Meeting the Emotional and Spiritual Needs of Patients

As modern medical science has yielded tremendous advances in new and exciting technologies to diagnose and treat disease, health professionals have begun to emphasise the physiological and biomedical aspects of health care. Doctors and nurses have increasingly been trained as expert technicians, equipped with the tools to treat illnesses quickly and efficiently. As a result, the person with the illness is often left out. The neglect of the whole person in modern health care has resulted in widespread dissatisfaction both for patients receiving such care and for health professionals delivering it. That dissatisfaction may be interfering with patient recovery and contributing to a rise in litigation against hospitals and providers. It is certainly affecting the skyrocketing rates of burnout among doctors and nurses.
Emotional and Spiritual Needs of Patients
Although most of us are taught about the emotional and social difficulties that accompany illness, there hardly seems time to adequately address these issues. Even more daunting is the notion that patients also struggle with spiritual needs, which may underlie and drive many of the problems that arise in the emotional and social areas as well. Health professionals receive almost no training in this subject, and, as a result, most feel unprepared.

What, then, are the emotional and spiritual needs of patients dealing with illness, disability and dependency?

A need to make sense of the illness. Patients need to understand why they have been singled out for illness, what it means for them, their future, and their families’ future. They need to know how they are going to cope with, and bear the burden of, a changed life that may involve long-term physical discomfort.

A need for purpose and meaning in the midst of illness. Patients need renewed purpose and meaning in order to continue to fight illness. They need to know that they can still contribute, despite their illness. Religious and spiritual beliefs often lie at the core of what gives life purpose and meaning in these circumstances.

A need for spiritual beliefs to be acknowledged, respected, and supported. When patients are sick and in the hospital, religious or spiritual beliefs become increasingly important. Patients need their health professionals to acknowledge, respect, and support those beliefs.

A need to transcend the illness and the self. Patients need to get their minds off of themselves to counteract the obsessive preoccupation with self that almost always accompanies serious illness. Focusing on spiritual matters often helps patients put their own concerns in perspective.

A need to feel in control and give up control. Hospitalisation takes control away and arouses anxiety. Many patients seek to regain that control and fight efforts by health professionals that are perceived as taking it away. Spiritual beliefs help to regain control over these situations.

A need to feel connected and cared for. Hospitalisation and illness make patients feel isolated from others. Spiritual beliefs, visits from their pastor or members of their congregations, or knowing that members of the faith community are praying for them, all help to re-establish connection with others. Feeling connected to, cared for, and loved by God also helps to relieve loneliness.

A need to acknowledge and cope with the notion of dying and death. Having illness serious enough to warrant hospitalisation sends a terrifying message to many patients – that they cannot live forever. Many fear death less than they fear the process of dying, and the discomfort, isolation and loss of control associated with it. Spiritual beliefs provide a world-view that makes sense of life, death, and suffering – and gives answers that medicine and science cannot provide. On the other hand, patients may not feel spiritually ready to die. They may fear punishment after they die, or worry about their relationship with God.

A need to forgive and be forgiven. Because illness can sometimes be perceived as punishment and because it forces us to confront our ultimate mortality, the need to give and receive forgiveness is greatly enhanced. Religious and spiritual rituals exist that help patients to forgive others and accept forgiveness themselves, releasing them from the emotional turmoil that guilt and bitterness produce.

A need to be thankful in the midst of illness. Being thankful and grateful for the health and relationships they still have helps patients to adapt more quickly to illness and maintain a positive outlook. Religious beliefs and stories both encourage an attitude-of-gratitude, and provide role models to help accomplish this.

A need for hope. Hope is the engine of motivation. Without hope, patients give up, neglect themselves, and strike out at others trying to help them. Spiritual beliefs are a powerful source of hope for many patients.

How Common, How Often Addressed
Spiritual needs are common among both medical and psychiatric inpatients. In a study of patients at a Chicago hospital, 76% of medical-surgical and 88% of psychiatric patients reported three or more religious needs during hospitalisation. Few patients have their spiritual needs addressed during acute hospitalisation and even fewer have those needs met in long-term care settings. For example, when patients were asked whether their doctor had addressed their spiritual needs, 80% indicated that they had never or rarely done so. In fact, several years ago, USA Weekend magazine conducted a nationwide poll of 1,000 adults, asking whether people believed that it was good for doctors to talk to patients about spiritual faith. Sixty-three percent indicated that this was something doctors ought to do. Fewer than 10% of health professionals regularly address their patients’ spiritual needs.

Consequences of Unmet Spiritual Needs
When spiritual needs are not addressed, spiritual struggles may result. The patient may perceive their illness as a punishment and become unable to use their faith as a resource for coping. God may start to be seen as weak, or as distant and uncaring, which may throw the person into an existential crisis.

In a prospective study of nearly 450 patients followed for two years after hospital discharge, we found that there were consequences of having such spiritual struggles, including an increased risk of death, poor mental health, and low quality of life. Unmet spiritual needs may also impact the length of hospital stay and need for long-term care services after hospital discharge.

On the other hand, when patients’ spiritual needs are adequately met, it reduces the likelihood that depression
will develop and speeds recovery from depression if it does. The fact that many hospitalised patients rely on their spiritual beliefs to cope with illness has been documented in many areas and the proportion may exceed 90% of patients in some hospitals. Having spiritual needs addressed may also influence speed of response to medical treatments.

How to Address Patients’ Spiritual Needs
All health professionals who have contact with patients should be trained to take a spiritual history. The spiritual history communicates to the patient that the health professional recognises the place and importance that spiritual factors play in their struggle with illness.

There are many ways of taking a spiritual history. When time is very limited, it may be as simple as asking the question: “How are you doing spiritually?” Patients usually don’t need much prompting to get them talking about such matters. In many cases, however, a structured spiritual history is useful to help guide the conversation. The following is an example of five questions that tap information important to the care of the patient:

Do your religious or spiritual beliefs provide comfort and support or do they cause stress?

How would these beliefs influence your medical decisions if you became really sick?

Do you have any beliefs that might interfere or conflict with your medical care?

Are you a member of a religious or spiritual community and is it supportive?

Do you have any spiritual needs that someone should address?

Once spiritual needs are uncovered, the health professional must orchestrate the meeting of those spiritual needs. This may involve a referral to chaplain services; providing access to inspirational reading material or directions to the hospital chapel; notifying the patient’s clergy or friends at church; praying with a patient; or simply listening and trying to understand. It almost never means giving spiritual advice or providing solutions to the patient’s spiritual struggles. The end result is usually deeply rewarding for patient and provider.

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OBJECTIVE: To review the basic components of measuring and addressing patients’ emotional and spiritual needs. To provide a basis for understanding patients’ perceptions, their emotional and spiritual needs. To describe how to measure and improve the quality of care of these needs.

BACKGROUND: Since 1985, Press Ganey has measured patient satisfaction with the experience of care using a holistic perspective derived from well-grounded research in medical anthropology, psychology, sociology and health sciences. Press Ganey began measuring emotional and spiritual care long before the Institute of Medicine made its recommendations and other entities began assessing how well spiritual needs are addressed. Press Ganey has evaluated more than 4,000 articles using evidence-based criteria and conducted interviews with high-performing and most-improved facilities in addressing patients’ emotional and spiritual needs.

SUMMARY:

This white paper provides a basic understanding of emotions and spirituality, how emotions relate to patient perceptions of their experience, what patients’ emotional and spiritual needs are and what staff can do to address these needs.

Original research findings may also help broaden understanding of the patient’s perspective on emotional and spiritual care:

- Patients place a high value on their emotional and spiritual needs.
- Addressing emotional and spiritual needs is a top priority for quality improvement in the U.S., Australia and Canada.
- Evidence exists to indicate a relationship between patient satisfaction with emotional and spiritual care and profitability.
- Patient demographic variables do not predict satisfaction in “…emotional and spiritual needs.”
- All patients possess emotional and spiritual needs, regardless of how unexpected or traumatic the admission.
- Patient satisfaction varies by diagnosis (DRG) to a great extent, even within major diagnostic categories (MDC).
- A small but meaningful difference in patient satisfaction exists between religious and non-religious hospitals.

Potential solutions, suggestions and additional resources are also discussed.
What are emotions?
Emotions are collections of chemical and neural responses generated by the brain affecting the brain and the body. Primary emotions are fundamental responses universally experienced by everyone: happiness, sadness, fear, anger, surprise and disgust. Social emotions are more diverse and complex subsets of the primary emotions; they include embarrassment, jealousy, guilt, pride, etc. These emotions accumulate to create background emotions or moods which linger for longer periods; they include anxiety, depression, calm, malaise, etc. (Damasio 1999).

What is spirituality?
Spirituality is the individualised, subjective experience of and from which a person derives purpose, meaning and hope (Miller & Thoresen 2003).

How are emotions created?
Current research in emotions and cognitive science has modeled the factors involved in creating an emotion (Figure 1).

Figure 1 (from Kihlstrom et. al. 2000).

Spirituality and spiritual practices help create emotions through eliciting stimulus, expressive behavior, physiological response and subjective experience.

For example, consider the elicitation of the relaxation response through prayer:

Eliciting stimulus: Chaplaincy visit. Eventually asks the patient if she would like to pray.

Subjective experience: Patient appreciates the visit, the attempt to meet spiritual needs and would like to pray.

Expressive behaviour: Repeated prayer (phrases)

Physiological response: Relaxation response elicited. Anxiety level, heart rate, oxygen flow, etc. affected.

Emotion/Emotional state: Positive, peaceful, content, etc.

The intersection and reinforcing interactions between eliciting stimulus, expressive behavior, subjective experience and physiological response to induce emotion explains how emotions can be affected individually (passed from person to person) and on a macro-scale as an infectious contagion (a gathering of friends creating an atmosphere engendering infectious happiness despite prior emotional state). It also explains how patient satisfaction with emotional/spiritual needs can be influenced by every encounter throughout the hospitalisation experience.

How do patients’ perceive their emotional and spiritual needs?
Patients largely do not perceive a distinction between an “emotional need” and a “spiritual need.” Perceptions of
emotional well-being, spiritual well-being, psychosocial health, mental health and physical health intermingle into a vision of a single self. While spirituality occasionally evokes the religious, actual identified needs appeal to the same broad psychological concepts:

- Search for meaning
- Hope
- Alleviation of fear
- Alleviation of loneliness
- Transcendence
- Desire to maintain religious practices
- Presence of God

Caring for patients’ emotional and spiritual needs invokes identical behaviours among staff:

- Caring
- Comfort
- Support
- Sensitivity
- Empathy
- Affirmation
- Attentiveness to unique needs

The patients’ evaluations of emotional and spiritual care as a single construct (i.e. “Degree to which staff address emotional/spiritual needs”) is solidly grounded in cognitive science, psychology, emotions research and how patients actually perceive these needs.

**Importance of emotional and spiritual needs**

Patients place a high value on their emotional and spiritual health and well-being. This is evidenced by the rank of “Degree to which staff address emotional/spiritual needs” near the top of the National Inpatient Priority Index every year since 1998. Recent Press Ganey research reveals that this prioritisation supersedes nationality and the structure of healthcare systems – emotional/spiritual needs ranked first on the Inpatient Priority Index for the United States, Canada and Australia in Q1 2003 (Williams 2003).

**Emotional/spiritual needs and profitability**

Press Ganey conducted a study to determine whether or not any relationship existed between facility patient satisfaction scores in emotional/spiritual needs and profitability.

**Methods:** Data was obtained from Expanded Modified Medicare Provider Analysis and Review (MEDPAR) and the Press Ganey national inpatient database. The states of Connecticut, New Jersey and Rhode Island were selected because they represent the most comprehensive picture of competition within a single market in the Press Ganey database; the sample included 76% of all hospitals over 100 beds and 91% of all large or mid-sized teaching hospitals. Although the most complete market snapshot available, the sample being only three states is a limitation.

**Results:** Controlling for case-mix index, bed size, teaching status and percentage of Medicare and Medicaid patients, aggregated hospital performance in satisfying patients’ emotional/spiritual needs exhibits a moderate, positive relationship with profitability ($r = 0.38$, $p = 0.002$; $n = 82$). The relationship between patient satisfaction with emotional/spiritual needs and profitability was even stronger among mid-sized and large teaching hospitals ($r = 0.44$, $p = 0.002$; $n = 49$) (Figure 2).

**Conclusion:** The best data available indicate the existence of a significant relationship between satisfying patients’ emotional/spiritual needs and hospital profitability, especially for teaching hospitals having more than 100 beds.
Demographic variables not predictive
Analysis of the Press Ganey national inpatient database shows that patients’ satisfaction with the degree to which staff addressed emotional and spiritual needs is not predicted by demographic variables such as age, gender, length of stay, or self-described health status. *Facility scores in emotional/spiritual needs are not driven by patient demographics.*

All patients possess emotional and spiritual needs
Analysis of the Press Ganey national inpatient database also demonstrates that patients’ satisfaction with the degree to which staff addressed emotional/spiritual needs is not predicted by whether this was the patient’s first hospital stay, whether the admission was through the ED and whether the admission was unexpected. Regardless of the prior experience or the relative seriousness of admission, *all patients consider their emotional/spiritual care needs as important and deserving of attention.*

Patient satisfaction varies by DRG
Patient satisfaction with the degree to which staff addressed emotional/spiritual needs varied significantly by DRG. Patients in some DRGs (e.g. chemotherapy w/ acute leukemia) rated their satisfaction with emotional/spiritual care exceptionally high while others (e.g. male reproductive cancer) rated extremely low (see Clark, Drain & Wolosin, 2003). *Patients with different diagnosis may possess different emotional and spiritual needs or receive different emotional and spiritual care.*

Religious hospitals and non-religious hospitals
The modern quality paradigm views outcomes as resultant from structure and process. Therefore, in evaluating the outcome of patient satisfaction with emotional/spiritual care, it is important to consider structure. The most basic structural question in this regard is “Do religious-affiliated acute care facilities perform better in meeting patients’ emotional/spiritual needs?”

<table>
<thead>
<tr>
<th>“Degree to which staff addressed your emotional/spiritual needs” (January-December 2002)</th>
<th>Mean</th>
<th>SD</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religious Hospitals</td>
<td>81.54</td>
<td>3.14</td>
<td>331</td>
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<tr>
<td>Non-Religious Hospitals</td>
<td>80.59</td>
<td>3.91</td>
<td>1157</td>
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</table>

Patients’ aggregate evaluations of the quality of emotional/spiritual care in religious hospitals was 0.95 [t(1,488) = 4.56, p < 0.001] greater than among non-religious hospitals. While the *t*-test indicates that the difference is statistically significant, calculating the effect size (ES) will quantify the practical significance of the difference (ES scale is 0-1; where an ES of 0 is no difference, 0.2 is small, 0.5 is medium and 0.8 is large). With an ES = 0.24, the gap between patients’ satisfaction with the quality of emotional/spiritual care at religious hospitals over non-religious hospitals is small, but meaningful.

Some focus groups and anecdotal evidence indicate that patients who select a religiously affiliated hospital possess greater expectations for emotional/spiritual care and hold staff to a higher standard. Hypothetically, as a group, religious hospitals may hurdle this raised bar through a stronger predisposition to direct staff time and resources to meeting patients’ emotional/spiritual needs. Religious hospitals may also be more predisposed to having a dedicated chaplaincy or pastoral care department.
To better understand patients’ perception of the source of emotional/spiritual care, we also compared correlations of patients’ ratings of degree to which staff addressed emotional/spiritual needs and different dimensions of the hospitalisation experience using the standard questions to calculate section scores.

If patients’ expectations and perceptions of emotional and spiritual care differ for religious hospitals vs. non-religious hospitals, then a comparison of the correlates of patients’ ratings would also demonstrate significant variance. The null hypothesis is, if patients’ hold identical expectations irrespective of the religious affiliation of the facility, one would expect to see no significant difference between what dimensions are associated with patients’ satisfaction with emotional and spiritual care.

Between religious and non-religious hospitals, only two dimensions of the hospitalisation experience differ significantly in their relationship to patients’ evaluations of the degree to which staff met their emotional and spiritual needs: Nursing and Personal Issues. The latter involves the items previously determined to be most highly correlated with emotional/spiritual needs (i.e. response to concerns/complaints, involvement in treatment decisions, and sensitivity to the inconvenience of hospitalisation). Thus, the components of personalised care tend to find increased covariance and interdependency in non-religious hospitals. The results also indicate that in non-religious hospitals, patient perceptions of the quality of nursing care and the quality of emotional/spiritual care are more closely associated with each other. A multitude of theories could be posited to explain this difference (e.g. patients in non-religious hospitals have a greater reliance upon nurses for emotional/spiritual care than in religious hospitals) but cause and effect cannot be inferred from these associations.

### Emotionally salient situations and actions

The most highly correlated items to “Degree to which staff addressed your emotional/spiritual needs” indicate emotionally salient situations where staff actions may affect patients’ satisfaction with emotional and spiritual care to the greatest extent:

1. Response to concerns/complaints made during your stay
2. Staff effort to include you in decisions about your treatment

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<table>
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<tr>
<th>Question</th>
<th>Pearson's Correlation</th>
<th>N</th>
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<tr>
<td>15. Response to concerns/complaints made during your stay</td>
<td>0.75</td>
<td>1212147</td>
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<tr>
<td>6. Staff effort to include you in decisions about your treatment</td>
<td>0.731</td>
<td>1205854</td>
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<tr>
<td>12. Staff sensitivity to the inconvenience that health problems and hospitalisation can cause</td>
<td>0.729</td>
<td>1263285</td>
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<tr>
<td>02. How well staff worked together to care for you</td>
<td>0.649</td>
<td>1320218</td>
</tr>
<tr>
<td>11. Staff concern for your privacy</td>
<td>0.645</td>
<td>1307143</td>
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### Relationships between “Degree to which staff met emotional/spiritual needs” and standard question section scores (Jan.-Dec. 2002)

<table>
<thead>
<tr>
<th></th>
<th>Religious Hospitals</th>
<th>Non-Religious Hospitals</th>
<th>Z-test*</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURSES</td>
<td>0.83</td>
<td>0.91</td>
<td>-3.1</td>
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<tr>
<td>ADMISSIONS</td>
<td>0.68</td>
<td>0.76</td>
<td>-0.59</td>
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<td>ROOM</td>
<td>0.72</td>
<td>0.78</td>
<td>-0.63</td>
<td>0.261</td>
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<tr>
<td>MEALS</td>
<td>0.64</td>
<td>0.73</td>
<td>-0.55</td>
<td>0.293</td>
</tr>
<tr>
<td>TESTS &amp; TREATMENT</td>
<td>0.83</td>
<td>0.88</td>
<td>-1.60</td>
<td>0.055</td>
</tr>
<tr>
<td>VISITORS &amp; FAMILY</td>
<td>0.84</td>
<td>0.90</td>
<td>-1.28</td>
<td>0.101</td>
</tr>
<tr>
<td>DOCTOR</td>
<td>0.66</td>
<td>0.69</td>
<td>-0.16</td>
<td>0.436</td>
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<tr>
<td>DISCHARGE</td>
<td>0.83</td>
<td>0.84</td>
<td>-0.25</td>
<td>0.403</td>
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<tr>
<td>PERSONAL ISSUES</td>
<td>0.91</td>
<td>0.96</td>
<td>-8.3</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>OVERALL ASSESSMENT</td>
<td>0.83</td>
<td>0.87</td>
<td>-1.0</td>
<td>0.16</td>
</tr>
</tbody>
</table>

### Survey Responses Highly Correlated with ‘Degree to which Staff Addressed Emotional/Spiritual Needs’ (R > 0.65) (Jan.-Dec. 2001)

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3. Staff sensitivity to the inconvenience that health problems and hospitalisation can cause

4. How well staff worked together to care for you

5. Staff concern for your privacy

These situations translate into emotionally satisfying organisational actions which would meet patients’ expectations in the aforementioned highly emotional situations:

1. Patients’ and/or families’ needs are handled in a timely, considerate and empathetic way

2. All tests, interventions, and treatments are explained in an emotionally sensitive and supportive decision-making process

3. Staff demonstrably provide empathetic emotional support

4. Staff work together to orchestrate resources to meet patients’ needs.

5. Staff respect patients’ confidentiality and physical privacy

(See Clark, Drain & Malone, 2003).

**Spiritual Resources**

Patients frequently desire several common spiritual resources during their stay that the hospital can provide or facilitate access to (Moadel et al. 1999; Shahabi et al. 2002; Tatsumura et. al. 2003).

- Personal or unique faith
- Prayer
- Scripture reading
- Prayer or dialog with fellow church members
- Counseling from chaplain or leader of faith
- Attending a religious service
- Daily spiritual experience
- Meditation
- Spending time at a location of spiritual energy (e.g. church, specific geographic location, or nature settings), and
- Help or counseling from ancestors

**Nursing Interventions**

Sheldon (2000) outlines several spiritual care interventions that nurses are capable of (after proper assessment). These include:

- Provide privacy, if appropriate
- Conduct life review or faith history
- Encourage storytelling of one’s spiritual life
- Suggest the patient keep a journal
- Read a Bible story and discuss it as it may apply to patient
- Observe relationships with family
- Offer to pray with a patient/family
- Refer patient to a spiritual care coordinator or clergy
- Facilitate spiritual practices or rituals
- Include patient’s spirituality / beliefs in plan of care
- Listen to patient
- Be open to patient’s questions
- Provide spiritual reading or videos, as requested
- Convey a respectful, empathic, supportive, nonjudgmental attitude in regard to patient’s beliefs
- Offer group support, if available

**What Are Patients’ and Families’ Emotional and Spiritual Needs?**

Taylor (2003) and Ross (1997) found patients’ expectations for emotional and spiritual care to be extremely modest:

- Kindness
- Respect
- Talking & listening
- Authenticity
- Physical presence
- Timely responses to requests
- Mobilising religious & spiritual resources
- Quiet space for reflection or prayer
- Information about church or chapel services
- Transportation to the chapel

(See Clark, Drain & Malone, 2003).
**Paediatric Patients**

Children also possess unique spiritual and emotional needs. Children can experience emotional and spiritual distress as frequently and deeply as adults. Children hold powerful images of religious figures and can benefit from visits from chaplains, pastoral care professionals or their local religious leader. In addition to other suggestions, several interventions apply specifically to paediatric settings, including (Davies et al. 2002; Feudtner et al. 2003; Kemper & Barnes 2003):

- Minimise separation from parents
- Minimise separation from personal items of emotional attachment
- Minimise disruption to childrens’ routines
- Limit the number of caregivers to help develop trusting relationship(s)
- Appropriate referrals to chaplains/pastoral care
- Red wagons for transportation
- Teddy Bear or other comforting stuffed animal
- Pen Pals with other patients in hospital or other children at other hospitals
- Consider pre-operative role-play with children to help prepare them for procedures
- In case of life-threatening or life-limiting illnesses, consider a special care plan designed to provide comprehensive emotional and spiritual care (e.g. make memories, special spiritual rituals, etc).

**Chaplains/Pastoral Care Teams**

Chaplains and pastoral care professionals are highly skilled, well trained and best equipped to provide complex spiritual care (Vandecreek & Burton, 2001). All staff need to be aware and capable of making timely referrals to chaplains and pastoral care (Astrow et al. 2001). Yet all patients possess some basic emotional and spiritual care requirements and simple needs (see above) which, through everyday actions and care, can be addressed by healthcare professionals.

Chaplains and pastoral care professionals cannot be saddled with exclusive responsibility for patient satisfaction with the degree to which staff addressed emotional and spiritual needs, especially when the number of patients visited is inherently limited. Rodrigues and colleagues (2000) report only 1 chaplain or pastoral care professional exists for every 64 patients in U.S. hospitals. Our qualitative research found that the highest percentage of admitted inpatients visited by a chaplain, resident chaplain or other pastoral care professional at a single hospital was 40%. Effective and satisfying emotional and spiritual care requires proactive collaboration between nurses, physicians and chaplains/pastoral care professionals (Vandecreek, 1997).

**Trends**

An increasing number of medical and nursing schools provide doctors and nurses with training in spiritual care (Graves, Shue & Arnold, 2002; Levin, Larson & Puchalski, 1997; Puchalski & Larson, 1998). Patients, families and caregivers now expect nurses and doctors to provide spiritual care (Koenig, 2002; Taylor, 2003). Increased awareness of possible religious and spiritual pathologies has lead to recognition of a need for clinicians to assess, understand and support or moderate patients’ spiritual and religious beliefs, practices and values (Koenig, McCullough & Larson 2001; Koenig, 2002). These and other trends amass to place an increased emphasis on measuring the quality of care for patients’ spiritual needs – distinct from care for emotional needs despite the high interrelationship between perceptions and behaviours related to the quality of care in addressing emotional and spiritual needs.
Meeting Your Needs for Emotional and Spiritual Care Measurement

Solution Suggestions

Ultimately, patients’ satisfaction with the emotional and spiritual experience of care represents an aggregate of the interactions and encounters throughout the entire hospitalisation. Globally optimising these everyday encounters to positively affect patients emotionally and spiritually will likely result in larger improvements in patient satisfaction than single interventions or a focus on extreme cases. The following are questions to ask yourself as you evaluate your performance in meeting patients’ emotional and spiritual care needs.

1. Do we have effective customer service behavioural standards in place that address privacy, respectful communication, kindness, etc.?

2. Do we systematically and frequently elicit and meet patients’ emotional and spiritual needs with screening questions like “How are you feeling?” “We care about your emotional and spiritual well-being. Do you have any needs or request that I can help with?”

3. Are we conducting Emotional or Spiritual Assessments or taking Spiritual or Faith Histories in order to understand patients’ preferences and assess needs? Are we connecting with patients? Are we reassessing or reconnecting patients on at least a daily basis? Are we understanding and reaching all patients?

4. Do we have an effective service recovery process? Have we trained all staff in service recovery? Do we have a service recovery or general discretionary fund?

5. Do we know how to communicate empathically to demonstrate to patients that you understand and empathise? Does everyone know how to communicate in ways that calm and soothe angry or upset patients?

6. Do we have a chapel or meditative place? Do patients know about it? Do we tell them when services are? Do we offer to take patients to the Chapel? Do we have and do patients know about religious programming on our T.V.?

7. What do staff know about your patient population’s culture, spiritual beliefs and related emotions? What are your organisational learning needs?

Future Research

The emotional and spiritual care of patients receives more research attention than any other individual measure of patient satisfaction with the experience of care. Other articles are available and more research will be forthcoming from Press Ganey Research & Development.
References


Organisations contributing to this report
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