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Multidisciplinary staff perspectives on the integration of spiritual care in a new setting: Israel

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Abstract

Objective. Integrating spiritual care into multidisciplinary care teams has seen both successful thoughtful collaboration and challenges, including feelings of competition and poor cross-disciplinary understanding. In Israel, where the profession is new, we aimed to examine how spiritual care is perceived by other healthcare professionals learning to integrate spiritual caregivers into their teams.

Method. Semi-structured qualitative interviews of 19 professionals (seven physicians, six nurses, three social workers, two psychologists, and one medical secretary) working with spiritual caregivers in three Israeli hospitals, primarily in oncology/hematology. The interviews were transcribed and subjected to thematic analysis.

Results. Respondents' overall experience with adding a spiritual caregiver was strongly positive. Beneficial outcomes described included calmer patients and improved patient–staff relationships. Respondents identified reasons for a referral not limited to the end of life. Respondents distinguished between the role of the spiritual caregiver and those of other professions and, in response to case studies, differentiated when and how each professional should be involved.

Conclusion. Despite its relative newness in Israel, spiritual care is well received by a wide variety of professionals at those sites where it has been integrated. Steps to improve collaboration should include improving multidisciplinary communication to broaden the range of situations in which spiritual caregivers and other professionals work together to provide the best possible holistic care.

Introduction

There is widespread consensus that patient care should be a collaborative effort of the multidisciplinary team (MDT). Best practices for MDT work in general (Bronstein, 2003) and for providing spiritual care within the MDT (Harr et al., 2009; Puchalski et al., 2009) have been described. It is a key for teams to establish good formal communication mechanisms and work to find common professional language (Harr et al., 2009; O'Connor and Fisher, 2011; Kao et al., 2017), articulate shared goals and values and a commitment to finding the added value gained by collaborating (Bronstein, 2003), and work to gain a deeper understanding of the unique role fulfilled by each profession and to learn to respect the different perspectives brought by each profession (Harr et al., 2009; O'Connor and Fisher, 2011).

MDT best practices require members of the team to have a clear understanding of each other's roles and contributions and a willingness to work together. The contribution of spiritual caregivers as part of this multidisciplinary collaboration has been hampered at times by the perceived poor understanding of their professional role by other members of the team (Wittenberg-Lyles et al., 2008; O'Connor and Fisher, 2011; Kao et al., 2017), which can lead to sub-ideal collaborative care and greater levels of stress (Williams et al., 2004).

A number of studies have examined the assessment of other professionals — physicians, nurses, social workers, and mental health professionals — regarding the contribution of spiritual care (Fitchett et al., 2011; Taylor et al., 2015; Fitchett, 2017; Willemse et al., 2018) and regarding when a referral should be made for spiritual care (Fogg et al., 2004; Flannelly et al., 2006; Galek et al., 2007, 2009; Vanderwerker et al., 2008; Weinberger-Litman et al., 2010; Fitchett et al., 2011).

While members of the MDT are generally very positive about spiritual care (Fitchett et al., 2009) and spiritual caregivers describe good working relationships across the professions; in

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practice, nurses refer far more often (Fogg et al., 2004; Vanderwerker et al., 2008; Galek et al., 2009) and ascribe more importance to spiritual care (Flannelly et al., 2006) than do physicians or social workers. Spiritual caregivers experience nurses as providing the most support (Wittenberg-Lyles et al., 2008) and as best understanding their role, while physicians and social workers see a more limited role for spiritual care (Galek et al., 2009). Furthermore, qualitative studies have raised more negative experiences, such as role conflict (Wesley et al., 2004), competitiveness, and "turf wars," especially among the more closely overlapping fields such as social work and psychology, or when role blurring takes place (O'Connor and Fisher, 2011), and even disrespect for what another profession has to offer (Harr et al., 2009).

The field of hospital-based spiritual care began in Israel a decade prior to this study. An earlier study interviewing Israeli healthcare directors and policymakers showed an acknowledged limited understanding of spiritual care and concerns with potential inter-professional conflict, especially between spiritual caregivers and social workers (Bentur et al., 2010). One unique aspect of Israeli spiritual care is that it was founded on spirituality broadly understood rather than religion and makes use of a wide range of cultural and spiritual resources. Professional spiritual caregivers in Israel are generally not ordained clergy (Bar-Sela et al., 2014; Pagis et al., 2017). This decision grew out of general developments in the field of spiritual care (Schultz et al., 2017), the specific setting, and its history of religious-secular tension (Pagis et al., 2017), and perhaps the fact that a very large majority of clergy in Israel are male and the profession did not want to exclude female practitioners.

Not enough is known about how other MDT members perceive and have received the new Israeli spiritual care profession. Therefore, the present study aims to explore the ways in which MDT members from a variety of professions understand the role of the spiritual caregiver, what takes place in a spiritual care visit, the contribution of spiritual care to patient and family member well-being, and their experience of working collaboratively with the spiritual caregiver. The study offers insights into the specific opportunities and obstacles for MDT collaboration in a relatively new setting for spiritual care provision with a different set of preconceived notions about spiritual care and is relevant worldwide as the role of spiritual caregivers shifts from a more religious role to a more broadly spiritual one.

Methods

To gain an in-depth understanding of how the work of spiritual caregivers is experienced by different healthcare professionals in different hospital settings, we adopted a phenomenological approach to qualitative research. In this way, we were able to develop a synthesized description of the essence of this experience (Creswell, 2013).

Following Polkinghorne's tradition of narrative analysis (Polkinghorne, 1989), we conducted 19 face-to-face semi-structured interviews in three Israeli university hospitals: Rambam Health Care Campus in Haifa, and Shaare Zedek and Hadassah Medical Centers, both in Jerusalem. By profession, the interviewees included seven physicians, six nurses, three social workers, two psychologists, and one medical secretary. By the medical area, seven worked in oncology, seven in hematology, one in geriatrics, one in internal medicine, one in women's health, one in cardiology, and one in gastroenterology. As is common in this kind of qualitative research, the interviewees were not randomly selected. We chose three hospitals at which the spiritual care service was relatively well established (over 4 years) and then identified all the key staff members who had significant experience of working together with the spiritual care providers. We aimed to achieve a balance between the different professions, although limited staff availability led to a higher representation of medical professionals. Hemato-oncology is relatively over-represented in this study, reflecting the relative distribution of spiritual care provision in Israeli hospitals in the early years of the Israeli field's development.

Table 1. Guiding questions for semi-structured interviews

Regarding what the profession of spiritual care is
1. What, in your opinion, is the role of the spiritual caregiver?
2. What, in your opinion, does the spiritual caregiver contribute?
3. Drawing on your acquaintance with spiritual care, what content areas and fields does it deal with?
Referrals to spiritual care
4. In your opinion, in what situations should a referral to spiritual care be made?
5. Are there situations where your sense is that you can't address it and a referral should be made to spiritual care? Which kinds of situations?
6. In your opinion, in what situations should a referral **not** be made to spiritual care?
7. In your opinion, at what stage in patient care is it advisable to offer spiritual care?
You and the spiritual caregiver
8. What is your role in the department?
9. Have you experienced situations in which the spiritual caregiver's work interfered with your work?
10. In what ways is your profession similar to spiritual care and in what ways is it different?
11. Have you experienced situations in which your role shrank as a result of the spiritual caregiver's involvement?
12. What, in your opinion, uniquely distinguishes spiritual care from other professions?

Because our study goal was to examine the nature of staff collaboration where spiritual care is involved, we were limited to interviewing staff who had experience of working collaboratively with spiritual caregivers. This would exclude staff whose negative attitudes toward spiritual care led them to be unwilling to work together with spiritual caregivers and had the overall potential to bias results toward positive feelings about spiritual care, although the anonymity of the study would hopefully mitigate against such a bias.

The study design included 12 open questions (see Table 1) and three case studies generated by study staff. The questions belonged to three categories: the nature and contribution of spiritual care, referring to spiritual care, and working collaboratively with the spiritual caregiver. Questions related both to opportunities and challenges as seen by the interviewees. After reading the three short case studies, interviewees suggested a multidisciplinary care plan for that scenario that could or could not include spiritual care. The semi-structured interviews covered the 12 guiding open questions, adapting their order to the interviewee's responses. The interviewer could follow up or expand on

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interviewee responses as appropriate with questions that had not been formulated previously. The case study analysis was conducted in the second half of the interview, thus enabling a comparison between the "theoretical" and the "practical" responses regarding multidisciplinary collaboration. The interviews were transcribed verbatim for analysis. The interviews, all of which were carried out by one of the study authors (SMB), were conducted at the interviewees' workplaces and were 20–30 min long each. The study design was approved by the Helsinki committee of the first author's hospital.

Thematic analysis (Braun et al., 2019) was conducted by JCC, YA, and MS who read through the transcribed interviews and formulated themes (coding was conducted independently by JCC and YA). The themes were then compared to gain a holistic comprehension of the data in the tradition that attempts to create a synthesis and reconfiguration of the data into a coherent expression of meanings and understandings derived from the data (Kelly and Howie, 2007).

Results

The themes we identified, as relating to the study's objectives, included a number of specific ways in which spiritual care supported and improved patient care, including several items that were unique contributions of the spiritual caregiver within the MDT; a limited sense of what actually took place in spiritual care visits; and items relating to the subjective experience of staff collaboration and the practical experience in developing multidisciplinary care teams.

The contributions of spiritual care

All the interviewees stated that their experience of having a spiritual care professional on their unit was positive, and they saw it as assisting other healthcare professionals in conducting their jobs. Spiritual care was described as conducive to staff's building supportive relationships with patients and family. Respondents stated that it helped patients to gain insight into their situation and to gain a different perspective that was helpful for their coping, even if it did not change their situation. Also, patients were reportedly calmer after meeting with the spiritual caregiver, which was seen as beneficial to the respondents' work environment and helpful in enabling them to do their jobs.

One nurse said:

> I feel like it's magic. After their meeting with a patient or family, all of a sudden I receive a patient that is prepared, ready, calm, quiet, and it is so great.

Furthermore, many interviewees emphasized the ability of the spiritual caregiver to create a relationship with the patient that is more personal and less formal, which other professionals are not able to do because of perceived or explicit professional guidelines to refrain from getting too close to the patient. The spiritual caregivers were also seen as beneficial in obtaining information about patients that could be helpful in treatment. The friendly relationship that spiritual caregivers are able to create enabled the patients to open up and share information about themselves more readily. Several staff members even reported receiving spiritual care themselves from the spiritual caregiver, helping them cope with difficult feelings that arose in their work, particularly in the care of dying patients, and find some release.

The role of the spiritual caregiver and the role of other team members

Spiritual care professionals were seen as a beneficial and integral part of the team. Even among professionals who felt that spiritual care ran on a parallel track to their work — i.e., psychologists and social workers — it was still felt that spiritual care made a meaningful contribution to patients' well-being and to improving the workplace atmosphere. In their view, patients are thirsty for attention and care, and having more staff providing this care is good for everyone. One similarity identified between spiritual care and the other health professions is the understanding that what is the most important is the person, not their illness.

Respondents also noted some of the differences in professional roles. One physician said:

> Spiritual care is something that we used to do naturally, and we've forgotten how to do it, how to accompany the patient the whole way, even when you cannot change … the patient's situation. Just travelling this path together with him, supporting him through the difficulty and the pain, simply being with him.

The role of the spiritual caregiver was seen as very fluid, including helping the patient to feel more at ease or to let go of things. One professional difference emphasized was that spiritual care as a profession did not stem from the pathological or the differentiation of what is and what is not normal or preferable (as opposed to medicine, psychology, etc.). The spiritual caregiver is not there to help the patient change, but rather comes from a position of acceptance. The spiritual caregivers are described as open and totally focused on what the patient "brings to the table." As one nurse stated:

> The spiritual caregiver enables the patient to connect to himself, to give him the space without deciding for him.

This role is seen as very important for the patient but difficult for most other staff to fulfill. Many emphasized that the spiritual caregiver has time to be with the patients, whereas other staff do not have the time and sometimes the resources to engage with the patients on as much of a personal level as they would like. Others emphasized the emotional difficulty of staff to cope with painful statements. One nurse said:

> I have been in this profession for many years, almost 20 years. I know that most of the time we need to give them the main stage, let the patient talk about their truest fears, about the hardest things … Usually the staff has no time … and the truth is that we can't deal with this difficult material.

In addition, the spiritual caregiver is seen as having the tools to help patients open up, that some of the staff feel they do not have. As one nurse stated, "he can get into the soul (of the patient)." However, respondents did not show a clear understanding of what those tools are or how, specifically, spiritual caregivers work.

A related distinctive aspect of spiritual care was described as "being" with the patients as opposed to the role of the other staff in "doing" for the patients. One nurse commented:

> We as staff – medical and nursing - are busy with what we call 'doing.' It's very easy for us to give advice, to tell them what the right thing to do is, who to ask, what pill to take. We go in that direction very quickly because that's what we know. Sometimes it is a type of escape to a more operative place. I think the spiritual caregiver is there first and foremost to listen. To

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> listen and understand … He doesn't try to fix or to guide them or decide for them … He goes with the direction that the patient chooses … .

Some staff spoke of the decreased stigma that goes along with talking to a spiritual caregiver as opposed to talking with a psychologist or a social worker. The patients may think that they are thought of as mentally ill if they referred to a mental health professional and have an easier time speaking with the spiritual caregiver. In addition, spiritual caregivers were perceived as being a non-institutional profession. Some interviewees stated that this could be beneficial, as spiritual caregivers are not seen as part of the "system" and, as a result, patients are quicker to open up to them. In one social worker's words:

> The spiritual caregiver doesn't wear a white coat. He radiates a kind of being closer to the patient, less like a part of the institution … He has better listening skills [than other professionals] …

Spiritual caregivers are seen as beneficial to family members and as working in concert with psychologists and social workers with difficult families and patients. Some staff members felt that the spiritual caregiver was more helpful to the family, while other professionals are more helpful to the patient himself.

When and for whom to refer to spiritual care

Many of the interviewees stated that spiritual care is always appropriate and of potential benefit to the patient. Some participants felt that it was unfortunate that spiritual care was primarily brought in as death approached and that it should be used to help with other kinds of difficulties. They expressed an understanding that resources are generally limited and, in that case, spiritual care is most needed when looking for answers during very difficult times and as a way to come to terms with the impending end of life. As one physician puts it:

> I think it is better for spiritual care to begin with diagnosis and for him to accompany the patient throughout treatment … I think the only situation that might not be appropriate would be if someone refuses. I don't think spiritual care has a contraindication (laughter) …

One potential concern that was stated is that patients at the very beginning stages of oncologic treatment might not have the mental space to engage in receiving spiritual care, as they are busy with the here and now of treatment and getting used to their new situation. In addition, one respondent suggested that very concrete patients would not benefit from spiritual care.

Interestingly, we found a noticeable discrepancy among some respondents between their responses to the general question when and for whom you would refer to spiritual care and their responses to the case studies presented. While professionals stated that, in general, spiritual care is almost always helpful, while responding to the case studies, they seemed to emphasize the importance of having other professionals involved in the case, and possibly using spiritual care as adjunct care, if needed. Additionally, many professionals emphasized that spiritual care was particularly appropriate if patients were religious or if the patient himself mentioned spirituality. This focus, as well as some perceived limitations of the spiritual care role, can be seen in the response of one social worker:

> [1st case:] With him and his parents, the topic came up of spirituality and religion and connection to worlds of meaning beyond the concrete, so I anticipate there could be a good connection to the spiritual caregiver … [2nd case:] I don't know how much it's possible to talk with this patient about matters of the spirit, how open he is … as his anxiety is so high. [3rd case:] This is the kind of situation we social workers generally deal with because it's crisis intervention … I more imagine the patient sitting in a quiet room with the spiritual caregiver.

Discussion

We found that staff members were supportive of spiritual care and, as a consensus, see it as contributing to both patient and staff well-being. This is in line with findings elsewhere (Resnitzky and Bentur, 2014), such as Fitchett's report of 90% physician satisfaction with spiritual care provision (Fitchett et al., 2009).

Regarding when to refer to spiritual care — one key element in understanding staff collaboration — our respondents cited a range of reasons, including emotional issues, such as anxiety and sadness, grief, death, and spiritual or existential questions, often at the end of life. A number of other studies asked staff people in what situations they would theoretically refer patients or family members to spiritual care, while others collected "live" data at the time of staff-generated referrals regarding the conditions of the referral. Key roles that these staff saw for spiritual care included grief work, the end of life, prayer, help with spiritual issues, such as questions of meaning or guilt, and emotional support (Fogg et al., 2004; Flannelly et al., 2006; Galek et al., 2007, 2009; Vanderwerker et al., 2008; Weinberger-Litman et al., 2010; Fitchett et al., 2011; Resnitzky and Bentur, 2014; Willemse et al., 2018). A less prominent but still significant role for spiritual care was in cases of medical issues, such as new diagnoses or prognoses, difficult decisions, noncompliance, or complaints about the quality of care (Galek et al., 2007, 2009; Vanderwerker et al., 2008; Weinberger-Litman et al., 2010; Resnitzky and Bentur, 2014). Most patients referred were not at the end of life (Vanderwerker et al., 2008), a noteworthy difference from our study. One Israeli, the nursing home-based study highlighted changes in residents' independent functioning as a key indicator (Resnitzky and Bentur, 2014). Staff noted that patients lacking social support should receive spiritual care (Willemse et al., 2018), in line with two Israeli studies (Bentur et al., 2010; Schultz et al., 2014). Religious needs consistently ranked low as a reason for the referral (Flannelly et al., 2006, Galek et al., 2009).

It is interesting to consider when spiritual caregivers themselves think they should be called in. In one Israeli study, spiritual caregivers highlighted end-of-life work and meaning-making (Pagis et al., 2017). In an American study, spiritual caregivers agreed with other staff regarding the high importance of their providing emotional support and the relatively low importance of their providing religious services, but ascribed relatively less importance to death and end-of-life spiritual care (Galek et al., 2009). Spiritual caregivers consistently thought that they should be involved in a broader range of situations than what other professions thought (Galek et al., 2007, 2009), yet that gap is less prominent in Israel.

Regarding outcomes of spiritual care, the staff we interviewed reported that spiritual care was good in helping patients or family members experiencing difficult emotions, helping them become calmer; and establishing close relationships and improving the staff–patient relationship. The calming effects were reported previously in Israel (Resnitzky and Bentur, 2014). Spiritual care

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in Israel seems to be meeting some of the outcomes reported elsewhere, where physicians have observed that integrating spiritual care into the MDT led to improved family–team communication and cultural understanding (Fitchett et al., 2011) and improved coping (Willemse et al., 2018). Patient-reported outcomes include making the hospital stay easier, improved trust in physicians, and improved MDT work (Fitchett, 2017).

Massey et al. (2015) studied spiritual caregivers' own goals, methods, and interventions. One highly ranked intervention was facilitating communication with the care team, and the top intended outcome was establishing a relationship of care and support, in line with our findings. In addition, several other intended outcomes reported by Massey related to helping patients and family members become calmer, as MDT members reported happened in practice in our study. Another outcome noted both elsewhere and in our study is the spiritual caregiver providing personal support for team members (Wittenberg-Lyles et al., 2008; Bentur et al., 2010; Fitchett et al., 2011; Jeuland et al., 2017; Willemse et al., 2018).

Interestingly, our respondents provided very little description of the content of the spiritual care visits and seemed to have a poor or even inaccurate sense of what it looks like, as compared with an Israeli study in which spiritual caregivers described the content and form of their visits (Bentur et al., 2010). This may lead to generalizations, such as the statement that spiritual care is always appropriate. Or, perhaps, it indicates that it is sufficient to know how spiritual care is helpful without knowing what it looks like. Respondents hardly mentioned actual spiritual issues discussed with patients and did not mentioned one of the unique elements of the content of Israeli spiritual care, the use of cultural and social resources, such as poetry and song (Pagis et al., 2017), although they did touch on a number of key dimensions of spirituality prominent in serious illness (Steinhauser et al., 2017).

Spiritual caregivers consistently identify collaboration with the MDT as a key element of and competency for their work (Cooper et al., 2010; Massey et al., 2015). The discrepancy between relatively undiscriminating endorsements of involving spiritual caregivers in the open questions and discerning care planning giving different roles to different professionals in the theoretical case studies suggests that staff have begun collaborating with spiritual caregivers in a thoughtful, intentional manner. Keys to successful collaboration include attaining flexibility, interdependence, a whole that is greater than the sum of its parts, and collective agreement on goals (Bronstein, 2003), and this approach can guide the Israeli field through the process of fully integrating spiritual care into existing care teams.

Conclusion

At a fairly early stage of integrating spiritual care into the Israeli healthcare system, the profession has been received positively by staff members that have begun collaborating with the spiritual caregivers. Spiritual care was seen as a positive addition, both by those who see their work as more similar to that of the spiritual caregiver and by those who highlighted the differences. Staff identified a number of indicators for referrals as well as common outcomes of spiritual care provision, similar to but more limited than those identified elsewhere in the world where the integration of spiritual care is more well established. Next steps for improving collaboration include improving staff understanding of the range of situations in which spiritual care can be beneficial, maintaining good communication and ensuring shared team goals, and using limited staff creatively and flexibly to develop the best possible patient care plans. While acknowledging cultural differences, we also see cross-cultural similarities in the challenges posed by poor understanding of the content of spiritual care. Further dissemination and the development of consensus terminology for describing spiritual needs, resources, and interventions will improve multidisciplinary understanding of spiritual care and the ability of staff to work together effectively.

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