SPIRITUAL CARE IN THE HEALTHCARE SETTING: *IS IT ETHICAL?*

Bob Mason, MDiv
Executive Director, Medical Strategic Network
Adjunct Faculty, Loma Linda Univ School of Medicine
Family Medicine Director of Spiritual Care Training, Loma Linda Univ Health

Thanks to Jess Tse Cheng, MD for her significant contributions to this presentation.

DISCLOSURES

PERSPECTIVE

OVERVIEW

- *Is there an ethical basis for assessing and addressing spiritual needs and issues in the healthcare setting?*
- *If there is, how can I do this in an ethical, patient-centered compassionate manner?*

1. Background: Spirituality and Health- is it relevant, helpful, patient centered?
2. Spiritual Care: Standards and Practice
3. Guiding Principles of Medical Ethics

KEY QUESTION

Is spiritual care in the healthcare setting ethical?

ANSWER:

- YES!
  - It can be VERY ethical
  - Or very UNethical

Not a New Idea

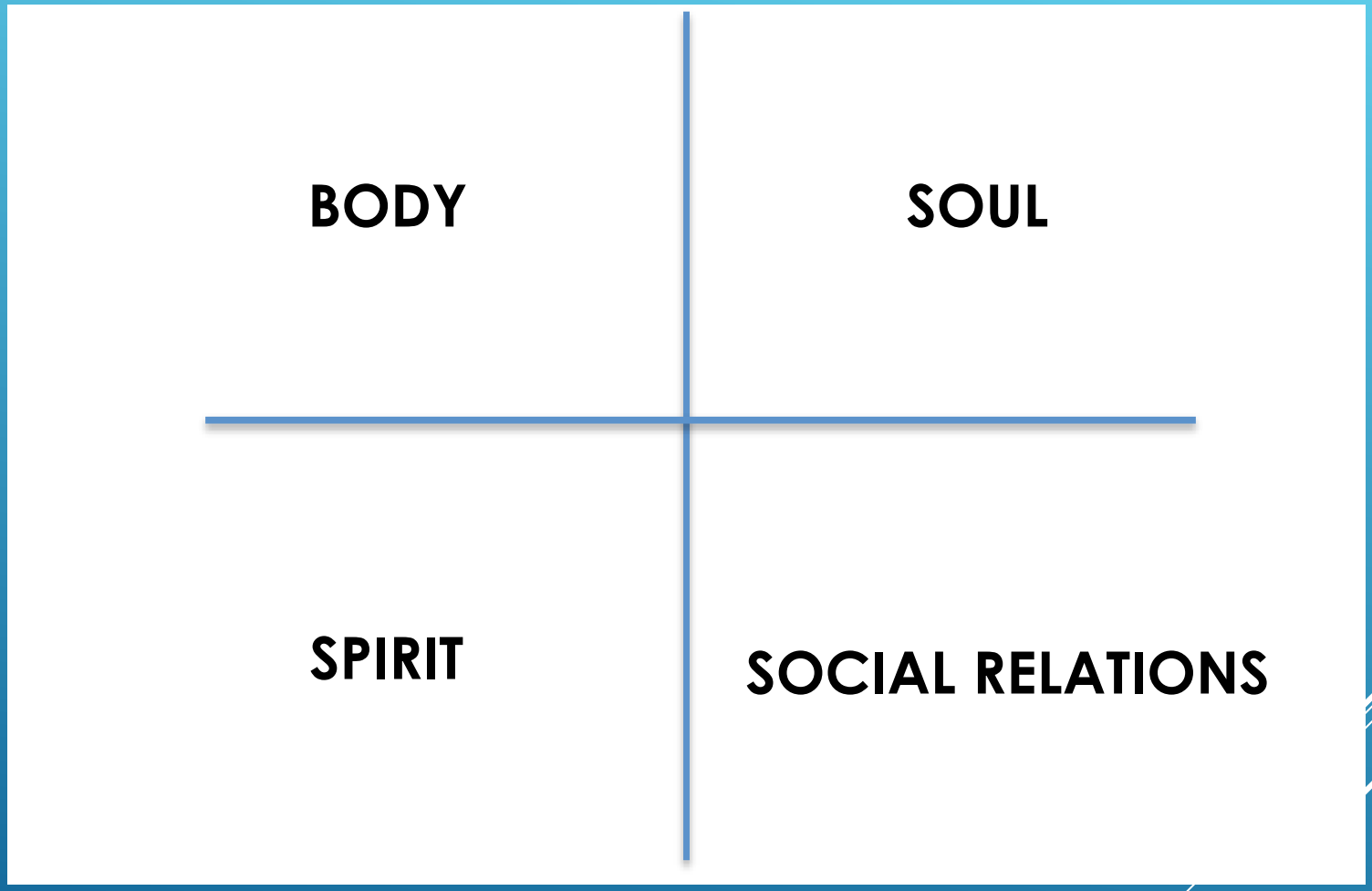
"The greatest mistake in the treatment of diseases is that there are physicians for the body and physicians for the soul, although ***the two cannot be separated****."*

- F

"As you ought not to attempt to cure the eyes without the head or the head without the body, so neither are you to attempt to cure the body without the soul. For ***the part can never be well unless the whole is well.***

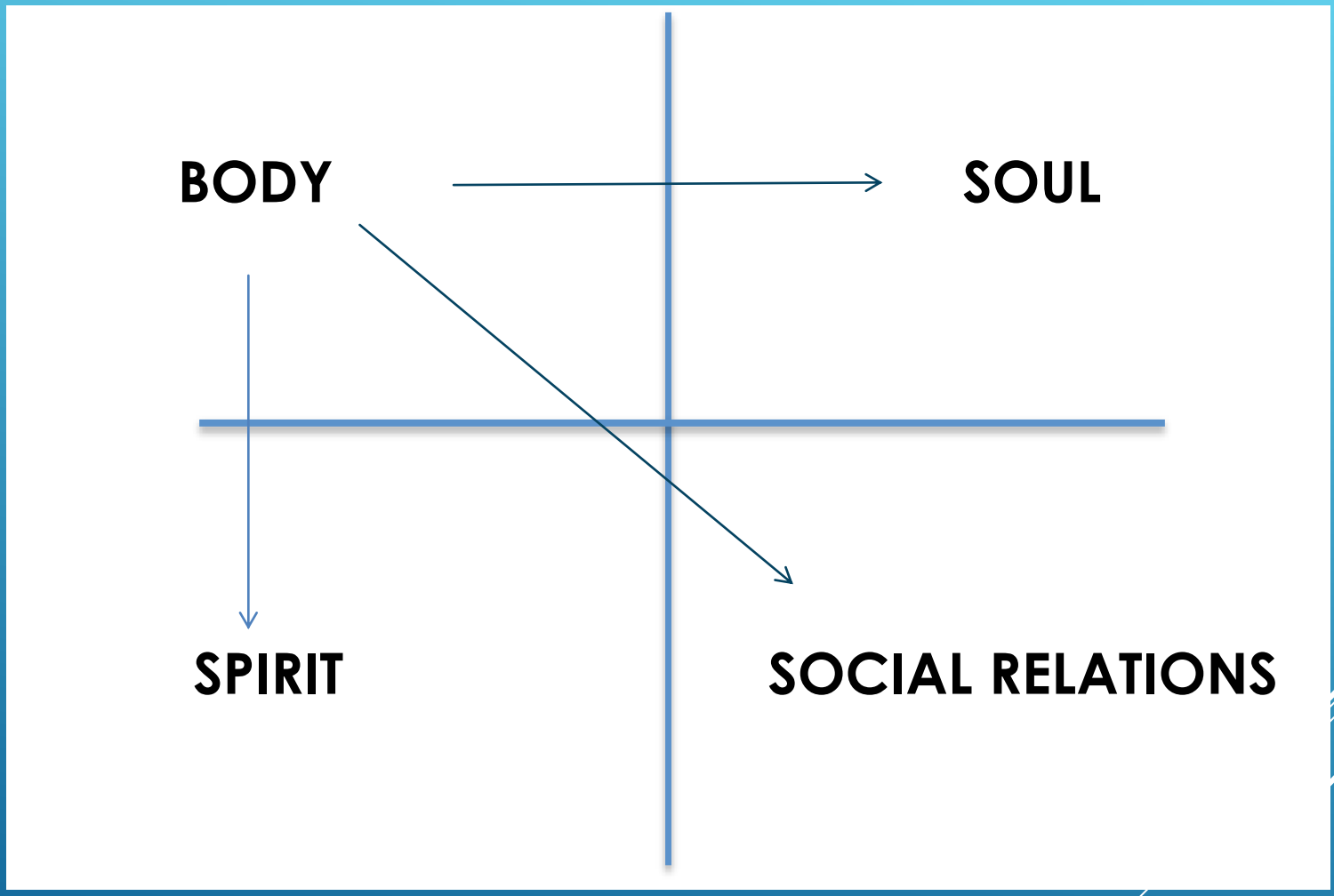
- Plato (~428-348 BC)

WHOLE PERSON PERSPECTIVE



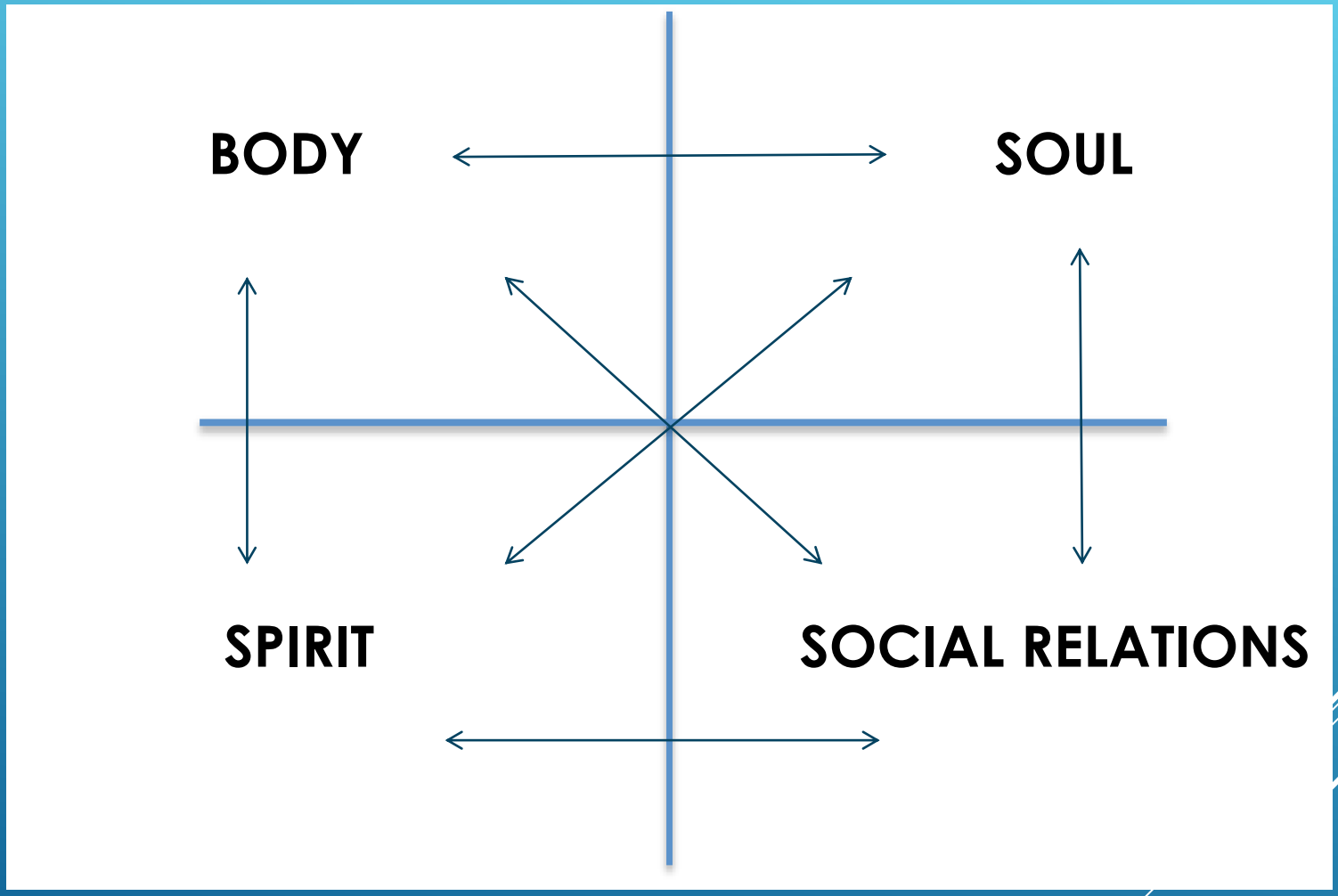
(Fountain and O'Donnell, 2008)

WHOLE PERSON PERSPECTIVE



(Fountain and O'Donnell, 2008)

WHOLE PERSON PERSPECTIVE



(Fountain and O'Donnell, 2008)

WHOLE PERSON PERSPECTIVE

BODY

Hypertension
Chronic pain, inflammation
Auto-immune disorders
Digestive Problems
Many infections
Malignancies

SOUL

Fear, worries
Anxiety
Anger, bitterness, resentment
Shame, guilt
Jealousy, envy
Grief

SPIRIT

Poor self-image
Depression
Meaninglessness
Sense of rejection
Loneliness

SOCIAL RELATIONS

Dysfunctional relationships
Divorce
Abuse
Poverty
Unemployment

BIBLICAL PERSPECTIVE

- Some physical diseases are spiritually based
  - *"When I refused to confess my sin, my body wasted away, and I groaned all day long."* Psalm 32:3
  - *"A tranquil heart gives life to the flesh, but envy makes the bones rot."* Proverbs 14:30
    - Broken relationship with God
    - Broken relationship with others
    - Broken relationship with self

THE PARALYZED MAN – A BIBLICAL PERSPECTIVE

17 On one of those days, as he was teaching, Pharisees and teachers of the law
were sitting there, who had come from every village of Galilee and Judea and
from Jerusalem. And the power of the Lord was with him to heal.[d] 18 And
behold, some men were bringing on a bed a man who was paralyzed, and they
were seeking to bring him in and lay him before Jesus, 19 but finding no way to
bring him in, because of the crowd, they went up on the roof and let him down
wit w
thei he

A person's **greatest** need is spiritual.

Pharisees began to question, saying, "Who is this who
speaks blasphemies? Who can forgive sins but God alone?" 22 When
Jesus perceived their thoughts, he answered them, "Why do you question in
your hearts? 23 Which is easier, to say, 'Your sins are forgiven you,' or to say, 'Rise
and walk'? 24 But that you may know that the Son of Man has authority on earth
to forgive sins"—he said to the man who was paralyzed—"I say to you, rise, pick
up your bed and go home." 25 And immediately he rose up before them and
picked up what he had been lying on and went home, glorifying God. 26 And
amazement seized them all, and they glorified God and were filled with awe,
saying, "We have seen extraordinary things today." Luke 5:17-26

BIBLICAL PERSPECTIVE

- Jesus healed physical and spiritual needs together
  - The paralyzed man
  - Woman who had a discharge of blood for twelve years
    - "and *who had suffered much under many physicians, and had **spent all** that she had, and was no better but rather **grew worse**. 27 She had heard the reports about Jesus and came up behind him in the crowd and touched his garment. 28 For she said, "**If I touch even his garments, I will be made well**." 29 And immediately the flow of blood dried up, and she felt in her body that she was healed of her disease. 30 And Jesus, perceiving in himself that power had gone out from him, immediately turned about in the crowd and said, "Who touched my garments?" 31 And his disciples said to him, "You see the crowd pressing around you, and yet you say, 'Who touched me?'" 32 And he looked around to see who had done it. 33 But the woman, knowing what had happened to her, came in fear and trembling and fell down before him and told him the whole truth. 34 And he said to her, "**Daughter, your faith has made you well;** go in peace, and be healed of your disease.*" - Mark 5:25-34

PRO ORGANIZATIONAL VIEWS

- AMA 1847 Code of Ethics
  - "For, the physician should be the minister of **hope** and **comfort** to the sick."
  - "It is, therefore, a sacred duty to guard himself carefully in this respect, and to avoid all things which have a tendency to discourage the patient and to depress his **spirits**."
  - The preamble to the 1847 Code of Ethics states explicitly that medical ethics "must rest on the **basis of religion and morality**." Like taking an oath, it rests on the presumption that professionals serve something higher than themselves

(American Medical Association, 1847)

WHO Definition since 1948:

Health is a state of complete physical, mental, social ***and spiritual*** *well-being and not merely the absence of disease or infirmity.*

AMERICAN ACADEMY OF FAMILY PHYSICIANS

SORT: KEY RECOMMENDATIONS FOR PRACTICE

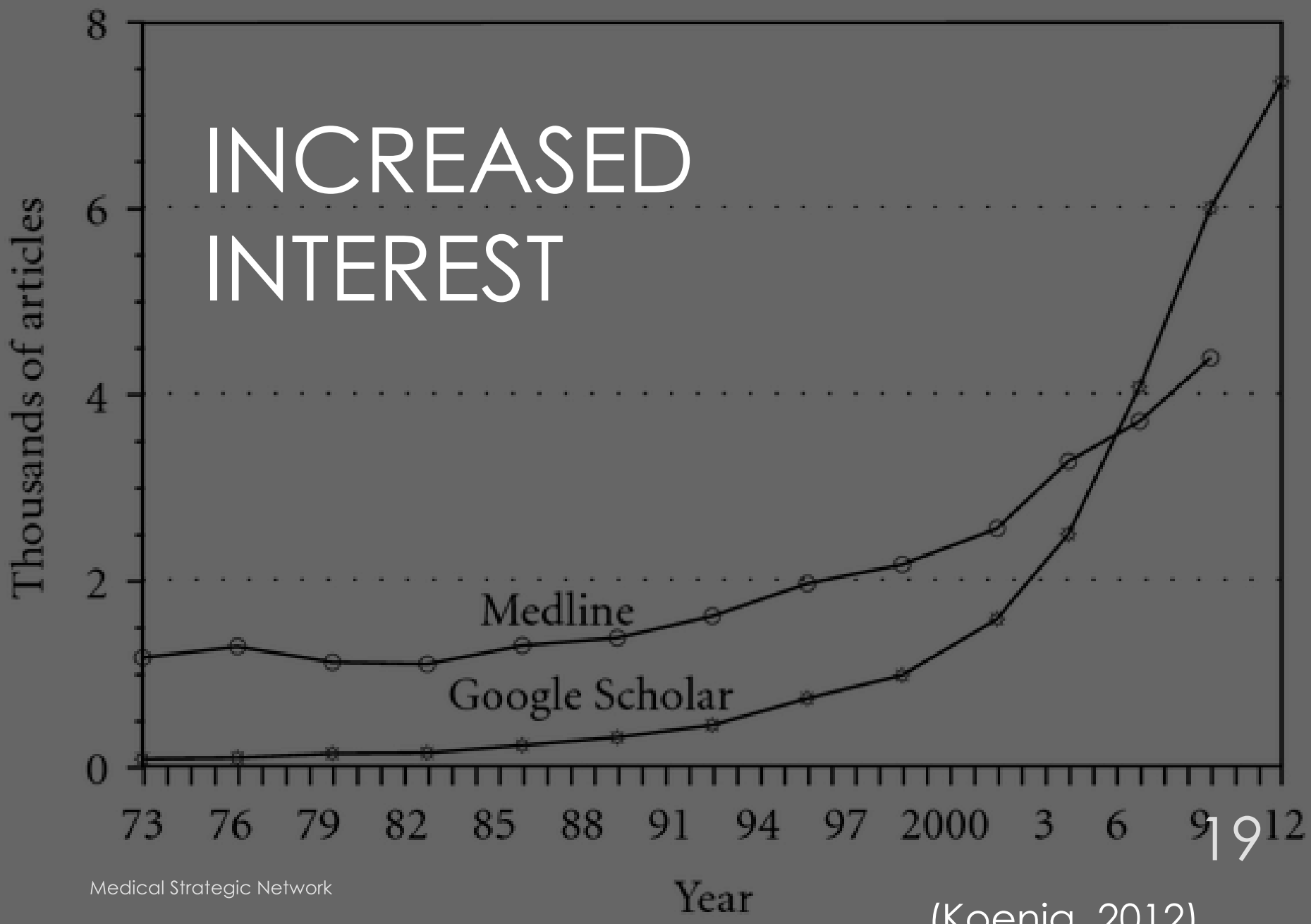
Clinical recommendation	*Evidence rating*	*References*
Patients should have a spiritual assessment upon admission to the hospital.	C	9
Addressing spirituality may help when forming a comprehensive treatment program for patients with chronic pain.	C	10
Spirituality should be addressed as one of the core components of quality palliative care.	C	11

A = consistent, good-quality patient-oriented evidence; B = inconsistent or limited-quality patient-oriented evidence; C = consensus, disease-oriented evidence, usual practice, expert opinion, or case series. For information about the SORT evidence rating system, go to http://www.aafp.org/afpsort.xml.

AMERICAN SOCIETY OF CLINICAL ONCOLOGY (ASCO)

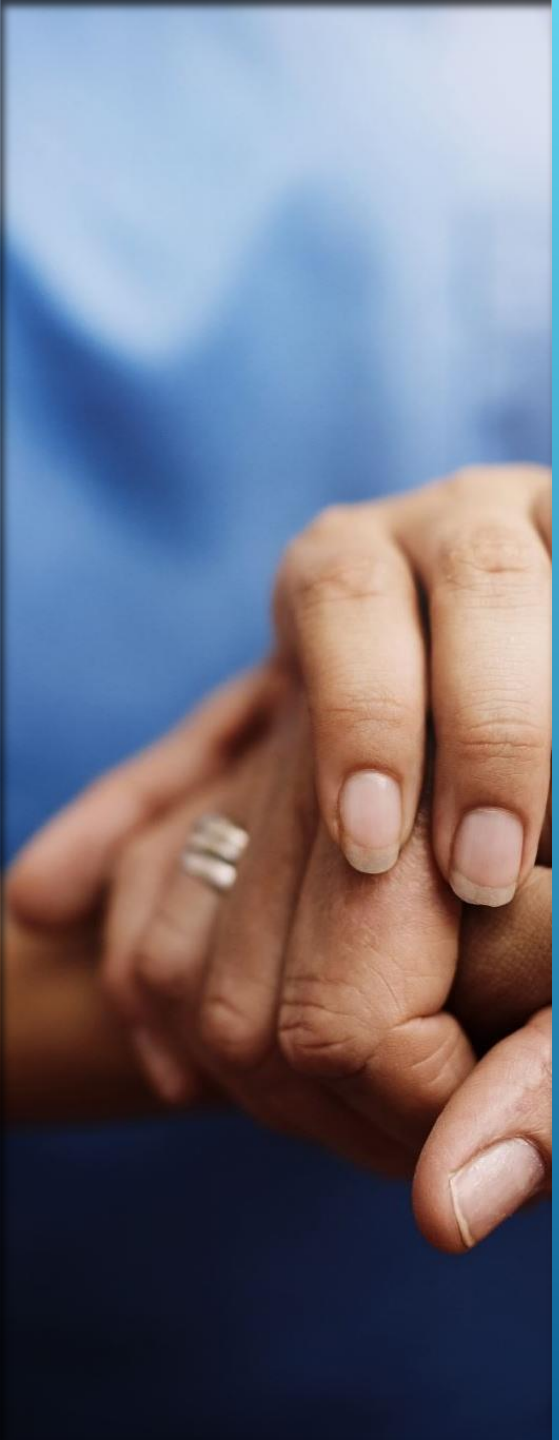
- "As with other components of the medical history, a **spiritual history is important for clinicians to take**, especially during the initial consultation. If the patient describes difficulty with coping and/ or that spiritual or religious resources are not working well for him or her, referral to a trained provider is advised."
- Clinicians **should document a patient's spiritual/existential distress**. All patients may be offered basic spiritual support, for example, giving a framework so they may consider goals and receive hope along with medical outcomes. **Ongoing assessment and evaluation** are suggested. Psychosocial, spiritual, and bereavement support are **key elements of palliative care.**

INCREASED INTEREST



Medical Strategic Network

(Koenig, 2012)



CURRENT STATE OF SPIRITUALITY IN HEALTHCARE

"Given the advances in this area over the past decade, physicians **can no longer ignore the spiritual aspects of care**. Nor are they able to ignore the spiritual aspects of delivering care." (Koenig, 2004)

"By keeping patients' beliefs, spiritual/religious needs and supports **separate** from their care, **we are potentially ignoring** an important element that may be at the core of patients' coping and support systems and may be integral to their wellbeing and recovery." (D'Souza, 2007)

The Joint Commission

- Founded in 1951, The Joint Commission seeks to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.
- The Joint Commission is the nation's oldest and largest standards-setting and accrediting body in health care.

THE JOINT COMMISSION

- "… the spirituality of patients should be **respected, assessed and attended to** in ways that are important to them."

  - Joint Commission on Accreditation of Healthcare Organizations 2010

- Current: It is important that the spiritual needs, beliefs, values and preferences **be evaluated** for patients receiving psychosocial services to treat **alcoholism or other substance use disorders** and those receiving **end-of-life care**. ***Each organization would determine how these needs will be identified as our standards do not define such elements.***

- Standard RI.01.01.01 for respecting patient's rights to cultural and personal values, beliefs, and preferences (EP6) as well as their right to religious and other spiritual services (EP9)

PATIENT VIEWS

- "Spiritual care is frequently desired by patients in serious illness as part of medical care, with estimates ranging from **50% to 96%** of patients wanting spiritual care."

- "Spiritual needs are infrequently addressed in medical care of seriously ill patients, with patient-reported spiritual care from medical teams ranging from **9% to 51%.**"

Balboni et al. Spirituality in Serious Illness and Health. JAMA. 2022.

UNMET NEED SPIRITUAL CARE FROM NURSES OR PHYSICIANS

- Advanced Cancer
- > 80% patients, nurses, and physicians thought spiritual care from nurses or physicians was important

AND YET…

- **MOST** (70-90%) patients never received any form of spiritual care

Balboni MJ et al, J Clin Oncol. 2013 Feb 1;31(4):461-7

WHY NOT OFFERED?

LACK OF TRAINING!

- **T**he strongest predictor for not providing spiritual care (odds ratio [OR] = **11.20**, 95% CI, 1.24 to 101; and OR = 7.22, 95% CI, 1.91 to 27.30, respectively)

BUT IS IT ETHICAL?

SPIRITUAL CARE IS AN ETHICAL STANDARD

- In its palliative care resolution, **WHO** notes that it is the **'ethical obligation of all health care professionals** and all health care systems to address spiritual issues of patients.'
- The **American College of Physicians** cites that it is the **ethical duty** of all physicians to attend to all dimensions of suffering psychosocial and spiritual, as well as physical.
- **Multinational Association of Supportive Care in Cancer** (MASCC) also supports this position.

- Puchalski et al. 2019, European Society of Med Onc


THOUGHTS?

PRINCIPLES OF MEDICAL ETHICS

- Beneficence
- Non-Maleficence
- Autonomy
- Justice

BENEFICENCE

"The quality or state of being good"

MAJOR SYSTEMATIC REVIEW

- **3,300** articles
- **Majority** of studies showed a significant relationship between religion/spirituality and **better health**

Koenig, 2012 Annals of Behavioral Medicine

MAJORITY OF STUDIES SHOW

Positive correlation

- Sense of well being
- Hope and optimism
- Meaning and purpose
- Higher self-esteem
- Adaptation to bereavement
- Social support
- Marital stability

Negative correlation

- Loneliness
- Depression
- Suicide
- Anxiety
- Psychosis
- Substance abuse
- Delinquency/crime

(Koenig, 2012)

LONGER LIFE EXPECTANCY

Average 37% increased survival with **increased religious service attendance**

Equivalent benefit as using cholesterol lowering medications or doing cardiac rehabilitation after myocardial infarction

(Koenig, 2012)

FREQUENT RELIGIOUS SERVICE ATTENDEES ARE MORE LIKELY TO:

Stop smoking

Start exercising

Increase social contacts

Stay married

(Gartner, Larson & Allen,1991; Koenig, 2012)

- A growing body of literature (primarily from Maximal resource settings) supports the notion that **spiritual care is a patient need**. The data also suggest that patients' spiritual, religious, and cultural beliefs affect health care **decision making** and health care **outcomes**, including **coping**, **QOL**, and **pain** management. Studies have reported that spirituality and/or religion may be important to patients with cancer and may influence medical decision making. Research shows spirituality or religion impact QOL, coping, **depression**, and **anxiety**, and play a role in improved **social functioning** and maintaining social relationships.

AMERICAN SOCIETY OF CLINICAL ONCOLOGY (ASCO)

PRAYER FOR COPING BEFORE CARDIAC SURGERY

70% found prayer **extremely helpful.**

(Saudia, Kinney, Brown, & Young-Ward, 1991)

RECOVERY FROM HIP SURGERY

Hip surgery patients with stronger religious beliefs were associated with **less post-operative depression** and **greater walking distance** at discharge.

(Pressman, Lyons, Larson, & Strain, 1990)

PATIENT SATISFACTION

- In a study of 1.7 million patients, including 33% of all U.S. hospitals, patient satisfaction with emotional & spiritual aspects of care was:
  - One of the **lowest** among all clinical care indicators
  - One of highest areas needing **quality improvement**

(Clark, Drain, & Malone, 2003)

- Patients who had discussions of religion & spiritual concerns were more likely to rate their care at the **highest level** on four different measures of patient satisfaction, regardless of whether or not they said they had desired such a discussion.

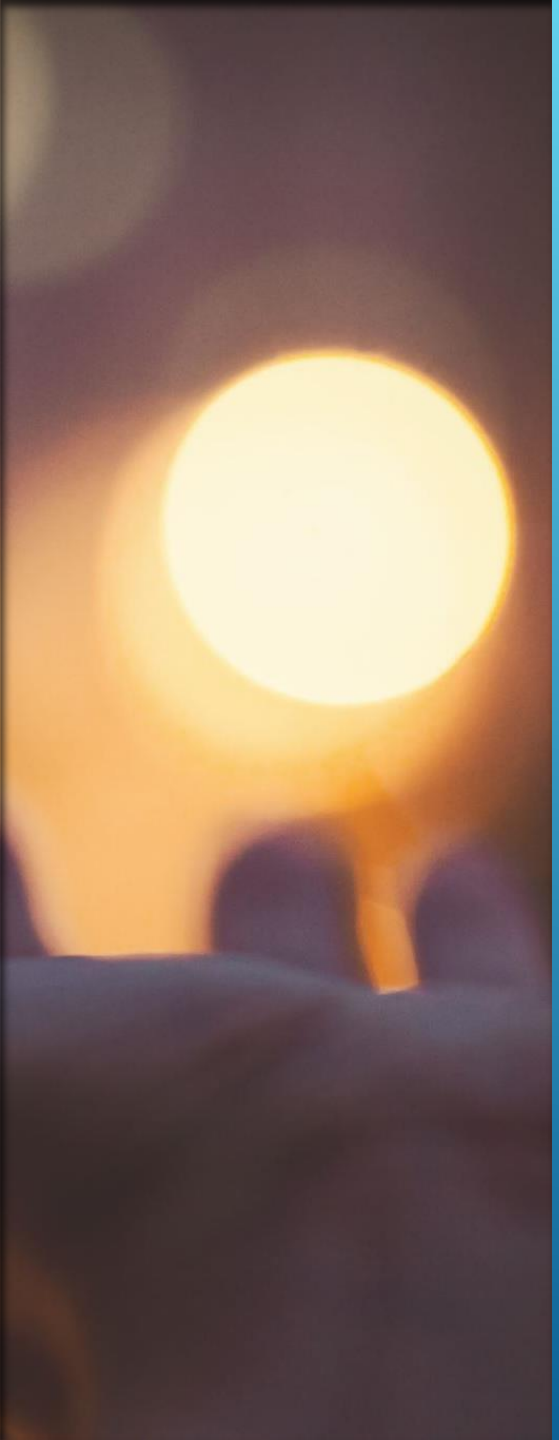
(William, Meltzer, Arora, Chung, & Curlin, 2011)

ADDITIONAL POTENTIAL BENEFITS OF SPIRITUAL CARE

- ✓ Strengthen patient-provider relationship
  - Increase patient compliance
  - Increases trust patient has towards clinician
  - Decrease malpractice claims
  - Decrease clinician burnout
- ✓ Tailor medical care to patient's religious tradition
- ✓ Help patients recognize spiritual challenges they are facing

PRINCIPLES OF MEDICAL ETHICS

- Beneficence
- Non-Maleficence
- Autonomy
- Justice



NONMALEFICENCE

"…an obligation not to inflict harm intentionally"

Do no harm

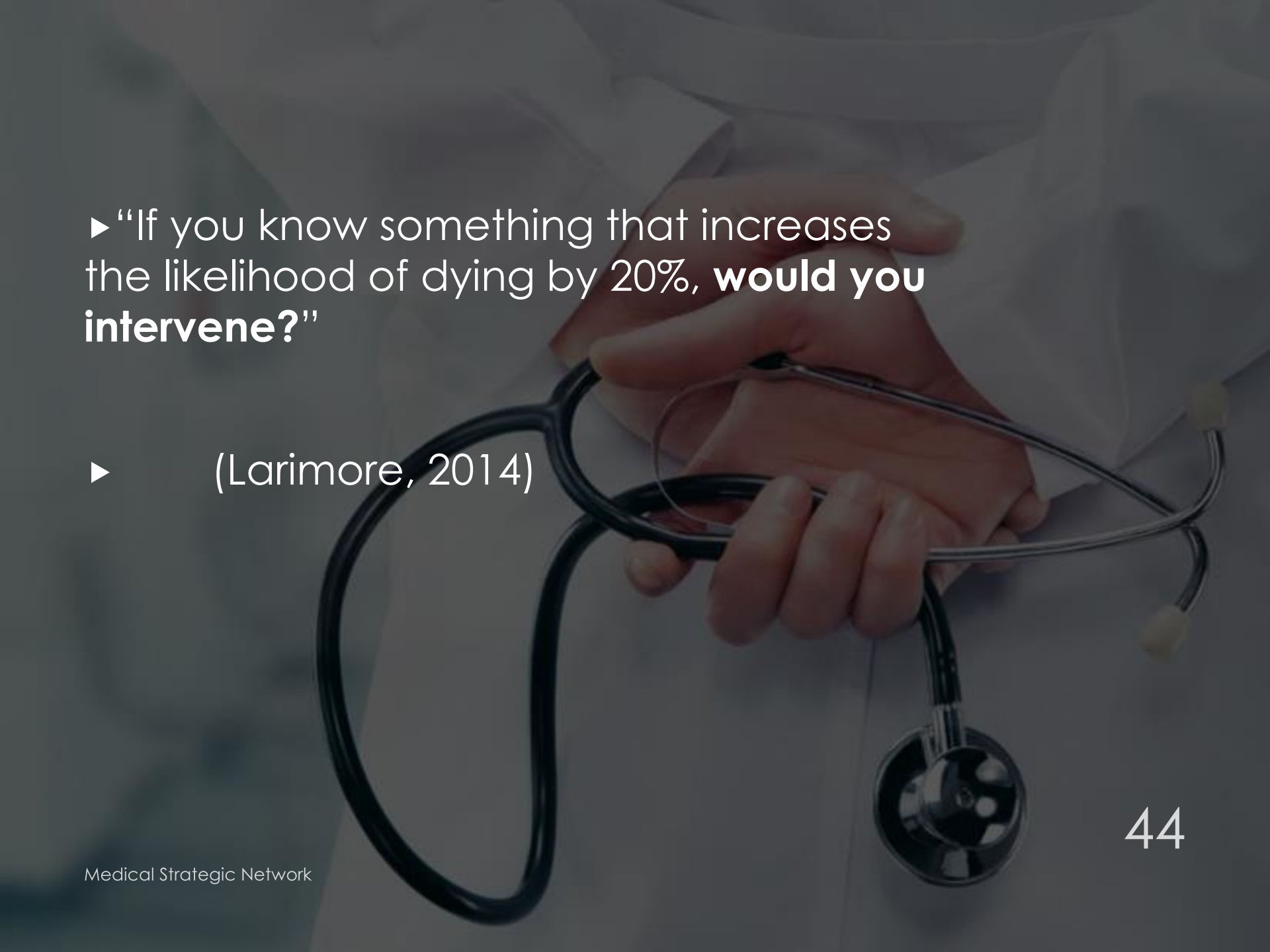
ASSESSING & ADDRESSING HARMFUL RELIGIOUS/SPIRITUAL BELIEFS

In a longitudinal study of hospitalized elderly patients, those who:

- Wondered whether God had abandoned them
- Questioned God's love for them
- Decided the devil made this happen
- Felt punished by God for their lack of devotion

experienced **16% to 28% higher mortality** in the 2-year period following hospital discharge.

(Pargament, Koenig, Tarakeshwar, & Hahn, 2001)



- "If you know something that increases the likelihood of dying by 20%, **would you intervene?**"
- (Larimore, 2014)

HARMFUL RELIGIOUS/SPIRITUAL BELIEFS

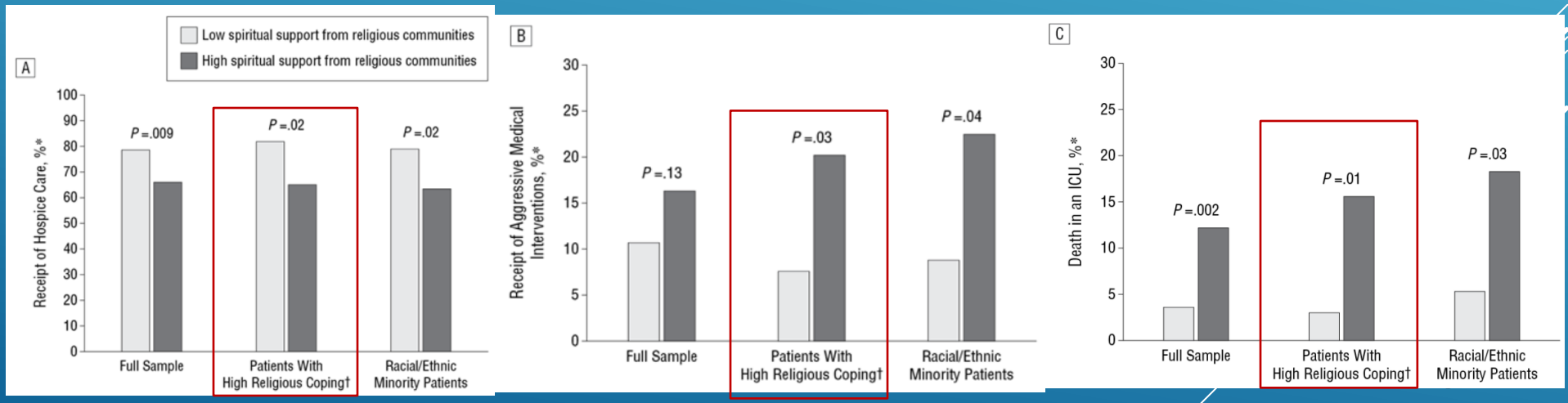
Negative religious coping as a correlate of suicidal ideation in patients with advanced cancer.

- Increased risk for suicidal ideation (OR **2.65** [95% CI, 1.22, 5.74], **p = 0.01**)

(Trevino et al. 2014)

END OF LIFE TRENDS AMONG HIGHLY RELIGIOUS PATIENTS

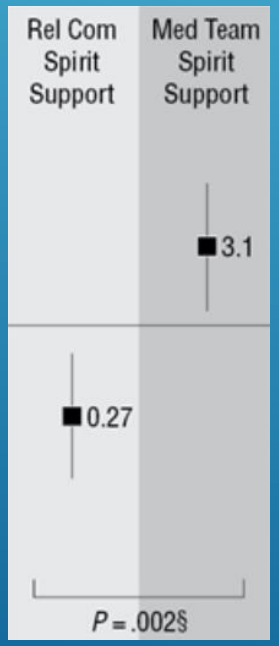
- Strong belief in miracles
- High spiritual support from religious communities
  - → Less receipt of **hospice**
  - → More **aggressive interventions** (ICU care, resuscitation, ventilation)
  - → More **death in the ICU**



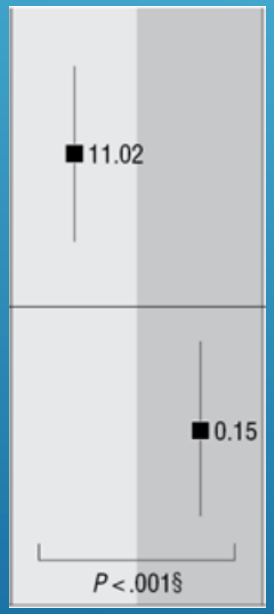
REST IN PEACE

- Spiritual care and end of life discussions by medical teams
- ***Dramatically change* the odds of…**

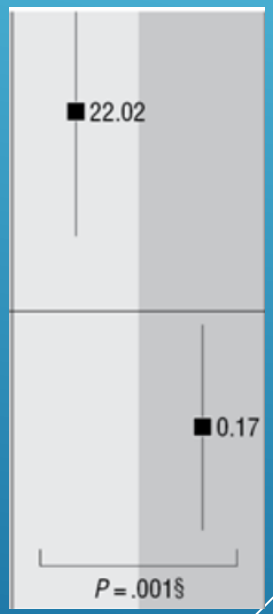
Receipt of Hospice



Aggressive Interventions



Death in an ICU



CAN SPIRITUAL INTERVENTION CAUSE HARM?

YES

- "Physicians may use the new emphasis on spirituality and relating personally to patients to **inappropriately shift the focus to themselves** and their beliefs, perhaps to engage in **proselytizing**."

(Kuczewski, 2007)

GUARDRAILS: A PATIENT-CENTERED APPROACH

- **Check your heart**
- No personal agenda
- Seek to understand **the patient's** spiritual needs

- Sensitivity
- Respect
- What is God already doing in this patient?

Join Him there…

- Within the boundaries of maintaining your integrity and of conscience

NET BENEFIT

PRINCIPLES OF MEDICAL ETHICS

- Beneficence
- Non-Maleficence
- Autonomy
- Justice

AUTONOMY

The quality or state of being self-governing; the right of self-government

Moral independence

"Deliberated self-rule"

AUTONOMY

"Medical ethicists are right in insisting the practitioner must honor the patient's autonomy, follow the patient's lead and needs, and utilize **permission**, respect, wisdom and sensitivity." (Larimore et al., 2002)

AUTONOMY

- Spiritual Care can help patients…
  - Make choices based on trust in God and **self-worth**
  - Not be controlled by fear
  - Grow in faith
  - Have comfort and peace
  - Experience acceptance and love
  - Feel seen and known in an often-dehumanizing experience
- Informed consent
- Spiritual Care should **empower** patient autonomy

PRINCIPLES OF MEDICAL ETHICS

- Beneficence
- Non-Maleficence
- Autonomy
- Justice

JUSTICE

- Be **fair and impartial**
- Aristotle once said, "giving to each that which is his due." This implies the fair **distribution** of goods in society and requires that we look at the *role of entitlement.* The question of distributive justice also seems to hinge on the fact that some goods and services are in short supply, there is not enough to go around, thus some fair means of allocating scarce resources must be determined.

ONE REASON TO TAKE A SPIRITUAL HISTORY?

DETERMINE IF THERE A SPIRITUAL NEED.

JUSTICE

- Christians have a VERY high standard of personhood


Damaged

JUSTICE

"He hath showed thee, O man, what *is* good; and what doth the LORD require of thee, but to do **justly**, and to love **mercy**, and to walk humbly with thy God?"

Micah 6:8

HOW WOULD YOU RESPOND?

"How can you talk about God and religion with your patients?

Isn't that ***UNETHICAL??!!"***

Spiritual care IS ethical as

benefits far outweigh **risks**

when done in a manner that **respects and empowers autonomy.**

ETHICAL CONCLUSION

ETHICAL REASONS ANSWERED AFFIRMATIVELY

- ✓ There are MANY **benefits**
- ✓ There is **harm in NOT addressing** religious struggle
- ✓ Harms from spiritual intervention can be prevented mostly by **informed consent, patient centered care, respect and sensitivity**
- ✓ Many **patients desire** it
- ✓ It supports **autonomy** by enabling deliberated decisions
- ✓ It is just to address spiritual needs in all who are human.
- ✓ Spiritual care is a standard!

ETHICALLY ASSESSING & ADDRESSING SPIRITUAL NEEDS

SOME TIPS

RED FLAGS - PATIENT

- Assess, especially for harmful spiritual beliefs
  - For the patient's sake, not your spiritual ego (or lack of)
  - Even when you don't feel like it
- Treat
  - Be genuine!
  - Harm can be done if not addressed or addressed halfheartedly
  - If you cannot meet the need, refer to a colleague or chaplain

WHEN PATIENTS SAY NO THANKS

- + Red Flag, Declining Intervention
  - Express respect for autonomy
  - Continue to offer intervention
  - Explore response
  - Similar to medical interventions
  - Watch for body language that communicates disinterest
- You are not entitled to know about anyone's religious/spiritual beliefs
- May need to establish more of a relationship first (trust/ rapport)
- Check your heart

TREATING PRECAUTIONS

- Praying for a patient is not necessarily a win for spiritual care.
- Not praying for a patient does not mean that you failed to do spiritual care.
- This is not an excuse to not pray when the Spirit leads you.
- If you are not spiritually attuned, refer to someone else.
- Clinical competence requires superior knowledge and skill
- Spiritual competence requires awareness–owning our brokenness.
- John 15:5 "I am the vine; you are the branches. If you remain in me and I in you, you will bear much fruit; **apart from me you can do nothing.**

SPIRITUAL INTERVENTION TRAINING…

- May decrease reliance on the Holy Spirit and increase reliance on spiritual care skills
- May lead to spiritual performance trap

PATIENT-CENTERED APPROACH

- **Check your heart**
- No personal agenda
- Seek to understand **the patient's** spiritual needs

- Sensitivity
- Respect
- What does the patient want?
- What is God already doing in this patient?

  Join Him there
- Within the boundaries of maintaining your own integrity and conscience

SPIRITUAL CARE

1. Pray God leads you, keeps you humble, and gives you a willing heart.
2. Listen to the patient.
3. Do it ethically.


QUESTIONS?

BOB MASON
BOB.MASON@MEDSN.ORG
909-800-0665

- American Medical Association. (1847, May). Proceeding of the National Medical Conventions, held in New York and in Philadelphia. Retrieved from http://ama.nmtvault.com/jsp/viewer.jsp?doc_id=ama_arch%2FAD000001%2F0039PROC&page_name=28
- Astrow, A. B., & Sulmasy, D. P. (2004). Spirituality and the patient-physician relationship. JAMA: The Journal of the American Medical Association, 291(23), 2884. doi:10.1001/jama.291.23.2884
- Astrow AB, Wexler A, Texeira K, He MK, Sulmasy DP. Is failure to meet spiritual needs associated with cancer patients' perceptions of quality of care and their satisfaction with care? J Clin Oncol. 2007 Dec 20;25(36):5753-7. doi: 10.1200/JCO.2007.12.4362. PMID: 18089871.
- Autonomy | Definition of Autonomy by Merriam-Webster. (n.d.). Retrieved May 30, 2017, from https://www.merriam-webster.com/dictionary/autonomy
- Balboni et al, *JAMA*. 2022;328(2):184-197. doi:10.1001/jama.2022.11086
- Balboni TA, Balboni M, Enzinger AC, Gallivan K, Paulk ME, Wright A, Steinhauser K, VanderWeele TJ, Prigerson HG. Provision of spiritual support to patients with advanced cancer by religious communities and associations with medical care at the end of life. JAMA Intern Med. 2013 Jun 24;173(12):1109-17. doi: 10.1001/jamainternmed.2013.903. PMID: 23649656; PMCID: PMC3791610.
- Balboni TA, Vanderwerker LC, Block SD, Paulk ME, Lathan CS, Peteet JR, Prigerson HG. Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. J Clin Oncol. 2007 Feb 10;25(5):555-60. doi: 10.1200/JCO.2006.07.9046. PMID: 17290065; PMCID: PMC2515558.
- Balboni, M. and Peteet, J. (2017) Spirituality and Religion within the Culture of Medicine. New York, NY: Oxford University Press, USA.
- Beneficence. (n.d.). Retrieved May 30, 2017, from https://www.merriam-webster.com/dictionary/beneficence
- Casar Harris, R., Amanda Dew, M., Lee, A., Amaya, M., Buches, L., Reetz, D., & Coleman, G. (1995). The role of religion in heart-transplant recipients' long-term health and well-being. Journal of Religion and Health, 34(1), 17-32. doi:10.1007/bf02248635
- Clark, P. A., Drain, M., & Malone, M. P. (2003). Addressing patients' emotional and spiritual needs. The Joint Commission Journal on Quality and Safety, 29(12), 659-670. doi10.1016s1549-3741(03)29078-x
- Curlin, F. A., Sellergren, S. A., Lantos, J. D., & Chin, M. H. (2007). Physicians' observations and interpretations of the influence of religion and spirituality on health. Archives of Internal Medicine, 167(7), 649-654. doi:10.1001/archinte.167.7.649
- D'Souza, R. (2007). The importance of spirituality in medicine and its application to clinical practice. Med J Aust, 186(10). Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/17516886
- Ethical (n.d.). Dictionary.com Unabridged. Retrieved May 26, 2017 from http://www.dictionary.com/browse/ethical?s=t
- Farthing, K. (2014). The ethical basis of spiritual care [PowerPoint slides].
- Ferreira-Valente A, Sharma S, Torres S, Smothers Z, Pais-Ribeiro J, Abbott JH, Jensen MP. Does Religiosity/Spirituality Play a Role in Function, Pain-Related Beliefs, and Coping in Patients with Chronic Pain? A Systematic Review. J Relig Health. 2019 Sep 18. doi: 10.1007/s10943-019-00914-7. Epub ahead of print. Erratum in: J Relig Health. 2019 Oct 26;: PMID: 31535274.
- Fortin, A. H., & Barnett, C. G. (2004). Medical school curricula in spirituality and medicine. JAMA: The Journal of the American Medical Association, 291(23), 2883. doi:10.1001/jama.291.23.2883
- Fountain, MD, MPH, D., & O'Donnell, DO, S. (2008). Helping hurting people. Bristol, TN: Selah Publishing Group, LLC.
- Gartner, J., Larson, D. B., & Allen, G. D. (1991). Religious commitment and mental health: A review of the empirical literature. Journal of Psychology and Theology, 19, 6-25. Retrieved from http://journals.biola.edu/jpt/volumes/19/issues/1/articles/6

- Ghorbani M, Mohammadi E, Aghabozorgi R, Ramezani M. Spiritual care interventions in nursing: an integrative literature review. Support Care Cancer. 2021 Mar;29(3):1165-1181. doi: 10.1007/s00520-020-05747-9. Epub 2020 Sep 14. PMID: 32929533.
- Hodges, G. (2016). Ethics of whole person care [PowerPoint slides].
- Joint Commission on Accreditation of Healthcare Organizations. (2010). Joint commission guide to allied health professionals. Oakbrook Terrace, IL: Joint Commission Resources
- Jung, J. (2015). The ethics of spiritual care in the healthcare setting [PowerPoint slides].
- Koenig, H. G. (2004). Religion, spirituality, and medicine: Research findings and implications for clinical practice. Southern Medical Journal, 97(12), 1194-1200. doi:10.1097/01.smj.0000146489.21837.ce
- Koenig, H. G. (2012). Religion, spirituality, and health: The research and clinical implications. ISRN Psychiatry, 2012, 1-33. doi:10.5402/2012/278730
- Koenig, H., McCullough, M. E., & Larson, D. B. (2001). Handbook of Religion and Health. New York, NY: Oxford University Press, USA.
- Kuczewski, M. G. (2007). Talking about spirituality in the clinical setting: Can being professional require being personal? The American Journal of Bioethics, 7(7), 4-11. doi:10.1080/15265160701399545
- Larimore, W. L., Parker, M., & Crowther, M. (2002). Should clinicians incorporate positive spirituality into their practices? What does the evidence say? Annals of Behavioral Medicine, 24(1), 69-73. doi:10.1207/s15324796 abm2401_08
- Larimore, W., & Peel, W. C. (Directors). (2014). Grace prescriptions [DVD]. USA: CMDA.
- Lyon, M. E., Garvie, P., He, J., Malow, R., McCarter, R., & D'Angelo, L. J. (2012). Spiritual well-being among HIV-infected adolescents and their families. Journal of Religion and Health, 53(3), 637-653. doi:10.1007/ s10943-012-9657-y
- Mouch CA, Sonnega AJ. Spirituality and recovery from cardiac surgery: a review. J Relig Health. 2012 Dec;51(4):1042-60. doi: 10.1007/s10943-012-9612-y. PMID: 22592500.
- Nonmaleficence | definition of nonmaleficence by Medical dictionary. (n.d.). Retrieved May 26, 2017, from http://medical-dictionary.thefreedictionary.com/nonmaleficence
- Osman H, Shrestha S, Temin S, Ali ZV, Corvera RA, Ddungu HD, De Lima L, Del Pilar Estevez-Diz M, Ferris FD, Gafer N, Gupta HK, Horton S, Jacob G, Jia R, Lu FL, Mosoiu D, Puchalski C, Seigel C, Soyannwo O, Cleary JF. Palliative Care in the Global Setting: ASCO Resource-Stratified Practice Guideline. J Glob Oncol. 2018 Jul;4:1-24. doi: 10.1200/JGO.18.00026. PMID: 30085844; PMCID: PMC6223509.
- Pargament, K. I., Koenig, H. G., Tarakeshwar, N., & Hahn, J. (2001). Religious struggle as a predictor of mortality among medically ill elderly patients: A 2-year longitudinal study. Archives of Internal Medicine, 161(15), 1881-5. doi:10.1001/archinte.161.15.1881
- Pew Forum on Religion & Public Life, & Pew Research Center. (2008). U.S. religious landscape survey: Religious affiliation: Diverse and dynamic. Retrieved from Pew Research Center website: http://www.pewforum.org/files/2013/05/report-religious-landscape-study-full.pdf

- Phelps AC, Lauderdale KE, Alcorn S, Dillinger J, Balboni MT, Van Wert M, Vanderweele TJ, Balboni TA. Addressing spirituality within the care of patients at the end of life: perspectives of patients with advanced cancer, oncologists, and oncology nurses. J Clin Oncol. 2012 Jul 10;30(20):2538-44. doi: 10.1200/JCO.2011.40.3766. Epub 2012 May 21. PMID: 22614979; PMCID: PMC4827261.
- Press Ganey. (2004). Press Ganey knowledge summary: Patient satisfaction with emotional and spiritual care. Retrieved from Press Ganey Associates website: http://docplayer.net/32105849-Press-ganey-knowledge-summary-patient-satisfaction-with-emotional-and-spiritual-care.html
- Pressman, P., Lyons, J. S., Larson, D. B., & Strain, J. J. (1990). Religious belief, depression, and ambulation status in elderly women with broken hips. American Journal of Psychiatry, 147(6), 758-760. doi:10.1176/ajp. 147.6.758
- Rippentrop, E. A., Altmaier, E. M., Chen, J. J., Found, E. M., & Keffala, V. J. (2005). The relationship between religion/spirituality and physical health, mental health, and pain in a chronic pain population. Pain, 116(3), 311-321. doi:10.1016/j.pain.2005.05.008
- Roberts, J. A., Brown, D., Elkins, T., & Larson, D. B. (1997). Factors influencing views of patients with gynecologic cancer about end-of-life decisions. American Journal of Obstetrics and Gynecology, 176(1), 166-172. doi:10.1016/ s0002-9378(97)80030-0
- Saudia, T. L., Kinney, M. R., Brown, K. C., & Young-Ward, L. (1991). Health locus of control and helpfulness of prayer. Heart & Lung: The Journal of Critical Care, 21(1), 60-65. Retrieved from http://europepmc.org/abstract/med/1988394
- Siddall, P. J., Lovell, M., & MacLeod, R. (2015). Spirituality: What is its role in pain medicine? Pain Medicine, 16(1), 51-60. doi:10.1111/pme.12511
- Stuckelberger A. 2005. Spirituality, Religion and Health United Nations Geneva Panel Report: "Spirituality, Religion and Social Health" 58th World Health Assembly in Geneva.http://www.rcrescendo.org/11.Siritualitetpastorale/ GINEBRA/SPIRITUALITY.pdf
- Taylor, D., Mulekar, M. S., Luterman, A., Meyer, F. N., Richards, W. O., & Rodning, C. B. (2011). Spirituality within the patient-surgeon relationship. Journal of Surgical Education, 68(1), 36-43. doi:10.1016/j.jsurg.2010.08.007
- Trevino KM, Balboni M, Zollfrank A, Balboni T, Prigerson HG. Negative religious coping as a correlate of suicidal ideation in patients with advanced cancer. Psychooncology. 2014 Aug;23(8):936-45. doi: 10.1002/pon.3505. Epub 2014 Feb 27. PMID: 24577802; PMCID: PMC4776639.
- USA Today. (1996, April 5). USA Weekend [New York].
- Williams, J. A., Meltzer, D., Arora, V., Chung, G., & Curlin, F. A. (2011). Attention to inpatients' religious and spiritual concerns: Predictors and association with patient satisfaction. Journal of General Internal Medicine, 26(11), 1265-1271. doi:10.1007/s11606-011-1781-y
- World Health Organization. Commission on Social Determinants of Health. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health : final report of the Commission on Social Determinants of Health. Retrieved from World Health Organization website http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf