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Effects of chaplain care on coping with cancer

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ABSTRACT A clinical decision report using:

Piderman KM, Radecki CR, Jenkins SM, et al. Hearing and heeding the voices of those with advanced illnesses. *Journal of Palliative Care.* 2020;35(4):248-255. https://doi.org/10.1177/0825859720928623

for a patient having difficulty coping with cancer.

Keywords: *chaplain, spiritual care, cancer, palliative care*

Clinical-Social Context

Mr. Julain (pseudonym) is a 86 year old man who presented from an outside hospital due to painless jaundice. Mr. Julian is a middle-class Caucasian from a predominantly Christian community. He initially was seen and admitted at an outside hospital two months prior to this encounter for acute painless jaundice and was diagnosed with biliary obstruction of unknown etiology and had a biliary stent placed. It was unknown whether a biopsy was done at this time and the patient did not follow up. He presented again to an outside hospital for continuing jaundice and ultimately was transferred to a tertiary care hospital due to shortage of staff to complete endoscopic retrograde cholangiopancreatography (ERCP). He was managed on the general practice unit one week prior to receiving ERCP due to failure to discontinue warfarin early enough for the procedure. While admitted, he spoke with the gastroenterology team and internal medicine providers daily and was well informed about the differential diagnosis for progressive painless jaundice. During his stay, he made comments such as “I have no control over my life” and “This must be God’s punishment.” He displayed symptoms of fatigue, lack of motivation and irritable mood. When asked about his religious identity, Mr. Julian explained “I grew up Catholic, but I stopped going to church around my 30s. So this must be God's punishment.” He had no notable family support and suspected that his closest family members were more interested in his inheritance than him, and thus did not want to involve them in decision making. After the ERCP, Mr. Julian was diagnosed with pancreatic adenocarcinoma. Due to his state of mind, there was concern for new onset depression, and a psychiatric- oncology consult was placed. However, by mistake a chaplain consult was also placed, and Mr. Julian was seen first by the chaplain, which he had not expected.

Clinical Question

What are the effects of Chaplain intervention on quality of life and mental well-being in cancer patients?

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Research Article

Piderman KM, Radecki CR, Jenkins SM, et al. Hearing and heeding the voices of those with advanced illnesses. *Journal of Palliative Care.* 2020;35(4):248-255. https://doi.org/10.1177/0825859720928623 [1]

Description of Related Literature

A PubMed search was conducted to find relevant literature using keywords “Chaplain” AND “(Depression OR Anxiety OR Coping)” AND “(Cancer patient OR Cancer)” with filters of 2002-2022. Sixty-three results were yielded, and articles were skimmed by title and abstract for relevancy. Due to the differing roles religiosity/spirituality play depending on cultural context, articles from countries other than the United States were not included. The identified studies below were the only articles found that specifically evaluated chaplain care or spiritual care in cancer patients, and one paper was included because it evaluated the spiritual needs of specifically hepatopancreatic cancer patients.

Kesetenbaum et al.[2] evaluated the impact of spiritual care in the form of the Spiritual Assessment and Intervention Model (AIM), delivered by Chaplains on patients with advanced cancer (defined as estimated mortality within 1 year). Thirty patients completed three sessions with chaplains and pre- and post- surveys were used to assess depression, anxiety, and religious coping via standardized questionnaires. This study offers advantages of qualitative and quantitative data. It was limited in its ability to randomize patients and its small sample size, as patients were assigned chaplains based on schedules. Patients were also receiving concurrent palliative care making it difficult to separate palliative cares effects on study changes. This study covers advanced cancer patients, and Mr. Julian was diagnosed with cancer, but was not staged at time of the encounter. Lastly, this study is about a specific model of spiritual care (AIM), which was not offered by hospital clergy for Mr. Julian.

A cross-sectional study conducted by Hays et al.[3] evaluated the impacts of clergy home visits on patients with stage IIB-IV metastatic lung cancer, stage IV metastatic breast cancer, colorectal, prostate cancer, class II-IV congestive heart failure, and chronic obstructive pulmonary disease with hypercapnia. The study measured depressive symptoms using Epidemiologic Studies of Depression Scale (CES-D) and found that patients who received visits had lower scores of depression than those who did not receive care. The study covered a larger sample size of 210 individuals. However, the patients who received clergy visits at home sought these out themselves. This creates a possibility of selection bias as these patients could have been more inclined to have greater outcomes with visits. Most of these patients were identified as active members in their religious faith.

Perez et al.[4] evaluated the acceptability and effects of outpatient chaplain-delivered semi-structured spiritual care to advanced stage IV lung and gastrointestinal cancer patients. Surveys were administered pre-intervention and 1, 6, and 12 weeks post-intervention, and showed improvement on standardized questionnaires on depression, anxiety, religious coping, and spiritual well-being. The study surveyed those with a similar religious background as Mr. Julian. Its limitations included lack of analysis of the role sociodemographic factors play in outcomes and no description on how these variables were controlled.

Kelly et al.[5] identified hepatopancreatic cancer patients on EMR and compared their utilization of spiritual care during inpatient admissions to a non-hepatopancreatic cancer group (breast and prostate cancer). The report found that 1 in 2 hepatopancreatic cancer patients used spiritual care during admission compared to 1 in 5 in the non-hepatopancreatic group. Though this report was the only study identified that covered the specific cancer type that Mr. Julian had, it did not address the effects of such interventions.

Lastly, Balboni et al.[6] conducted a study of patients with advanced cancer (disease refractory to first line chemotherapy and metastatic disease), to evaluate spiritual care on end of life therapies and quality of life near death. The report found an increased quality of life in those who received spiritual care compared to those who did not, assessed using the McGill Quality of Life Questionnaire. The study surveyed 343 patients across multiple institutions. However, what was included in “spiritual care” was never defined.

Ultimately, a longitudinal study conducted by Piderman et al.[1] was chosen for critical appraisal because it specifically evaluated chaplain care provided by the medical institution, had a larger population size, evaluated the variables included in the clinical questions: quality of life, well-being and coping and analyzed the impact sociodemographic factors play in outcomes. The strength of

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recommendation earns a B score on SORT criteria.[7] There were no studies identified that specifically evaluated chaplain care inpatient, or at time of cancer diagnosis. There were also no randomized control trials found on Chaplain care intervention. The articles reviewed above agreed with the critical appraisal article's results of increased quality of life, well-being, and religious coping after chaplain visits/spiritual care. Kesetenbaum et al.[2] did not have randomization and specifically used the Spiritual AIM model that would not be offered to Mr Julain. Hays et al.[3] did have a control group, but confronted significant issues in selection bias due to patients seeking out their own chaplain care. Perez et al.[4] evaluated all variables posed in the clinical questions, but failed to evaluate or control the role of sociodemographic factors on outcomes. Kelly et al.[5] did not address the variables asked in the question, but did shine light on the specific patient population. Lastly, Balboni et al.[6] did have a large sample size and had a control. However they did not specify what was involved in "spiritual care" received.

Critical Appraisal

Piderman et al.[1] conducted a longitudinal study on the impact of spiritual care conducted by hospital chaplains on spiritual well-being, coping, and quality of life on patients with advanced illness. The study took place between July 2012-2014 and recruited patients from Mayo Clinic. The study was completed in two phases: phase one included patients specifically diagnosed with a brain tumor or other neurologic illness, and phase two was expanded to include patients with advanced diseases such as advanced cancer, cardiac, pulmonary, or renal failure. Patients were referred to the study via palliative care services. Pre- and post-surveys included quantitative standardized questionnaires including Functional Assessment of Chronic Illness therapy- Spiritual Well-being Scale (FACIT-Sp-12), Quality of Life Linear Analog Scale Assessment (LASA) which measures quality of life, well-being and emotional well-being, and lastly the positive Religious Coping Scale (RCOPE).

After completing the pre-survey, the participant was randomly assigned to a Chaplain who administered spiritual care that involved life review and a spiritual legacy document, a reflection on patient spiritual/religious values. These meetings were semi-structured, but chaplains had the ability to lead the conversations. Phase one follow-up questionnaires were provided one and three months after Chaplain care. Phase two was two weeks after care. This study meets level 2 evidence by SORT criteria.[7]

Phase one included 32 participants and phase two included 98. However, only 77 completed the intervention and 59 completed the post assessment. This was mainly due to rapid advancement of illness hindering completion. The majority of patients were Protestant (43%) or Catholic (30%), as well as the majority (57%) had cancer. Significant improvements were found in RCOPE scores, LASA scores, well-being assessment and spiritual well-being assessments. There, however, was not significant changes in FACIT. The study also analyzed no significant differences across sociodemographic identities.

This study was one of the few that specifically identified the impact of Chaplain care on cancer patients/advanced illness and was the only study that covered life-review comparable to what would be offered to Mr. Julian. Other studies investigated other interventions that would not be offered. The patient cross section had similar religious and cultural backgrounds to Mr. Julian. It also was one of the studies that analyzed sociodemographic identities and religiosity in relation to outcomes to rule out possible confounders. However, this study had many limitations. It was not a randomized control trial and did not have a control group to compare the intervention to. Attrition bias was an issue with the large number of patients not being able to complete the study due to illness. Additionally, not all the patients in the study had cancer, reducing the study's external validity to this patient. The variables evaluated are subjective to patients and could encompass recall bias. Furthermore, there is the possibility of selection bias as all patients were seen at the same medical center. Nevertheless, this study did still have significant results and was one of the only reports completed that evaluated hospital Chaplain care on quality of life and well-being in cancer patients.

Clinical Application

Mr. Julian reported surprise at the chaplain's visit, and, while unexpected, he reported being grateful to have someone who wasn't a doctor to talk to, someone concerned with him and not his illness. He reported that his initial visit with the chaplain was a positive experience and wanted to talk with the chaplain more. After reviewing the study by Piderman et al.[1] and their results demonstrating improved quality of life, mental well-being and religious coping after chaplain care, the chaplain consult was left active for the duration of Mr. Julian's stay. The chaplain visited Mr. Julian again and discussed his attitudes towards illness, religious/spiritual values, and life review. After the discussions, the patient reported improved mental well-being and explained "I'm feeling okay

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with my cancer diagnosis now." He no longer felt that this diagnosis was a punishment from God. Though Piderman et al.[1] was applicable to our patient's scenario, there are limiting factors in external validity. Specifically, the study was not solely on the hepatopancreatic cancer patient population or during specific coping during cancer diagnosis. Also, it is difficult to standardize chaplain intervention. The conversations that chaplains have with their patients are subjective to chaplains' beliefs and patient needs. Regardless, we propose that spiritual needs should be evaluated in vulnerable populations as a part of treating the whole patient, and not just the biomedical conditions. The spiritual aspect of illness, especially terminal illness like pancreatic cancer, is often left untreated and unaddressed by medical professionals.

New Knowledge Related to Clinical Decision Science

Physical healing is and has been the focus of allopathic medicine. However, patients are holistic beings within a social context and need healing on aspects of their livelihood beyond just physical. Patients that face difficult medical news or diagnosis may have religious/spiritual needs to foster coping with diagnosis. These needs may exist without being readily apparent, in the case of our patient. Here, the patient's unmet spiritual needs were a key component of his depressive symptoms. This case exemplifies the importance of recognizing those needs and the possible positive outcomes of intervening with appropriate spiritual care. It's important to note that this experience is not universal as the role religion/spirituality plays in individual lives are different for each person. Regardless of this subjectivity, a patient's spiritual needs should be identified to evaluate if intervention is needed. How should this evaluation take place? Using the facit SP12 (Version 4), a cohort study for patients with high morbidity indices could be done to answer the following question: Does spiritual well-being change once a patient receives a terminal diagnosis? Alternatively, is it appropriate to screen for spiritual well-being at the time of hospital admission?

Conflict Of Interest Statement

The authors declare no conflicts of interest.

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