The DEI Shift Podcast
Episode 4: Religious and Spiritual Diversity in Healthcare
S2E4 December 15, 2020
Hosts: Dr. Maggie Kozman, Dr. Brittäne Parker
Episode Guest: Chaplain Ermanno Willis

[Music]

[00:00:00 - 00:02:24] Introduction

Brittäne Parker: Welcome to *The DEI Shift*, a podcast focusing on shifting the way we think and talk about diversity, equity, and inclusion in the medical field. I'm Dr. Brittane Parker (BP), an internal medicine hospitalist and host of today's episode along with my co-host…

Maggie Kozman: Dr. Maggie Kozman (MK), a medicine/pediatrics Hospitalist. Today, we're very excited to bring you an episode on a topic near and dear to our hearts: religious and spiritual diversity in health care.

This flavor of diversity is often not the first one we think about when we hear the words "diversity, equity, and inclusion," but it's one that has undeniable implications in our lives, and especially in healthcare in both the classroom and the clinical setting. In fact, even as our team was trying to come up with a title for this podcast about a year ago, my faith background impacted my own brainstorming and ideas.

We chose *The DEI Shift* as a play on the idea of the day shift and night shift that healthcare professionals work in the hospital. But for me personally, another concept came into play. There's a concept in the Abrahamic faiths, so, Judaism, Christianity, and Islam, mostly Sufism within Islam, that humans were created in the "Imago Dei," which when translated from Latin means, "in the image of God." There are different understandings of what that means, but speaking from my perspective as a Christian, and not "the" Christian perspective, this refers to the idea that every human being shares intrinsic foundational qualities that reflect and point to the God who created them, and therefore, every human being has intrinsic dignity and value that should be honored and treated justly, no questions asked. To not recognize and honor that dignity and value is to call God's own dignity and value into question. And now, while this was my own personal inspiration as we were brainstorming and not the beliefs of everyone else on the podcast team or the

reason we chose our title, it underlines a foundational belief we all do share in the dignity and worth of every human being, which has motivated all of our DEI work.

I may not have been able to share that this was a point of inspiration for me with the rest of our team several months later, as we were trying to process the murder of George Floyd, if we hadn't already established an environment together in which we each feel free to share our diverse beliefs and know that we'll be listened to and respected.

[00:02:25 - 00:03:52] Defining Religious and Spiritual Diversity

BP: Thank you for sharing, Maggie. Before we delve into this topic, we want to define what we mean by religious and spiritual diversity. We're using this broad term because it encompasses a wide range of belief systems, including the many world religions, atheism, agnosticism, and other belief systems, but also things like meditation, art, and spending time in nature.

These belief systems and practices are how we find meaning and connectedness. They impact our values, habits, political stances, how we relate to others and to our environment, and how we interpret and respond to life events, including illness. They are fundamental to the human experience, but since they're not the first type of diversity we think of, they tend to be under-addressed.

We also want to define the term "spiritual care." Spiritual care does not necessarily mean religion. It is often about connecting one on one with another person. A person's spiritual or religious needs is often a part of their healing process. In discussing their beliefs and/or faith, it communicates to the patient that their healthcare team acknowledges aspects of their life that are of value and importance to them. Patients may ask questions such as, "What happens if I die?", or family members may grapple with the suffering that a loved one is experiencing. This is where the power of spiritual care is evident to support patients and their families. Spiritual care is meant to be complementary to health care.

[00:03:53 - 00:08:36] Co-hosts Share Their Inspiration For The Episode

MK: So, we're going to keep those definitions in mind throughout the episode. We also wanted to give our listeners an inside look at why we each personally wanted to do an episode on this topic. For me, it was because of my own experiences in medical

training and in my career thus far, in which I felt intolerance for healthcare providers like myself, who hold to any belief systems that don't conform to current conceptions of "what people of science can and should believe."

Even in liberal cities in California where I've trained that pride themselves on tolerance, I've had this experience. As a medical student, I also felt that the burgeoning diversity curriculum I was lucky enough to have in medical school still lacked teaching in the area of religion and spirituality. This impacted me enough that it motivated me to gather some like-minded friends and create an elective course about this very topic that was open to all the health profession students at our institution.

And we were met with many students eager to learn about it. Like me, 32% of my school colleagues endorsed having personally experienced micro- or macro aggressions during medical school because of their religious or spiritual beliefs or because of political stances they held as a result of their beliefs. And I'll put in a reminder here that microaggressions are "brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults to the target person or group," according to Dr. Derald Sue from Columbia University. Macro aggressions are those more overt and blatant expressions of discrimination. And so, 58% of my medical school colleagues had seen others experience these micro or macro aggressions when it came to religious or spiritual diversity. And when I assessed my classmates, 92% of them were interested in taking an elective to learn more about this issue of diversity, and none of them felt that it was already addressed by our curriculum in other ways.

BP: Thank you for sharing, Maggie. For me, I have been in many situations where healthcare staff are just unsure of how to approach the subject of faith or spirituality with patients. As a student and resident, I remember rotating with the medical team where a patient brought up their faith and how it was influencing their medical decisions. The healthcare team member who was leading the discussion was visibly uncomfortable and moved forward awkwardly, causing the patient and everyone in the room to feel the same unease. I've also seen a more senior physician blow right past a subtle hint that the patient was giving to share a key component of who they were. For me, as a person of faith, I, too, was unsure how much of the discussion was allowed during conversations of spirituality, until I

worked with an attending who embraced this opportunity that these conversations provide for the patient and physician to discuss an important aspect of the patient's life.

As Maggie shared, the classroom environments in which we train, learn about healthcare policy, and discuss ethical issues is often fraught with instances where some religious and spiritual minorities may feel unwelcome or less than, as if those students don't belong in healthcare. And as my own experiences illustrate in the clinical setting where different healthcare providers are treating patients, faith and spirituality can influence their medical decisions and outcomes in a number of ways. Some examples of spirituality's impact on medical decision-making include Jehovah's Witnesses and acceptance of blood products, American Indian/Alaskan Native culture with traditional healing, and in the Hmong religion, some of you may have read *The Spirit Catches You and You Fall Down*. Here, Anne Fadiman chronicles Hmong refugee families' journey in the medical system and their beliefs surrounding her seizures being a part of spiritual factors and the dichotomy of how the medical staff perceived the problem.

MK: Other examples include diet, vaccinations, prenatal care, patients' compliance with treatments and drugs, their willingness to be referred to psychologists or psychiatrists, or to return for medical follow-up. Religion and spirituality also heavily impacts people's end-of-life care, their code status, what it means to choose DNR/DNI, and what it means to not offer or to stop providing life-prolonging therapies. And in different cultures like elderly Korean-Americans in the southeastern US, family spirituality can play a role as well, not just the individual spirituality that's captured in the predominantly Western-centric literature about spirituality and health. So now that we've laid the groundwork for this episode, we'd like to introduce our fantastic guest.

[00:08:37 - 00:10:43] Introduction of Mr. Ermanno Willis

BP: I am so pleased to introduce Mr. Ermanno Willis (EW). Mr. Willis graduated with a Bachelor of Arts in English from Clark Atlanta University in Georgia and a Master's in Divinity at the Interdenominational Theological Center in Atlanta. He has a diverse background working in spiritual care and worked as a chaplain at Mayo Clinic for 10 years. He has experience working in many settings, including the emergency department, intensive care units as an integral part of the palliative care team, and in the hospice environment. During his time at Mayo Clinic, he

served as a consultant to the Spiritual Care Department as a whole, co-created an evidence-based process for chaplains to improve communication with interdisciplinary teams. He trained with the Red Cross on disaster spiritual care and even served as a preceptor for medical students to introduce them to the services that chaplains provide within the care management model. Mr. Willis has worked as a living donor advocate, providing emotional and spiritual support to loved ones who are seeking to donate a solid organ. He has even officiated a wedding for a patient who was not ready for discharge at that time.

Mr. Willis, it seems like you have a wealth of experience. Is there anything you would like to add about your background?

Ermanno Willis: No. I think you covered all of my background well. Thank you.

BP: Well, thank you for being with us. So, we've been referring to our guests by their first names on the show. Is it okay if we call you Ermanno?

EW: Absolutely, please.

MK: Well, Ermanno, thank you so much for joining us for this important conversation, and welcome. We're eager to hear from you about this topic, but before we get into the discussion, we wanted to take a minute for our "A Step in their Shoes" segment, in which we ask each of our guests on *The DEI Shift* to share something with our listeners about themselves. This can be something like a hobby, a favorite food, or a meaningful experience of yours that helps us get to know you and your background a little better and for us to flex our cultural humility muscles.

[Music]

[00:10:52 - 00:12:47] A Step In Their Shoes Segment

So, what's one thing about yourself that you'd like to share with us and our listeners?

EW: Well, I have been on a journey throughout my chaplain career, and my journey is how to better care for my own self and my own being. One of the things that I discovered as I was a resident in the Memphis area as a chaplain, there was another chaplain who introduced me to woodworking. And so, over the years, I've loosely

been interested in woodworking and have assembled quite a few tools. And now, I'm a budding furniture maker.

BP: Well, that's exciting.

EW: I'm excited to be able to share that if you want to get to know me, let's talk about building some furniture.

MK: That's great. What types of pieces have you been making?

EW: Mainly stuff for the house. A table, entertainment center, beds. Everybody has a bed that I built in the house. Desk, frames, you name it, whatever you want in the house, I'm your guy.

BP: I wonder how you have time to serve as a chaplain. [Laughter]

MK: Maybe we'll contract you to build some things for us, too. [Laughter]

EW: Well, it's a part of my self-care journey. So, you have to learn how to say "no" to certain things. When you say "yes" to everything, you also say "no" to others. You have to pick and choose which one you want.

BP: That's a really great point.

[Music]

[00:12:48 - 00:15:24] Ermanno Talks About His Journey In Becoming A Chaplain

BP: Well, I guess let's start just by finding out more about what made you want to become a hospital chaplain.

EW: So, I think my journey as a chaplain overall was more out of the need of necessity. When I finished seminary, I was excited about the opportunity to be able to move into a full-time pastoring position, and coming from a Methodist tradition, we're assigned where we go. We don't interview. We're just evaluated by our leaders, and then they say where you go, and they try to match a congregation with a pastor. And I was devastated when my name was not included in the list of pastors to go to a church.

And so, when I finished seminary, my oldest daughter was born. She was six months. We had just moved to the Memphis area. And while I was in seminary, I did a little small class rotation of clinical pastoral education, which is the beginning of one's journey to becoming a chaplain, especially in healthcare. And I said that I was going to one day, maybe sort of kind of briefly, think about doing hospital work or healthcare work and expand the opportunity of becoming a chaplain. Well, the time was now, and I needed to figure out how do I get into a program that pays a little stipend as well as allow me to grow in developing my own spiritual practice and leadership skills through this thing called chaplaincy. Praise God, I was able to be admitted in an offseason point of admission when I was allowed to start my training in Methodist healthcare system in Memphis, Tennessee. So, from there, I just kept on doing both chaplaincy, in varying different roles and shifts and status, and pastoring churches, often simultaneously, over the past 15, 16 years.

[00:15:26 - 00:33:58] Ermanno Describes The Role of A Chaplain

BP: That sounds like it's been a very long career. I wonder if you might be able to tell our audience, who may not know what a chaplain does in a hospital, what the role of a chaplain is from your perspective.

EW: That is 90% of my job, it seems like, explaining to people, even in the hospital, what is a chaplain and what role a chaplain plays in this healthcare process. So, there's the simplified version of explaining that a chaplain is here to support one as they go through this healthcare system. And there's no necessarily one specific way that a chaplain supports a patient, their family members, or even some of the staff that are involved in the healthcare team, but one unifying thing is presence, and along with presence is time. So, one of the things that many of my colleagues, we love to pat ourselves on the back about, is that when you're in the hospital, in particular, any acute setting, everyone is on a time crunch. It's almost down to a measured science that you have about seven minutes, 30 seconds to interact with a patient, get any information you can out of them, and impart any information that is necessary for the next steps of their treatment plan, and then move on to the next patient while documenting and other multitask events. Everyone is under similar kind of time pressures, whether it's seven minutes and 30 seconds or a few minutes longer. But chaplains have the unique perspective of spending as much time as needed or wanted by the patient, so there are some moments where I spend parts of my day where I'm just doing a brief introduction of who I am, my

role, and how I might be of support if they think that I might be of benefit in visiting and sharing with them. And they say “yes” or “no,” and it’s real quick, and it’s real brief, the same kind of five- to seven-minute encounter with several different people. But then there may be some times where “I’m glad you came,” and it leads to a two-, sometimes three-hour, conversations. This certainly doesn’t happen every single day, but it is something that sometimes has happened throughout my career, at least once a week sometimes depending on the intense, I guess, health challenges that a patient may be facing while in the hospital.

BP: I really like what you said, and I’m reflecting on that where you talked about how a chaplain supports the patient, family, and the staff, which we’ll talk about in a little bit, but you said there’s really two things, presence and time. And I could just think of the days when I’m running around seeing patients and do feel that, that pressure. I can only imagine how a patient might perceive that, that healthcare or the staff may be a little impersonal or just disconnected from who they are, and they were just focusing on their disease. So, I just think it’s wonderful that we have services and people like yourself, who can just be there and be present and give the patient as much time as they need to process what’s going on, to talk about the questions that they have in their mind, because it’s such a vulnerable time for patients.

EW: I would dare suggest, as my friend Dr. Mishark would say, it’s one of the most traumatic and humiliating experiences, being a patient in the hospital.

MK: Yeah, and given that as healthcare providers, we haven’t always had the experience of being on the other side, of being the patient in that incredibly vulnerable time. I think that’s a really important key to remember.

[Music]

MK: So, Ermanno, you talked about some of your experiences with patients on the inpatient side, inside the hospital, but you’ve also had a really well-rounded experience as a chaplain or a spiritual care provider in a lot of different settings. Can you share with us a little bit about what it’s been like to be a chaplain through hospice programs and through the Red Cross?

EW: Yes. So, I think, universally, the role of a chaplain is applicable no matter what the setting. There are some differences with hospice patients. The largest difference would be the setting. It's not in a hospital. It's, well, generally in their home, wherever they call their home, whether it's their actual home address, or sometimes it could be a nursing home where they are permanently residing, or assisted care, wherever their mailing address and they find their self resting overnight, that's their home life.

There, again, the same kind of role takes place. One of the major differences that I find in hospice care is that not all patients in hospice care are able to engage or have a meaningful presence during a chaplain visit. Several people, in my experience in hospice, have been on memory care services. So, you know, they just really don't know who you are. They're pleasantly confused, and then they move from pleasantly confused to absolutely terrified because they know nothing around them. Nothing is recognizable, and so you find yourself having to go with the waves, these different emotions, these different experiences, for someone who's not fully mentally capable, being able to engage in any kind of visit, but I often found myself, especially in homes for hospice patients, caring and attending to the caregivers, who were desperately doing all they could to take care of their mother or their spouse or whoever it is that is important, and they gave up absolutely everything in their life, their career, sometimes, even their important relationships or at least put them on pause, to care for this person until their transition from on hospice care to actual end-of-life, and providing a sacred space sometimes. Sometimes, just an escape by being able to talk about something that's important to them instead of being so concerned about their loved one or the one they're caring for.

I think that's kind of the unique difference with hospice, but in the spiritual care environment with the Red Cross, I actually have never had opportunity to be deployed. So, you have all of our natural disasters that go on in the world, and one of the things that I found myself in my training was being prepared to be deployed. I just found myself oftentimes in conflict with either work schedule or other church responsibilities where I couldn't be deployed for three, sometimes four, weeks at a time to assist in whatever hurricane, fire, wildfires, or flooding, or whatever the event, that chaplains might be especially useful during some type of natural disaster. But I've been trained to respond, but the training is reinforced by what I've already experienced in my everyday work as a chaplain. The same is true, time

and presence is the most valuable thing a chaplain can offer anybody that they encounter.

MK: Well, I think that's really interesting to hear the different venues in which you've practiced and trained, and you highlighted a couple of interesting key points, one of which we mentioned briefly earlier that family spirituality comes into play in an individual patient's care. So, you're not only providing a service and providing your presence and time to the patient, but to their family members as well, whether or not the patient is necessarily always at their best or able to communicate everything they might want to with you given their illness. And then the second thing is that I would say, definitely for myself and for most of my colleagues, we, as a profession, are not necessarily aware that organizations like the Red Cross train and have chaplains ready for deployment, basically, in the setting of any disaster. And I think it's really good for us to know as a resource and to be aware, and we thank you that you've basically been training and ready to deploy at any moment for any disaster that may come.

BP: So, Ermanno, I wonder if you might also tell us a little bit more about some of the challenges that a chaplain or a spiritual care practitioner might encounter within the healthcare system when trying to address the spiritual needs of a patient. I wonder if you have a story that might highlight this.

EW: I think the biggest challenge from my experience is making an initial connection with people. I know that, especially working in ICU and hospice, there are a lot of people who, when they hear the word "chaplain" in those particular settings, it's always, "Are they coming to give me my last little whatever so I can die in peace," or "No, I'm not dying, I don't need a chaplain." That's the biggest, I guess, perception that is a barrier in the work that I have as a chaplain.

But in more times than not, there's the opportunity, and from my own spiritual practice, I classify this as just a movement of the spirit, that I end up being in the right place at the right time for the right person, wherever I go, and there are some times where I'm not received for varying different reasons. I don't know if it's because my hair is too short or I don't know, but for whatever reason, as a chaplain, not received well or received at all. It usually has more to do with what's going on the inside of the person who's not accepting a visit at all or just cuts me off altogether and excuses me.

But there's one particular story that I have about a patient that I was able to make a connection with, and it was over, I want to say over the span of like five minutes of trying to just see if there's any connection that we can make. So, this young man was, I want to say, in his mid to late 30s. What I remember most about him was that he shared with me that he wasn't all that religious; he wasn't one that really professed any particular kind of faith. He did kind of loosely say, "Well, I believe there's God, but I wouldn't say that I'm really connected with God at this point, but hey, I'll listen to you. What do you have to say? Why are you here? What do you want?" So, he didn't just flat-out excuse me out of the room. And so, I took that as an opportunity that, "Well, maybe there's something more to this." So, we just got to talk, and I said, "Well, that's okay. I'm not here to try to convert you into anything. I'm not here to just try to make you believe what I believe. I'm just here with you. What's been going on with you? How long have you been here? Maybe through that, we'll be able to figure out a way to continue the conversation. If not, you know, I can leave and just know that we wish you well in this journey, whatever it is you're here for."

He shared that he was dealing with a stage 4 of some type of cancer. I don't remember which one. This was more than 10 years ago. And one of the things that he ended up sharing with me is that he came from a very similar Methodist tradition that I grew up in. However, he was not a practicing person of faith, and he says, "Well, I don't really go to church," and so the discussion changed. "Well, what do you do? What do you like to do? What are your hobbies? What brings meaning to your life?" He shared this long, long journey of how he loved to go on racetracks, and so he was an amateur racetrack driver. And he started out with go-karts. His dad and the rest of the family made trips going all over the country, and this was just a real important meaningful community for him, the race community. He moved from go-karts to trucks and from trucks to - he never made it to NASCAR, but I forget what level it was that was before you get to NASCAR. And so, I was like, "Oh, so you went to church; it was just the church of left turns."

From that point on, [Laughter] we just connected, and I ended up, it was one of those days where I stayed at least two hours just talking to him about what's going on with him, how he's dealing with this cancer, and how talking about racing really encouraged him and got his mind off of whatever chemotherapy treatment he was receiving in the room. And I got to meet his wife, and then his father came in, and

then the racing continued in just the traditions that they were able to share. And it was just a wonderful, meaningful experience, just for me to be invited in that space.

So, I kept on visiting him during the course of his - I want to say, maybe a two-month stay in the hospital. I check on him at least once a week and make sure things are going. And one of the most honorable things that happened, he did eventually die, but his wife asked that I offer a eulogy for him. And I was just so dumbfounded, like, "Really?" She says, "You were the closest thing to a pastor we all have ever had, and we would be honored if you would say some kind words about our now-deceased loved one."

MK: How incredibly powerful.

BP: Yeah, I was going to say the same thing. I think that your story really highlights what we mentioned before about how spiritual care does not mean religion. It's really about connecting with another person. So, even though you have your own spiritual practice, you're able to connect with a wide range of people, and you're bringing not only your interpersonal skills, but your patience and introspection, which I'm sure you had to do when you are interacting with this gentleman who is skeptical and navigating that conversation, so that's wonderful.

[Music]

[00:34:08 - 00:40:10] Evidence That Patients Want Religion and Spirituality Addressed By Their Health Care Providers

MK: Well, as part of this discussion, we also want to lay out for our listeners some evidence and statistical information about what patients want from their healthcare providers when it comes to religion and spirituality and how addressing this aspect of patients' lives actually contributes to treating their illnesses and maintaining their health. There's a book called *Spirituality in Patient Care: Why, How, When, and What* by Dr. Harold Koenig, who's a psychiatrist and a geriatrician at Duke University and the director of Duke Center for Spirituality, Theology, and Health. Dr. Koenig has written extensively on the topic of spirituality in healthcare, and this book that I mentioned was first published in 2002 but has a couple subsequent editions as well.

In it, Dr. Koenig reported some survey-based data from things like the Gallup Poll that showed that at that time, over 96% of Americans believed in God. More recent sources suggest that it's over 90% who say they believe in God or a universal spirit. More than 90% said that they prayed. More than 40% said that they had attended church, temple, or synagogue within the prior seven days before they took the survey. And nearly 80% of them said that the statement, "I receive a great deal of comfort and support from my religious beliefs" was completely or mostly true for them. In certain parts of the US, Dr. Koenig also found that more than 40% of people in those areas said religion was the most important factor that enabled them to cope with physical illness, and he also described some surveys of both outpatients and inpatients that indicated that two-thirds of those patients thought that their doctors should ask about their spiritual faith or consider their spiritual needs, but that most of them, and that's as in 80% to 90% of them, said that they had never been asked about those needs by a physician. So, I just wanted to see how you, both of you, Ermanno and Brittäne, felt about that, if you feel like that's true to your experience.

EW: So, my overall experience is always based on whoever the practitioner is. I know of several physicians who have their own spirituality that they bring forward, and it's no secret what their spiritual practice may be or how certain decisions are made, even in medicine, based on their spirituality. And then the opposite is true where there is no spiritual practice that is associated with any particular organized religion, at least, and decisions are made or encounters with patients are just missed and ignored a lot of times when those kinds of attitudes are brought to the table for practicing medicine. I would suggest, as any kind of provider on any level, and I kind of preach this to my other colleagues, is that we have to honor whoever is before us, and the best way we can honor them is it needs to acknowledged that they have something, whether it's good in our opinion, bad in our opinion, or indifferent in our opinion, or whatever it is, our opinion is our opinion, and we're here to connect with people and try to make the world a better place, whatever way we came. All begins with acknowledging.

BP: I completely agree, and one thing I've noticed too, just in my own practice, is that it really takes a whole team to address a patient's needs, and there have been times where I may be rotating on the teaching service and I'm not only thinking about patients, but I'm also thinking about education for my residents and my medical students, and I forget a part of that history that I'm taking, trying to get to

know the patient, and it's actually the nursing staff or the physical therapists that say, "Hey, Dr. Parker, I was talking with this patient, and they have a certain faith or certain belief. I think we really should call the chaplain." And I'll say, "Oh, my goodness. Thank you so much." I was so busy with everything else that I forgot to make that unique connection or just to ask that question. And so, I have a really great physician assistant, Brenda Camry, who works with me, and one thing that she does is she has it in her standard H&P questions, that just like all the other components like medications, allergies, substance use, sexual history, she has in their spiritual and faith beliefs, and that way, she doesn't miss it. It's just a part of her practice.

MK: I think that's an incredibly key point, and we're definitely going to explore that more. I get the feeling that some of our listeners at this point may not necessarily be convinced that that is within their scope of practice based on interactions I've had. And I think, like we were just discussing, even just knowing that two-thirds of patients want their physicians to talk to them about these things or members of their healthcare team to talk to them about these things, but most of them never really getting that expectation met. That is a big thing that, I think, most providers don't necessarily know about and was shocking to me when I first learned it.

[00:40:11 - 00:43:56] The Benefits of Religious/Spiritual Beliefs on Health

The other thing that I thought was really motivating that Dr. Koenig's book and one of his subsequent review articles in 2015 mentions is that there are multiple outcomes, patient outcomes, that have been measured in tons of different studies that show the positive effects of religious and spiritual beliefs on health. So, he refers to observational and prospective studies, but even clinical trials too, that have shown that religious beliefs and activities are correlated with higher well-being, positive emotions, sense of purpose and meaning in life, maybe not so surprising there, larger and higher quality support networks, also not necessarily surprising, but even higher immunity. So, lower measured IL-6 levels in elderly patients, higher CD-4 counts in HIV patients, higher NK and T-cell counts in women with metastatic breast cancer, and even higher PFTs, or pulmonary function tests, in patients who have cystic fibrosis. And similarly, they've shown a lot of different studies that show lower depressive disorder or fewer depressive symptoms, lower suicide rates, and more negative attitudes towards suicide, lower substance use, and, even surprising to me, lower blood pressure and rates of coronary heart disease, and even lower overall mortality. And he goes as far as to say that

religious attendance has the same association with longer survival as not smoking cigarettes does, which I think should really make us as providers take pause and consider if there are interventions that we are missing here for our patients.

BP: Absolutely. And I really hope that our listeners are reflecting on some of this data, and I think this conversation is just so needed, more than ever, I think, in this time in our country, as there's high stress levels, and there's isolation because of social distancing with COVID-19. I hope that the statistics are impressing on everyone that addressing patients' faith and spiritual beliefs can really be key to their health and treating their disease. It's something that many of our patients want but may be lacking, and we know that when it comes down to it, having these conversations can be anxiety-provoking and awkward even though they are really crucially important.

There is an article in an ACP from 2016, entitled *Improving The Patient Experience by Focusing on Spiritual Care*. There, in the article, Dr. Daniel Sulmasy, professor of Medicine and Ethics at the University of Chicago was quoted as saying, "Physicians do not have to be religious or even particularly spiritual to help make sure their patients get spiritual support. You don't even have to accept a patient's religious beliefs in order to know they're important to the patient and then to respond to them." So, in this article, it also reminds the reader that they don't have to feel like they have to address or solve any particular issue on their own, that it's okay to acknowledge the patient's need, thank them for their trust in sharing something so personal with you, and then direct them to someone with more experience. So, you could say something like, "Would you mind if I told our chaplains about what you shared and ask them to come by?" This is really similar to any other consult we do in the hospital. We ask those with expertise to come and help alongside of us to help take care of our patients, someone like Ermanno.

[00:43:57 - 00:48:10] The Concept of Collecting A Patient's Spiritual History

MK: Ermanno, when you get consulted, do you have a template or a screening tool you use to take a patient's spiritual history, like Brittäne was alluding to, and guide your conversations with them?

EW: I have a spiritual assessment tool that I use, which is a very fluid tool, and it's developed by Timothy Ledbetter. It's called *The Five Triads of Pastoral Care*, and in

this tool, it focuses on five questions. I don't necessarily go through each of the five questions when I'm meeting with a patient as a chaplain in any particular setting, but it is also most useful in my documentation, if I can answer any or all of these five questions, so that I can help communicate what's going on to the rest of the interdisciplinary team and what other people may want to be looking out for.

So, those five questions, the first question that I'm kind of keeping in the back of my mind is "What's changed?" And with this five-triad model, each question has three categories as options you can place the response in. When it comes to what changed, was it a physical change, was it a spiritual change, or was it a psychosocial change?

The second question that I bring in every encounter is, "What's it like for you, whatever this change that has occurred? How have you experienced this? Have you experienced this change as comfort, as suffering, or is this a stressor?"

The third question that I bring to the table is, "What do you want? This change has brought about this experience. What intentions are you hoping to get out of this overall process that you find yourself in?" And their intentions can be brought into the three categories of relief, improvement, or survival.

The fourth question that I have going on the back of my mind, as I'm trying to think about this overall process of the encounter, and this fourth question is usually at the point of when I'm trying to document and make recommendations or assess the patient after I've visited with them, is, "What will help you?" Sometimes, I'm able to ask them, if they're in that state of mind, "What resources do you have within your reach?" or "What resources do you think you're lacking?" So, is it the support of others, is it your faith tradition, or is it a vitality of yourself?

Which leads to the outcome and often some type of recommendation to communicate to other people, whether it's my other colleagues as chaplains or other colleagues within the interdisciplinary team, referring appropriately. That question is, "What does new health look like for you?" and "Is new health a part of an adaptation? Is new health an integration? Or Is new health recovery?"

And however I'm able to be able to assist patients in this kind of journey in these five questions with three triads, if you will, with the three options of categories to

help me communicate their story to other people in the team usually leads to a more whole and human experience in the hospital.

[00:48:12 - 00:51:48] Spiritual Screening Tools

MK: I love hearing that. I think that's definitely something that I've never heard before, that tool that you mentioned and that guideline. And also, really important for us as clinicians working with chaplains in clinical settings to hear, on your end, what your assessments are like and what types of things you're keying into, and as we talked about, a clinician doesn't always have as much time to be able to ask all of these questions in the time that they merit, but there are some tools on the clinician side that we've been learning about created, one by a chaplain called the FACT algorithm or spiritual assessment tool, and then a couple by clinicians, specifically physicians, that healthcare providers can, as a way of screening, gathering a spiritual history, and even more during and creating a spiritual assessment in order to figure out what support, including a chaplain or community faith leader, a patient might need.

So, a few of those validated tools include, like I mentioned, the FACT tool created by a chaplain, Mark LaRocca-Pitts, and he describes it as you did for the algorithm that you use as a spiritual assessment tool, emphasizing it's not just a history-gathering tool, but really leads you to make an assessment and a plan for the patient.

And so, I want to share a couple of these, and we'll definitely post information for our listeners on our website about these different algorithms you can use when you're starting to collect a spiritual history and make a spiritual assessment for your patients.

So, FACT, all of these are acronyms. Fact is F-A-C-T. So, F is faith, you ask the patient open-ended questions like, "What is your faith or belief?" or "Do you consider yourself a person of faith or a spiritual person?" or "What types of things give your life meaning and purpose?"

The A stands for a number of things. The first one is Active, "Are you currently active in your faith community, and then in the setting of your current situation, your illness, have you found that your religious and spiritual community or

activities are, A, available or, A, accessible to you? Do you have the capability at this point in your illness to be able to get those resources you need?"

The C of FACT is coping, "How are you coping with your medical situation?" or "How are your faith beliefs helping you to cope? Are they providing Comfort? Are you experiencing Conflict in those beliefs because of your illness? Or do you have other Concerns that you have for our medical team that's caring for you?"

And finally, getting more towards the assessment and plan part of this is the T, the treatment. So, if a patient is coping well, you can kind of help bolster those support systems that are in place, but if they're not coping well, you can do an assessment and even provide an intervention like consulting a chaplain or a faith community leader or talking about prayer with the patient and things like that, which we can discuss in more detail later.

And then the other ones I mentioned, there's the FICA, F-I-C-A, by Dr. Puchalski and Dr. Romer, and then the HOPE algorithm, H-O-P-E, by Dr. Anandarajah and Hight. We'll put all of these on our website along with a couple of articles that compare them.

[00:51:49 - 00:55:57] The Difference Between A Spiritual Screening Tool and A Spiritual Assessment Tool

Have you interacted with any clinicians, Ermanno, that have used some of these tools or do you have any thoughts about them in comparison to one another?

EW: I have not met a clinician that used any of those tools. I am very familiar with those, but I know that I would classify them a little bit differently. I would classify those as screenings and not assessments. And I would say that distinction, especially with those that focus on what is your faith. So, when you focus on what is your faith, I think we can agree, and I believe this was a part of the introduction, that religious faith is not all-encompassing of spirituality. And if your beginning tool assumes that one has to have a faith, then you are going to miss a large percentage of the population that you're trying to care for. And when you do that, I think - I'm not trying to negate the tool, I think you just need to downgrade it as a screening. I mean, it's not meant to catch everything, but what you can catch, this is a good tool to start with.

BP: I really wish that you had come to my medical school to teach me how to do some of this. I'm just listening, like, "Oh, my gosh, I have to re-listen to this podcast, so that I can write this stuff down, so I can use it in my practice."

EW: But I would say, as a clinician, it's very appropriate to use a screen because, at least in my experience, you still only have seven and 30 seconds to encounter all of your patients. So, this is a good beginning and to see if this is an appropriate referral to a chaplain, and this will reiterate my overall thesis of a chaplain has presence and time and can go deeper than just what the screening can provide.

MK: Would you recommend focusing more, especially at that first letter, on open-ended questions like, "What things bring you hope or meaning in your life" instead of "What faith do you adhere to?" Or something like that?

EW: Not necessarily. I mean, you can use it however you think is appropriate. It's flexible. It's open-ended. I'm just making the distinction between assessment and screening. If you have that as your base, understanding that this isn't supposed to be able to catch everything, and this is just a screening tool. If I identify anything from the screening tool, I need to refer appropriately.

MK: That's a great point, and I think we in healthcare are constantly being forced to learn to admit when we don't know things and refer to those who know better than us and have more expertise. So, again, this is one example of that. And I think the chaplaincy is an often-underutilized resource that we all have as consultants that we should take advantage of.

BP: Yes, that's our message today.

EW: Well, if there are any other chaplains that would agree with me, whether utilized, over-utilized, under-utilized, we're still here, and we're still available.

MK: We definitely appreciate you being there.

[00:55:58 - 00:58:24] Intolerance of Spiritual Diversity in Health and Healthcare Education

Besides patient care like we've been focusing on in the last few minutes, we also wanted to not neglect the other aspect of religious and spiritual diversity in healthcare that we mentioned earlier in the episode that also needs to be

addressed, which is intolerance of spiritual diversity in the classroom or learning setting, where trainees are interacting with one another and with their teachers. And while there's no particular algorithm or tool for doing this, it really just comes down to checking our own implicit biases anytime we're having conversations with our colleagues, whether we're in small group sessions, large lectures, or casual hangouts. We shouldn't be conversing with one another in a way that assumes everyone in the room thinks exactly as we do and that anyone who disagrees is less-intelligent, scientific, or worthy of being in healthcare. Using tools like the Harvard Implicit Association Test can help us identify biases that we may not even realize we hold against people of various spiritual beliefs.

And for me, the most powerful and meaningful interactions I've had both inside and outside the classroom about different belief systems have taken place when colleagues and I have been able to open-mindedly listen to one another's perspectives, without judging, without assuming, and even better yet, when we've been able to ask questions curiously that open the door for others to freely share a different viewpoint or worldview. So, for example, having one particular classmate take time to sit down and ask me about a belief of mine that I know they don't share was really impactful for me as a medical student. And hopefully, she's listening. I'm going to give her a personal shout out to honor the fact that she did that. And these tools that we're kind of discussing, identifying our implicit biases and taking a step back and the assumptions we make in our conversations should be applied to all the interactions we have with every member of our multidisciplinary healthcare teams as well. So, that includes our colleagues in medicine and nursing, pharmacy, nutrition, physical and occupational therapy, you name it.

BP: Maggie, I really appreciate how you said, "asking questions curiously," because I think sometimes, especially since you were so busy and you were trained to get answers, we may just ask questions without truly being open to that answer and coming at a place of curiosity, so I think that's really important.

[00:58:25 - 01:05:55] Two Key Issues to Navigate: Power Dynamics and Professionalism

Before we conclude this episode, we want to highlight two other important issues to keep in mind anytime we're discussing religious and spiritual belief systems with our classmates, team members, patients. And the first is power dynamics. We have to keep in mind that within our relationships in healthcare, there's often a real or perceived power differential. Patients may feel unable to voice their beliefs to

their medical providers, medical students, or even non-physician team members. And others within the healthcare team may feel unable to voice differing beliefs from the attending physician. And so, I think it's so important to be sensitive, open-minded, and to ask questions curiously.

MK: Yes. Absolutely, and the second closely related issue to navigate in these conversations is professionalism. We have to keep appropriate boundaries between patients and providers and between classmates or colleagues when we're in professional settings. Things like transference and countertransference or sharing personal parts of ourselves with others, like patients, can definitely impact our patient care and even our relationships with coworkers and we need to keep that in mind. For example, and Ermanno, please jump into this, there are arguments both for and against providers praying with their patients and not specifically chaplains, although, of course, they fall within the provider team, but specifically thinking about clinician providers who are not as experienced as the chaplains are. I'm of the opinion that in the right setting, as in you share the same belief system as your patient and your patient wants to pray with you, that praying with your patient can be a positive intervention for them, but this isn't the case in all situations. What do you think about how we should balance professionalism in this area, Ermanno, and also the power dynamics that Brittäne was talking about?

EW: Very interesting question, and I would respond, to many people's surprise, that I rarely pray with patients. And I say that in the sense that everybody expects the chaplain to pray with a patient, but there's so much more underneath the surface than if you go in, what I call, with a "Band-Aid prayer," and everything is better now. There is no need for you to be in the hospital because the chaplain has prayed for you.

However, it doesn't mean that I don't pray for patients or even pray with patients. I only pray with patients who explicitly ask me to pray with them. And so, I don't leave the room trying to suggest, "Do you want me to pray with you before I leave?" I leave the room, just like everybody else would leave the room, in and out. I've done the job that I've come to do, I'm offering support whether you accept it or not. By the way, if prayer is requested, and it does have to come from them, I will engage in such activity. I say that in the sense, also, because I come from the mindset that people really know what they need and what they want. And if we listen to some of the things that they're saying, whether it's overtly, just kind

of mixed messaging, if there is any type of mixed messaging, or just any question, I may ask, "Well, can you tell me more? Are you suggesting X, Y, and Z?" and then make appropriate decisions on whether or not something, and I would encourage all providers, no matter what spiritual expression you have, to hear if a patient is requesting you for certain kinds of spiritual interventions.

You'd be surprised. I had the opportunity to share with some medical school students during my time at Mayo Clinic and Mayo Clinic Medical School, and we got on this topic of what if a patient requests for you to pray. And of course, I had a group of agnostics, professed atheists, as a part of my group that we were trying to discuss some spiritual interventions. One thing that I offered those, especially who had a differing faith, belief, or spiritual expression or did not proclaim a spiritual expression, I shared with them, "Are you open enough for them to lead the prayer? Are you open enough to be present for the patient who obviously needs something to hold on to more than the prescription that you're able to give them, more than the medical advice you can give them? Can you just be present enough and allow them to pray and express whatever it is that they have in their own expression? If you can do that, that is more helpful and more beneficial than any pill you can prescribe them."

BP: Ermanno, I really appreciate your insights, and I believe this is such sound wisdom, and you're going back to your point again and again about really being present. I just had a visual in my head of just showing up there, being willing to give to that patient whatever it is that they need. It may just be sitting there and allowing them to lead and allowing yourself to be a part of that experience. I think it really shows our patients how much we care and how far we are willing to go to meet them where they are.

EW: Absolutely, and you can still do that even with the time constraints that you have.

MK: Well, as we close out this episode, we want to acknowledge that we know this is obviously a new aspect of patient care for many clinicians to consider implementing. In healthcare, there's always continued growth with respect to our learning and incorporating new ideas. Brittäne and I have found it helpful to ponder and feel out for ourselves what ways we are individually willing and able to address patients' religious and spiritual needs while still holding true to our own beliefs without compromising them. We encourage all of our listeners to do the same, and

we also hope our listeners join us in reflecting on how we are each influencing our own learning and work environments in terms of whether space is being made for diverse belief systems and values to be expressed and honored.

BP: Ermanno, we want to thank you for joining us for this episode and sharing your expertise in creating an educational and clinical environment that welcomes different religious and spiritual belief systems.

EW: It's my pleasure.

MK: Yes, thank you so much for being here.

[01:05:56 - 01:06:30] Continuing The Conversation and Outro

BP: We'd love to keep talking about this topic with our listeners, and we want to hear your experiences and thoughts about religion and spirituality in health care. So, connect with us via Instagram or Twitter at the handle *@thedeishift*, and again that's DEI, or email us at thedeishift@gmail.com.

MK: And you can find this episode's learning objectives, show notes, full transcript, and the resources referenced on our website, thedeishift.com. We hope you enjoyed this episode and look forward to joining us next time on *The DEI Shift*.

[Music]

[01:06:36 - 01:06:59] Outtake

BP: That was so awesome!

MK: Yaaay!

BP: My bar definitely went red because I just yelled. [Laughter] Ermanno, thank you so much! I learned so much, and I wasn't kidding when I said I was going to go back and listen to this because you were talking about your assessment, and I was trying to write, but I couldn't keep up. [Laughter]

[Music]

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