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Methods or Approaches Proposed for Assessing Spiritual Needs in Palliative Care

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Abstract

According to its definition, palliative care is "An strategy that enhances the quality of life of patients and their families who are dealing with issues related to life-threatening disease." With the detection, evaluation, and treatment of pain and other issues, whether they are physical, psychological, or spiritual, it avoids and alleviates suffering. I want to learn about and satisfy the needs of my patients and their loved ones as a palliative care physician. I am a generalist since I have had specialised training in psychological, social, and spiritual difficulties, as well as in evaluating and treating "pain and other bodily symptoms". The evaluation of spiritual requirements in palliative care is presented using two methods: The first involves incorporating the four analytical aspects of palliative care: utilising an instrument, assessing spiritual requirements or well-being, and assessing overall life satisfaction while paying particular attention to spiritual matters. Second, a wholistic strategy is encouraged, with consideration for the patient's account of their life, illness, and suffering. Medical, ethical, and spiritual topics may be covered in the clinical interaction without compromising its integrity. It is essential to expand our clinical vocabulary to include terms related to ethics, psychological issues, and religion. Self-analysis, interdisciplinary cooperation, and specialised interdisciplinary training may be helpful to establish such a clinical vocabulary.

Keywords: Palliative care; End of life; Illness; Spiritual care; Suffering

Introduction

Palliative care is defined by the World Health Organization as "An strategy that enhances the quality of life of patients (adults and children) and their families who are dealing with challenges related to life-threatening disease" (source). With the early detection, accurate evaluation, and treatment of pain and other issues, whether they be physical, psychological, or spiritual, it avoids and alleviates suffering. I strive to thoroughly assess and attend to my patients' and their loved ones' needs as a palliative care physician. I am especially trained as an expert in evaluating and treating "pain and other bodily symptoms," therefore this may be a difficult task. I view myself as a generalist in terms of psychosocial and spiritual matters, with psychologists and social workers serving as experts in psycho-social care and health care chaplains serving as experts in the care of spiritual needs. In this essay, I'd want to discuss some ways that generalists like myself may take to detecting spiritual needs and delivering spiritual care in palliative care, as well as how multidisciplinary cooperation and specialised training might be advantageous, first and foremost to our patients. In this study, I would want to discuss some ways that generalists like myself may take to detecting spiritual needs and delivering spiritual care in palliative care, as well as how multidisciplinary cooperation and specialised training might be advantageous, first and foremost to our patients. I work as a consultant for doctors and nurses who are dealing with difficult palliative issues as a palliative care specialist. A general practitioner recently phoned me for advice regarding one of her palliative patients during a consultation. The conversation serves as an illustration of how spiritual concerns might come up during a clinical consultation between a doctor and patient.

The 34-year-old lady was the subject of the consultation. Just after her second pregnancy, she underwent a cervical cancer screening, and the results were disastrous: Pap 5, stage IV. Ascites resulted from metastases in her lungs, peritoneum, and abdomen. She continued to undergo palliative chemotherapy and an experimental medication while she was still being treated by the oncologist till recently. Because the tumour was continuing to grow and a metastasis in her peritoneum was producing up to 1.5 L of ascites per day, the oncologist had discontinued the therapy because it was no longer working. She had a drain and could access the liquid on her own. She had recently returned from a camping trip with her family, so things were going ok. She has been experiencing nausea and vomiting more often since yesterday, especially at night. All night, she had been throwing up. She was worn out. She is described as a strong lady by the doctor, and neither anxiety nor sadness is present. She has repeatedly stated her desire to spend as much time as possible with her spouse and their two small children. Of course, there may be patients who express their spiritual needs to their doctor directly [1], but for the most part, the patient communicates their needs to the doctor in a manner akin to that described in the consultation: they may mention their spiritual needs at some point in the course of telling their story. The link between the four components of palliative care is depicted in a model in the Dutch Guideline Spiritual Care in Palliative Care. In this concept, the spiritual dimension is both the least obvious and the most personal. The red and blue arrows also show how the four aspects of palliative care interact dynamically with one another. These dimensions can be distinguished but not separated, and they are also expressly mentioned in the WHO definition. Current research indicates that this may even be challenging, particularly when separating the psycho-social from the spiritual components [2].

In order to meet a patient's spiritual requirements, one strategy is to attempt to identify them, such as by employing tools that have been

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shown to evaluate spiritual needs or spiritual well-being in palliative care [3]. The Quality of Life at the End of Life (QUAL-E) measure [4] and the Missoula Vitas QOL [5] are two instruments that measure the quality of life at the end of life and include items on the spiritual dimension. Other instruments, like the Spiritual Needs Inventory [6] and the JAREL Spiritual Well-being Scale, focus specifically on spiritual issues [7]. Why do we still employ models in palliative care that reflect the four aspects as though we are divided into "pieces" if differentiating between psycho-social and spiritual requirements is complex? These four aspects provide four distinct approaches to discuss and consider our patient's pain. The following discussion and analysis of the patient's sickness, symptoms, and available treatments may be useful, for example, in determining the appropriate professional assistance for the patient: A referral to a medical chaplain or a qualified psychologist or social worker should be taken into consideration, for instance, if a patient receives a low score on QUAL-E elements that assess spiritual well-being or a low score on the SNI.

For instance, in the patient mentioned in consultation, the (physical) disease's symptoms, such as the discomfort from nausea, vomiting, ascites, and weariness, are visible. The interaction between these symptoms and her ability to say goodbye to her husband and kids, as well as her ability to accept this situation-including the very inconceivable concept that she will have to leave her kids behind- is also tangible. These demands are a reflection of difficulties that may be "labelled" as psycho-social, existential, or spiritual needs. These brought to mind the EAPC's definition of spirituality, which includes "Existential problems" including "questions about identity, meaning, suffering and death, guilt and shame, reconciliation and forgiveness, freedom and responsibility, hope and despair, love and joy." She may experience less pain and find it simpler to concentrate on the process of letting go and saying goodbye to her loved ones if she receives medical treatment for the nausea and vomiting. Here is an illustration of how a theoretical model of the four aspects of palliative care may be beneficial in easing patients' pain.

Palliative care as holistic care

Another method that is more thorough and occasionally time-consuming can be used to determine whether the patient is experiencing spiritual pain, which is in line with the holistic nature of palliative care. This strategy suggests to me that I should try to meet a patient as a "complete person" when we consult (not as a conglomerate of four dimensions). I must give my patients the opportunity to tell me about their circumstance as they know it and have experienced it in order for me to properly comprehend their pain. Due to the fact that the patient can only really be known via sharing their narrative, my job in this therapeutic encounter will be to be totally alert and open. I can use open-ended, inviting inquiries that are tailored to the patient to invite and encourage them. For instance, inquiries like "Tell me about your vomiting" and "Tell me what this is like for you" may be relevant for the patient who was the subject of the consultation [8].The depth of this aspect of being human initially made me feel a little insecure and uncomfortable because, as interns, we were taught to ask these kinds of questions. I was aware of the intimate territory these questions referred to, and I remember being a little uncomfortable because I felt I had to open myself to this depth inside of me. I was fortunate to be an intriguing intern, though. We would jokingly and securely experiment with these questions between us, disclosing and exploring this region in both ourselves and each other. For example, we might ask, "Tell us more about it," when one of us appeared fatigued on Monday morning and stated, "Ooh, I'm so tired." This was first meant as a joke, but after a year, we grew accustomed to accepting each other's stories and paying attention to their life stories. Additionally, we discovered through conversations with our patients that rather than taking a short cut and advancing the conversation a little bit faster with information from questionnaires and categorizing questions, asking these open-ended questions and being a little patient may make a significant difference in assisting the patients in disclosing as much of the entirety of their narrative as possible and letting them know that they have been heard. The latter may even give patients the impression that they were unable to accurately tell their narrative and that a course of therapy was likely suggested based on this misleading depiction. The patient's narrative, which we should respect in the way it is shared with us, whether coherent or not, whether perplexing, inconsistent, or upsetting or not, differs greatly from taking a medical history; it is the distinction between the disease, the symptoms and signs, and the patient [9,10].

The idea of the clinical encounter's integrity is related to the "wholeness" of the patient's story. Both (1) "the characteristic of being entire and complete" and (2) "the quality of being honest and having principles" are definitions of integrity. This integrity of the professional interaction implies that I will discuss medical, ethical, and spiritual problems with the patient. The patient's story and our request to elaborate on topics that are significant to them should flow smoothly from one to the next. From this free-flowing discourse, the patient's most pressing needs-including spiritual wants and issues-will manifest. Most medical professionals are aware that a full consultation with a patient will involve medical knowledge and information, the patient's spiritual understanding and appreciation of the current situation, and ethical decisions and considerations; one always entails the others because they are not separate. For example, in the case of the young woman who was seen in the consultation, the discussion can and must move effortlessly, understandably, and simultaneously between the abdomen's MRI results, the potential for a shortened lifespan, the tapping of the ascites fluid, the significance of losing her children, the obligations she feels to herself and her family, decisions about medication that might make her more sleepy, and sources of support like her husband and her sage.

Multidisciplinary cooperation and training are important

Being specialists in one area, in my instance the medical, but generalists in other areas and dimensions, how can we as doctors establish a clinical language that goes naturally between all the varied inquiries and requirements of the patient? For the majority of us, it will begin as a "internal" pidgin in which we have our roots in our own professional (and personal) vocabulary and take elements of languages from other disciplines, like ethics, social work, psychology, and spirituality, to develop a language that gradually entails more and more aspects. My clinical vocabulary is anchored on the terms used in geriatric and palliative care to describe and discuss symptoms, methods for managing them, and ethical issues. Health care chaplains and colleagues from other professional disciplines may provide inspiration as we work to broaden and improve our clinical vocabulary. Social workers, for example, have helped me understand what it means to be in "total pain" by demonstrating how financial hardships and interpersonal difficulties may affect how the patient feels pain or nausea, and the chaplain has stressed the value of paying attention to the patient's use of proverbs and sayings and exploring their meaning, such as "When I heard the diagnosis, my heart stopped," anticipating grief, and, of course, welcoming the patient.

In order to help patients and their carers, a team approach is encouraged under the WHO definition of palliative care. When

we have the chance to work together with colleagues from other professional disciplines, and when those colleagues greet a patient with a similar openness, it gives us the chance to have an even more thorough and comprehensive understanding of the patient during an interdisciplinary encounter. A referral to a spiritual care professional and assistance from a health care chaplain, a qualified psychologist, or social worker should be taken into consideration when this understanding reveals that a patient has spiritual needs. In addition, coworkers at a team meeting like this could encourage one another to improve your own clinical language.

Discussion

I see myself as a generalist when it comes to spiritual concerns because I have a medical training that is primarily somatic. A team member who is a health care chaplain may serve as an important source of inspiration for the development of our own clinical language and our ability to specifically "thread" consideration of spiritual matters into our knowledge of the patient. We observe a hopeful and comprehensible growth because it is challenging to discriminate between spiritual and psycho-social needs: In recent years, psychologists, psychiatrists, and medical social workers have also developed interventions to support/treat patients, such as Meaning Centred Therapy [11], CALM [12], and Dignity Therapy [13]. It would be fascinating to monitor the best practices in how different disciplines succeed in partnership to meet patients' most fundamental needs. The Dutch guideline Spiritual Care in Palliative Care 2018 empowers collaboration between the chaplains and the psycho-social specialists. International curricula are also created, such the three-day Interprofessional Train-the-Trainer Spiritual Care Education Curriculum course offered by the George Washington Center for Spirituality and Health. These training programmes are designed to introduce and encourage interprofessional collaboration in palliative care for patients from all professional disciplines, in order to address their requirements including their spiritual needs [14-20]. In addition to focusing on the formation of an open and listening attitude and developing communication skills regarding spiritual themes, the programme strikes a balance between knowledge of spirituality and spiritual care.

Conclusion

In palliative care, analytical and holistic techniques are utilised to evaluate the patient's suffering, including their spiritual anguish. A holistic approach suggests the difficulty of creating a personal therapeutic language that will allow us to accept and encourage patients to share their own narratives as they are aware of them and to be alert to emerging concerns and patient needs, including spiritual needs. In our efforts to develop this clinical language, which is the bearer of our witnessing the patient's suffering and discussing the support that as closely as possible matches the patient's needs, self-reflection, high-level interdisciplinary collaboration, and specific training in interdisciplinary collaboration may be helpful.

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Note applicable.

Conflict of Interest

Author declares no conflict of interest

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