Editorial

Advancing the place of spiritual care within palliative care

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The recognition of the importance of spirituality at the end of life is not new. Since the pioneering work of Cicely Saunders in the 1960s, leaders in palliative care have realized that life-threatening illness is a spiritual event. Saunders' identification of the multi-dimensional nature of spiritual suffering at the end of life as 'total pain' remains foundational to the understanding of the need for holistic palliative care (1).

Data suggest that attention to religiousness and spirituality increase with the onset of life-threatening illness (2). The diagnosis of life-threatening disease threatens a patient's understanding of their world as they are forced to confront their finitude, raising existential questions which, if left unanswered, can precipitate an existential crisis (3). Kellehear reviewed the palliative care literature and developed a theoretical model of spiritual needs which characterised them as multi-dimensional and all directed towards finding meaning in the illness experience in order to overcome suffering (4).

Interest in spirituality is found even in countries where religiosity is known to be decreasing. Therefore, religious surveys of the general population may underestimate the importance of spirituality and religion in the context of serious illness. Freud believed this shift emerges out of a direct confrontation with one's fear of death or hope for immortality. Whatever the cause, if spiritual concerns are not addressed, patient outcomes are worse (5).

Studies using measures of spiritual wellbeing have found that spiritual well-being is positively associated with quality of life, independent of other factors; subjects with high levels of spiritual well-being will report high life enjoyment even in the presence of high levels of physical symptoms. Indeed, spirituality was found to be associated with quality of life to the same degree as physical well-being (6).

We will, therefore, want to do what we can to improve the spiritual wellbeing of palliative care patients and their carers. Spiritual care helps patients and carers make sense of events happening around them and find meaning or a way through the current circumstances. The growth of evidence-based medicine threatened to make symptom control the focus of palliative care, but spirituality challenges the reductionist approach. This change of focus has been found to be of benefit to clinicians as well as those in their care (7). However, current levels of spiritual care do not yet meet patient need (8).

A recent review found that barriers to spiritual care provision include a lack of perceived competence in spiritual care by clinicians and reduced visibility of spirituality within healthcare institutions (8). Other documented barriers include misunderstanding the term 'spirituality' to mean 'religion', and rejecting it on those terms (9). This has particularly been a problem in countries where translation of the word 'spirituality' involves terms which imply religiosity in some way (10).

It is therefore encouraging to see the publication of '*Competencies for quality spiritual care in palliative care in Latin America: from the Spirituality Commission of the Latin American Association for Palliative Care*' (11). At the core of the document is the recognition that spiritual care training for staff and raising the profile of spiritual care are vital

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if spiritual distress at the end of life is to be adequately addressed. The authors recognize that spiritual care must be based on a biospychosocialspiritual model of the human being (12). The paper assumes a Generalist/Specialist model of spiritual care, where all staff members are responsible for general spiritual care in collaboration with a spiritual care specialist (also known as a chaplain or pastoral care practitioner in some countries) (13). There are many aspects of this document which are to be applauded.

Firstly, by developing specifically Latin American competencies, it recognizes the cultural element of spiritual care, frequently overlooked (14), and the need to contextualize strategies to ensure plans are feasible. Integral in a region encompassing multiple cultural and language groups, is the need to find common vocabulary with which to clearly articulate concepts such as religion and spirituality (Competency 1). Primacy is also given to the need for the clinician to address one's own spiritual growth, which has been identified as a crucial aspect for the success of spiritual care training as well as being protective for staff burnout (15).

Another important area addressed is the need for consideration of the ethical aspects of spiritual care (Competency 2). Keeping the patients and their caregivers at the centre of care is suggested to ensure that personal preferences are recognized, as well as addressing at an organizational level the need to respect human dignity. The value of examining one's own spirituality is seen here, so that the clinician's understanding of spirituality and their own existential distractions do not impinge on the patient's access to spiritual care (16).

Competency 3 focuses on the assessment of spiritual need and spiritual care interventions, and identifies the need to develop locally relevant tools which can be adapted to the developmental stage of the patient as well as their place on the disease trajectory. The inclusion of bereavement care in this competency is good to see as it can be forgotten in strategies for implementing spiritual care (17).

Competency 4 focuses on communication. The need for improvement in interdisciplinary communication has been previously recognized, as has the suggestion that spiritual care should be sufficiently valued that staff invest in the use of interpreters to ensure that it is accessible for all patients and carers (18).

Collaboration within the interdisciplinary team is the focus for Competency 5. The recognition that not all facilities will have access to a specialist spiritual care professional is important in a continent where palliative care services are still developing. It is also relevant in places where local religious authorities prefer to focus on ritual rather than spiritual care (10). However, the responsibility given to spiritual care professionals in this document needs to be accompanied by introduction of adequate training programs so that they are able to meet their obligations (19).

Inclusivity and diversity as the final competency recognize once again the need for spiritual carers to recognize the preferences of individual patients and carers, highlighting cultural aspects of spiritual care and the need for the clinician to be aware of their own spiritual beliefs.

Areas mentioned within this document which will need further research include determining how spiritual care education is best maintained over the long term—while a continuous academic education plan is envisaged here, the ideal content and timing of such courses has not yet been established (20). Similarly, while indications for referral to a spiritual care professional are listed, this is still an area of development (21). It is refreshing to see the authors making a clear articulation of what spiritual care professionals should be called in Latin America, a step which would be welcomed in the English-speaking world.

The competencies for quality spiritual care in palliative care is an important aspirational document for palliative care services across Latin America, but should not be geographically limited. This documentation of the components required to provide high quality spiritual care in the palliative care setting will prove valuable to all those seeking to implement spiritual care in their own context. This is an essential step to improve the care of and quality of life for patients approaching the end of life.

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