What Do Chaplains Do: The Views of Palliative Care Physicians, Nurses and Social Workers

Corresponding author:

Annelieke Damen, MA

PhD student Outcomes of Chaplaincy

University of Humanistic Studies

Kromme Nieuwegracht 29

3512 HD Utrecht, The Netherlands

0031-(0)633696388

A.Damen@uvh.nl

Dirk Labuschagne, MDiv

MPH student University of Illinois at Chicago

1026 Randolph St Apt 1S

Oak Park, Illinois 60302

224-244-3777

dlabus2@uic.edu

Laura Fosler, RN, MS, FNP-BC, ACHPN

Section of Palliative Medicine

Rush University Medical Center

1717 W. Congress Pkway

Suite 1129 Kellogg

Chicago, IL 60612

312-942-6078

laura_fosler@rush.edu

Sean O'Mahony, MB, BCh, BAO

Associate professor Hospice and Palliative Medicine

Rush University Medical Center

1725 W. Harrison street

Chicago, IL 60612

312-5633700

Sean_OMahoney@rush.edu

Stacie Levine, MD, FAAHPM

Professor and Chief

Section of Geriatrics and Palliative Medicine

Department of Medicine

University of Chicago Medicine

5841 South Maryland Ave.

Chicago, IL 60637

773-834-8130

slevine@medicine.bsd.uchicago.edu

George Fitchett, DMin, PhD, BCC

Professor and Director of Research

Department of Religion, Health, and Human Values

Rush University Medical Center

1653 West Congress Parkway

Chicago, Illinois 60612

312-563-4801

George_Fitchett@rush.edu

What Do Chaplains Do: The Views of Palliative Care Physicians and Nurses and Social Workers

Annelieke Damen, MA[1], Dirk Labuschagne, MDiv[2], Laura Fosler, RN, MS, FNP-BC, ACHPN[3], Sean O'Mahony, MB,BCh, BAO[4], Stacie Levine, MD[5], George Fitchett, PhD[6].

[1] Care Ethics, University of Humanistic Studies, Utrecht, The Netherlands.

[2] School of Public Health, University of Illinois at Chicago, IL, United States.

[3] College of Nursing, Section of Palliative Medicine, Rush University Medical Center, Chicago, IL, United States.

[4] Palliative Care, Rush University Medical Center, Chicago, IL, United States.

[5] University of Chicago Medicine, Chicago, IL, United States.

[6] Religion, Health and Human Values, Rush University Medical Center, Chicago, IL, United States.

What Do Chaplains Do: The Views of Palliative Care Physicians and Nurses and Social Workers

Abstract

It is well accepted that attention to spiritual concerns is a core dimension of palliative care. It is similarly well accepted that chaplains are the spiritual care specialists who should address such concerns. However, what chaplains do when they provide care for patients and families is often poorly understood by their palliative care colleagues. Having a clear understanding of what chaplains do is important because it contributes to improved utilization of the spiritual care and other resources of the palliative care team and thereby to better care for patients and families. The aim of this study was to describe what palliative care physicians, nurses and social workers understand about what chaplains do. Brief surveys were distributed to participants at two workshops for palliative care professionals in 2016. The survey was completed by 110 participants. The majority reported that they understood what chaplains do moderately well or very well. Thirty-three percent of the written comments about what chaplains do were very general, a quarter were more specific. Only a small proportion of the participants were aware that chaplains provide care for the team, are involved in facilitating treatment decision-making, perform spiritual assessments and bridge communication between the patient/family/team/community. Based on our survey, palliative care colleagues appear to have a broad understanding of what chaplains do but many may be unfamiliar with important contributions of chaplains' to care for patients, families, and teams. These findings point to the need for ongoing education of palliative teams about what chaplains do in palliative care.

Key words: Palliative care, Spiritual care, Chaplain, Chaplaincy, Spirituality

Introduction

It is well accepted that attention to spiritual concerns is a core dimension of palliative care.[1,2] Research suggests that religion and spirituality are important to palliative patients,[3-6] and integral to their coping with illness.[7-9] Failure to meet spiritual needs is associated with patients reporting lower ratings of quality and satisfaction with care,[10] poor quality of life,[4] and end-of-life despair.[11] Support of spiritual needs on the other hand is associated with higher quality of life, greater hospice utilization, less aggressive care and lower costs at the end-of-life.[12,13]

It is similarly well accepted that chaplains are the spiritual care specialists on palliative care teams who should address such concerns, based on a generalist-specialist model of care in which clinicians provide general spiritual care and refer to a chaplain for more extensive spiritual support.[14,15] Yet what exactly chaplains do when they provide care for patients and families is often poorly understood by their palliative care colleagues.[16] This is not surprising given the limited content that addresses spiritual concerns in undergraduate and graduate-level medical and nursing curricula and even in palliative care specialty training.[17-19] Many palliative care teams do not have a chaplain and this further limits physicians, nurses and social workers from learning about their contribution.[18,20]

Some existing research on the understanding of what chaplains do among pediatric physicians in large academic hospitals[21] and physicians in pediatric palliative care programs[22,23] suggests that physicians see chaplains as part of the interdisciplinary team, providing emotional and spiritual support to patients and families (especially around death), performing rituals, improving family-team communication about goals of care and supporting team members. While some of these physicians had positive assessments of chaplains' contributions, they also expressed concern about chaplains' ability to provide care for people from

diverse religious traditions, indicating possible unfamiliarity with chaplains' experience in providing interfaith care.[21]

Two studies point to differences in vocabulary between physicians and chaplains when describing what chaplains do. Physicians describe the outcomes of chaplaincy care whereas chaplains emphasize the process of their care using broad terms such as wholeness, presence and healing.[21,23] These different vocabularies may compromise chaplains' efforts to educate their professional colleagues about their role in caring for palliative care patients and their families.

One study reports ICU nurses' perceptions of what chaplains do. This includes listening, providing physical touch (hand-holding, hugging), praying, counseling, and performing religious rituals.[24] Nurses also indicate that:

> "…chaplains were particularly able to fulfill these supportive roles because, paradoxically, while chaplains are ''insiders'' in that they are members of the medical team, they are also viewed as ''outsiders'' because of their unique position in the hospital. They are not responsible for making clinical decisions or dealing with the daily minutiae of caring for a patient. This allows them to serve as a familiar, yet somewhat removed, source of comfort for patients and their families" (p. 43).

Nurses expressed a wish for a better understanding of the chaplains' role to eliminate barriers to requesting chaplaincy services for patients, families and the team.[24]

No study was found that focused exclusively on social workers' perceptions of chaplains. Social workers were included in one small study of the palliative care teams' understanding of what chaplains do.[25] The team members named support with spiritual/religious coping, holistic care, addressing spiritual needs, assisting in advance care planning, support

for families and leading family meetings, and support for the team as main activities of the chaplain.

Having a clear understanding of what chaplains do is important because it contributes to improved utilization of resources of the palliative care team and thereby better care, including spiritual care, for palliative care patients and their loved ones**.** The aim of this study was therefore to describe what palliative care physicians, nurses and social workers understand about what chaplains do.

Method

Brief surveys were distributed to participants at two workshops for palliative care professionals in 2016 (a pre-conference workshop about addressing spiritual issues in palliative care at the annual meeting of the American Association for Hospice and Palliative Medicine, and a session on spiritual care at a two-day multi-professional conference that was part of the Coleman Palliative Medicine Training Program[26]). The survey had three parts. The first part asked participants to rank the questions "How well do you understand chaplains' training and scope of practice" and "How well do you feel you understand what chaplains do" on a scale of 1 to 4 (1 = ”I understand very well,” 4 = “I have no understanding”). The second part asked participants to “Write down one, two or three things that chaplains contribute in palliative care”. The third part asked several questions about the participant's background.

For questions about understanding of chaplains’ training and work we report percentages and means for the sample as a whole and within professional subgroups. To discern if scores between the professions differed significantly, we used the Kruskal-Wallis test. For the correlation between "How well do you understand chaplains' training and scope of practice"

and "How well do you feel you understand what chaplains do", as well as the correlation between years in the profession and years in palliative care, we used Spearman's Rho.

For the qualitative analysis of the descriptions of what chaplains do we began with a sample of comments from 40 participants (20 MDs and 20 RNs). Two authors (AD and GF) examined these comments and developed an initial codebook for the major themes in the comments. Four authors (AD, GF, LF and SO) subsequently coded the comments from this sub-sample and proposed changes and additions to the initial codebook. Two authors (AD and DL) used the revised thematic codebook to code the comments of all the participants; they consulted GF in case of disagreement.

Results

The survey was completed by 120 participants. For six of the participants profession was missing and four participants came from other professions (one each) so we decided to exclude these ten questionnaires from the sample, leaving a sample of 110 participants. The characteristics of the participants are shown in Table 1. The sample consisted of almost equal proportions of physicians (42%) and nurses (44% ,with approximately half of those now practicing as NPs) as well as some social workers (15%). Many had been in their respective professions for two decades but had only worked in palliative care for less than five years.

Insert Table 1 Sample description

The majority of the participants reported that they understood what chaplains do moderately well or very well; their self-rated understanding of chaplains' training and scope of practice was slightly lower overall (See Table 2). The two ratings were strongly correlated ($r=0.76$, $p<.001$). There were slight differences in the self-rated understanding of chaplains

by professional group but these were not statistically significant. Years in one's profession, and especially years in palliative care, were associated with greater self-reported understanding of chaplains (see Table 3).

Insert Table 2 Participants' self-rating of understanding chaplains' training and work

Insert Table 3 Table 3. Association of the understanding of chaplains' training and work to years in the profession and in palliative care

It was somewhat difficult to evaluate the participants' grasp of what chaplains do from their written descriptions. There were many comments about specific ways in which chaplains provide support for palliative care patients and families (25%), as well as comments about chaplains' performing spiritual assessments (8%). Nine percent of the comments described chaplains' involvement in goals of care and advance care planning conversations (private conversations about these topics with patients and families as well as conversation that were part of team meetings with families). Some comments noted chaplains' assistance in facilitating communication when there was conflict between patients and families and the team (4%). While an important part of chaplain care includes offering prayer and leading other religious rituals, we found it interesting that only a small proportion of the comments mentioned these stereotypical activities (7%). These comments notwithstanding, the largest proportion of the comments (33%) were very general statements about chaplains listening or providing support to palliative care patients, families, or team members. Table 4 shows the major categories for participants' descriptions of what chaplains do. Table 5 has examples of participants' descriptions of chaplain activities.

Insert Table 4 Types of comments: total and by professional group

Insert Table 5 Examples of participants' descriptions of chaplain activities

Discussion

The majority of the palliative care physicians, nurses and social workers in this study report understanding of what chaplains do moderately well or very well, with slightly lower self-rated understanding of chaplains' training and scope of practice. Years in the profession and especially years in palliative care are associated with greater understanding. At the same time, one third of the participants' comments are very general statements of what chaplains do. They vary from very short to longer unspecified answers about chaplains listening or providing support to palliative care patients, families, or team members. For example, a short comment was "Counseling", a longer comment was "Providing spiritual care at all phases of life". Comments that include more detail named specific ways in which chaplains support palliative care patients and families (for example "Help patients/ families find meaning at the end of life"), report that chaplains perform spiritual assessments, are involved in goals of care and advance care planning conversations, offer prayer and lead religious rituals, and assist in facilitating communication when there is conflict between patients and families and the team.

Key activities described by our participants are broadly similar to the findings of prior studies,[21-25] and also to a small body of evidence of key chaplain activities in palliative care[27-30] and to chaplain care in general.[31] Based on this broad similarity, the participants' self-rating of understanding what chaplains do moderately well or very well seems appropriate. However, as we have seen, a substantial proportion of the comments missed some important chaplain activities in their descriptions. Respondents seem to be less aware of chaplain activities as for example conflict resolution[27] or facilitating goals of care conversations.[28,39] Further education of palliative care teams about chaplain care appears warranted. Chaplains also need to accept that an integral part of their job is educating their health care colleagues

about what they do and how they contribute to good outcomes for patients, families and the team. Effective ways to educate colleagues include participating in trans- or interdisciplinary palliative care curriculums,[32,33] by pairing medical residents with chaplain interns[34] or inviting medical residents to shadow chaplains,[25,35] by quality documentation of patient encounters in the patient's record, and through daily presence in team meetings.[25] Sharing case studies of chaplain care can also be effective.[30,36-38] Furthermore chaplains need to be more articulate about the work that they do. An important step in this direction is the recent development of a taxonomy of chaplain activities in palliative care.[31] The taxonomy was the result of a multi-stage research process that included a literature review, chart reviews, focus groups, concept mapping and reliability testing. The resulting list offers the possibility of a standardized description of chaplain actitivies, an important new development for the profession.

This study has a number of limitations. The sample is a convenience sample of workshop participants and therefore unrepresentative of palliative care teams in general. Moreover the brief survey did not include demographic information about the participants (gender, race, age), their place of work, their education about spiritual issues in palliative care and experience of working with a chaplain. Future research should therefore focus on a more rigorous study of what proportion of palliative care professionals have an effective understanding of what chaplains do and the factors that contribute to that understanding. It is widely recognized that spiritual care is an important component of palliative care. Chaplains are making important contributions addressing the spiritual needs of palliative care patients and their loved ones. Our findings suggest palliative care colleagues appear to broadly understand what chaplains do but continued education will enhance their understanding of and collaboration with the spiritual care specialists on their team.

References

1. National Consensus Project for Quality Palliative Care (2013). *Clinical Practice Guidelines for Quality Palliative Care, 3rd ed.* https://www.nationalcoalitionhpc.org/ncp-guidelines-2013/. Accessed February 19, 2018.
2. World Health Organization. *WHO definition of palliative care*. http://www.who.int/cancer/palliative/definition/en/. Accessed February 19, 2018.
3. Alcorn SR, Balboni MJ, Prigerson HG, et al. "If God wanted me yesterday, I wouldn't be here today": Religious and spiritual themes in patients' experiences of advanced cancer. *J Palliat Med*. 2010;13(5):581.
4. Balboni TA, Vanderwerker LC, Block SD, et al. Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. *Journal of Clinical Oncology*. 2007;25(5):555.

5. Egan R, Llewellyn R, Wood S, et al. The cancer stories project: Narratives of encounters with cancer in Aotearoa, New Zealand. *Psychooncology*. 2016;25(3):300.
6. Winkelman WD, Lauderdale K, Balboni MJ, et al. The relationship of spiritual concerns to the quality of life of advanced cancer patients: Preliminary findings. *J Palliat Med*. 2011;14(9):122-1028.
7. Phelps AC, Maciejewski PK, Nilsson M, et al. Religious coping and use of intensive life-prolonging care near death in patients with advanced cancer. *JAMA*. 2009;301(11):1140-1147.
8. Tarakeshwar N, Vanderwerker LC, Paulk E, Pearce MJ, Kasl SV, Prigerson HG. Religious coping is associated with the quality of life of patients with advanced cancer. *J Palliat Med*. 2006;9(3):646.
9. Vallurupalli M, Lauderdale K, Balboni MJ, et al. (2012). The role of spirituality and religious coping in the quality of life of patients with advanced cancer receiving palliative radiation therapy. *Journal of Supportive Oncology 10*:81-87.
10. 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? *Journal of Clinical Oncology*. 2007;25(36):5753.
11. Mcclain CS, Rosenfeld B, Breitbart W. Effect of spiritual well-being on end-of-life despair in terminally-ill cancer patients. *The Lancet*. 2003;361(9369):1603-1607.
12. Balboni TA, Paulk ME, Balboni MJ, et al. Provision of spiritual care to patients with advanced cancer: Associations with medical care and quality of life near death. *Journal of Clinical Oncology*. 2010;28(3):445.
13. Balboni T, Balboni M, Paulk ME, et al. Support of cancer patients' spiritual needs and associations with medical care costs at the end of life. *Cancer*. 2011;117(23):5383-5391.

14. Puchalski C, Ferrell B, Virani R, et al. Improving the quality of spiritual care as a dimension of palliative care: The report of the consensus conference. *J Palliat Med*. 2009;12(10):885.

15. Puchalski CM, Vitillo R, Hull SK, Reller N. Improving the spiritual dimension of whole person care: Reaching national and international consensus. *J Palliat Med*. 2014;17(6):642-656.

16. Cunningham C, Panda M, Lambert J, Daniel G, DeMars K. Perceptions of chaplains' value and impact within hospital care teams. *J Relig Health*. 2017;56(4):1231-1247.

17. Balboni MJ, Sullivan A, Enzinger AC, et al. Nurse and physician barriers to spiritual care provision at the end of life. *J Pain Symptom Manage*. 2014;48(3):400-410.

18. Ettema E, Wulp M, Van Leeuwen R, Leget C. Embedding of the spiritual dimension in palliative consultation services in the Netherlands: Inventory, evaluation, and recommendations. *Progress in Palliative Care*. 2015;23(5):259-266.

19. Selby D, Seccaraccia D, Huth J, Kurrpa K, Fitch M. A qualitative analysis of a healthcare professional's understanding and approach to management of spiritual distress in an acute care setting. *J Palliat Med*. 2016;19(11):1197-1204.

20. Spetz J., Dudley N., Trupin L., Rogers M., Meier D, Dumanovsky T. Few hospital palliative care programs meet national staffing recommendations. *Health Affairs.* 2016;35(9): 1690-1697. doi:10.1377/hlthaff.2016.0113.

21. Cadge W, Calle K, Dillinger J. What do chaplains contribute to large academic hospitals? the perspectives of pediatric physicians and chaplains. *J Relig Health*. 2011;50(2):300-312.

22. Fitchett G, Lyndes KA, Cadge W, Berlinger N, Flanagan E, Misasi J. The role of professional chaplains on pediatric palliative care teams: Perspectives from physicians and chaplains. *J Palliat Med*. 2011;14(6):74-707.

23. Lyndes KA, Fitchett G, Berlinger N, Cadge W, Misasi J, Flanagan E. A survey of chaplains' roles in pediatric palliative care: Integral members of the team. *J Health Care Chaplain*. 2012;18(1-2):74-93.

24. Kim K, Bauck A, Monroe A, Mallory M, Aslakson R. Critical care nurses' perceptions of and experiences with chaplains: Implications for nurses' role in providing spiritual care. *Journal of Hospice & Palliative Nursing*. 2017;19(1):41-48.

25. Jackson-Jordan E, Stafford C, Stratton SV, Vilagos TT, Janssen Keenan A, Hathaway G. Evaluation of a chaplain residency program and its partnership with an in-patient palliative care team. *J Health Care Chaplain*. 2018;24(1):20-29.

26. O'Mahony S, Levine S, Baron A, et al. Palliative Workforce Development and a Regional Training Program. *American Journal of Hospice and Palliative Medicine.* 2018; 35(1):138-143.

27. Wirpsa MJ, Johnson RE, Bieler J, et al. Interprofessional Models for Shared Decision Making: The Role of the Healthcare Chaplain. *Journal of Healthcare Chaplaincy.* (in press).

28. Idler E, Binney Z, Grant G, Perkins M, Quest T. 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 (S710). *J Pain Symptom Manage*. 2015;49(2):412-412.

29. Jeuland J, Fitchett G, Schulman-Green D, Kapo J. Chaplains working in palliative care: Who they are and what they do. *J Palliat Med*. 2017;20(5):52-508.

30. Kearney G, Fischer L, Groninger H. Integrating spiritual care into palliative consultation: A case study in expanded practice. *J Relig Health*. 2017;56(6):2308-2316.

31. Massey K, Barnes MJD, Villines D, et al. What do I do? developing a taxonomy of chaplaincy activities and interventions for spiritual care in intensive care unit palliative care. *BMC palliative care*. 2015;14(1):10.

32. Forrest C, Derrick C. Interdisciplinary education in end-of-life care: Creating new opportunities for social work, nursing, and clinical pastoral education students. *Journal of Social Work in End-Of-Life & Palliative Care*. 2010;6(1-2):91-116.

33. Otis-Green S, Ferrell B, Spolum M, et al. An overview of the ACE project—Advocating for clinical excellence: Transdisciplinary palliative care education. *J Canc Educ*. 2009;24(2):120-126.

34. Hemming P, Teague P, Crowe T, Levine RB. Demystifying spiritual care: An interprofessional approach for teaching residents and hospital chaplains to work together. *Journal of Graduate Medical Education*. 2016;8(3):454.

35. Talley A, J., Magie A, R. The integration of the "Spirituality in medicine" curriculum into the osteopathic communication curriculum at kansas city university of medicine and biosciences. *Academic Medicine*. 2014;89(1):43-47.

36. Cooper RS. The palliative care chaplain as story catcher. *J Pain Symptom Manage*. 2018;55(1):155-158.

37. Fitchett, G., & Nolan, S. (2015). *Spiritual Care in Practice: Case Studies in Healthcare Chaplaincy.* London: Jessica Kingsley Publishers.

38. Nolan S. "He needs to talk!": A Chaplain's case study of nonreligious spiritual care. *J Health Care Chaplain*. 2016;22(1):1-16.

39. Lee AC, McGinness CE, Levine S, O'Mahony S, Fitchett G. Using Chaplains to Facilitate Advance Care Planning in Medical Practice. *JAMA Intern Med.* 2018;178(5):708–710.

Table 1. Sample Description

Current employment (*N* = 110, *n*, %)		
Physician	46	41.8
Advanced practice nurse	21	19.1
Registered nurse	27	24.6
Social worker	16	14.6
Years worked in the profession (*N* = 110, mean, SD)	20.0	11.8
Years worked in palliative care (*N* = 108, median[a], IQR)	4	1.5, 9.5
Survey distributed in meeting (*N* = 110, *n*, %)		
American Academy of Hospice and Palliative Medicine pre-conference workshop	58	52.7
Coleman Palliative Medicine Training Program	52	47.3

[a]Years worked in palliative had a skewed distribution.

Table 2. Participants' self-rating of understanding chaplains' training and work

	Understanding of chaplains' training and scope of practice (%)[a]					Understanding of what chaplains do (%)[b]				
	Mean, SD	1 = very well	2 = moderately well	3 = slightly	4 = no understanding	Mean, SD	1 = very well	2 = moderately well	3 = slightly	4 = no understanding
Physician	2.20, 0.81	21.7	39.1	37.0	2.2	2.02, 0.65	17.4	65.2	15.2	2.2
Nurse practitioner/ advanced nurse practitioner	2.19, 0.75	19.1	42.9	38.1	0	1.86, 0.57	23.8	66.7	9.5	0
Registered nurse	2.07, 0.68	18.5	55.7	25.9	0	1.85, 0.46	18.5	77.8	3.7	0
Social worker	1.88, 0.72	31.3	50.0	18.8	0	1.69, 0.60	37.5	56.3	6.3	0
Total	2.12, 0.75	21.8	45.6	31.8	0.9	1.90, 0.59	21.8	67.3	10.0	0.9

a The Kruskall-Wallis Test for differences for understanding of training between the professions was non-significant, Chi-square = 2.48, DF = 3, $p > .05$.

b The Kruskall-Wallis Test for differences for understanding of work between the professions was non-significant, Chi-square = 3.99, DF = 3, $p > .05$.

Table 3. Association of the understanding of chaplains' training and work to years in the profession and in palliative care

	Understanding of chaplains' training and scope of practice Spearman's Rho, *p*	Understanding of what chaplains do Spearman's Rho, *p*
Understanding what chaplains do	0.76, p < .001	
Years in the profession	-0.20, *p* < .05	-0.26, *p* < .05
Years in palliative care	-0.37, *p* < .001	-0.39, *p* < .001

Table 4. Types of comments: total and by professional group

Type of Comment	Total (n=110)	MD (n=46)	APN (n=21)	RN (n=27)	SW (n=16)
General support, listening, provide space	33%	32%	32%	34%	38%
Support for specific concern	*25%*	27%	29%	18%	24%
Team focused: support, renewal, educate	12%	14%	13%	10%	7%
Involvement in decision-making, family mtgs, ACP + AD	9%	4%	13%	8%	16%
Spiritual assessment and spiritual history-taking	8%	9%	9%	7%	5%
Provide rituals, prayer	7%	6%	1%	16%	7%
Bridge communication and conflict between pt/family + team	4%	7%	0%	4%	0%
Bridge communication beween team/hospital + pt/family local religious leaders/community	2%	1%	1%	4%	3%

Table 5. Examples of participants' descriptions of chaplain activities

Type of comment	Exemplary quotation
General support, listening, provide space	*Provide spiritual support to patients, families & staff*
Support for specific concern	*Addressing meaning/ purpose/ existential suffering*
Team focused: support, renewal, educate	*Discussions with staff about spiritual distress and staff support*
Involvement in decision-making, family mtgs, ACP + AD	*Provide a reflective supportive healthy space to support difficult medical decision*
Spiritual assessment and spiritual history-taking	*Robust spiritual assessments using a language consistent with patients' needs*
Bridge communication and conflict between pt/family + team	*They are often an immediate consult for our miracle thinking families and are able to be supportive and explore deeper the miracle context of their beliefs and inform the health care team*
Bridge communication beween team/hospital + pt/family local religious leaders/community	*Liaison between patients and the health care team (help translate "doctor speak")*