June 2011 Article of the Month

This month's article was proposed by Fr. Henry Heffernan.
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Balboni, T., Balboni, M., Paulk, M. E., Phelps, A., Wright, A., Peteet, J., Block, S., Lathan, C., VanderWeele, T., and Prigerson, H. "**Support of cancer patients' spiritual needs and associations with medical care costs at the end of life**." *Cancer* 117, no. 23 (December 1, 2011): 5383-5391.

SUMMARY and COMMENT: Over the past several years, a group of researchers based largely out of the Dana-Farber Cancer Center (Boston, MA) has produced an impressive string of studies indicating the importance of spirituality for cancer patients' care near the end of life. Two of these studies have already been featured as Articles-of-the-Month (April 2009 and January 2010). This month's article builds upon that previous work and ventures a dollar assessment of differences in end-of-life care costs when patients do and do not feel spiritually supported by the health care team.

The authors' key findings are as follows:

> This study demonstrates that advanced cancer patients who report that their religious/spiritual needs are insufficiently supported by the health care team have increased medical costs in the final week of life. EOL costs among advanced cancer patients reporting low support of their religious/spiritual needs by the health care team were $2441 more on average as compared with those who reported themselves well supported. Notably, low religious/spiritual support among racial/ethnic minority patients and high religious coping patients was associated with greater cost differences in the last week of life, on average $4206 more among minorities and $4060 more among high religious coping patients. These findings are robust considering adjustment for multiple potential confounding factors such as EOL discussions and geographic location. [p. 5388]

The data are from a sample of 339 advanced cancer patients from seven major outpatient clinics in Massachusetts, New Hampshire, Connecticut, and Texas; out of a total of 920 eligible patients approached between September 1, 2002 and August 31, 2007. Participants completed an assessment upon enrollment, and within three weeks after the patient's death medical records were reviewed and a caregiver who was present during the last week of the patient's life was interviewed. Measures included the patients' rating of the "the degree to which their spiritual needs were met by the health care team" [p. 5384] and patients' self-report of positive and negative religious coping (via the Brief RCOPE measure), quality of Life, existential well-being, and social support (via the McGill Quality of Life questionnaire), as well as information about physician relationship and discussion of end-of-life care and Advance Directives. Postmortem chart reviews included referral to hospice, days in the Intensive Care Unit (with and without a ventilator), and receipt of resuscitation

or chemotherapy in the last week of life. Results showed that "patients reporting that their religious/spiritual needs were poorly supported were less likely to receive a week or more of hospice care and were more likely to die in an ICU, with the impact being greatest among racial/ethnic minority and high religious coping patients" [p. 5387].

It is important to note that patients' assessment of spiritual support does *not* distinguish support from chaplains per se but rather refers to perceived support from the whole care team. However, a previous study by these same researchers is cited concerning this limitation: "...patients' ratings of support of their religious/spiritual needs [in the earlier study] are significantly associated with receiving pastoral care visits, ...suggesting that pastoral care is a key aspect of spiritual care" [p. 5389]. That earlier study, by the way, did not find that pastoral visits alone predicted EOL medical care. More research is obviously needed to assess the impact of chaplains in particular, perhaps examining their role both in direct pastoral visitation and in supporting and guiding the whole multidisciplinary team in the spiritual care of patients at the end of life.

Further regarding costs and potential savings, the authors extrapolate their findings to the wider context of health care in the US:

> The implications of the provision of spiritual care to dying patients are noteworthy given that it represents higher quality EOL care that, despite its presence in national care quality standards, frequently remains absent at the EOL. The projected economic impact is approximately $1.4 billion ($2441 x 562,340 annual cancer deaths) for care delivered in the last week of life, or approximately 1.5% of direct cancer costs per year ($1.3 billion of $93.2 billion). Furthermore, this study's cost estimates only comprise cancer care in the last week of life; spiritual care could result in greater cost implications if other EOL clinical settings were included and examined over a longer time period. Whereas some hypothesize that ample supply of aggressive technologies creates unnecessary demand, our study suggests that medical demand is impacted by medical system engagement of underlying psychosocial issues that mediate EOL decision making. [p. 5389]

And as to mechanisms by which spiritual care may affect EOL care:

> Potential causal mechanisms include facilitating resolution of spiritual needs and distress that would otherwise result in more aggressive and QOL-compromising care. Recognition of patients' religion/spirituality as part of EOL care may also assist patients in transitioning away from a focus on extending life to a focus on spiritual priorities at the EOL, such as finding spiritual peace--a factor of primary importance to patients facing death that is associated with less aggressive care at EOL. Involving patients' religion/spirituality in medical decision making may assist patients in recognizing less aggressive EOL care options that remain consistent with their religious/spiritual beliefs. [pp. 5388-5389]

Any attempt to discern the relationship between spiritual care and medical expenses is risky, because it pairs the *fuzziness* of spirituality with the controversial subject of health care economics. This study concerns just one subset of patients, does not break out chaplains as care providers, and assesses patients' sense of spiritual support only in the baseline interview; but it nevertheless thoughtfully establishes some basic figures against which future data may be compared as research continues. The authors line out well their methodology, present several very clear tables to illustrate results, and provide a thorough bibliography.

For chaplains in the US, this work offers an intriguing quantification of the effect of spiritual support. [See also: Related Items of Interest §III and subsequent NOTE (below).] As such, it surely plays into chaplains' arguments that spiritual care is -- in addition to being a good idea on the basis of principle and valuable for patients' well-being -- potentially advantageous to hospitals focused on their bottom line. However, arguments about the costs and benefits of spiritual care need not be simply utilitarian, and chaplains usually bristle at the thought of an instrumental view of spirituality. What the authors here conclude isn't that spiritual care is a means to suppress expenses but that it may help in "avoiding" futile and unnecessarily aggressive treatments [see p. 5389]. If spiritual care is conceived first and foremost as an essential element in the optimal care of patients, then the

issue isn't about justifying the cost of spiritual care but realizing the various costs that may follow from its *absence*.

Suggestions for the Use of the Article for Discussion in CPE:

What do students think about any association of spiritual support with medical cost savings? What might be the attraction of such a line of thought, and how might it be problematic? While this study does not evaluate chaplains in particular, how do students feel that their work could affect reductions in excessive end-of-life treatment and/or transitions to hospice? Do chaplains ever feel pressed to pursue such outcomes as an agenda for their pastoral interaction? Also, what are the various ways that patients might feel spiritually supported by the *care team* as a whole, and what roles might a chaplain play as part of the team (e.g., improving referral processes or encouraging and guiding other providers in offering spiritual support), in addition to direct patient interaction. Finally, since the article notes that spiritual care by the medical team is "culturally competent care mandated by national guidelines" [p. 5388], students might want read and discuss the report of the National Consensus Project for Quality Palliative Care [--see: Related Items of Interest §I (below)].

Related Items of Interest:

I. This month's article references the report of the National Consensus Project for Quality Palliative Care (www.nationalconsensusproject.org). The report mentions spirituality throughout, but see specially the section on "Spiritual, Religious and Existential Aspects of Care," on p. 49 of the *Clinical Practice Guidelines for Quality Palliative Care*.

II. Other recent articles by members of the team who produced our featured study:

> Alcorn, S. R., Balboni, M. J., Prigerson, H. G., Reynolds, A., Phelps, A. C., Wright, A. A., Block, S. D., Peteet, J. R., Kachnic, L. A. and Balboni, T. A "**"If God wanted me yesterday, I wouldn't be here today': religious and spiritual themes in patients' experiences of advanced cancer**." *Journal of Palliative Medicine* 13, no. 5 (May 2010): 581-588. [(Abstract:) This study sought to inductively derive core themes of religion and/or spirituality (R/S) active in patients' experiences of advanced cancer to inform the development of spiritual care interventions in the terminally ill cancer setting. METHODS: This is a multisite, cross-sectional, mixed-methods study of randomly-selected patients with advanced cancer (n = 68). Scripted interviews assessed the role of R/S and R/S concerns encountered in the advanced cancer experience. Qualitative and quantitative data were analyzed. Theme extraction was performed with interdisciplinary input (sociology of religion, medicine, theology), utilizing grounded theory. Spearman correlations determined the degree of association between R/S themes. Predictors of R/S concerns were assessed using linear regression and analysis of variance. RESULTS: Most participants (n = 53, 78%) stated that R/S had been important to the cancer experience. In descriptions of how R/S was related to the cancer experience, five primary R/S themes emerged: coping, practices, beliefs, transformation, and community. Most interviews (75%) contained two or more R/S themes, with 45% mentioning three or more R/S themes. Multiple significant subtheme interrelationships were noted between the primary R/S themes. Most participants (85%) identified 1 or more R/S concerns, with types of R/S concerns spanning the five R/S themes. Younger, more religious, and more spiritual patients identified R/S concerns more frequently (beta = -0.11, $p < 0.001$; beta = 0.83, $p = 0.03$; and beta = 0.89, $p = 0.04$, respectively). CONCLUSIONS: R/S plays a variety of important and inter-related

roles for most advanced cancer patients. Future research is needed to determine how spiritual care can incorporate these five themes and address R/S concerns.]

Balboni, M. J., Babar, A., Dillinger, J., Phelps, A. C., George, E., Block, S. D., Kachnic, L., Hunt, J., Peteet, J., Prigerson, H, G., Vanderweele, T. J. and Balboni, T. A. "**'It depends': viewpoints of patients, physicians, and nurses on patient-practitioner prayer in the setting of advanced cancer**." *Journal of Pain & Symptom Management* 41, no. 5 (May 2011): 836-847. [(Abstract:) CONTEXT: Although prayer potentially serves as an important practice in offering religious/spiritual support, its role in the clinical setting remains disputed. Few data exist to guide the role of patient-practitioner prayer in the setting of advanced illness. OBJECTIVES: To inform the role of prayer in the setting of life-threatening illness, this study used mixed quantitative-qualitative methods to describe the viewpoints expressed by patients with advanced cancer, oncology nurses, and oncology physicians concerning the appropriateness of clinician prayer. METHODS: This is a cross-sectional, multisite, mixed-methods study of advanced cancer patients (n=70), oncology physicians (n=206), and oncology nurses (n=115). Semistructured interviews were used to assess respondents' attitudes toward the appropriate role of prayer in the context of advanced cancer. Theme extraction was performed based on interdisciplinary input using grounded theory. RESULTS: Most advanced cancer patients (71%), nurses (83%), and physicians (65%) reported that patient-initiated patient-practitioner prayer was at least occasionally appropriate. Furthermore, clinician prayer was viewed as at least occasionally appropriate by the majority of patients (64%), nurses (76%), and physicians (59%). Of those patients who could envision themselves asking their physician or nurse for prayer (61%), 86% would find this form of prayer spiritually supportive. Most patients (80%) viewed practitioner-initiated prayer as spiritually supportive. Open-ended responses regarding the appropriateness of patient-practitioner prayer in the advanced cancer setting revealed six themes shaping respondents' viewpoints: necessary conditions for prayer, potential benefits of prayer, critical attitudes toward prayer, positive attitudes toward prayer, potential negative consequences of prayer, and prayer alternatives. CONCLUSION: Most patients and practitioners view patient-practitioner prayer as at least occasionally appropriate in the advanced cancer setting, and most patients view prayer as spiritually supportive. However, the appropriateness of patient-practitioner prayer is case specific, requiring consideration of multiple factors.]

Balboni, T. A, Paulk, M. E., Balboni, M. J., Phelps, A. C., Loggers, E. T., Wright, A. A., Block, S. D., Lewis, E. F., Peteet, J. R. and Prigerson, H. G. "**Provision of spiritual care to patients with advanced cancer: associations with medical care and quality of life near death**." *Journal of Clinical Oncology*, 28, no. 3 (January 20, 2010): 445-452. [See the January 2010 Article-of-the-Month.]

Balboni, T. A., Vanderwerker, L. C., Block, S. D., Paulk, M. E., Lathan, C. S., Peteet, J. R. and Prigerson, H. G. "**Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life**." *Journal of Clinical Oncology* 25, no. 5 (February 10, 2007): 555-560. [(From the abstract): Nearly half (47% [of 230 participants]) reported that their spiritual needs were minimally or not at all supported by a religious community, and 72% reported that their spiritual needs were supported minimally or not at all by the medical system.]

Phelps, A. C., Maciejewski, P. K., Nilsson, M., Balboni, T. A., Wright, A. A., Paulk, E. M., Trice, E., Schrag, D., Peteet, J. R., Block, S. D. and Prigerson, H. G. "**Religious coping and use of intensive life-prolonging care near death in patients with advanced cancer**." *JAMA* 301, no. 11 (March 18, 2009): 1140-1147. [See the April 2009 Article-of-the-Month.]

III. The argument from published literature for the cost effectiveness of hospital chaplains continues to be an indirect one, based either upon the assumption that chaplains can be a key link or catalyst for the widely

evidenced benefits of spirituality to health or upon a calculation of the very modest cost of chaplains in light of an overall sense of their potential value to an organization (e.g., patient satisfaction). For some examples, see:

> Marek, D. V. "**How much does it cost for chaplain services?**" *Vision Magazine (National Association of Catholic Chaplains)* 15, no. 7 (July 2005): n.p. Reprinted online as a "most requested article" at www.nacc.org/vision/most-requested/how-much-does-it-cost-for-chaplain-services. [This article is notable in comparison to VandeCreek, & Lyon's 1994-1995 estimate (see citation below). Marek, Director of Chaplain Services at the Mayo Clinic in Rochester, MN, took the approach of itemizing costs for chaplains' Units of Work for anticipated death ($81.64), death ($102.05), pastoral contact ($20.41), and spiritual care ($61.23).]
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> Newell, C. and Carey, L. B. "**Economic rationalism and the cost efficiency of hospital chaplaincy: an Australian study**." *Journal of Health Care Chaplaincy* 10, no. 1 (2000): 37-52. [This article from Australia states, "The values and perspectives of hospital chaplains stand in stark contrast to current economic rationalism" (p. 39), but the authors go on to make a case for the value of chaplains to hospitals. Data are offered regarding how health care staff consider a chaplain's contribution to services of "great importance" (p. 40), how chaplains may play into the care of liver transplant patients (pp. 41-42), and how chaplains themselves see their professional work as cost efficient to institutions (pp. 47-50).]
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> VandeCreek, L. and Burton, L. "**Professional chaplaincy: its role and importance in healthcare**." *Journal of Pastoral Care* 55, no. 1 (Spring 2001): 81-97. [This "White Paper" contains a section on The Benefits of Spiritual Care Provided by Professional Chaplains, citing both research and broad argument. The article is available online.]
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> VandeCreek, L. and Lyon, M. "**The general hospital chaplain's ministry: analysis of productivity, quality and cost**." *The Caregiver Journal (Journal of the College of Chaplains)* 11, no. 2 (1994/1995), 3-13. [The authors estimate the services of professional chaplains ranged between $2.71 and $6.43 per patient visit. Though now obviously dated, the data are worth considering as a serious attempt to quantify the comparatively small cost of chaplaincy services.]

NOTE: Regarding the cost savings benefit of hospital chaplains in particular, the following is often cited: Bliss, J. R., McSherry, E., and Fassett, J., "Chaplain intervention reduces costs in major DRGs: an experimental study," in Hefferman, H., McSherry, E. and Fittgerald, R. (eds), *Proceedings of the NIH Clinical Center Conference on Spirituality and Health Care Outcomes*, March 21, 1995. Findings from this research seem to have been distributed widely on September 20, 1996, through a report by Terese Hudson Thrallon on the Hospitals and Health Network's website for the *HHN Magazine*, titled "Measuring the results of faith":

> ...a 30-month study tracking 700 cardiac patients at a Veterans Affairs Hospital in Brockton, Mass., completed in 1993. Those in the group who received daily chaplain visits on average left the hospital three days earlier than those who saw the chaplain only for a few minutes during their stays. Study author Elisabeth McSherry, M.D., estimates savings of up to $4,000 per patient while the pastoral visits cost only $100 per patient.

The study was then cited in: Koenig, H. G., Larson, D. B. and Weaver, A. J., "Research on religion and serious mental illness," pp. 81-95 in Fallot, R. D., ed., *Spirituality and Religion in Recovery from Mental Illness* (no. 80, Winter 1998, of *New Directions for Mental Health Services*, ed. by Lamb, H. R., for the Jossey-Bass Psychology Series), Jossey-Bass, Inc., 1998; and given the following summary:

> Bliss, McSherry, and Fassett (1995) randomized 133 open-heart surgery patients to either a chaplain intervention (Modern Chaplain Care) or Usual Care group. Patients in the intervention group had an average post-op hospitalization that was two days shorter, resulting in an overall cost of savings $4,200 per patient. [pp. 88-89]

This report and citation by Koenig, Larson and Weaver was reiterated in the highly influential *Handbook of Religion and Health*, by Koenig, H. G., McCullough M. E. and Larson, D. B. (Oxford University Press, 2001), pp. 420-421.

However, in spite of these citations, the study by Bliss, McSherry and Fassett was never actually published, nor apparently were any formal proceedings published of the 1995 meeting at which Dr. McSherry made an oral presentation. The popularized details of the study seem to have come from individual recollections and notes of meeting attendees. In a personal communication (with John Ehman, 3/16/05), Dr. McSherry indicated that she believed the original data were valid and relevant but that final analysis and publication had been delayed for a variety of reasons, with the project eventually becoming sidelined. It should be noted that in the 1980s, Dr. McSherry was one of the early and strong voices for the economic importance of chaplains: for example, McSherry, E., "Economic impact of chaplaincy on the hospital environment," *The Caregiver Journal (Journal of the College of Chaplains)* 4, no 1 (August 1987): 28-43; in which she offers data from her own work and from others, concluding, "So, whenever it has been carefully studied, chaplaincy has been shown to have significant favorable impact on hospital economics" [p. 34].
