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SYMPOSIUM: THE RELIGIOUS AND SECULAR IN MEDICINE AND HEALTH

The Evolution of Spiritual Assessment Tools in Healthcare

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Abstract This article explores the history of spiritual assessment tools as a lens through which to consider the place of spirituality and religion in American healthcare. While precise definitions of spiritual assessment have evolved with the concept, the phrase generally refers to the process of evaluating someone's spiritual needs and resources and addressing those needs in the context of clinical healthcare. We trace the diffusion of spiritual assessment tools from their origins in chaplaincy and pastoral counseling in the 1970s through nursing, medicine and social work in subsequent decades. While engaging with patients around religion and spirituality began as the professional jurisdiction of chaplains, spiritual assessment tools were designed – in part - to enable professionals in other fields to talk with patients about these topics. As such they are both a mechanism of diffusion – a set of questions healthcare professionals who advocate for greater attention to spirituality and religion teach their colleagues to ask – and a symbolic representation of how that diffusion is taking place and where there have been conflicts and bumps along the way.

Keywords Religion · Spirituality · Healthcare · Spiritual assessment

In the 1990s, Christina Puchalski, a physician and founder of the George Washington Institute for Spirituality & Health (GWish), developed a spiritual assessment tool to enable healthcare providers to gather information about religion and spirituality from patients. Known by the acronym FICA, the tool prompts providers to ask patients about **F**aith or belief, the **I**mportance and influence of these issues in their lives, and **C**ommunities of support and to **A**ddress these issues in the context of clinical care (Puchalski and Romer 2000). While GWish was the first to print the FICA acronym on plastic pocket cards for ease of access in the clinic, Puchalski was not the first to develop a spiritual assessment tool or to ask questions about religion and spirituality that might inform clinical care.[1]

This article explores the history of spiritual assessment tools as a lens through which to consider the place of spirituality and religion in American healthcare. While precise definitions of spiritual assessment have evolved with the concept, the phrase generally refers to the process of evaluating someone's spiritual needs and resources and addressing those needs in the context of clinical healthcare. While specific conceptions of spirituality vary with the tools, most creators envision spirituality as broader than religion, concerned with meaning-making, human connection and community connected to or quite apart from a sense of God or the sacred.[2] Few empirical studies investigate whether and how spiritual assessments are actually conducted,

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[1] See http://www.gwumc.edu/gwish/clinical/fica-spiritual/fica-spiritual-history/index.cfm.

[2] Individual spiritual assessment tools, as described throughout this chapter, make varying assumptions about what spirituality is and how to approach and measure it though there is much overlap in the dimensions. This approach mirrors broader approaches to spirituality and religion evident in ethnographic research about religion and spirituality in large academic medical centers Cadge, W. (2012). *Paging God: Religion in the Halls of Medicine*. Chicago, University of Chicago Press. For more on the relationship between spirituality and religion see Bender, C. (2007). "Religion and Spirituality: History, Discourse, Measurement." *SSRC Forum*, Bender, C. (2010). *The New Metaphysicals: Spirituality and the American Religious Imagination*. Chicago, University of Chicago Press.

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with the evidence suggesting that they take place inconsistently in healthcare contexts and in non-standard ways (Fitchett 1993a, b; O'Connor et al. 2005). That said, attention to spiritual assessment has been ongoing in the medical and nursing literatures for the past 30 years and talked about in diverse ways among professional chaplains.[3]

Spiritual assessments are one of many ways that religion and spirituality are present in modern healthcare. As sites of birth, death and a range of existential issues in between, modern hospitals are organizations within which questions of life, death, suffering and joy are addressed among patients and families as well as among healthcare staff. While there are multiple ways to conceptualize and look for religion and spirituality in healthcare, we focus narrowly in this article on spiritual assessments (for other approaches see (Cadge 2012; Berger 2015)).

We trace the diffusion of spiritual assessment tools from their origins in chaplaincy and pastoral counseling in the 1970s through nursing, medicine and social work in subsequent decades.[4] Our analysis is based on articles published about spiritual assessment that are catalogued in PubMed or cited by sources catalogued there. We focus on tools designed by U. S. based authors for clinical, rather than primarily research, use in healthcare.[5] While engaging with patients around religion and spirituality began as the professional jurisdiction of chaplains, spiritual assessment tools were designed—in part–to enable professionals in other fields to talk with patients about these topics. As such they are both a mechanism of diffusion—a set of questions healthcare professionals who advocate for greater attention to spirituality and religion teach their colleagues to ask—and a symbolic representation of how that diffusion is taking place and where there have been conflicts and bumps along the way.

Since the mid-1970s, more than 30 spiritual assessment tools have been developed by a range of healthcare professionals, sometimes in partnership but more often in single professional groups. Rather than drawing on tools from disciplines other than their own, we find individuals in different healthcare disciplines developing their own tools either for general use or targeted towards specific patient groups, particularly those at the end of their lives. While some argue there is no way to accurately assess and measure spirituality, proponents of these tools view them as essential components of holistic patient care, taping both a meaning-making or spiritual sense they believe intrinsic to all people and/or opening the door to conversation about religion in more traditional ways.[6] The current proliferation of spiritual assessment tools, the lack of fertilization across healthcare disciplines, and the broadness through which spirituality is framed and approached mirror many of the broader ways spirituality and religion have been addressed in American healthcare more generally.

The Beginnings: 1970s and 80s

Spiritual assessment tools have their origins in pastoral care and counseling as well as nursing and psychiatry in the 1960s and 1970s. Chaplain-researcher George Fitchett traces their history to the 1976 publication of psychologist Paul Pruyser's book, *The Minister as Diagnostician*, in which Pruyser called on clergy to make diagnoses by integrating their psychological and theological skills (Fitchett 1993a, b). Nurses also developed related diagnoses, and Presbyterian pastor Anton T. Boisen, a pioneer in chaplaincy education, influenced early efforts at narrative spiritual assessment.[7] A few spiritual assessment tools–like one created by nurse Ruth Stoll in 1979–traced their history to Edgar Draper, a psychiatrist, who tested the idea that a psychiatrist could make an accurate diagnosis based only on information about a patient's religious beliefs (Stoll 1979; Fitchett 1993a, b). Nurses need to ask patients about religion and spirituality as part of caring for them as whole beings, Stoll argued, and she grouped questions in what she called a spiritual history guide into four areas including the concept of God or deity, sources of hope and strength, religious practices, and the relationship between spiritual beliefs and heath. She was clear that "the values and beliefs elicited in these areas may or may not be expressed by the person through conventional religious language and rituals" and called on nurses to recognize and respect all values and beliefs ((Stoll 1979), p. 1574).

Chaplains and nurses were the main healthcare professionals who developed spiritual assessment tools in the

[3] It is important to note that chaplains are not taught to conduct spiritual assessments in any standard ways in their training.

[4] Our goal is not to evaluate particular assessment tools. For evaluative discussion see the discussion of the six areas along which they should be evaluated in Fitchett, G. (1993). *Assessing Spiritual Needs: A Guideline for Caregivers*. Minneapolis, Augsburg Publications. The Healthcare Chaplaincy Network, an advocacy organization for chaplains based in New York City, also published the following to help chaplains evaluate such tools: https://www.healthcarechaplaincy.org/docs/publications/sri/pb_discerning_patient_needs_spiritual_assessment.pdf

[5] There are also a number of articles catalogued in PubMed that describe the process of spiritual assessment in the United Kingdom. We do not include those here because of the differing relationship between healthcare organizations and the state and differing requirements about chaplaincy and spiritual care. Also, we rely on whether authors said particular tools were for clinical use in deciding which tools to include in this article.

[6] For one critical discussion see Bishop, J. (2013). "Of Idolatries and Ersatz Liturgies: The False Gods of Spiritual Assessment." *Christian Bioethics* **19**(3): 332–347.

[7] There are also a number of theologians cited in the early pastoral care literature whose ideas influenced developing ideas of spiritual assessment as described by Fitchett, G. (1993). Assessing Spiritual Needs: A Guideline for Caregivers. Minneapolis, Augsburg Publications.

1980s. Changes to Medicare reimbursement in 1983 led hospitals to be paid fixed amounts for each Medicare patient based on their diagnostic related group (DRG) and increased pressure on chaplains to document their contributions to patient care. Spiritual assessment tools were one way, of many, chaplains tried to do this.[8] Nurses also remained concerned about spiritual well-being and developed several new spiritual assessment tools during the decade (as described in (Berggren-Thomas and Griggs 1995; Lewis 2008).

Some of these new tools were for general use while others, like a two-stage model designed by chaplain Edward Holland, were specifically for use in hospice contexts (Holland 1985). Brenda Yeadon, then a vice-president of Hospice with the Visiting Nurses Association in Butler County, Pennsylvania, published an article about a tool designed by a community-based hospice for its own use that identified the spiritual needs of the patient and his/her family and offered a concise summary of planned interventions (Yeadon 1986). And chaplain Milton Hay outlined the model used by the San Diego Hospice in the *American Journal of Hospice Care* in the late 1980s (Hay 1989).

The first spiritual assessment tools designed by physicians were also introduced in the 1980s. Physician Elisabeth McSherry worked with chaplains, George Fitchett argues, to develop what she called a "clinical science" or specialized body of knowledge that might inform their work. She developed a Spiritual Profile Assessment (SPA)—three questionnaires including the Personal Health Inventory, the Religiosity Index, and the Ultimate Values Test—for individuals to complete themselves and a Semi-Structured Interview (SSI) or set of questions to be in conversation about with a chaplain. Her hope was that these materials would help chaplains make better care plans for individual patients and better document changes that resulted from their efforts (as described in (Fitchett 1993a, b)). In a separate effort, physician Clifford Kuhn addressed physicians arguing in a 1988 article in *Psychiatric Medicine* that "spiritual elements are those capacities that enable a human being to rise above or transcend any experience at hand" and are characterized by "the capacity to seek meaning and purpose, to have faith, to love, to forgive, to pray, to meditate, to worship, and to see beyond present circumstances" (p. 91). He designed a spiritual inventory, or "list of exercises or manifestations of the spirit that can be measured or assessed in the examination of any patient" and called on physicians to be in conversation with their patients about them to enhance the healthcare they provide (Kuhn 1988).

This increasing focus on approaching patients as whole people, especially in cases of terminal illness, was likely fostered by the hospice movement of the 1960s and early 1970s that emphasized care for the patient physically, emotionally, and spiritually (Clark 2007). The development of these early spiritual assessment tools reflects such efforts to treat the patient beyond solely physical symptoms and to integrate a psychosocial-spiritual element in healthcare.

Diffusion and Growth: 1990s

The number of spiritual assessment tools in circulation grew in the 1990s alongside and indicative of a loosely oriented, and growing, spirituality in healthcare movement comprised of nurses and physicians advocating for more attention to religion and spirituality in clinical care.[9] Chaplains continued to develop new tools including Gary Berg's Computer Spirirtual Assessment and the Spiritual Injury Scale he developed that was used by many chaplains in the Veterans Administration (Berg 1994) as well as (Nash 1990; Stoddard and Burns-Haney 1990). Nurses and physicians also joined conversations in their fields about tools to use in clinical care and research. Among nurses, the 21 question JAREL tool, for example, was designed to evaluate spirituality, specifically in people over age 65, and included attention to issues of faith, life and satisfaction (as described in (Lewis 2008)). Physician Christina Puchalski published her FICA tool in 1996 and Todd Maugans MD published his SPIRITual History tool in the mid-1990s to encourage physicians to approach spirituality as a relevant medical topic. In describing his tool—which focuses on **S**piritual belief systems, **P**ersonal spirituality, **I**-ntegration with a spiritual community, **R**itualized practices and **R**estrictions, **I**mplications for medical care and **T**erminal events planning—Maugans noted that other tools had been designed by and for healthcare professionals but that physicians needed a distinct tool given the particular kinds of relationships they have with patients (Maugans 1996).

Tools for use in hospice and palliative care contexts also continued to emerge in the 1990s. Jerry Muncy, Director of Pastoral Care at Hospice Inc. in Wichita, Kansas published Muncy's comprehensive spiritual assessment tool in the *American Journal of Hospice and Palliative Care* (Muncy 1996). While chaplains always need to understand the beliefs of patients, Muncy argued this is "especially important in hospice work where the chaplain often has to work quickly to develop rapport with, as well as have an understanding of, the patient's beliefs." Questions in the tool, which was designed to be used in an interview fashion, focus on people's understandings of themselves and others, their religious / spiritual histories, and the care plan moving forward. Following broad conversations about palliative care conducted by the American College of Physicians—American Society of Internal Medicine in the 1990s, physicians Bernard Lo, Timothy

[8] For more on this history see c. 2 in Cadge (2012). *Paging God: Religion in the Halls of Medicine. Chicago, University of Chicago Press.*

[9] For further description of this movement see Cadge (2012).

Quill and James Tulsky also published a piece, "Discussing Palliative Care with Patients" in the *Annals of Internal Medicine* in 1999 that included questions physicians could use to assess a patient's religious and spiritual resources (Lo et al. 1999).[10] These four questions were: 1. Is faith (religion, spirituality) important to you in this illness? 2. Has faith (religion, spirituality) been important to you at other times in your life? 3. Do you have someone to talk to about religious matters? and 4. Would you like to explore religious matters with someone?

Alongside tools designed by and for nurses and physicians in the 1990s were two important interdisciplinary efforts. In 1991 Jared Kass, a professor of counseling and psychology, collaborated with colleagues in psychology and psychiatry on the INSPIRIT tool. They introduced this tool—an Index of Core Spiritual Experiences—to chaplains at a 1992 national chaplaincy convention though they intended it primarily as a research tool.. Unlike earlier tools that focused on beliefs and practices, this tool—which is built around seven questions–asks about religious and spiritual experiences including those that may be mystical or otherwise that patients interpret (Kass et al. 1991; VandeCreek et al. 1995; Lewis 2008).

Also in the late 1980s and early 1990s, an inter-disciplinary group at Rush Medical Center in Chicago published a tool called 7×7 that was designed to make as few assumptions about spirituality as possible. Recognizing the pluralistic contexts within which they worked, chaplain George Fitchett, nursing professor Julia Quiring Emblen and colleagues opted for a functional approach to spirituality; "We wanted a model that could be used to describe the spirituality of the care recipient with as few assumptions as possible about what that spirituality had to include" ((Fitchett 1993a, b), p. 97). To do this, the tool asks how people find meaning in life while also paying attention to substantive aspects of their life including relationships, rituals and beliefs. It is called the 7 x 7 model because it focuses on seven holistic dimensions of assessment—the medical dimension, psychological dimension, psychosocial dimension, family systems dimension, ethnic and cultural dimension, societal issues dimension and spiritual dimension—as well as seven aspects of spirituality. These include beliefs and meaning, vocation and consequences, experience and emotion, courage and growth, ritual and practice, community, authority and guidance. The authors describe all aspects of the model in detail but do not prescribe a specific set of questions encouraging users to amend it as needed given the time and clinical context within which it is used (Fitchett 1993a, b).

[10] LaRocca-Pitts refers to this as a spiritual history tool, rather than a spiritual assessment tool though argues that because of the follow-up questions, the tool "blurs the conceptual differences between a spiritual history and a spiritual assessment" LaRocca-Pitts, M. (2008). "FACT: Taking a Spiritual History in a Clinical Setting." *Journal of Health Care Chaplaincy* **15**: 1–12.

More than ten new spiritual assessment tools were designed and written about in the 1990s by chaplains, nurses and physicians. With the exception of the two interdisciplinary tools, most focused within single disciplines where advocates increasingly made arguments about the importance of focusing on spirituality and assessing it in patient care (for example (Newshan 1998)). That many of these tools mirror other sorts of assessments in healthcare through their prescribed sets of questions and use of acronyms as names is obvious and part of how advocates aimed to make spirituality as familiar and like others topics covered in patient care as possible. They were also techniques to help providers remember the tools and questions for ease of use in patient care. The success of these efforts was evident in the 1990s as the terms spiritual and assessment began to be used together by the Joint Commission that sets standards for healthcare organizations.[11]

Refinement and Institutionalization: 2000s

In 2003, *Hospital Peer Review* published a question and answer column with Pat Staten, the associate director for standards interpretation of the Joint Commission. "Does the Joint Commission standard on spiritual assessment apply only to behavioral health or to all health care settings?" the question asked and "What are we expected to do in making this spiritual assessment?" While the behavioral health standards specify a more thorough assessment of a patient's spiritual outlook, Staten answered, the Joint Commission "expects you to conduct a spiritual assessment of every patient in every healthcare setting." At minimum the assessment should determine, "the patient's religious denomination, beliefs, and what spiritual practices are important to the patient," she explained, with the specifics varying by setting and circumstance (Staten 2003).

Staten's use of the phrase "spiritual assessment" indicates the continued diffusion of the concept in the 2000s and the success of healthcare providers and organizations like the George Washington Institute for Spirituality and Health and related efforts at Duke University and other medical schools across the country who had been advocating for greater attention to spirituality in healthcare now for many years. Such advocacy was evident in increasing calls in the published literature for spiritual assessments, articles about how to teach spiritual assessment, and ongoing conferences and public events about religion and spirituality in healthcare more generally.[12]

While Staten said in 2003 that spiritual assessment is required in all healthcare settings, it is important to recognize

[11] For details see Cadge (2012). *Paging God: Religion in the Halls of Medicine*. Chicago, University of Chicago Press.

[12] Ibid.

that her description of what that assessment should include indicated just part of what many of the spiritual assessment tools in use during the decade attempted to describe. As in the 1990s, tools continued to emerge in the 2000s with more than fifteen new tools entering the published literature with acronyms like HOPE, FACIT-Sp, and FACT (Anandarajah and Hight 2001; LaRocca-Pitts 2008; Lewis 2008; Monod et al. 2011). Some were designed for general use and others for more specific patient populations including cardiac patients and those with cancer (Skalla and McCoy 2006; Timmons and Kelly 2008).

Harold Koenig, a psychiatrist and leader in the spirituality and healthcare movement at Duke University, added his CSI-MEMO tool to the list in the 2000s which prompted physicians to ask patients whether their religious and spiritual beliefs provide comfort or are a source of stress, whether they have spiritual beliefs that might influence their medical decisions, whether they are members of a religious or spiritual community and whether it is supportive, and whether they have other spiritual needs they would like someone to address (Koenig 2002). While most of these new tools were question focused, some were more narratively oriented like those proposed by Dean Hodge and discussed by social workers throughout the decade (Hodge 2001; Moore 2003; Pierpont 2003).[13]

The conceptions and assumptions about spirituality that underlie spiritual assessment tools designed in the 2000s remained quite broad as in earlier decades. While some tools assumed belief in God or a theistic approach, many others were as concerned about sources of hope, coping, support and community inside or outside of traditional religious contexts. In the words of Christina Puchalski and Anna Romer, spirituality is "that which allows a person to experience transcendent meaning in life. This is often expressed as a relationship with God, but it can also be about nature, art, music, family or community—whatever beliefs and values given a person a sense of meaning and purpose in life" ((Puchalski and Romer 2000), p. 129). Some tools privileged belief while others focused more on experience or practice (Monod et al. 2011). It is noteworthy that almost all of these tools were called "spiritual" rather than "religious" assessment tools indicating both their broad approach to questions of meaning making and their efforts to be as inclusive and applicable to as wide a range of people as possible.[14]

While some new spiritual assessment tools were introduced quietly in the 2000s others, like the HOPE tool introduced by physicians Gowri Anandarajah and Ellen Hight and published in the *American Family Physician* in 2001, sparked conversation and debate (Anandarajah and Hight 2001). A spiritual assessment is a "practical first step in incorporating consideration of a patient's spirituality into medical practice," Anandarajah and Hight stated in the abstract to their article (p. 81). They encouraged physicians to pay attention to patients for clues about spirituality and religion and also use the formal assessment tool they presented. The HOPE tool was initially designed in a teaching context to encourage medical students, residents and practicing physicians to include questions about spirituality in medical interviews. Topics for discussion included **H**—sources of hope, meaning, comfort, strength, peace, love and connection; **O**—organized religion; **P**—personal spirituality and practices; **E**—effects on medical care and end of life issues. In addition to describing the tool, the authors also outlined what physicians might do with the information they gathered.

The original article was published alongside editorials in support of spiritual assessment and raising questions that were likely designed to spark debate.[15] A spirited conversation followed in subsequent letters to the editor. Some writers were supportive of the idea of spiritual assessment though raised questions about the specific questions recommended and assumptions about spirituality and religion embedded in the article and / or commentaries. They expressed concerns about how to identify patients interested in a conversation about religion or spirituality and how not to project their own beliefs on patients in this setting. Other writers suggested alternative questions physicians might ask to open discussion about religion and spirituality in the context of clinical care while others called for significantly less intervention. Many of the critiques focused on the commentaries rather than the article and reflected ethical and practical concerns.[16]

Drs. Anandarajah and Hight responded to the letters to the editor acknowledging power differentials and the possibility of coercion between physicians and patients around spirituality and religion while calling on physicians to have a "humble acknowledgement" of their ignorance and a "genuine respect for people to tell" them what is "important to them" and how physicians can help.[17] Indicating disputes over professional jurisdiction or whose responsibility it is to work with patients around spirituality and religion they also wrote, "Clinical pastoral education (CPE) trained interfaith chaplains must undergo extensive training, self-reflection and supervision to ensure that they can provide spiritual care without imposing their own beliefs" and called on physicians to grapple with their

[13] Some of the tools designed by and for social workers included spiritual lifemaps, ecomaps, genograms, ecograms and other things not previously a part of spiritual assessment.

[14] An important exception during the 2000s is the Ironson-Woods Spirituality/Religiousness Index that was designed mostly for research to "include items that were both pertinent to traditional religion and relevant for those who described themselves as spiritual only or as both religious and spiritual" Ironson G, Solomon GF, Balbin EG and e. al. (2002). "The Ironson-Woods Spirituality/Religiousness Index is associated with long survival, health behaviors, less distress and low cortisol in people with HIV/AIDS." *Ann Behav Med* **24**: 34e48.

[15] See 2001, January 63(1).

[16] These letters were published in volume 64(3).

[17] This response was published in volume 64(3).

own beliefs and biases before talking with patients about religious and spiritual issues. This article and the exchanges that followed illustrate, on a small scale, the kinds of suspicions, controversies and ethical questions that have been a regular part of efforts to promote not just spiritual assessment tools but attention to spirituality in healthcare more generally in recent years.[18]

With the proliferation of spiritual assessment tools in circulation by the end of the 2000s, some proponents began to distinguish spiritual assessment tools from spiritual screens or spiritual histories, distinctions that are not agreed on by all proponents and which also marked jurisdictional disputes about who could and should gather information about religion and spirituality from patients.[19] Spiritual screens are generally understood to be just that, screening tools, that allow healthcare providers to determine whether spirituality is relevant for a given patient and whether additional information should be gathered. Chaplain Mark LaRocca Pitts writes, "A spiritual screen is performed upon admission to most healthcare institutions. This often includes one or two questions aimed at determining a person's particular religion or faith and whether there are any specific spiritual, religious or cultural needs the hospital can address during hospitalization…..Information obtained during a spiritual screen rarely changes in the course of hospitalization" ((LaRocca-Pitts 2008), p. 5). Chaplain-researcher George Fitchett describes spiritual screens a bit differently saying they are "designed to provide initial information about whether a patient is experiencing spiritual distress or a possible spiritual crisis and whether referral for a more in-depth spiritual assessment is indicated" ((Fitchett 2012), p. 299).

Spiritual histories, in contrast, elicit more information than spiritual screens. Spiritual history taking, Fitchett writes, "is the process of interviewing a patient, asking them about their spiritual life, in order to develop a better understanding of their spiritual needs and resources" ((Fitchett 2012), p. 299). Mark LaRocca Pitts describes a spiritual history a bit differently as seeking to "understand how a person's spiritual life and history affect their ability to cope with their present health crisis." It is more involved than a spiritual screening and the information gathered may change during the course of an illness or hospitalization. "A spiritual history tool needs to account for a patient's ability to cope as changes occur as well as provide options for follow-up treatment" ((LaRocca-Pitts 2008), p. 5–6). While some commentators place the amount of information gathered in a spiritual assessment as between the amount gathered in a spiritual screen and a spiritual history, others like LaRocca Pitts and Fitchett see a spiritual assessment as following a spiritual screen and history if needed.[20]

From a sociological perspective, some of the distinction between types of tools seems designed to mark jurisdiction or territory and to indicate who is qualified to gather and assess information about spirituality and religion from patients. While this was all the domain of the chaplain in the 1960s and 1970s, the diffusion of spiritual assessment tools coupled with the professionalization of healthcare chaplains has led some—particularly chaplains—to try to publicly claim spiritual assessments as their professional responsibility. While other healthcare professionals may be qualified to conduct spiritual screens or, in some cases spiritual histories, it is chaplains who have the training and knowledge required to conduct spiritual assessments and work with patients around the findings some chaplains argue. "If the spiritual history presents concerns in the patient's ability to utilize their spirituality successfully," Mark LaRocca Pitts writes, "then a spiritual assessment is recommended, which is a more in-depth investigation into the patient's spiritual life and history…. Professional chaplains are best equipped to conduct spiritual assessments" (p. 6).[21] While other professionals can gather general information about spirituality and religion, it is the chaplains who are the experts or spiritual specialists.[22]

At Present: 2010s

Today there are more than 40 spiritual assessment tools available in the U.S. based medical literature designed, as described here, by chaplains, nurses, physicians, social workers

[18] Such concerns during the 2000s were further evident amongst nurses in an editorial authored by two British nurse-educators Draper, P. and W. McSherry (2002). "A critical view of spirituality and spiritual assessment." *J Adv Nurs* **39**(1): 1–2.

[19] These distinctions were first written about in Massey, K., G. Fitchett and P. A. Roberts (2004). *Assessment and Diagnosis in Spiritual Care. Spiritual Care in Nursing Practice*. K. L. Mauk. Philadelphia, Lippincott, Williams & Wilkins: 209–243

[20] For additional discussion of these issues see Puchalski, C. B, B. Ferrell, R. Virani, S. Otis-Green, P. Baird, J. Bull, H. Chochinov, G. Handzo, H. Nelson-Becker, M. Prince-Paul, K. Pugliese and D. Sulmasy. (2009). Improving the Quality of Spiritual Care as a Dimension of Palliative Care: the Report of the Consensus Conference. *Journal of Palliative Medicine. 12*(10): 885–904

[21] LaRocca Pitts calls many of what we write about as spiritual assessment tools, spiritual history tools. For more on these jurisdictional disputes see Cadge (2012). *Paging God: Religion in the Halls of Medicine. Chicago, University of Chicago Press.* VandeCreek, L. (1999). "Professional chaplaincy: an absent profession?" *Journal of Pastoral Care* **53**(4): 417–432.

[22] On spiritual generalists and specialists see Robinson, M. R., M. M. Thiel and E. C. Meyer (2007). "On being a spiritual care generalist." *American Journal of Bioethics* **7**(7): 24–26. Chaplain Annette Olsen also developed a tool in the late 2000s, BASIC-6 Spiritual Care Screen, designed in her words, "to be tools-for-transition between the initial spiritual care screen (generally done by multidisciplinary caregivers or a rounding chaplain), the chaplain's spiritual assessment process, and the patient's discharge, transfer or decendent caregiving" Olsen, A. (2009). "Olsen's BASIC-6 Spiritual Care Screens." *PlainViews* **6**(22). This tool helps the chaplain makes sense and be the expert on various other spiritual assessments that have been conducted.

and other healthcare professionals. With few exceptions, those who designed these tools intended others in their profession rather than interdisciplinary care teams to use them and there is relatively little cross-disciplinary conversation or ongoing diffusion across professional boundaries (see also (Fitchett 2012)). This finding mirrors ethnographic research that suggest that healthcare providers, even within the same institutions, often think and talk about spirituality and religion in ways that are distinct from one another and not mutually understandable (Cadge 2012). While nurses may utilize approaches to spiritual assessment published in the nursing literature, physicians may use models described in medical journals and chaplains different frames all together. Not only does the lack of cross-fertilization not allow ideas about spiritual assessment to be shared but it makes inter-disciplinary conversation about spirituality and religion challenging and leads members of each discipline to create tools anew rather than learning from those which came before.

That said, spiritual assessment tools have clearly diffused from pastoral care to nursing, medicine and social work and have a place in healthcare. Such a place is marked by the Joint Commission's references to spiritual assessment and the regularity with which spiritual assessment is taught and talked about among medical and nursing educators. Advocates of the still loosely organized spirituality and healthcare movement continue to call on their colleagues to use these tools and to teach nursing and medical students about them as part of their core curriculums. Despite that, much more continues to be written about the tools of spiritual assessment and how to teach them than is known about how they are actually used in clinical practice and how people in different fields use and learn from them. Theological discussions about their assumptions and use have also returned, for example in Michael Balboni's article in a recent issue of *Christian Bioethics* (Balboni 2013).

Since 2010, only a few new tools have been published (Rosmarin et al. 2011; Sharma et al. 2012; Galchutt 2013; Hodge 2013). Some commentators, most notably chaplain-researcher George Fitchett, have called on healthcare providers to stop creating new tools. In the past 25 years, Fitchett argues, numerous models for spiritual assessment have been developed. "In light of this," he writes, "I believe we no longer need to develop new models for spiritual assessment. Rather we need to focus attention on a critical review of existing models and the dissemination of best practices in spiritual assessment" ((Fitchett 2012), p. 299). The proliferation of tools has led to confusing variation in practice as have inconsistent uses of the terms spiritual assessment, screen and history.

While fewer spiritual assessment tools and greater cross-disciplinary fertilization could, in theory, lead to a focus on best practices the underlying jurisdictional disputes or questions about who is best prepared to conduct spiritual assessments remain. While chaplains, assisted primarily by nurses with holistic approaches to patient care, have historically supported patients around spirituality and religion, today—in part because of the ease with which spiritual assessments can be used—some other healthcare providers are laying claim to that territory. Chaplains have not let go of spiritual assessment as a key part of their work, but not all use the language of spiritual assessment in describing the work that they do.[23] This lack of consistency among chaplains and the lack of clarity in healthcare organizations more generally about who is responsible for addressing spirituality, how that relates to religion, and what that responsibility includes are evident in discussions of spiritual assessment and reflective of them.

Very rarely in broader interviews and observation of healthcare providers did we hear the words spiritual assessment and almost never did speaker and listener agree on their meaning. Perhaps, as we are suggesting here, the tools can be read sociologically as symbolic of the shifting place of spirituality in healthcare, the broad meanings of spirituality, and the variability with which healthcare professionals, patients and families approach the topic and select from the many meanings of spirituality the one that best fits their experiences and needs. Such variability can lead to confusion within healthcare organizations, a lack of clear communication among healthcare disciplines and messiness in how religion and spirituality are present on the ground in healthcare. While the term spiritual assessment has become familiar to many in healthcare, its precise meaning, use and application continue to evolve.

Further Reading

Anandarajah, G., & Hight, E. 2001. Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment. *American Family Physician*, *63*(1), 81–89.

Balboni, M. J. 2013. A Theological Assessment of Spiritual Assessments. *Christian Bioethics 19*(3), 313–331.

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