Intervention, Ethical Decision-Making, and Spiritual Care

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Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices. (Puchalski, Vitillo, Hull, Reller, 2014, p. 646)

Essential Questions

- How does spirituality affect advance care planning?
- What are the similarities and differences between hospice and palliative care?
- How would a nurse explain the Christian principle(s) for administering spiritual care to patients? Why is this worldview important to the nurse and patient?
- How would a nurse complete a spiritual care intervention with a patient? What type of open-ended questions should be as

Introduction

All human beings seem to be born with an intrinsic desire for meaning, transcendence, purpose, and belonging. This desire is wl drives all of human life from beginning to end. Any and every worldview is essentially an attempt to decipher and live out one's ultimate meaning and purpose. Four fundamental points follow from this observation. First, all human beings desire to discover their ultimate meaning and purpose might be. An easy way of beginning to decipher where one derives his or her ultimate purpo to simply notice the things that one considers to be priorities in everyday life. For some, it is to make as much money as possibl to further one's career at the cost of all else. For others, it may be family or the pursuit of comfort. Ultimate purpose is linked to a person considers to be the most valuable and to be sought after above all else. The term *worship*, often relegated to only descri religious practices, can actually describe all of human behavior because *worth-ship*, the root word from which the term *worship* comes, refers to ascribing ultimate value and meaning to something or someone. In short, whether religious or not people can view that human beings are worshipers by nature.

Secondly, every person has a spiritual nature, whether he or she realizes it or not. Spirituality is informed and developed within t context of a person's worldview. A person's spirituality is reliant upon his or her faith, lack of faith, theological interpretations, a even how they view the origins of creation and humanity. What they value above all else is once again dependent upon what is t real and what it means to live fully as a human being. A person's worldview shapes his or her inner life and character, such that not purely an academic or intellectual question but will involve his or her emotions, thoughts, feelings, desires, and will. In the s way that all people have a worldview, all people will have or express a particular kind of spirituality, even if it is not always recognizably religious.

Thirdly, a person's worldview and, in turn, what they come to worship shapes, informs, and transforms them spiritually. It is not question of whether or not they will be spiritually formed because all are being formed or developing internally in one way or another, rather the question is what exactly are they being formed into? Dallas Willard (2002) addresses this idea as follows:

> We may be sure of this: the formation, and later transformation of the inner life of [human beings], from which our outer existence flows, is an inescapable human problem. *Spiritual formation, without regard to any specifically religious context or tradition, is the process by which the human spirit or will is given a definite "form" or character.* It is a process that happens to everyone. The most despicable as well as the most admirable or persons have had a spiritual formation. Terroris as well as saints are the outcome of spiritual formation. Their spirits have been formed. Period. (p. 19)

Finally, given the first two points above, the importance of a person's spirituality and inner workings must be considered. That i what considerations each individual has internally, what one values, especially when it comes to serious matters he or she may h not been exposed to or confronted with. When people have to face fears and unknown questions, people then rely on their real p deep down inside, their human spirit. This is where an understanding of the importance of the concept of spirituality and how it relates to patient care begins. It is a serious mistake to think of spiritual care as simply a last-ditch effort to provide emotional comfort to patients after all other medical treatments have failed. Nor is it accurate to relegate spiritual care to the realm of simp facilitating the performance of religious rituals and rites, void of compassion and empathy. As a matter of fact, if human beings

When a health care provider does his or her job with skill, competence, and understanding, most people will be shaped by gratitu joy, and trust. On the other hand, if a patient's experience with a health care provider is characterized by indifference, belittling, even technical negligence, such a patient's inner world will likely develop an aversion to and distrust of health care providers. Equally disturbing is the damage caused to what a Christian worldview would call the soul, the inner being that experiences real emotional wounding. This means that helpful interventions and ethical decision-making flow out of a person's spirituality and n other way around. The core of a person's being, what he or she values pours into these important decisions.

Puchalski et al.'s (2014) comprehensive definition of spirituality reveals the complex nuances of humanity's spiritual nature. Th definition can be well supported by diverse faith and spiritual traditions, but also by Christian beliefs and biblical principles. If a person believes he or she was created by God, then this person must assume that his or her spirituality was given by God to be u for God-glorifying purposes (Psalm 29:2; 1 Corinthians 10:31). The quality of a Christian's spiritual experiences is connected to depth of his or her relationship with an interactive, redemptive, and holy God who gives peace, joy, and deep life satisfaction wh one's life and faith beliefs are aligned with godly principles of living and purpose (Colossians 2:6; 3:1–17; Ephesians 2:4–10; Galatians 5:16–25; Philippians 2:13; 4:13).

This chapter will review the key role that personal beliefs play in informing ethical and end-of-life-decisions. In the next section Christian theological basis for spiritual care will be established to serve as a foundation for a discussion of how health care prov can utilize practical spiritual screens, histories, and specific assessments to better understand and care for their patients and their families. Building upon this discussion will be an overview of the key aspects of surrogacy laws, hospice and palliative care, an how a patient's beliefs play into their decisions.

Christian Spiritual Care

As discussed earlier in this book, worldview questions (e.g., "Where did I come from?") correspond to the basic Christian narrat acts of creation, the fall, redemption, and restoration, as people make sense of God, their relationship with God, and their role an actions in this world according to the Bible. This understanding also guides how important decisions are made. With the context human beings are inherently spiritual beings, then they have a need for spiritual care in whatever stage of life. For nurses and otl health care providers, understanding a patient's internal worldview is at the core of how providers approach their administration health care, their ability to respect that worldview, and the belief system of the patient. Being intentional and attentive to a patien his or her family's spiritual needs leads to positive holistic health care outcomes.

Nursing has long been associated with spirituality and how it helps to inform and make meaning of life situations to patients. Nu educators Timmins and Caldeira (2017) state that for religious people, "spirituality refers to the soul and its protection and nurtu during life … 'protected' through correct moral thought and by living as directed through sacred texts" (p. 50). Research contin demonstrate that there is a positive relationship between spirituality, health, and well-being (Hall, Hughes, & Handzo, 2016). Spirituality affects every aspect of a person's life, so offering emotional and spiritual care support should be an important focus f health care providers.

Even though The Joint Commission (TJC) requires all patients be asked about how their spiritual and religious preferences may impact their health care, only 54-63% of hospitals fulfill these requirements through employing professional health care chaplai (Hall et al., 2016). Nurses who understand the importance of spirituality and faith can effectively fill in the gap and administer effective soul care to those in need. By understanding and providing interventions that help relieve spiritual distress, nurses can l reduce the patient's worries and concerns, which allows for more complete physical, emotional, and social well-being. Often a n can promote this by asking simple questions such as, "What has helped you cope well in the past?" or "What gives meaning to y life?" and "Do you have any spiritual or faith preferences?" If a nurse is truly attentive, he or she can easily see what may bring comfort or angst as a patient provides answers to these questions.

A patient's spiritual needs, even if unspoken, should always be a primary focus for treatment in this area, not the spiritual ideals specific religion of the nurse. Nurses should not assume they must be religious or steeped in a specific faith tradition to give qua spiritual care, attending to the whole person inwardly. Although many patients will follow formal religious and theological doctr and often express those beliefs through traditional religious rites and practices, many others will seek to express their spiritual beliefs, morals, and life values in other diverse ways. These can sometimes be determined by looking at a patient's overall deme Similar to a hospital chart that identifies levels of pain through simple facial expressions, with some practice, a health care professional can also look for expressions of sadness, gloom, depression, concern, and fear, among others.

Because of the complexity of spirituality, "nurses feel underequipped to provide spiritual care" and often "struggle to articulate a functional or 'actionable' definition of spirituality, and are 'uncertain about what constitutes spiritual care'" (Hughes et al., 2017 3). Most patients and their families "do not anticipate in-depth, specialized spiritual care from their nurses, but they do have a st expectation for some basic spiritual care connections including interventions such as active and empathic listening, proactively communicating, and expressing compassion" (Hughes et al., 2017, p. 8). Another way to view this is to consider what the perso experiencing internally even as nursing care primarily focuses on physical care.

As reviewed, a person's spiritual beliefs and values will guide day-to-day decisions as well as critical health and end-of-life-treat choices. Within that context, this chapter will discuss the topics of advance care planning, end-of-life care options and decisions

topics and decisions are the individual's worldview that really does inform how individuals view life and death. As previously introduced, this understanding of one's worldview both determines and distinguishes each patient's unique personal values, experiences, and spiritual beliefs.

Role of Spirituality in Clinical Care and End-of-Life Decision-Making

A person's spirituality and faith values impact his or her understanding of illness as well as health care decisions. Several critical decisions informed influenced by one's spirituality are advance care planning, self-autonomy preferences around treatment, and understanding of illness and medication treatment compliance (Puchalski et al., 2014). For example, does the indiv view his or her current diagnosis and illness as a blessing, a curse, or anoth form of punishment from God? Understanding the person's perception of t illness can aid the clinician's development of appropriate treatment plans. someone thinks the illness is a punishment, he or she may not be amenable treatment. The nurse should consider: What is the patient's life story, and h does the illness and treatment choices fit into that story?

Spirituality, beliefs, and faith values will, in turn, impact a patient's compliance to medical treatment recommendations. For example, religious beliefs may impact choices about blood transfusions use of certain medical treatments. For example, a member of the Christian Science faith tradition is highly discouraged against t vaccinations, a Muslim patient may want to be alert at the time of death and decline a palliative treatment of morphine, or a Jeh Witness is unlikely to consent to blood products because of religious views, even if the choice leads to death.

Common Spiritual Screen and History Questions

Nurses can quickly assess a patient's spirituality with a few questions during initial intake assessment and through periodic chec ups. Common questions may include, "Do you have any spiritual or faith preference?" (e.g., Catholic, Hindu, Muslim), or "Do y have any spiritual needs or concerns related to your health?" (e.g., dietary or medical restrictions, grief, hopelessness).

When it comes to spiritual history questions, they are more expanded, open-ended, and specific as compared to the spiritual scre The CSI-MEMO (Koenig, 2013, p. 56) is an easily used and adaptable style nurses can use with patients. The key four question CSI-MEMO are:

1. Do your religious/spiritual beliefs provide comfort, or are they a source of stress?
2. Do you have religious/spiritual beliefs that might influence your medical decisions?
3. Are you a member of a religious/spiritual community, and is it supportive to you?
4. Do you have any other spiritual needs that you'd like someone to address?

The spiritual screen and spiritual history questions should be not asked in a robotic or impersonal manner. Nurses should ask the open-ended questions in a personal and informal way as they discover what the spiritual needs of their patient might be. Some informal examples are noted below, but these questions could also be reworded in more direct ways with lead-in phrases of "I w like to ask…," or "May I ask you if …," versus the more informal questioning method. Social work professor David Hodge (20 proposes the following questions as modified versions of the TJC spiritual needs inquiry:

- I was wondering if spirituality or religion is important to you?
- Are there certain spiritual beliefs and practices that you find particularly helpful in dealing with problems?
- I was also wondering if you attend a church or some other type of spiritual community?
- Are there any spiritual needs or concerns I can help you with? (p. 319)

Other ways a few spiritual needs questions could be expressed include:

- I was wondering what gives you inner strength and ability to cope?
- In what ways do you express your faith beliefs?
- Are there things that are worrying you at this time?
- How has your illness affected your family?
- Would you mind if a chaplain stopped by for you to talk with about your situation and health decisions?
- Does anyone from your faith community know you are hospitalized?

See Appendices A and B for additional questions and spiritual assessment models that nurses might use with patients and famili well as several case example transcripts with reflections.

Most importantly, ensure the patient has been given an adequate assurance that all aspects of care and comfort are the maximum

discussions, their patients get the sense that their medical affliction and its impact upon all aspects of their lives is of great importance. Accordingly, this helps to put patients at ease, which contributes greatly to their sense of well-being and satisfaction their care.

Patient Advocacy and Intervention for End-of-Life Decision-Making

Advocating for others requires understanding and respecting their values and wishes. This section will consider spiritual aspects are involved in ethical decision-making, the issue of consent and competence, health care or medical power of attorney, and vari documents that express end-of-life wishes for an individual when treatment for sustaining quality life is no longer an option. Eac these areas is crucial for nurses and other important health care providers to understand and apply properly in order to fully resp the autonomy and end-of-life wishes of the individual.

The Spiritual Aspects of Ethical Decision-Making

An individual's worldview is based upon their values, beliefs, experiences, culture, and how they abide by societal norms, moral codes, and religious practices. This is how decisions are determined to be right or wrong and how individuals believe they ought think or act. For people with a Christian worldview, these decisions are aligned to biblical concepts and Christian principles of li For those with a different worldview, other spiritual and religious beliefs will inform them in what they determine to be proper ethical decisions. With respect to the four ethical principles discussed in previous chapters, Table 4.1 lists how various Christian biblical principles would spiritually support the concepts of autonomy, beneficence, nonmaleficence, and justice.

Table 4.1

Spiritual Support of Ethical Principles

Ethical Principle	Biblical Principle/Scriptural Support
Autonomy	Sanctity of life/imago Dei (Genesis 1:26-27; 9:5-6) Humanity placed as steward of God's creation (Genesis 1:28; 2:15, 19-20) Humanity given free choice between right or wrong/good or evil (Genesis 2:16-17; 3:1-7) "Choose this day whom you will serve" (Joshua 24:15)
Beneficence	In all things, love and do good to self and others (Matthew 22:36-40; Mark 12:28-31; Luke 10:25-28)
Nonmaleficence	Live in peace and harmony with others (1 Timothy 2:2-3) Love mercy (Micah 6:8) Turn the other cheek; forgive (Matthew 5:39)
Justice	Respect other's rights and dignity (Colossians 3:25; 1 Peter 2:17) Love your enemies (Matthew 5:43-48) Do not judge (Matthew 5:7, 7:1-5) Act and live justly (Isaiah 10:1-4; Micah 6:8)

Consent and Competence

Patients usually possess full autonomy to decide what type of care they wish to receive. Under federal and state laws and comm medical ethical principles, all patient communication with health care providers that include test results procedures, and diagnos are considered strictly confidential. Any conveyance of this information should only be made per the patient's knowledge and written, legal, **informed consent**. Individuals who are dying no longer have the decision-making **capacity** or may be in a weake

cognitive state prior to severe decline, resulting in a deteriorated mental capacity to make rational choices. The legal "right of co to treatment endures after the patient becomes incapacitated, even though the exercise of that right by the patient…is no longer possible" (Foreman, Kitzes, Anderson, & Kopchak Sheehan, 2003, p. 110).

Assigning a **surrogate decision maker** or health care proxy is highly recommended prior to when mental capacity and **competence** declines. In determining competence, one might ask, "Can the individual hold a conversation—verbal or nonverbally—that expresses their desires and understanding of the pros and cons of treatment?" If the person can do this in a rat manner, then competence and mental capacity is in place. If there is a question about capacity and competence, then a psycholog evaluation should be considered to help make this determination. If the patient does not possess adequate cognitive decision-mal capacity, then an appointed surrogate or health care agent should be appointed. Surrogates should know the patient's beliefs, val faith traditions, and lifestyle well enough to make decisions that the patient would have made while competent, not decisions as surrogates might decide for themselves. Normally, this would be a predetermined family member or someone the patient trusts t make decisions for him or her. It is important to have this information in place should an unforeseen emergency arise when a qu decision must be made.

Refusal of Medical Treatment

Patients have the right to refuse medical options or even withdraw their consent once given. This may go against accepted medi advice, but patients have this autonomy. Religious beliefs may restrict use of normally acceptable medical practices. For exampl previously mentioned, patients who follow the Jehovah Witness faith tradition do not want whole blood transfusions, even in the of medical emergency because of religious faith practices. This medical restriction is based upon the faith tradition's interpretati several biblical passages (Genesis 9:4; Leviticus 17:10; Acts 15:28–29).

End-of-Life Decision-Making

To avoid misunderstanding patients' end-of-life wishes, crucial conversations regarding advance-care planning with appropriate documents expressing their explicit wishes are needed ahead of any crisis. These documents allow people to share treatment preferences in the event they can no longer speak for themselves. In general, there are two kind of advance-care planning docum legal documents and medical orders.

Legal documents include **advance directives**, living wills, and health care power of attorney (HCPOA). These documents are id completed by competent adults during noncritical times. These legally binding documents identify the individual's surrogate dec maker(s) and clearly outline future, predetermined decisions regarding medical treatment and end-of-life instructions.

Advance Directive

An advance directive is a written statement that is witnessed and executed while the patient has legal capacity. These may also b called health care directives. The document gives direction to what type of care the patient would or would not want in the situa that they lose mental capacity and decision-making capabilities. Often, a specific health care agent is listed who would become t surrogate decision maker for the patient.

Many spiritual questions may arise with advance directive and end-of-life discussions. A few examples might include:

- "What is the meaning of my life?"
- "Does my religion consider advance directives moral?"
- "How can I find meaning in planning for the final days of my life?
- "How will advance directives give me peace or mind or benefit my loved ones?"
- "Who can I rely upon to carry out my advance directives in a way that is true to my wishes and respectful of my religious spiritual beliefs?" (Blanchfield, 2011, para 8)

Living Will

A living will is a legal document that makes one's end-of-life wishes known. The document records the patient's desires regardi medical treatment or action used in terminal conditions. It may also outline wishes in the event of a persistent vegetative state or irreversible coma. While a living will legally records the individual's end-of-life wishes, it is not an active decision-maker. If the individual loses competence, then the patient must have previously selected a specific surrogate decision-maker to be the health or medical power of attorney (MPOA). If a health care agent is not assigned, then a court-appointed guardian would be selected.

The living will becomes binding on the attending physician when the individual loses decision-making capacity. The document is not considered a medical order and is often not completely followed by medical staff or the health care proxy. Living wills on become operative when it is provided to the attending physician and the individual is incompetent and has a serious illness (Lev & Zucker, 2017). Of course, the living will documents are not binding and operative when the patient is capable of making deci or upon the individual's death.

Surrogates or Health Care Proxy

The HCPOA or MPOA is a legal document that identifies a specific surrogate decision-maker for the individual in the event tha or she does not have the mental capacity to make treatment decisions. The surrogate decision-maker should be aware of the

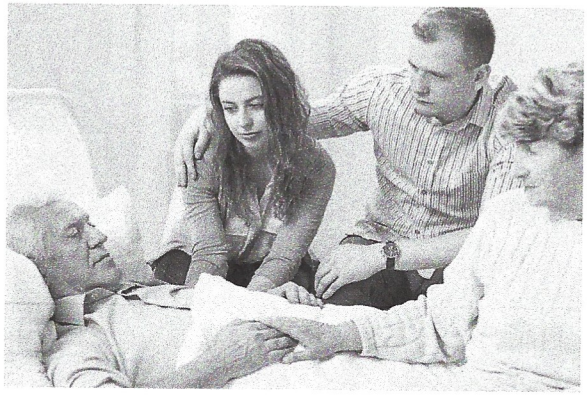
A few states have a psychiatric or mental health care power of attorney (MHCPOA). Often, the HCPOA is not allowed to make decisions regarding psychiatric care. This document provides instructions regarding treatment or services one wishes to have or have during a mental health crisis. A mental health crisis occurs when a person is unable to make or communicate rational decis The surrogate agent named under a MHCPOA can decide for the individual to be admitted into psychiatric facilities for treatmer without a court decision.

If the individual is incapable of making decisions and has not previously selected a specific HCPOA or proxy to speak for him c then a competent proxy is selected based upon a next-of-kin hierarchy. In most states, the hierarchy follows this descending orde an adult patient:

- Spouse/significant other (if legally recognized by the state)
- Adult child
- Parent(s)
- Domestic partner
- Adult siblings
- Close friend
- If none of the above is available, then guardianship would be legally assigned.

The selected surrogate would be asked to consider the patient's values and wishes and then offer substitutionary judgment for th patient's medical decisions. It is critical for any surrogate to understand the individual's spiritual, religious, and cultural beliefs a values that might impact care decisions. It is important for surrogates to follow what the individual may have decided, not what surrogate thinks is right; therefore, these types of crucial conversations should be completed with the individual and potential surrogates or health care proxy while the individual is still mentally competent and can express his or her values and desires in a rational way.

The second type of advance-care planning documents are medical orders. Medical orders involved **do not resuscitate (DNR)** and **physician orders for life-sustaining treatment (POLST)**. These medical orders translate the patients' wishes into specific medical orders or treatments specific to their situations. These orders are normally only completed once the individual i seriously ill and may only have a year or less to live.



The DNR is a physician's order to not provide cardiopulmonary resuscitati (CPR) or advanced cardiac life support in situations when the patient's hea breathing stops. The DNR is decided upon between physician and patient c patient's surrogate prior to a cardiopulmonary event occurring.

Conflicts may come up for patients and families about their wishes and the religious or cultural beliefs that inform decisions. The HCPOA or proxy m disagree with the patient's religious or cultural mores, which can be very difficult for patients, families, and health care professionals. Having somec on the health care team who understands nuances of diverse spiritual and cultural beliefs and expressions as well as diverse religious customs and practices can be invaluable so that end-of-life discussions can be done in a respectful manner (Health Care Chaplaincy Network, 2016).

Case Study: Robert

Robert, a 94-year-old widower, is actively dying. He has advanced metastatic cancer with ascites and is currently on total parenteral nutrition (TPN). The medical team deems any further treatment will be futile and that there is no hope of recovery. Robert is a Buddhist and has only one living son, Roger, who is a devout in his Catholic faith. Earlier in Robert's life, he advocated that his cousin's parents remove life support from his cousin Julia after she slipped into a persistent vegetative state caused by a neurodegenerative disorder. Roger remembers that 30 years ago, his father and his cousin Julia verbally expressed wishes for their lives to not be prolonged in a persistent vegetative state or any other futile situation. This end-of-life wish was specifically written in Julia's advance directive. Although Robert held the same wishes to have the DNR and do not intubate (DNI) orders as his cousin, he did not take the effort to have them written in an advance directive or living will before he beca seriously ill. His son, Roger, feels very conflicted about his father's verbal decision because he now sees removing nutrition ar

changing code status to DNR as a violation of his faith tradition's religious teachings. Should Roger withhold his father's wish from years ago and request that everything medically appropriate be done? If so, would this involve cardiopulmonary resuscitation and artificial ventilation? What is the best ethical way for Roger to proceed?

Physician Orders for Life-Sustaining Treatment

The POLST form is intended to be used when the patient has a terminal illness with a life expectancy of a year or less. The POL was created in 1991 by health care providers in Oregon who wanted to "translate a person's preferences and values into medical orders" (Levenson & Zucker, 2017, p. 2). The POLST offers many choices for patients and physicians to discuss and decide upo including whether the patient would want to have cardiopulmonary resuscitation (CPR) or to allow a more natural death, or whe the patient wants comfort, limited, or full medical interventions if his or her pulse or breathing is lacking. Studies reveal that, in cases, the patient's wishes are fulfilled when the POLST is completed and available to providers (Collier, Kelsberg, Safranek, & Neher, 2018).

Advance directives and POLST forms are both voluntary, yet complementary in nature. Both encourage needed advance-care planning conversations among loved ones as well as with their providers with a goal to understand the patients' goals of care an treatment preferences so that these can be honored when patients are no longer able to speak for themselves. Both of these direc are patient-centered and place deep regard for the patients' moral, spiritual, and religious beliefs (Vandenbroucke, Nelson, Boml Moss, 2015).

Hospice Care and Palliative Care

According to Payne, Seymour, and Ingleton (2008),

> hospice care and palliative care share a brief history. The evolution of one into the other marks a transition which, if successful, could ensure the benefits of this model of care previously available to just a few people at the end of life, and will in time be extended to all who need it, regardless of diagnosis, stage of disease, social situation, or financial means. (p 51)

Origin of Hospice Care

The origin of the **hospice care** concept goes back to the 11th century (Siebold, 1992). But it would be inaccurate to draw too clo parallel between places referred to as hospice in early times to today's hospice facilities and organizations. Centuries ago, long-t care was given to a very broad spectrum of the diseased. Now, modern day hospice care focuses on the supportive needs of patie with terminal illnesses.

The early founders of hospice care, including Jeanne Garnier, Mary Aikenhead, and Rose Hawthorne, shared a common concer the care of the dying. Many of "their achievements created the preconditions for modern hospice and palliative care developmen (Health Care Chaplaincy Network, 2016, para. 9). It was not until the nineteenth century that the concept of hospice became mo solidified and structured as an end-of-life model of compassionate care. Dying patients were deemed hopeless cases and were nc longer welcome to remain in hospitals and cared for alongside nonterminal patients. As a result, hospices were established to pr care to those nearing death.

Historian Clare Humphreys (2001) researched the early beginnings of hospice care. Humphreys (2001) discovered that early hospices and homes for the dying were established as "a response to perceived deficiencies in medical, domiciliary and spiritual for the dying" (p. 146). A common religious perspective was that a person's "body and soul were viewed as inseparable and mo and spiritual aid were felt to be as important as physical care and material assistance" (Humphreys, 2001, p. 155). This led to str philanthropic support for these end-of-life care homes.

By the mid–20th century, medical advances and specializations rapidly advanced with a great expansion of new treatments and medical options. This triggered a health care emphasis upon cure and rehabilitation. But this hope of increased cure also brough more deaths occurring within hospital settings. In a series of famous lectures published in 1935, the American physician Alfred Worcester (1935) stated,

> Many doctors nowadays, when the death of their patients becomes imminent, seem to believe that it is quite proper to leav the dying in the care of the nurses and the sorrowing relatives. This shifting of responsibility is unpardonable. And one of i results is that as less professional interest is taken in such service less is known about it. (p. 33)

approached end of life.

In 1967, Dame Cicely Saunders founded St. Christopher's Hospice in South London. Saunders, who would become known as th mother of hospice, "was a nurse, social worker, physician and writer for whom religious faith was a central motivation" (Hughe al., 2017, p. 3). In leading the first modern hospice, Saunders

> sought to combine three key principles: excellent clinical care, education, and research. It therefore differed significantly from the other homes for the dying which had preceded it and sought to establish itself as a centre of excellence in a new field of care. Its success was phenomenal, and it soon became the stimulus for an expansive phase of hospice development not only in Britain, but also around the world. (Payne, Seymour, and Ingleton, 2008, p. 44)

Within a decade of St. Christopher's inception, Saunders's principles of hospice care began to be

> practiced in many settings: in specialist in-patient units, but also in home care and day care services; likewise, hospital unit and support teams were established that brought the new thinking about dying into the very heartlands of acute medicine. . Modern hospice developments took place first in affluent countries, but in time they also gained a hold in poorer countries. (Payne, Seymour, and Ingleton, 2008, p. 45)

Hospice Care Today

Hospice care is focused on managing symptoms and supporting patients with a life expectancy of 6 or fewer months. Hospice ca defined as care for the terminally ill who are in a hospice location, a residential hospice program, or their own homes. It is a tear oriented approach of expert medical care and pain management, with emotional and spiritual support provided as part of that car The emphasis of hospice care is on compassionate care, not on curing.As a model of care, hospice is a program of expert management of symptoms and suffering that is intensified as patients move closer to death. Hospice care does not hasten death r does it delay it, rather, it comes alongside the natural process as the body is in the stages of dying. Hospice is a type of comfort c palliative care for people who, in general, have only 6 or fewer months to live. In other words, hospice is always palliative, but r all palliative care is hospice care.

Origin of Palliative Care

Current **palliative care** practices evolved out of hospice. Saunders (1961) asked dying patients what they needed, documented tl needs, and analyzed over one thousand cases. Saunders (1961) believed that spiritual pain and emotional suffering should be addressed as vital elements of care along with the needs for quality physical care and symptom management. For Saunders (196 and her followers, such work served as a measure of the worth of a culture, stating, "A society which shuns the dying must have incomplete philosophy" (p. 3).

Specialty recognition of palliative care first occurred in Britain in 1987 and was seen by some scholars as a turning point in hosp history. By the end of the 20th century, there was a growing commitment toward evidence-based health care. Two forces for this progress were clearly visible. First, there was the impetus to move palliative care further upstream in the disease progression, th seeking integration with curative and rehabilitation therapies, shifting the focus beyond terminal care and the final stages of life. Secondly, there was a growing interest in extending the benefits of palliative care to those with diseases other than cancer, maki the provision of palliative care a reality for all (Health Care Chaplaincy Network, 2016).

Palliative Care Today

Palliative medicine applies to all patients with deteriorating, chronic illness, and addresses psychosocial and spiritual concerns i addition to biological disease. The definition of palliative care from the National Consensus Project for Quality Palliative Care (2018) is:

> Beneficial at any stage of a serious illness, palliative care is an interdisciplinary care delivery system designed to anticipate prevent, and manage physical, psychological, social, and spiritual suffering to optimize quality of life for patients, their families and caregivers. Palliative care can be delivered in any care setting through the collaboration of many types of care providers. Through early integration into the care plan of seriously ill people, palliative care improves quality of life for bo the patient and the family. (p. ii)

The NCP holds elements of spiritual and emotional care to patients in high regard. Spirituality is recognized as a fundamental as of compassionate, as well as patient- and family-centered care. It is defined as a dynamic and intrinsic aspect of humanity throu which individuals seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, comm

Nurses can be more intentional and comprehensive in their holistic care approach by adding spiritually focused questions and assessments in their interactions with their patients and families. Specific intervention tools will be presented later in this chapte

The World Health Organization (WHO, 2014) has also described and affirmed key characteristics of palliative care:

- Relieves pain and other distressing symptoms
- Positively affirms life
- Regards dying as a normal process
- Neither hastens nor postpones death
- Takes a bio-psycho-social-spiritual approach to patient care (p. 4)

Because palliative care addresses the whole person and the person's family, it enhances the quality of life of both the patient and family. Most patients with advanced diseases have stated that religion and spirituality are important to them in the care received during illness and at the end of life. There is a growing body of evidence that a patient's religion and spirituality are associated w greater quality of life and are key aspects of care desired (WHO, 2014).

Patients want to discuss religious or spiritual concerns. Patients who have their spiritual and religious needs met have reported greater satisfaction with their hospital stays. While all members of the health care team play a vital role in assessing and respond to spiritual needs, specifically trained spiritual care providers are frequently required.

The Center of Advance Palliative Care (CAPC) recommends that all hospitalized patients be screened upon admission to determ their palliative care needs. All hospital staff should be prepared in general principles of palliative care, while specialized palliati care needs are addressed by a palliative care service, which includes spiritual care support. CPAC challenges clinicians to identi patients who they think are likely to die within 12 months, as they may be in need of referral to palliative care.

TJC began accrediting hospitals with an Advanced Certification in Palliative Care in September 2011. Specific requirements for certification include having a formal, organized palliative care program with an interdisciplinary team that includes a spiritual ca provider (The Joint Commission [TJC], 2018).

Christian Reflection on Spiritual Care

This section will review some biblical and Christian concepts that support the need for offering spiritual care to patients. A theological context with scriptural support, most specifically, the parable of the Good Samaritan (Luke 10:30–37), will first be reviewed. This will be followed by a short discussion of the theoretical premise for how offering spiritual care and support bene patients and their families.

A Christian Theological Context for Spiritual Care

The Judeo-Christian theological basis for spiritual care is grounded on the imago Dei concept that humanity is created in the ima and likeness of God (Genesis 1:26–27; 9:6). This premise of showing respect, compassion, dignity, and empathy to others is supported by the scriptural premise of the two great commandments found in the New Testament. The first great commandment "You shall love the Lord your God with all your heart and with all your soul and with all your mind" (Deuteronomy 6:5; Matthe 22:37), sets the intention and motivation of one's actions. The second, "You shall love your neighbor as yourself" (Leviticus 19: Matthew 22:39), reveals the level of concern and care to be rendered to others. Christians are called to love one another as Jesus does.

Core Christian principles are practically displayed through the biblical parable of the Good Samaritan (Luke 10:30–37). This pa reveals the theological context of showing human compassion, empathy, and kindness to others of differing cultures, faiths, and status with an impartial and humble attitude. The following is a modern retelling of the ancient parable of the Good Samaritan (L 10:30–37) with a context for health care providers. Characters in the original telling of the parable (a priest and a Levite) have b replaced by contemporary characters (a pastor and a faithful church member) in an attempt to help modern readers better unders the way the parable attempts to challenge understandings of what it means to be a neighbor and providing needed care.

A man journeying along a desolate road is attacked and robbed by a group of thugs and left to die in a ditch. Sometime later, a prominent pastor sees the man and while walking down the road and, without breaking stride or even checking on the man, cont down the path. One would think that a deeply religious person would have compassion, and maybe the pastor did, but for some reason, the pastor saw the unconscious man and just kept on walking. Was it religious restrictions of the pastor that kept him fro touching a potential corpse or assisting? The Bible does not provide an answer to this question, it just says that the pastor kept walking.

Soon after the pastor, a faithful church member approached and saw the wounded man. Like the pastor, he kept walking and did help the man. Maybe he was busy or late for an appointment that was more important. Maybe the church member cynically thou to himself, "Wow, poor guy, he should have known better than to travel alone along this desolate road. He should have protected himself better. I am sure he brought this on himself. Maybe he is a robber himself and will hurt me if I stop?" The Bible does no

Finally, a third person approached the dying man in the ditch. This person was from a group of people, called the Samaritans, wl were widely considered outcasts and detestable by the cultural norms of the day. Most people of that time would rather have suf and died in the ditch than receive help from a Samaritan.

But the Samaritan felt compassion for the man in the ditch. The Samaritan did not switch sides of the road as the religious leade church member had done. This Samaritan went into the ditch to assess and assist the man who was in desperate physical need. T Samaritan did this without any preconceived assumptions or judgment of the man or his character, but simply attended to him o respect as being another fellow human in need. Jesus, the storyteller of this parable, closes the story by telling his listeners to go become a neighbor to everyone, just as the Good Samaritan did.

This parable raises many questions, such as what innately makes a person someone's neighbor, and why should a person care fo another in need? Christian theology would say they are all humans are each other's neighbor simply because they are humans w inalienable rights as such. They are all neighbors because they all were uniquely created by an almighty and powerful God, whi gives them value, worth, and unalienable rights from above. In religious terms, this forms the premise of the imago Dei (Genesis 1:26–27). Everyone may not agree with others' decisions in life, but they can respect them and care for their core needs because were uniquely created and given life by God. This is why Jesus said, "Love your neighbor as yourself" (Matthew 22:39; Mark 1 Luke 10:27). This is the way everyone should respond to individuals of diverse cultures, ethnicity, lifestyles, and needs. It all be with an inner attitude of understanding of who one's neighbors are and what it means to be neighborly (Evans, 2017). For health providers, the premise of the Good Samaritan parable is at the foundational core for the premise of healing and delivering compassionate, respectful care to all patients from diverse backgrounds of life.

A Theoretical Premise for Offering Spiritual Care and Support

The work of psychologist Kenneth I. Pargament (1997) has been especially well received within the medical field. Pargament (1 has written extensively on the psychology of an individual's resiliency based upon religion and spirituality as positive coping ski Pargament's (1997) behavioral theories and literature reviews can easily be extrapolated to include individuals under any stress.

Attending to a person's spirituality has been shown to help a person's overall resiliency after crisis and stress. Balboni et al. (201 noted that individuals who have spiritual and religious resources available to them during a time of crisis, such as critical life situations and nearing death itself, incur lower overall medical costs. One can infer from this study that the individuals became l anxious and more emotionally and psychologically relaxed when they felt more supported. They felt less vulnerable. As this occurred, there was less need for anxiety or pain medications, which led to the patients feeling more comfortable and rested and increased healing rates because their immune systems improved. When this occurs, the patient will often have a shorter length o and better satisfaction with overall care. For the multitude of patients who also are on spiritual quests for their own deeper mean and purpose in life in relation to their medical situation, the well-equipped and skilled provider may prove to be an incredible as them. Being available to give emotional and spiritual support to patients influences many areas of care dramatically.

How to Provide Spiritual Care

Many providers feel inadequate to provide quality spiritual care to their clients and patients. First, understanding what spiritualit and is not will guide the more practical steps of performing a spiritual screen, spiritual history, or full spiritual needs assessment

What is Spirituality?

Most people practically function on the assumption that human spirituality exists, and every person possesses a spirituality, whe they fully recognize it or not. But a person's spirituality is not by nature or by definition solely about religion or religiosity. Gilb Fairholm (1997) explains,

> One's spirituality is the essence of who he or she is. It defines the inner self, separate from the body, but including the physical and intellectual self…Spirituality also is the quality of being spiritual, of recognizing the intangible, life-affirming force in self and all human beings. It is a state of intimate relationship with the inner self of higher values and morality. It i recognition of the truth of the inner nature of people. (p. 29)

As French Jesuit priest, paleontologist, and philosopher Pierre Teilhard de Chardin acclaimed, "We are not human beings having spiritual experience; we are spiritual beings having a human experience" (Evans, 2017, p. 41). Science can explain how somethi functions, but it does not explain why it functions in terms of its motivation. A person's spirituality, faith, and moral beliefs infor and guide their choices and motivations.

Each person has a choice to look well beyond their physical existence for life's purpose and meaning. People's worldview of spirituality and faith informs and shapes each of their perspectives. For scholars, it has taken many years to arrive at a consensus how to define *spirituality*, as spirituality can be viewed from many perspectives. The following definitions are helpful when

transcendent, addressing ultimate questions about life's meaning, or meaning of one's existence, and one's relationship with the transcendent/holy (Fetzer Institute, 1999). Spirituality is a broad definition that may include religion but also extends beyond religion.

At the 2009 National Consensus Conference on Improving the Spiritual Domain of Palliative Care, a consensus-derived definiti spirituality was developed,

> Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred. (Puchalski al., 2009, p. 887)

Spirituality has also been explained as an awareness of relationships with all creation or an appreciation of presence and purpos includes a sense of meaning. Though not true generations ago, a distinction is frequently made today between spirituality and religion, the latter focusing on defined structures, rituals, and doctrines. One might state that spirituality stems from one's inner consciousness and is the source behind the outward form of defined religious practices (Guillory, 2000).

Religion is more strictly defined as how one's spirituality is practiced within a specific doctrinal or theological context. Religion shared practices, worship styles, and rituals that are usually expressed in community with others of similar perspectives (Fetzer Institute, 1999). While religion and medicine were virtually inseparable for thousands of years, the advent of science created a c between the two. The term spirituality is a contemporary bridge that renews this relationship (VandeCreek & Burton, 2001). An individual's spirituality shapes his or her perspective of life and level of future hope. This is key to possessing realistic optimism governs one's daily resiliency when distressed or in a crisis.

The Spiritual Needs Assessment

Spiritual interventions do not have to be difficult or intimidating. By applying some key concepts, providers can become more comfortable with effective spiritual interventions. The spiritual needs of patients or any individual can be accomplished in vario formats. According to Hughes et al. (2018) and Marin (2017), spiritual interventions may be administered in the form of spiritua screens, histories, or assessments:

Spiritual screen: a few simple questions regarding if the patient has a faith preference and if any specific religious/spiritual con should be made known to healthcare providers (i.e., dietary or medical option restrictions).

Spiritual history: more specific questions regarding how religious/spiritual beliefs provide comfort, influence medical treatmer options and if specific faith support is present or not for the patient during their admission.

Spiritual assessment: a broad-base of questions which involve topics included in spiritual screen and history, but also regardin patient's religious/spiritual practices, beliefs, and values affect how the patient (and their friends and family) are approaching a specific health or life situation.

In general, spiritual needs assessment tools are designed to discover four root areas or dimensions of the individual: meaning an purpose, transcendence, values, and self-identity (Monod et al., 2010). Meaning and purpose provides orientation to an individu life and promotes his or her life balance. Meaning is a central component to spirituality, closely associated with a global meanin purpose for life and death. Life balance is necessary because it helps people to better cope with illness or physical disability. Lif balance provides for greater resiliency to life stressors (Monod et al., 2010).

The second root area is transcendence, which can be defined as an anchor point that is exterior to the person. It is the relationshi with an external foundation that, ironically, provides a sense of self or inner grounding (i.e., nature, beauty, art, the sacred or Go Transcendence may also be defined as the existence or experiences beyond the normal or physical level (Monod et al., 2010).

Thirdly, exploring the areas of personal values is vital to the spiritual assessment. Values determines "goodness and trueness for person" (Monod et al., 2010, p. 5), which is displayed through the individual's actions and life choices. Values can also be gener defined as a principles or standards of behavior that are important in one's life.

The last area or dimension that is normally included in spiritual needs assessments is the area of self-identity and the person's concepts of personhood. How does the individual view and think about him or herself? How does his or her faith and beliefs inf who he or she is? Identity can also be shaped from a patient's environment—society, caregivers, family, and close relationships– that, together, make up a person's singular identity (Monod et al., 2010). During spiritual needs assessment conversations, patien will reveal their needs for life balance (meaning), connection with others and/or their faith (transcendence), acknowledgement o their situation and their need to retain or maintain control of their life situation (self-worth and value), and how to maintain or redefine their identity (self-identity). These important aspects of life and how one defines their self-identity and personhood will uniquely shaped by their faith and religious beliefs.

George Fitchett's (1993) book, *Assessing Spiritual Needs: A Guide for Caregivers*, has become a classic among professional spi

impersonal diagnostic surveys.

The spiritual assessment is the foundation for developing an action plan that will direct soul care as well as promote intentional a effective spiritual communication. It is also a way to evaluate interactions of spiritual providers, maintain personal accountabilit provide quality assurance, and establish the role and purpose of the spiritual care provider. No matter which spiritual assessment model is used, these objectives should be foundational to the model's overall purpose.

Fitchett (1993) developed a spiritual assessment model called the 7 x 7 Model. This model is conceptual, functional, and holistic provides a great framework for a spiritual care provider in any setting for spiritual assessments. It is built around seven dimensic

1. Medical
2. Psychological
3. Psychosocial
4. Family systems
5. Ethnic and cultural
6. Societal issues
7. Spiritual dimensions

One can easily see the influence that each of these seven dimensions has upon an individual's life and perceptions of holistic wellness. Within the spiritual dimension, Fitchett's (1993) 7 x 7 Model describes seven smaller categories that give the broader perspective and complex intricacies of an individual's overall spirituality:

1. Beliefs and meaning
2. Vocation and consequences
3. Experience and emotion
4. Courage and growth
5. Ritual and practice
6. Community
7. Authority and guidance

Fitchett's (1993) 7 x 7 Model is a logical and thorough approach. It provides a practical list of areas or dimensions that a provide explore conversationally. It helps bring an awareness of how a person's spirituality and faith beliefs connect with all aspects of li This conceptual framework by Fitchett (1993) is seen in varying degrees in spiritual need assessment models (see Appendix A).

The Practical Benefits of the Spiritual Assessment

Performing a spiritual assessment should not be about imposing a set of rigid questions on an individual. It should be an interact conversation between individuals. Most spiritual assessment models have been developed within and for clinical settings. This section will center on health care settings, but the spiritual assessment can be administered in any setting with individuals who n be hurting spiritually.

Cadge and Bandini (2015) wrote an overview of spiritual assessment tools in health care. Cadge and Bandini researched more th 40 spirituality assessments that have risen over the past four decades with a focus on spirituality's importance and place within American health care. Each assessment studied had differing purposes based on the type of provider and patient setting (e.g., inpatient, outpatient, ambulatory clinical settings), but a general theme as to what the clinician or chaplain is striving to discover be seen quickly when reviewing these spiritual assessment tools.

As these tools became more utilized and scrutinized by academia and health care researchers, it became more obvious that some tools were spiritual histories, while others were spiritual screens or full-blown spiritual assessments. With so many spiritual assessment tools now available, it is now believed that there is no longer a need to develop new models for spiritual assessment. Rather, attention should be focused on a critical review of existing models and the dissemination of best practices in spiritual assessment (Fitchett, 1993). A review of several spiritual-needs assessment tools can be found in Appendix A. Upon review of t common themes can be found within each to help spiritual care providers create their own set of spiritual needs questions that be their clinical setting.

A few common questions that nurses may ask to guide them in their ethical decision-making processes include:

1. What are the ethical issues involved in the care of this patient and/or family?
2. What factors or set of principles should I consider in determining what is ethically best for this patient and family? What principles guide my ethical decisions in this case?
3. What do I consider to be the right or loving thing to do for this situation? Why?
4. What will be the result or outcome of my ethical decision for this patient and family, and can I live with it?

Thomas is an 84-year-old retired Army colonel with multiple comorbidities, which include advanced diabetes, liver and cardia issues, as well as a need for weekly dialysis. Four days ago, Thomas slipped while stepping out of his shower at home and stru his head on the bathroom countertop. Thomas was admitted into the intensive care unit with an unstable upper cervical spine fracture, cerebral hemorrhage, left-sided hemiparalysis, and altered mental status. Upon admission, the family told registration that Thomas had an advance directive on file with the hospital. After four days, a new intensivist on the case, Dr. Perez, had a impromptu meeting with family members who were present in Thomas's room, and he discussed Thomas's injuries and lack o response to care so far.

Dr. Perez related to the family that, despite best medical efforts, Thomas probably would not recover. Dr. Perez estimated that, because of Thomas's poor neurologic presentation, he would not get his full cognition back and that he would continue to decl physically and may even pass away within the next few weeks to months. Dr. Perez recommends that the family change Thomas's full code status to Do Not Resuscitate/Do Not Intubate (DNR/DNI) and consider placing Thomas on palliative care measures or even have a hospice care consult.

Thomas's two adult sons, Steve and Alan, were present, and they both agreed with the physician's recommendation, but Delor their father's second wife of 3 years, adamantly stated, "God will take him when God wants to take him. Keep doing everythin for him, Dr. Perez. I demand it!" Steve responded, "What if God is wanting to take him now?" To that, Alan commented, "Dac always said that he didn't want to live as a quad on a feeding tube." Delores rebutted, "But we should not play God! God gives and God takes away, but not us!"

Becky, the intensive care unit social worker (SW) walked by and heard the tense discussion between Dr. Perez and the family. She entered the room and informed Dr. Perez that she had just discovered that Thomas's former spouse, Dana, is still his offic MPOA on file at the hospital, a form that Thomas obviously had forgotten to update after he and Dana divorced 5 years ago a after he married his former high school girlfriend, Delores.

Becky returned to her office and called the contact number on Thomas's MPOA to speak with Dana. But someone else answe stating that Dana was with a group of ladies on a 2-week trans-Atlantic cruise and could not be reached. Becky informed Dr. Perez and the family regarding the surrogacy issue.

Reflection and Analysis of Case Study

1. Based on the information provided in the case, who would be the appropriate health care agent (MPOA) or next-of-kin surrogate decision-maker for Thomas?
2. Do you believe there is an ethical dilemma present in this case? If so, what seem to be the ethical issues involved?
3. What ethical principle or principles—autonomy, beneficence, nonmaleficence, and justice—are in question and why?
4. As a nurse, how would you approach the family to help navigate this dilemma? What type of spiritual needs screen, history, or assessment questions would you as a nurse want to ask the family (see Appendix A for examples of spiritual assessment models)?
5. How would a spiritual assessment help to guide decision-making in this case?
6. What would change if the family and patient faith/spiritual traditions were different (e.g., Islam, Jehovah's Witness, Christian/Catholic/Protestant, or Buddhist)? Would family decisions be different based upon different faith, religious, o

7. Are there any cultural issues that you suspect are involved in the family's decision-making process?
8. Would there be any cultural differences if the family were of Eastern or an African culture versus Western? How would each of these cultural differences effect decision-making (e.g., individualistic versus collective decisions, autonomy ver paternalistic)?
9. What are the family dynamics of Thomas, his sons, and current wife Delores?
10. What emotional or spiritual issues/concerns do you believe they are each dealing with as they hear the medical update o their father and husband?

Conclusion

This chapter's introduction quickly reviewed the concepts of worldview, the importance of understanding spirituality in a health context, the Christian narrative and its unique view of human spirituality, and bioethical principles. These concepts were revisite throughout this chapter with a focus on how they relate and influence spirituality in clinical care and end-of-life decision-makin These critical health care and ethical decisions are guided and determined by a person's worldview, which includes his or her perspectives of spirituality and faith. When it comes to end-of-life determinations, these decisions are recorded within various ty of advance-care plans as patients face death and consider hospice and palliative care measures.

This chapter also offered a Christian theological and theoretical basis for nurses attending to the spiritual needs of patients with dignity and compassion. Nurses are present not only to help in the physical care giving, but also assist in the emotional and spiri aspects of their patients' plan of care. We desire that each reader will leave understanding that because human beings are inhere spiritual beings, quality spiritual care is an important part of treating the patient holistically, attending to the body, mind and spir Nurses who understand these Christian concepts of personhood and see the biblical support of what guides ethical decisions will great satisfaction when tending to patients in a God-honoring and Christ-glorifying manner.

Additional Resources

American Academy of Hospice and Palliative Medicine (AAHPM)

Center of Advance Palliative Care (CAPC)

The End-of-Life: Exploring Death in America

End-of-Life Nursing Education Consortium (ELNEC)

Hospice and Palliative Nurses Association (HPNA)

National Comprehensive Cancer Network (NCCN)

National Hospice and Palliative Care Organization (NHPCO)

Social Work Hospice and Palliative Care Network

Key Terms

Advance Directives: Legal documents that describe health care decisions for an individual in the future event that they lose the capacity to make decisions.

Capacity: The mental ability to understand, reason, and effectively discuss and communicate one's own decisions.

Do Not Resuscitate (DNR): This is a physician order or the agreement by patient or their surrogate to not provide cardiopulmo resuscitation if the patient's breathing stops or heart stops beating.

Hospice Care: A philosophy of care focused on comfort and dignity of life for individuals who have a terminal illness usually v life expectancy of 6 or fewer months—and are no longer seeking curative treatment. Hospice is usually implemented as a progr facility that provides an environment of care for those in the end stages of a terminal illness. Hospice care focuses on the physic emotional, social, and spiritual needs of patients who are terminally ill.

Informed Consent: The process by which a patient learns about and understands the purpose, benefits, and potential risks of a medical treatment and agrees to receive the treatment.

Palliative Care: Medical and nursing care that focuses on symptom management, pain relief, and improved quality of life, as opposed to treatments aimed at curing patients with life-threatening or terminal illnesses. Palliative care is also designed to meet patient's emotional, social, and spiritual needs, as well as provide support for family coping.

Physician Orders for Life-Sustaining Treatment (POLST): A medical order that lists specific end-of-life treatment choices o patient to be honored by health care workers in times of a medical crisis. The POLST form is intended to be used when the patie has a terminal illness with a life expectancy of a year or less.

Spiritual Needs Assessment: A set of discussion questions that assist in discovering the spiritual and/or religious resources nee to help an individual find meaning and better cope during a stressful life situation.

Spirituality: Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, transcendence, and experience relationship to self, family, others, community, society, nature, and to the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices. This search for meaning in life is often found beyond physical reality and may include religious beliefs. Christian spirituality is the discovery of life's meaning through a personal relationship with God as revealed in the Bible.

Surrogate Decision Maker: A health care proxy or agent who advocates for incompetent patients.

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