a *spiritual care professional*?"

Several events have stimulated a reexamination of this issue for me in my work as a clinician, researcher, teacher, and advocate. Recently I had the privilege of being invited to attend a consensus conference on "Improving the Quality of Spiritual Care as a Dimension of Palliative Care," organized by Betty Ferrell of the City of Hope and Christina Puchalski of the George Washington Institute for Spirituality and Health and supported by the generosity of the Archstone Foundation. The conference has ambitions to produce important and practical outcomes and is ongoing as I write this piece. I mention this conference held in Pasadena

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on February 17–18, 2009, because of the fact that I relearned a great deal, including relearning some important lessons of the need for compassion and tolerance for the perspectives of others.

The Pasadena Consensus Conference was attempting to build on important work of the National Consensus Project (NCP) for Quality Palliative Care (2004) and its *Clinical Practice Guidelines for Palliative Care* and the National Quality Forum (2006) and its *National Framework and Preferred Practice for Palliative and Hospice Care Quality.* The NCP Guidelines describe eight domains of palliative care, with Domain 5 being *Spiritual, Religious, and Existential Aspects of Care*. One might point out that including spiritual, religious, and existential aspects of care all into a single domain of care ignores the distinctions between these three terms or constructs. This is further confounded by the fact that the NCP has listed *Psychological and Psychiatric Aspects of Care* as a separate domain of care (Domain 3), and, additionally, separates out ethical, cultural, and social aspects of care into separate domains of care. The result, I believe, is the perhaps unintentional identification of Domain 5 as essentially a *religious* domain that is the province only of clergy and health care chaplains, in fact excluding other disciplines from a legitimate role in *spiritual* care. Scott et al. (2008) have recently described the essential elements of *spirituality* in end-of-life care and point out the National Quality Forum (NQF) Preferred Practices associated with *spirituality* (i.e., NCP Domain 5 above). Their very useful article discusses the important role of the *spiritual advisor* on the interdisciplinary palliative care team and the advantages of including certified chaplains in the team to provide such care. NQF Preferred Practice 22 states: "Specialized palliative and hospice care teams should include *spiritual care professionals* appropriately trained and certified in palliative care."

Several questions then are raised: (1) Which of the multiple professional disciplines involved in palliative care are appropriate to be *spiritual care professionals*? (2) What training and expertise is required for *spiritual care*, as opposed to *religious care* or *existential care*? Identifying distinct NCP domains of care related to social, cultural, ethical, psychological and psychiatric aspects of care seems to suggest that social workers, psychologists, psychiatrists, ethicists, philosophers, and others have no legitimate role in the *spiritual domain* of palliative care. The role of the nurse or the palliative care physician in dealing with spiritual issues or even existential issues remains very unclear.

I believe that there is no discipline represented in the interdisciplinary palliative care team that has seriously challenged the fact that health care chaplains and clergy are the sole discipline represented on the team that is the most appropriate and preferred discipline to provide *religious care* to palliative care patients. Yet there are those in the clergy and health chaplaincy field who question whether mental health professionals (e.g., psychologists, psychiatrists, and social workers) are suited to deal with spiritual issues or even issues of how and where meaning and purpose and dignity are derived, because mental health professionals tend to be much less religious than the general population (and perhaps even harbor an antipathy toward religion) and so do not ascribe to the religious belief that meaning, purpose, and dignity are derived primarily from God (Galanter et al., 1991; Curlin et al., 2005). This has led to counterattacks that clergy or health care chaplains have inadequate training and no role in providing existential or spiritual counseling to nonreligious patients or patients of a differing faith tradition. In fact, a survey by Lloyd-Williams et al. (2006) found that, whereas most clergy felt they possessed adequate liturgical skills, only 26% felt their training in pastoral skills in the care of the dying was adequate.

There is growing evidence, however, that mental health professionals are not only more attuned to and tolerant of spiritual and even religious aspects of care (Curlin et al., 2007), but are responsible for a dramatic explosion of novel counseling interventions that focus on such spiritually oriented constructs as meaning, dignity, and peace (Chochinov & Cann, 2005; Steinhauser et al., 2006; Breitbart et al., 2009). The notion that mental health professionals should not play a role in spiritual care at the end of life is misguided, but I fear that, at its worst, it may represent a veiled attempt to preserve a religious foothold in the secular world of medicine and science where religion is perceived as unwelcome. Meador (2006) points out that indeed not only do mental health professionals have an essential role in providing spiritual care to the dying, he even makes a case for physicians and nurses being trained to provide such care because of the preponderance of evidence suggesting that patients would prefer discussing spiritual concerns around dying with their medical health providers (Ehman et al., 1999).

What was truly transformational at the Pasadena Consensus Conference was that a room full of clergy, chaplains, palliative care physicians, palliative care nurses, psychologists, psychiatrists, and social workers all agreed that *spirituality* was an inclusive concept, not exclusively religious or secular, and that the responsibility for quality *spiritual care* was a shared responsibility of the entire interdisciplinary team. As we further test and disseminate novel spiritually based interventions (e.g., dignity conserving

therapy, meaning-centered therapy), it becomes possible to give tools to all the members of the interdisciplinary team so that they are can obtain the training and skills to participate as *spiritual care professionals*.

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