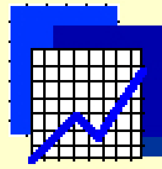

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October 2017 Articles of the Month

This month's article selection is highlighted by John Ehman,
University of Pennsylvania Medical Center-Penn Presbyterian, Philadelphia PA.

Steinhauser, K. E. and Balboni, T. A. "**State of the Science of Spirituality and Palliative Care Research: Research Landscape and Future Directions**." *Journal of Pain and Symptom Management* 53, no. 3 (September 2017): 426-427.

Steinhauser, K. E., Fitchett, G., Handzo, G. F., Johnson, K. S., Koenig, H. G., Pargament, K. I., Puchalski, C. M., Sinclair, S., Taylor, E. J. and Balboni, T. A. "**State of the Science of Spirituality and Palliative Care Research Part I: Definitions, Measurement, and Outcomes**." *Journal of Pain and Symptom Management* 53, no. 3 (September 2017): 428-440.

Balboni, T. A., Fitchett, G., Handzo, G. F., Johnson, K. S., Koenig, H. G., Pargament, K. I., Puchalski, C. M., Sinclair, S., Taylor, E. J. and Steinhauser, K. E. "**State of the Science of Spirituality and Palliative Care Research Part II: Screening, Assessment, and Interventions**." *Journal of Pain and Symptom Management* 53, no. 3 (September 2017): 441-453.

SUMMARY and COMMENT: This two-part review (plus an introduction) by leaders in the field of spirituality research grew from a conference on the "State of the Science in Spirituality and Palliative Care Research," held at Duke Integrative Medicine (Durham, NC) and supported by the National Palliative Care Research Center [--see Related Items of Interest, §VII, below], September 30 - October 1, 2014; though the articles' bibliographies show that the authors were updating their content well into the fall of 2016. The currency, breadth, concision, and practicality of these articles make them recommended reading for all chaplains, not just for those working in palliative care and research. The review should resonate with every chaplain contending with questions about assessment, standards of spiritual care, and effectiveness. For researchers in particular, Karen E. Steinhauser and Tracy A. Balboni, who co-led the conference, state in their introductory piece:

> ...[R]esearch in the field of spirituality and palliative care is at a critical juncture. ...[R]esearch priorities are identified as critical next steps to further our understanding of the role of spirituality in the experience of serious illness. They are underscored by clear extant evidence of the potential for spirituality research to transform palliative care provision and outcomes for patients and families. [--"Research Landscape and Future Directions," p. 426]

The following overview, arranged according to the articles' structure, is intended to give a general sense of this rich contribution to the literature.

Part I (Steinhauser, et al.):

Definitions --

A foundational problem:

> In the palliative care literature, spirituality often is operationalized with a single item that serves overarching reference to dimensions of spirituality as diverse spiritual or religious beliefs, rituals and practices, coping, distress, relationship with the transcendent, sense of meaning, or life purpose. The lack of definition and taxonomy inhibits clear study design, increases potential for confounding constructs, and impedes independent investigations from systematically informing one another. [p. 429]

After reviewing the evolving definitions of *spirituality* and *religion* and citing work done to bring about consensus [pp. 429-430; and see Related Items of Interest, §II, below], the authors note that there are "mixed and sometimes competing goals of defining spirituality for clinical and research contexts" [p. 430].

> In a clinical setting, the goal is to honor individuality, promote conversations, capture the breadth of experience of spirituality, and emphasize similarities rather than distinctions. In clinical care, constructs may overlap with other constructs; for example, spiritual and emotional concerns are often related, and conversation of one elicits expression of another. However, language that is useful in clinical settings may have less applicability in research settings where discriminative abilities of measurement are necessary. In a research context, operational definitions must be unambiguous, and constructs must be distinct and unique. [p. 430]

Key features of this review are concise tables summarizing analyses and recommendations. A table of Research Priorities in Spirituality and Palliative Care [Table 3, p. 437] addresses the issue of Definitions and Taxonomy, highlighting the need to define spirituality in terms of the context of application (clinical vs. research) and to focus on unique qualities and core attributes, with an eye toward how the dimensions of spirituality could be measured in a specific research context. Other tables provide summaries of Empirically-Derived Dimensions of Religion and Spirituality in Serious Illness [Table 1, p. 432] and a Preliminary Set of Core Dimensions of Religion and Spirituality in Palliative Care [Table 2, p. 433]. The basic question of conceptualization is then dovetailed with that of measurement.

Measurement --

A strategy for approaching measurement and overall methodology is outlined according to five points:

1. "Identify the purpose of the investigation and establish whether the goal is to conduct a clinical assessment (e.g., screening), research (e.g., focused on observational description or comparison), quality improvement (e.g., to refine a clinical process), or accountability (e.g., tracking patient satisfaction for organizational accountability)" [p. 431]

2. "Specify a conceptual model" --connecting *a priori*-identified dimensions to be assessed and their hypothesized relationships to outcomes, and taking into account moderation, mediation, and mechanisms affecting outcomes. The authors emphasize the potential usefulness of developments in the field of the social scientific study of religion, which "include major theoretical advances integrating spirituality into attachment theory, meaning-making theory, coping theory, and self-regulation theory..." [p. 431].

3. "Identify the specific dimensions to be assessed, based on the conceptual model" [p. 431] --concentrating on the most salient dimensions at play. A table [p. 432] gives six lists of dimensions. In addition, since "there remains a lack of clarity regarding what dimensions should be included in spirituality and palliative care research," the authors suggest "preliminary core dimensions...investigators may wish to consider" [pp. 431-432, and see Table 2 on p. 433].

4. "Select relevant measures of those dimensions" [p. 432] --favoring multi-dimensional instruments that may work across culturally diverse populations. The authors give guidance for drawing upon measures that have been used in other settings and stress a collaborative process for new tool development.

5. "Consider potential confounding constructs" [p. 432] --watching for how "confounding relationships between independent variables and dependent outcomes... [may come from] a lack of clarity about the content and construct validity of many existing measures" [p. 432]. An example is given of spirituality measures whose items overlap with constructs of positive mental states.

Outcomes --

The first article of this two-part review closes with a look at evidence of the relationship between spirituality and palliative care outcomes, "describ[ing] foundational work while also naming research gaps that inform research priorities" [p. 433]. Two figures [--see pp. 434 and 436] cleverly show relationships between patient/family spiritual domains and outcomes, and they reference the involved studies and characterize their methodology. Chaplains may be especially interested in the authors' review of the "few studies examin[ing] the impact of spiritual care provision (e.g., chaplains, medical teams, faith communities) on patient/family outcomes" [p. 435].

While more research is needed on all fronts, the existing studies fairly strongly suggest...

> ...an association between spirituality and QOL (for patients and family caregivers), and patient medical decision making and care, with a potential role in disparities in EOL medical care for certain racial/ethnic groups. They also suggest spiritual care influences patient QOL, informs medical decision making and care at the EOL, and promotes culturally and spiritually sensitive care, particularly for groups in which spirituality plays a prominent role. [p. 436]

Significantly, regarding the relationship between spirituality and patient survival, the authors hold that the data "are too limited to draw conclusions" [p. 436]. They recommend "particular lines of research for future investigation" [--see esp. pp. 436-437 and Table 3, p. 437], in order to firm up the foundation for spiritual screening, assessment, interventions, and education.

Part II (Balboni, et al.):

Screening, History-Taking, and Assessment --

Part II of the review begins with the statement that "[k]nowledge regarding how spiritual domains influence outcomes, even if elevated in rigor and depth, is fruitless without research that informs application to the care of seriously ill patients and families" [p. 442]. Hence, the practical question: How do we assess for spirituality?

The authors distinguish the functional goals of three actions and their related tools: *spiritual screening* ("...evaluat[ing] the presence or absence of spiritual needs and/or distress with the goal of identifying those in need of further spiritual assessment and care" [p. 442]), *spiritual history-taking* ("us[ing] a broad set of questions to capture a patient's spiritual characteristics, resources, and

needs [and] typically conducted within an initial, comprehensive evaluation by a clinician" [p. 442]), and *spiritual assessment* (as "an in-depth, on-going process of evaluating a patient's spiritual needs and resources completed by chaplains or other individuals possessing advanced training in spiritual care" [p. 444]). Two tables ground this section of the review: one sets out a straightforward comparison of the three types, and the other gives a quite full list of tools with their constituent domains [pp. 442 and 443-444]. Regarding spiritual assessment in particular, the authors underscore a couple of tools: the Spiritual Distress Assessment Tool (SDAT) and the Grupo de Espiritualidad de la SECPAL (GED) questionnaire, as "mak[ing] significant advances by quantifying spiritual assessment, having established psychometric properties, and using language that is inclusive and actionable" [p. 444]; and they comment on research priorities for further tool development and refinement.

Interventions --

Surveying categories of spiritual interventions -- i.e., Psychotherapeutic, Life Review, Mind-Body, and those that operate through the dynamics of a Multidisciplinary Team -- the authors observe a widespread problem of a "lack of conceptual clarity regarding what constitutes spirituality" and the fact that "many studies lacked a conceptual model of how the spiritual intervention is hypothesized to be related to the outcome(s)" [p. 448], harkening back to themes in Part I of our review. Once again, a content-rich table is provided to summarize research priorities in this area [--see Table 4, p. 448]. One recommendation not included explicitly in that table, however, is that of translating interventions developed for post-traumatic stress disorder, when they already may include a spiritual component, for use in palliative care [--see p. 447].

Of special interest to chaplains is a section here on *chaplaincy care*. The authors point out that chaplaincy research has to date not accumulated sufficient evidence to guide practice, "but four important themes are emerging from research on chaplaincy care in the palliative care setting": "patient and/or family needs for chaplaincy care in serious illness," "the distribution and function of chaplains in the hospital setting," "what chaplains do," and "outcomes associated with chaplaincy care" [p. 445].

> Chaplaincy research is in its infancy, with limited data suggesting: needs for chaplaincy care are frequent in palliative settings; chaplain resources vary across and are often limited in hospital settings; chaplains play key roles in hospitals in providing EOL support to patients and families; they perform a diversity of interventions to patients and families; needs for chaplaincy care are primarily assessed by nursing; and chaplaincy care is associated with greater patient and/or family care satisfaction. [p. 445]

To bolster and expand this evidence,

> Studies are needed among patients, families, and palliative care staff that identify 1) key resources and needs for spiritual care, 2) critical content of chaplaincy spiritual care in serious illness, and 3) how specific chaplaincy care influences outcomes. [p. 445]

Research priorities for chaplains are additionally listed in Table 3, p. 448.

Training Healthcare Professionals --

The final area of this review covers education: How do we train healthcare professionals to address spirituality in palliative care? The authors recall recommendations from the 2009 Spiritual Care Consensus Conference (mentioned above) but acknowledge that "spiritual care in the palliative care setting remains infrequent" [p. 449]. Barriers to progress in this area include "a dearth of evidence-based development of curricula to train in the identified spiritual care competency areas,

> as well as the lack of standardized methods of assessing those competencies" [p. 449]. "Although clear strides have been made in spirituality education in the medical school setting, such training in the post medical school setting is limited" [p. 449], and "[s]piritual care interdisciplinary roles and skill sets (e.g., clinical care providers, social workers) need to be defined to guide training for varying specialties" [p. 449].

For this reader, the section on training other healthcare professionals seems one in which ACPE members could contribute based upon our special vantage on the intersection between spiritual caregiving and education. As research is increasingly used to develop the ACPE's own educational process, it may enlighten pathways and programs for non-chaplains as well. Also, here as in all areas of spirituality & health research, chaplains may bring practical and theoretical insight to the tasks of conceptual clarification and validation for studies and of the potential connection of theory and research to bedside practice. While the theme of the review is palliative care, the analysis offers useful guidance for chaplains working in many contexts. In fact, this review might best be read not all at once but rather one section at a time over an extended period -- to allow "space" to contemplate how the many points and suggestions made in the text and tables relate to one's own individual clinical work and/or research interests. Carefully taking in these articles will help chaplains get a bearing on just how much of their practice can rest currently on research and how much should continue to proceed largely from non-empirical bases.

Suggestions for Use of the Articles for Student Discussion:

The content density of these review articles might call for a special strategy for use with CPE groups. Instead of reading and discussing them in a single sitting, they could be covered a section or sub-section at a time over 6-10 sessions integrated with other group activities during an academic unit. In each session, the basic questions to be discussed could be: 1) What does the literature suggest? 2) What are the weaknesses and gaps in the literature? 3) What is the relevance of the authors' points to your work? and 4) What issues does this review make you want to explore further? An overarching question that could be considered periodically is: How are you seeing research itself an important aspect of chaplaincy? The section on *Chaplaincy Care* [p. 445] might warrant special attention, and students could be asked which of the four identified themes are of greatest interest to them. After finishing the article, the group could be asked what *outcomes* students would like to see from their pastoral work, then they could think back from that point to consider how such outcomes might be brought about, by what mechanisms and interventions, according to what conceptualizations, and by what means of measurement. In this way, the group might move back through the topics of the articles from the end to the beginning to explore the interrelation of the various sections of the review.

Related Items of Interest:

I. Also just published in the past month is the following review of chaplaincy-related research, which includes a section on Spiritual Needs and Chaplain Care in Palliative and End of Life Care [pp. 168-169, but see additional mention of studies on pp. 164, 167, and 170].

> Fitchett, G. "**Recent progress in chaplaincy-related research**." *Journal of Pastoral Care and Counseling* 71, no. 3 (September 2017): 163-175. [(Abstract:) In light of the continued growth of chaplaincy-related research this paper presents an overview of important findings. The review summarizes research in six broad areas: what chaplains do; the importance of religion and spiritual care to patients and families; the impact of chaplains' spiritual care on the patient experience; the impact of chaplain care on other patient outcomes; spiritual needs and chaplain care in palliative and end of life care; and chaplain care for staff colleagues. It concludes with a description of

several innovative and important new studies of chaplain care and notes areas for future investigation.]

II. For more on the work to build a consensus on a definition of spirituality in palliative care [--see p. 430 of Part I (Steinhauser, et al.)], our June 2014 Article-of-the-Month features a report from the 2012 International Consensus Conference and notes preceding conferences and related information.

III. Regarding reviews of measures relating to spirituality and palliative care [--see p. 431 of Part I (Steinhauser, et al.)], our featured authors reference several good sources: e.g., Selman, L., Harding, R., Gysels, M., Speck, P. and Higginson, I. J., "**The measurement of spirituality in palliative care and the content of tools validated cross-culturally: a systematic review**," *Journal of Pain and Symptom Management* 41, no. 4 (April 2011): 728-753. One additional review article of possible interest but not referenced here is: Gijsberts, M. J., Echteld. M, A., van der Steen, J. T., Muller, M. T., Otten, R. H., Ribbe, M. W. and Deliens, L., "**Spirituality at the end of life: conceptualization of measurable aspects--a systematic review**," *Journal of Palliative Medicine* 14, no. 7 (2011): 852-863; which was highlighted in our Winter 2012 *Newsletter* (Item #10).

IV. Our Authors state, "To our knowledge, only one study, Coping with Cancer 1, addresses the relationship of patient religious dimensions and actual medical care received at the EOL" [p. 435 of Part I (Steinhauser, et al.)], namely: 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. For more on this important study, see our April 2009 Article-of-the-Month.

V. One of the gaps in research noted in our review is that there are "no studies addressing the role of caregivers' spirituality in medical decision making (e.g., when acting as a surrogate decision maker)" [p. 435 of Part I (Steinhauser, et al.)]. Chaplains are often a witness to -- and involved in -- the dynamics around surrogate decision-making. For more on those dynamics, see our June 2010 Article-of-the-Month.

VI. Among articles pertaining to spirituality and palliative care published *after* the current review was completed:

Aslakson, R. A., Kweku, J., Kinnison, M., Singh, S. and Crowe, T. Y. 2nd for the AAHPM Writing Group. "**Operationalizing the measuring what matters spirituality quality metric in a population of hospitalized, critically ill patients and their family members**." *Journal of Pain & Symptom Management* 53, no. 3 (March 2017): 650-655. [(Abstract:) CONTEXT: Measuring What Matters (MWM) quality indicators support measurement of the percentage of patients who have spiritual discussions, if desired. OBJECTIVES: The objective of this study was to 1) determine the ease of, and barriers to, prospectively collecting MWM spirituality quality measure data and 2) further explore the importance of spirituality in a seriously ill, hospitalized population of critically ill patients and their family members. METHODS: Electronic medical record (EMR) review and cross-sectional survey of intensive care unit (ICU) patients and their family members from October to December 2015. Participants were in four adult ICUs totaling 68 beds at a single academic, urban, tertiary care center which has ICU-assigned chaplains and an in-house, 24-hour, on-call chaplain. RESULTS: All patients had a "Spiritual Risk Screen" which included two questions

identifying patient religion and whether a chaplain visit was desired. Approximately 2/3 of ICU patients were eligible, and there were 144 respondents (50% female; 57% patient and 43% family member), with the majority being Caucasian or African American (68% and 21%, respectively). Common religious identifications were Christian or no faith tradition (76% and 11%, respectively). Approximately half of patients had an EMR chaplain note although it did not document presence of a "spiritual discussion." No study patients received palliative care consultation. A majority (85%) noted that spirituality was "important to them" and that prevalence remained high across respondent age, race, faith tradition, or admitting ICU. CONCLUSION: Operationalizing the MWM spirituality quality indicator was challenging as elements of a "spiritual screening" or documentation of a "spiritual discussion" were not clearly documented in the EMR. The high prevalence of spirituality among respondents validates the importance of spirituality as a potential quality metric.]

Bandini, J. I., Courtwright, A., Zollfrank, A. A., Robinson, E. M., Cadge, W. "**The role of religious beliefs in ethics committee consultations for conflict over life-sustaining treatment**." *Journal of Medical Ethics* 43, no. 6 (June 2017): 353-358. [(Abstract:) Previous research has suggested that individuals who identify as being more religious request more aggressive medical treatment at end of life. These requests may generate disagreement over life-sustaining treatment (LST). Outside of anecdotal observation, however, the actual role of religion in conflict over LST has been underexplored. Because ethics committees are often consulted to help mediate these conflicts, the ethics consultation experience provides a unique context in which to investigate this question. The purpose of this paper was to examine the ways religion was present in cases involving conflict around LST. Using medical records from ethics consultation cases for conflict over LST in one large academic medical centre, we found that religion can be central to conflict over LST but was also present in two additional ways through (1) religious coping, including a belief in miracles and support from a higher power, and (2) chaplaincy visits. In-hospital mortality was not different between patients with religiously versus non-religiously centred conflict. In our retrospective cohort study, religion played a variety of roles and did not lead to increased treatment intensity or prolong time to death. Ethics consultants and healthcare professionals involved in these cases should be cognisant of the complex ways that religion can manifest in conflict over LST.] [This article was featured as our April 2017 Article-of-the-Month.]

Idler, E. L., Grant, G. H., Quest, T., Binney, Z. and Perkins, M. M. "**Practical matters and ultimate concerns, 'doing,' and 'being': a diary study of the chaplain's role in the care of the seriously ill in an urban acute care hospital** ." *Journal for the Scientific Study of Religion* 54, no. 4 (December 2015): 722-738. [Systematic observational studies of the chaplain's role and function in the secular health-care setting are few. With an episode-based diary recorded on handheld digital tablets, palliative care chaplains at a large urban hospital with a diverse patient population recorded details of patient visits in near-real time. Cluster analysis revealed groups of activities we called "doing" and "being," and conversation topics of "practical matters" and "ultimate concerns"; chaplains were most satisfied with visits that involved all of these. Chaplains offer patients and families a space to express significant concerns; however, visits with spiritual or religious activities or topics were relatively rare. Broad quality of life concerns are central to the evolving professional role of chaplains in the secular setting of the modern hospital.] [This article was featured as our June 2016 Article-of-the-Month.]

Jackson-Jordan, E., Stafford, C., Stratton, S, V., Vilagos, T. T., Janssen Keenan, A. and Hathaway, G. "**Evaluation of a chaplain residency program and its partnership with an in-patient palliative care team**." *Journal of Health Care Chaplaincy* (2017): 10pp., published online May 23, 2017, ahead of print. [(Abstract:) In 2009 a Consensus Conference of experts in the field of spiritual care and palliative care recommended the inclusion of Board-certified professional chaplains with at least 1,600 hours of clinical pastoral education as members of palliative care teams. This study evaluates a clinical pastoral education residency program's effectiveness in preparing persons to provide spiritual care for those with serious illness and in increasing the

palliative care team members' understanding of the chaplain as part of the palliative care team. Results showed chaplain residents felt the program prepared them to provide care for those with serious illness. It also showed that chaplain residents and palliative care team members view spirituality as an integral part of palliative care and see the chaplain as the team member to lead that effort. Suggested program improvements include longer palliative care orientation period, more shadowing with palliative care team members, and improved communication between palliative care and the chaplain residents.]

Jeuland, J., Fitchett, G., Schulman-Green, D. and Kapo, J. "**Chaplains working in palliative care: who they are and what they do**." *Journal of Palliative Medicine* 20, no. 5 (May 2017): 502-508. [(Abstract:) BACKGROUND: Palliative care (PC) programs utilize chaplains to address patients' spiritual care needs; however, there is no comprehensive description of chaplaincy in PC programs nationally. OBJECTIVE: To describe chaplains working in PC across the United States, including their integration on the PC team and visit content. DESIGN: National online survey conducted February-April 2015. SUBJECTS: We invited participation from hospital-based chaplains belonging to four national professional chaplain associations who spent 15% or more of their working hours with PC teams. Measure(s): We developed a 41-item survey to investigate main outcomes of chaplain demographics, practice information, integration into the PC team, and visit content. RESULTS: 531 valid responses were received. We report on respondents who were full-time chaplains (n=382). Almost half were women (46%), and the majority was Protestant (70%). The average number of PC patients seen per day was 5.2 (SD=3.5, range 1-30). Half (52%) reported frequently participating in PC rounds. Primary chaplain activities were relationship building (76%), care at the time of death (69%), and helping patients with existential issues or spiritual distress (49%). Over half (55%) reported addressing goals of care 60% of the time or more. DISCUSSION: This survey provides the first description of chaplains working in PC across the United States. We describe chaplains' critical role in attending to relationship building, care for the dying, and goals of care conversations. Our results highlight how the chaplains' level of involvement in PC affects the content of their visits. Our study suggests that when chaplains are more involved in PC teams, they provide more comprehensive support to PC patients and their families.] [This article was featured as our March 2017 Article-of-the-Month.]

Kearney, G., Fischer, L. and Groninger, H. "**Integrating spiritual care into palliative consultation: a case study in expanded practice**." *Journal of Religion & Health* 9pp., published online May 26, 2017, ahead of print. [(Abstract:) Recognizing and addressing spiritual needs has long been identified as a key component of palliative care (PC). More often than not, the provision of spiritual care involves referral to a hospital chaplain. In this study, we aim to describe the role of a PC chaplain embedded within the interdisciplinary PC team and demonstrate how this palliative chaplain role differs from that of a traditional hospital chaplain. We postulate that integrating spiritual care provision into a PC team may offer a broader spiritual care experience for patients receiving PC and begin to delineate expanded clinical roles for the palliative chaplain.]

Kestenbaum, A., Shields, M., James, J., Hocker, W., Morgan, S., Karve, S., Rabow, M. W. and Dunn, L. B. "**What impact do chaplains have? A pilot study of Spiritual AIM for advanced cancer patients in outpatient palliative care**." *Journal of Pain & Symptom Management* (July 21, 2017): published online ahead of print by the journal. [(Abstract:) CONTEXT: Spiritual care is integral to quality palliative care. Although chaplains are uniquely trained to provide spiritual care, studies evaluating chaplains' work in palliative care are scarce. OBJECTIVES: The goals of this pre-post study, conducted among patients with advanced cancer receiving outpatient palliative care, were to evaluate the feasibility and acceptability of chaplain-delivered spiritual care, utilizing the Spiritual Assessment and Intervention Model ("Spiritual AIM"); and to gather pilot data on Spiritual AIM's effects on spiritual well-being, religious and cancer-specific coping, and physical and psychological symptoms. METHODS: Patients with advanced cancer (n=31) who were receiving outpatient palliative care were assigned based on chaplains' and patients' outpatient schedules, to one of three professional chaplains for three individual Spiritual AIM sessions,

conducted over the course of approximately six to eight weeks. Patients completed the following measures at baseline and post-intervention: Edmonton Symptom Assessment Scale (ESAS), Steinhauser spirituality, Brief Religious Coping (Brief RCOPE), Functional Assessment of Chronic Illness Therapy-Spiritual (FACIT-Sp-12), Mini-Mental Adjustment to Cancer (Mini-MAC), Patient Dignity Inventory, Center for Epidemiological Studies - Depression (CES-D, 10-item), and Spielberger State Anxiety Inventory (STAI-S). RESULTS: From baseline to post-Spiritual AIM, significant increases were found on the FACIT-Sp-12 Faith subscale, the Mini-MAC Fighting Spirit subscale, and Mini-MAC Adaptive Coping factor. Two trends were observed, i.e., an increase in Positive religious coping and an increase in Fatalism (a subscale of the Mini-MAC). CONCLUSION: Spiritual AIM, a brief chaplain-led intervention, holds potential to address spiritual needs, as well as religious and general coping in patients with serious illnesses.] [This article was featured as our August 2017 Article-of-the-Month.]

Levine, S., O'Mahony, S., Baron, A., Ansari, A., Deamant, C., Frader, J., Leyva, I., Marschke, M. and Preodor, M. "**Training the workforce: description of a longitudinal interdisciplinary education and mentoring program in palliative care**." *Journal of Pain & Symptom Management* 53, no. 4 (April 2017): 728-737. [(Abstract:) CONTEXT: The rapid increase in demand for palliative care (PC) services has led to concerns regarding workforce shortages and threats to the resiliency of PC teams. OBJECTIVES: To describe the development, implementation, and evaluation of a regional interdisciplinary training program in PC. METHODS: Thirty nurse and physician fellows representing 22 health systems across the Chicago region participated in a two-year PC training program. The curriculum was delivered through multiple conferences, self-directed e-learning, and individualized mentoring by expert local faculty (mentors). Fellows shadowed mentors' clinical practices and received guidance on designing, implementing, and evaluating a practice improvement project to address gaps in PC at their institutions. RESULTS: Enduring, interdisciplinary relationships were built at all levels across health care organizations. Fellows made significant increases in knowledge and self-reported confidence in adult and pediatric PC and program development skills and frequency performing these skills. Fellows and mentors reported high satisfaction with the educational program. CONCLUSION: This interdisciplinary PC training model addressed local workforce issues by increasing the number of clinicians capable of providing PC. Unique features include individualized longitudinal mentoring, interdisciplinary education, on-site project implementation, and local network building. Future research will address the impact of the addition of social work and chaplain trainees to the program.]

Piderman, K. M., Egginton, J. S., Ingram, C., Dose, A. M., Yoder, T. J., Lovejoy, L. A., Swanson, S. W., Hogg, J. T., Lapid, M. I., Jatoi, A., Remtema, M. S., Tata, B. S. and Breitkopf, C. R. "**I'm still me: inspiration and instruction from individuals with brain cancer**." *Journal of Health Care Chaplaincy* 23, no. 1 (January-March 2017): 15-33. [Individuals with brain cancer face many challenges, including threats to cognition, personality, and sensory and motor functioning. These can alter one's sense of identity and result in despair. Chaplain-led spiritual interviews were conducted with 19 patients with brain cancer as part of a larger spiritual legacy intervention called "Hear My Voice." The majority was female (58%), married (68%) and had aggressive/advanced tumors (63%). Participants were 22-68 years of age and expressed the following religious affiliations: Protestant (42%), Catholic (21%), Muslim (5%), and none (32%). Framework analysis was applied to reduce and understand the interview data. Primary codes were relationships with: God or the spiritual, others, and self. Brain cancer was reported to deepen and enrich patients' commitment to these relationships. Struggle and grief were also revealed. Results suggest the continued vitality, growth and generativity of these participants and provide insight for chaplains and others on the medical team.] [This article was featured as our February 2017 Article-of-the-Month.]

van de Geer, J., Groot, M., Andela, R., Leget, C., Prins, J., Vissers, K. and Zock, H. "**Training hospital staff on spiritual care in palliative care influences patient-reported outcomes: results**

of a quasi-experimental study." *Palliative Medicine* 31, no. 8 (September 2017): 743-753. [(Abstract:) BACKGROUND: Spiritual care is reported to be important to palliative patients. There is an increasing need for education in spiritual care. AIM: To measure the effects of a specific spiritual care training on patients' reports of their perceived care and treatment. DESIGN: A pragmatic controlled trial conducted between February 2014 and March 2015. SETTING/PARTICIPANTS: The intervention was a specific spiritual care training implemented by healthcare chaplains to eight multidisciplinary teams in six hospitals on regular wards in which patients resided in both curative and palliative trajectories. In total, 85 patients were included based on the Dutch translation of the Supportive and Palliative Care Indicators Tool. Data were collected in the intervention and control wards pre- and post-training using questionnaires on physical symptoms, spiritual distress, involvement and attitudes (Spiritual Attitude and Involvement List) and on the perceived focus of healthcare professionals on patients' spiritual needs. RESULTS: All 85 patients had high scores on spiritual themes and involvement. Patients reported that attention to their spiritual needs was very important. We found a significant (p=0.008) effect on healthcare professionals' attention to patients' spiritual and existential needs and a significant (p=0.020) effect in favour of patients' sleep. No effect on the spiritual distress of patients or their proxies was found. CONCLUSION: The effects of spiritual care training can be measured using patient-reported outcomes and seemed to indicate a positive effect on the quality of care. Future research should focus on optimizing the spiritual care training to identify the most effective elements and developing strategies to ensure long-term positive effects.]

VII. The National Palliative Care Research Center (NPCRC) is an initiative out of the Department of Geriatrics and Palliative Medicine at the Icahn School of Medicine at Mount Sinai, working in partnership with the Center to Advance Palliative Care under the umbrella of the Patty and Jay Baker National Palliative Care Center at Mount Sinai. The mission of the NPCRC is "to strengthen the evidence-based foundation needed for health policy and clinical practice in palliative care medicine by growing and supporting the community of palliative care research scientists and stimulating expanded research and innovation" [--from the website]. A further explanation of the center's mission can be found in Morrison, R. S. and Meier D. E., "The National Palliative Care Research Center and the Center to Advance Palliative Care: a partnership to improve care for persons with serious illness and their families," *Journal of Pediatric Hematology/Oncology* 33, suppl. 2 (October 2011): S126-131. The NPCRC offers consultancy and grant review in addition to its own grant program. The website's Resources section lists a fairly large number of measurement and evaluation tools as well as links to materials from several years of webinars and workshops (including those some on methodology). While not focused on spiritual issues in particular, the organization should be of interest to chaplain researchers in palliative care.

If you have suggestions about the form and/or content of the site, e-mail Chaplain John Ehman (Network Convener) at john.ehman@uphs.upenn.edu .
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