32nd IAPCON Jammu 2025
Annual Conference of the Indian Association of Palliative Care

Indian Association of Palliative Care

IAPCON 2025
32nd International Conference of the
Indian Association of Palliative Care(IAPC)
30th Jan 2025 -Pre Conf. Workshop | 31st Jan - 2nd Feb, 2025-Conference | AIIMS, Jammu
Organized by: J&K chapter of IAPC and All India Institute of Medical Science, Jammu.

Relevance, Evidence & Challenges of Spiritual caring in Healthcare

Evidence related to Spiritual Care

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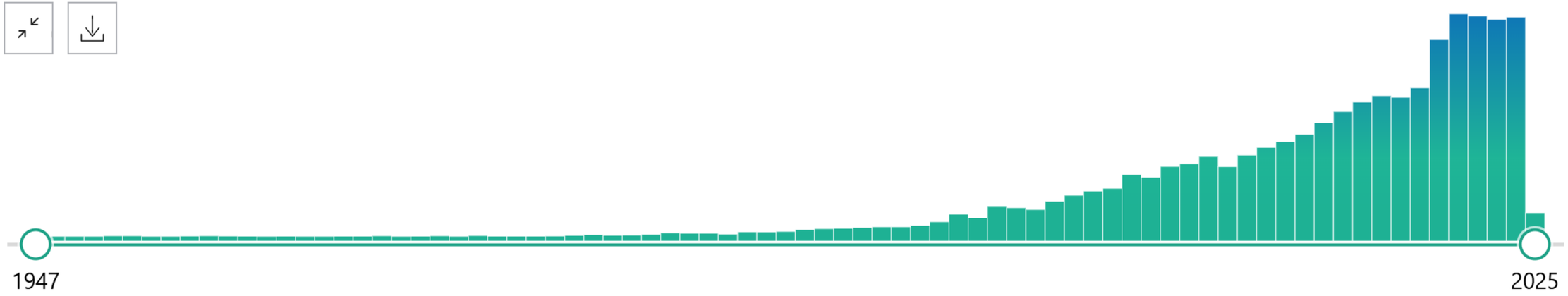

Spiritual care in the intensive care unit

Maciej W Klimasiński [1] [2] [3]

Affiliations + expand

PMID: 34714016 PMCID: PMC10165982 DOI: 10.511

Abstract

The aim of the present paper is to describe the re
care units (ICUs) in Poland. Faced with suffering a
a source of comfort and hope. Spiritual care is int
spiritual needs. The literature review indicates the
Spiritual care improves the quality of life of patie
or alleviates the negative psychological conseque

Spiritual care provision to end-of-life patients: A systematic literature review

Elizabeth Batstone [1], Cara Bailey [2], Nutmeg Hallett [2]

Affiliations + expand

Review > J Hosp Palliat Care. 2023 Dec 1;26(4):149-159. doi: 10.14475/jhpc.2023.26.4.149.

Spiritual Care Guide in Hospice·Palliative Care

Kyung-Ah Kang [1], Do-Bong Kim [2], Su-Jin Koh [3], Myung-Hee Park [4], Hye Yoon Park [5],
Deuk Hyoung Yoon [6], Soo-Jin Yoon [7], Su-Jeong Lee [8], Ji-Eun Choi [9], Hyoung-Suk Han [10],
Jiyoung Chun [1]

Affiliations + expand

PMID: 38075589 PMCID: PMC10703561 DOI: 10.14475/jhpc.2023.26.4.149

Abstract

The Spiritual Care Guide in Hospice·Palliative Care is evidence-based and focuses on the universal and integral aspects of human spirituality-such as meaning and purpose, interconnectedness, and transcendence-which go beyond any specific religion. This guide was crafted to improve the spiritual well-being of adult patients aged 19 and older, as well as their families, who are receiving end-of-life care. The provision of spiritual care in hospice and palliative settings aims to assist patients and their

Editorial > Ann Palliat Med. 2020 Mar;9(2):144-148. doi: 10.21037/apm.2019.11.24.
Epub 2019 Dec 16.

Patients with Parkinson's disease need spiritual care

Piret Paal [1], Stefan Lorenzl [2]

Spiritual Care Charting/Documenting/Recording/Assessment: A Perspective from the United Kingdom

Review > Nurs Forum. 2022 Nov;57(6):1559-1566. doi: 10.1111/nuf.12845. Epub 2022 Nov 30.

Spiritual comfort, spiritual support, and spiritual care: A simultaneous concept analysis

Ana Patrícia Tavares [1], Helga Martins [2] [3], Sara Pinto [4], Sílvia Caldeira [2], Patrícia Pontífice Sousa [2], Beth Rodgers [5]

Affiliations + expand

PMID: 36448491 PMCID: PMC10099816 DOI: 10.1111/nuf.12845

Abstract

Background: Spirituality is a dimension of life and the human being that should be included in holistic healthcare. One major barrier often described by nurses on implementing spirituality in practice relates to perceiving the concept of spirituality as subjective and sharing confounding similarities with other concepts. In this sense, the concepts of spiritual comfort, spiritual care, and

y [2]
euhold [1], editors.

Emerging Role of Chaplaincy Records in Global Health Care [Internet].

D: NBK565689 DOI: 10.1007/978-3-030-47070-8_6

itual aspects of care are being documented within the UK with a
imarily in the nursing and chaplaincy professions. This has not been an

Indian J Palliat Care. 2022 Jan-Mar; 28(1): 13–20.
PMCID: PMC9165459
Published online 2022 Mar 24. Prepublished online 2022 Feb 1. doi: 10.25259/IJPC_50_21
PMID: 35673385

Psychometric Assessment of SpiDiscI: Spiritual Distress Scale for Palliative Care Patients in India

Joris Gielen,[1] Komal Kashyap,[2] Suraj Pal Singh,[2] Sushma Bhatnagar,[2] and Santosh K. Chaturvedi[3]

▸ Author information ▸ Article notes ▸ Copyright and License information Disclaimer

Abstract

Go to: ▸

Objectives:

Spirituality has an impact on the quality of life of palliative care patients and it influences the way in which they experience their disease. Spiritual distress is a common issue among palliative care patients in India that is best assessed through a tool specifically designed for them. This study presents the findings of a psychometric assessment of SpiDiscI: a 16-item spiritual distress scale for Hindi speaking palliative care patients in India.

BMC Medical Education

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Spirituality and health in the curricula of medical schools in Brazil

Giancarlo Lucchetti, Alessandra Lamas Granero Lucchetti, Daniele Corcioli Mendes Espinha, Leandro Romani de Oliveira, José Roberto Leite & Harold G Koenig

BMC Medical Education **12**, Article number: 78 (2012) | Cite this article

14k Accesses | **40** Citations | **6** Altmetric | Metrics

Abstract

Background

According to recent surveys, 59% of British medical schools and 90% of US medical schools have courses or content on spirituality and health (S/H). There is little research, however, on the teaching of S/H in medical schools in other countries, such as those in Latin America, Asia, Australia and Africa. The present study seeks to investigate the current status of teaching on S/H in Brazilian medical schools.

Methods

All medical schools in Brazil (private and public) were selected for evaluation, were contacted by email and phone, and were administered a questionnaire. The questionnaire, sent by e-mail, asked medical school directors/deans about any S/H courses that were taught, details

A Spirituality and Medicine Elective for Senior Medical Students: 4 Years' Experience, Evaluation, and Expansion to the Family Medicine Residency

Gowri Anandarajah, MD; Sister Maureen Mitchell, DMin

Background: *Evidence suggests that spirituality is important in patient care and medical education, yet there are few reports of spirituality and medicine curricular evaluation.* Methods: *We developed, implemented, and evaluated a 17-hour elective on spirituality and patient care for 4 consecutive years. We presented the elective to 10 fourth-year medical students (MS4s) in years one and two and to eight MS4s and 15 residents, faculty, and staff in years three and four. We evaluated knowledge and skills using pre-course and post-course questionnaires and written cases and learner satisfaction using course evaluations.* Results: *Students' knowledge improved on the evidence about spirituality, clinical resources, role of chaplains, approaches to patient care, and recognizing spiritual distress. Reported course strengths included diversity of topics and instructors, universal principles, small-group format, case discussions, and opportunity for self-reflection. Comments reflected enhanced value in the "meaning in medicine" and "whole person care."* Conclusions: *Senior medical students rated the elective positively and increased their knowledge of spirituality and medicine. It was also positively received by residents, faculty, and staff and paved the way for residency curricula in this subject.*

(Fam Med 2007;39(5):313-5.)

An emerging body of evidence demonstrates spirituality's beneficial role in patient care.[1-3] In response to that evidence, the Association of American Medical Colleges (AAMC),[4] the World Health Organization (WHO),[5] and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) all recommend including spirituality in clinical care and education. Currently, more than 50% of medical schools[6] and 31% of family medicine residencies[7] offer courses on spirituality and medicine. However, a 2006 MEDLINE search revealed few articles evaluating spirituality curricula.[8-10] At Brown Medical School, we developed, implemented, and evaluated a 17-

From the Department of Family Medicine

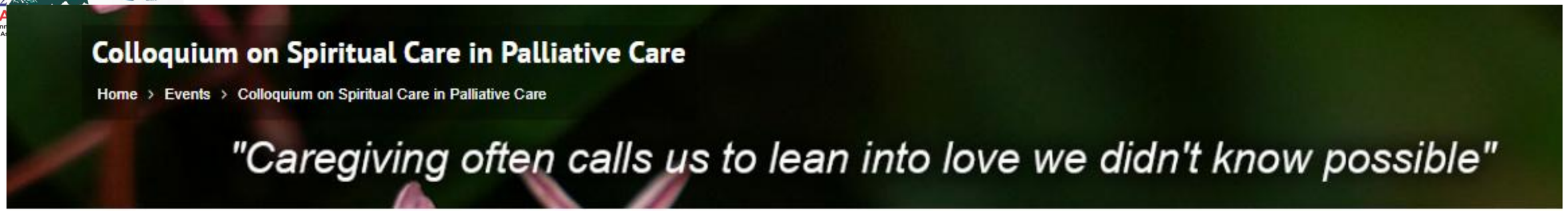
care. For 2 years, we presented this elective to fourth-year medical students (MS4s), and subsequently we opened it to residents, faculty, and staff. In this article, we describe our initial 4-year experience and report our evaluation data.

Methods

Curriculum Design and Development

Colloquium on Spiritual Care in Palliative Care

Home > Events > Colloquium on Spiritual Care in Palliative Care



Spiritual care is now being recognised as an important component of palliative care.

How can we deliver spiritual care? How do we address this in a multi-cultural society like India? How does one take a spiritual history? What is the current state of research on this aspect?

The Bangalore Hospice Trust – Karunashraya is organizing a colloquium to seek answers to these questions and more. Prof. Santosh Chaturvedi and Prof. Prabha S Chandra of the National Institute of Mental Health and Neurosciences (NIMHANS) will direct the colloquium.

Dr. Christina Puchalski, Director of the George Washington Institute of Spirituality and Health, Washington DC, will be among the national and international experts who will be participating.

Venue: Hotel Fortune Select Trinity, Bengaluru, India.

Dates: February 10 and 11, 2015.

Sessions: IAPCON 2020 and 2021
Workshop - The Namasthe of Caring: IAPCON 2023

Med Sci (Basel). 2019 Feb; 7(2): 25.
Published online 2019 Feb 7. doi: 10.3390/medsci7020025
PMCID: PMC6409788
PMID: 30736416

Overview of spirituality in palliative care

Authors: Christina M Puchalski, MD, MS, FACP, FAAHPM, Betty Ferrell, PhD, MA, FAAN, FPCN, Shirley Otis-Green, MSW, MA, LCSW, ACSW, OSW-CE, FNAP, FAOSW, George Handzo, BCC, CSSBB
Section Editor: Susan D Block, MD
Deputy Editor: Jane Givens, MD, MSCE

Contributor Disclosures

All topics are updated as new evidence becomes available and our peer review process is complete.

Literature review current through: **Dec 2022.** | This topic last updated: **Apr 13, 2022.**

INTRODUCTION

Spirituality is a fundamental element of human experience. It encompasses the individual's search for meaning and purpose in life and the experience of the transcendent [1]. Spirituality also encompasses the connections one makes with others, themselves, nature, and to the sacred realms, inside as well as outside of traditional religion [1]. Viewed in this way, spirituality is an important component of quality of life (QOL) and may be a key factor in how people cope with illness, experience healing, and achieve a sense of coherence [2].

The diagnosis of chronic or life-threatening illness can lead to spiritual struggles for patients. The turmoil may be short for some patients and protracted for others as individuals attempt to make sense of the reality of their diagnosis with what gives them value and meaning in life. The journey may result in growth and transformation for some patients and families, distress and despair for others, and both for many people [3].

Spiritual care is an essential domain of palliative care. This topic will provide an overview of key spiritual issues in palliative care, describe approaches to spiritual assessment in the clinical setting, and propose a way to integrate treatment of spiritual distress into a palliative care treatment or care plan. Specific discussions on the incorporation of palliative care with regard to various religious traditions are beyond the scope of this topic [4]. For more information regarding their role in clinical care, the clinician is advised to seek input from their local and institutionally based chaplaincy services.

A discussion about the influence of spirituality and religiousness on outcomes (ie, health care decision-making, QOL) in palliative care patients is provided separately. (See "Influence of spirituality and religiousness on outcomes in palliative care patients".)

JOURNAL OF PALLIATIVE MEDICINE
Volume 12, Number 10, 2009

DOI: 10.1089/jpm.2009.0142

Special Report

Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference

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Karen Pugliese, M.A., B.C.C.,[7] and Daniel Sulmasy, O.F.M., M.D., Ph.D.[8]

Abstract

A Consensus Conference sponsored by the Archstone Foundation of Long Beach, California, was held February 17–18, 2009, in Pasadena, California. The Conference was based on the belief that spiritual care is a fundamental component of quality palliative care. This document and the conference recommendations it includes builds upon prior literature, the National Consensus Project Guidelines, and the National Quality Forum Preferred Practices and Conference proceedings.

Introduction

In the early 1990s, academic medical centers, medical and nursing schools, residency programs, and hospitals began to recognize the role of spiritual care as a dimension of palliative care. A growing body of literature[1–5] as well as attention from the lay press[6–8] raised awareness of and questions about the role of spirituality in health care. Surveys have demonstrated that spirituality is a patient need,[9,10] that it affects health care decision-making,[11, 12] and that spirituality affects health care outcomes including quality of life.[13–18] Spiritual and religious beliefs can also create distress and increase the burdens of illness.[19,20]

Studies have raised critical issues including the need for a commonly accepted definition of spirituality, the appropriate application of spiritual care in palliative care settings, clarification about who should deliver spiritual care, the role

quality care. To this end, a Consensus Conference sponsored by the Archstone Foundation of Long Beach, California, was held February 17–18, 2009, in Pasadena, California. The Conference was based on the belief that spiritual care is a fundamental component of quality palliative care. According to the National Consensus Project (NCP) for Quality Palliative Care,[21] "The goal of palliative care is to prevent and relieve suffering and to support the best possible quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies." Palliative care is viewed as applying to patients from the time of diagnosis of serious illness to death. In this way, the principles of spiritual care can be applicable across all phases and settings for the seriously ill, without regard to culture, religious tradition, or spiritual frames of reference.

The goal of the Consensus Conference was to identify points of agreement about spirituality as it applies to health

re identified and provided the framework for the Consus Conference. The resulting document and conference ommendations builds upon prior literature, the NCP idelines[21] and National Quality Forum (NQF) Preferred ctices[22] and Conference proceedings. This article reprets the final Consensus Report. An expanded description of Conference content and each section of this article is curtly in preparation and will be published as a book.

liative Care Guidelines and Preferred Practices

he first clinical practice guidelines for palliative care were ased in 2004 by the NCP[23]; the guidelines were revised and cond edition was published in 2009.[21] These guidelines are licable to specialist-level palliative care (e.g., palliative care ns) delivered in a wide range of treatment settings and to work of providers in primary treatment settings where liative approaches to care are integrated into daily clinical ctice (e.g., oncology, critical care, long-term care). Specifiy these Clinical Practice Guidelines are intended to

- Facilitate the development and improvement of clinical palliative care programs providing care to diverse patients and families with life-limiting or debilitating illness.
- Establish uniformly accepted definitions of the essential elements in palliative care that promote quality, consistency, and reliability of these services.
- Establish national goals for access to quality palliative care.
- Foster performance measurement and quality improvement initiatives in palliative care services.

of 40 national leaders, including physicians, nurses, psychologists, social workers, chaplains and clergy, other spiritual care providers, and health care administrators (Table 2). Participants agreed to develop a consensus-driven definition of spirituality, make recommendations to improve spiritual care in palliative care settings, identify resources to advance the quality of spiritual care to be made available through the George Washington Institute for Spirituality and Health SOERCE website,[24] and help with dissemination of the final documents. Prior to the conference, participants received a written overview of spiritual care as a dimension of palliative care drafted by Christina Puchalski, M.D. and Betty Ferrell, Ph.D., R.N., Principal Investigators. This document was, in effect, the first draft of this Consensus Report and incorporated feedback from an advisory committee and conference participants. It provided a common base from which the group could identify recommendations to improve spiritual care.

The conference began with an overview of the purpose of the conference, its structure, and its relation to the existing NCP guidelines and NQF preferred practices. This was followed by an overview of the developing Consensus Report, its structure, and areas of agreement and disagreement based the participants' reviews. The conference was facilitated by a consultant who established "ground rules" to create a safe environment for discussion and disagreement, for sharing all ideas, and for respect and the opportunity to speak without fear of judgment about diverse views.

At the conclusion of the first plenary session, participants attended one of five preassigned working groups each with an assigned facilitator. Each working group developed a proposed definition of spirituality and identified the key components of spirituality. After the first working group session,

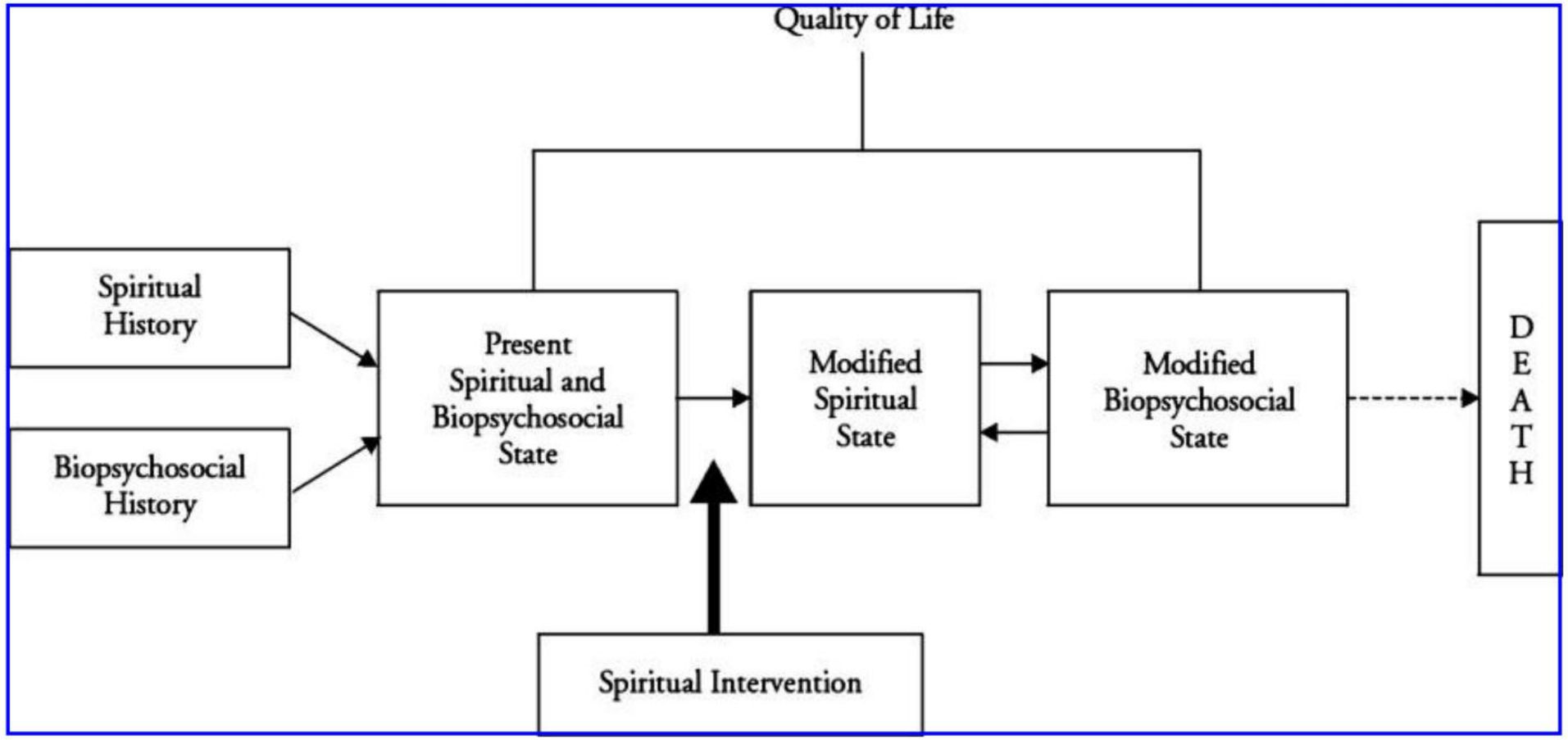
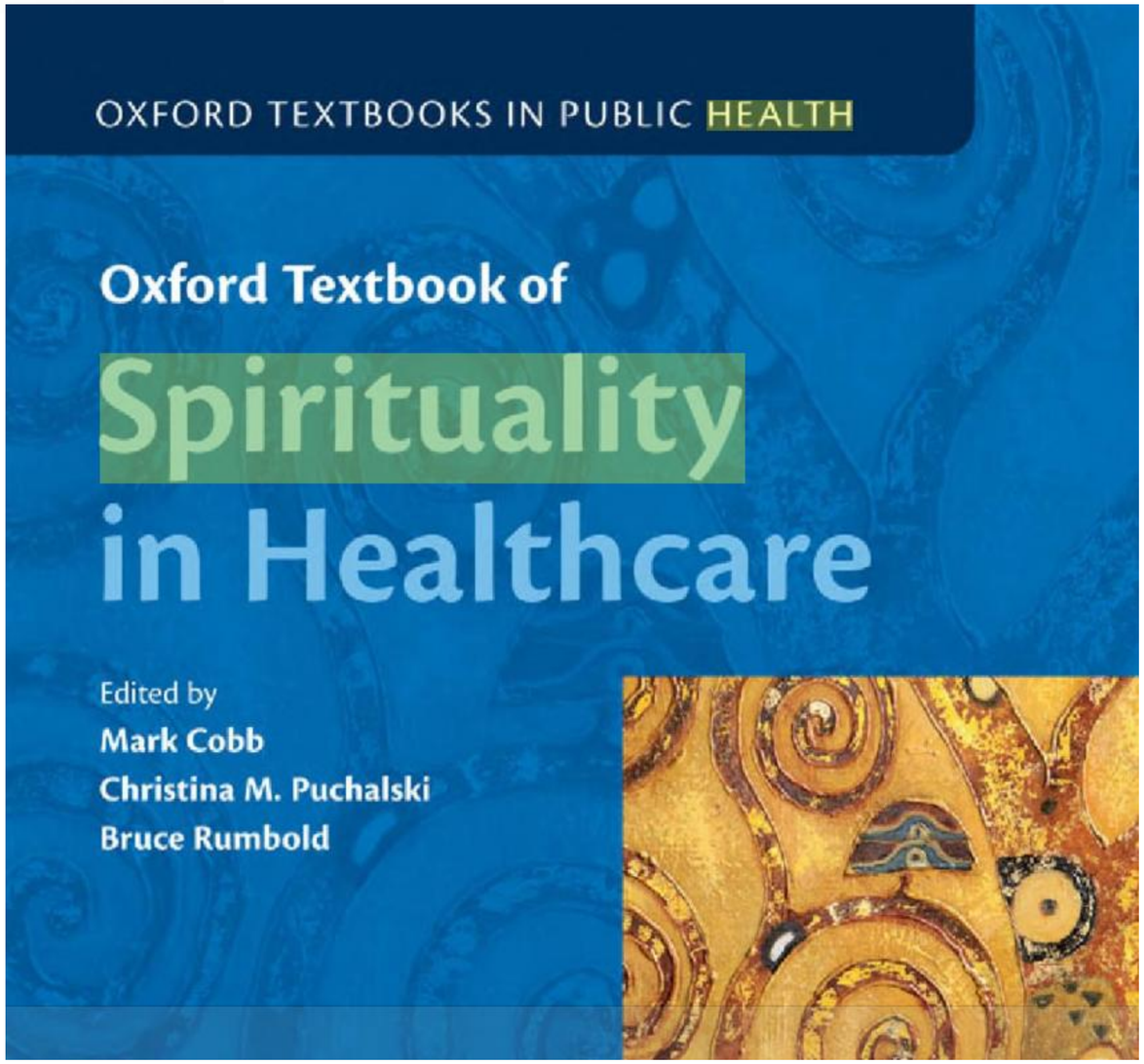
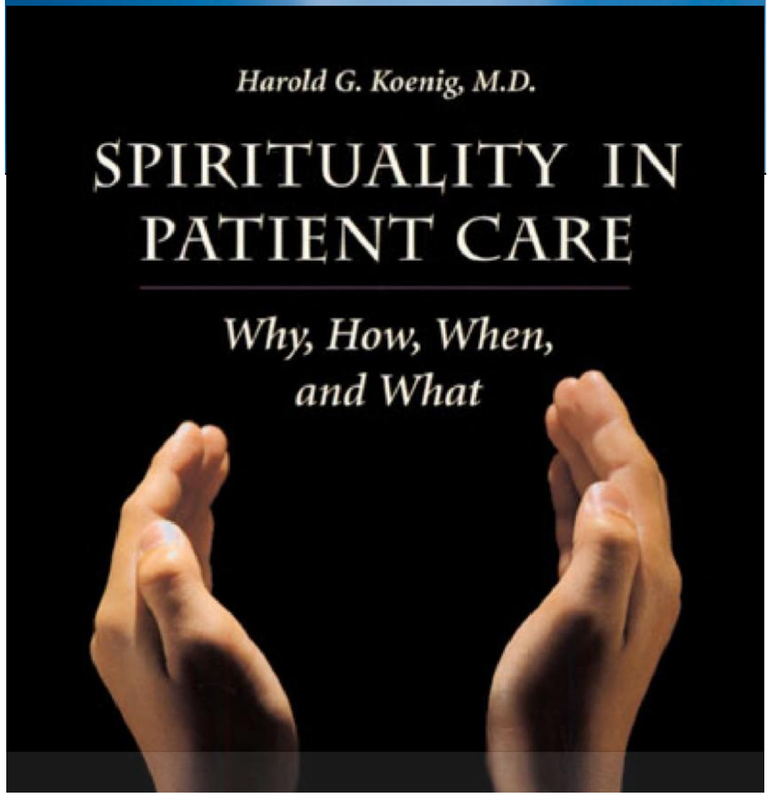


FIG. 3. The biopsychosocial-spiritual model of care. From Sulmasy DP: A biophysical-spiritual model for the care of patients at the end of life. Gerontologist 2002;42(Spec 3):24–33. Used with permission.





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National Comprehensive Cancer Network®

NCCN Guidelines Version 2.2023
Distress Management

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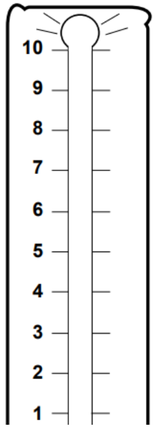
NCCN DISTRESS THERMOMETER

Distress is an unpleasant experience of a mental, physical, social, or spiritual nature. It can affect the way you think, feel, or act. Distress may make it harder to cope with having cancer, its symptoms, or its treatment.

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week, including today.

Extreme distress



PROBLEM LIST

Have you had concerns about any of the items below in the past week, including today? (Mark all that apply)

Physical Concerns
- ❑ Pain
- ❑ Sleep
- ❑ Fatigue
- ❑ Tobacco use
- ❑ Substance use
- ❑ Memory or concentration
- ❑ Sexual health
- ❑ Changes in eating
- ❑ Loss or change of physical abilities

Emotional Concerns
- ❑ Worry or anxiety
- ❑ Sadness or depression
- ❑ Loss of interest or enjoyment
- ❑ Grief or loss
- ❑ Fear
- ❑ Loneliness
- ❑ Anger
- ❑ Changes in appearance
- ❑ Feelings of worthlessness or being a burden

Social Concerns
- ❑ Relationship with spouse or partner
- ❑ Relationship with children

Practical Concerns
- ❑ Taking care of myself
- ❑ Taking care of others
- ❑ Work
- ❑ School
- ❑ Housing
- ❑ Finances
- ❑ Insurance
- ❑ Transportation
- ❑ Child care
- ❑ Having enough food
- ❑ Access to medicine
- ❑ Treatment decisions

Spiritual or Religious Concerns
- ❑ Sense of meaning or purpose
- ❑ Changes in faith or beliefs
- ❑ Death, dying, or afterlife
- ❑ Conflict between beliefs and cancer treatments
- ❑ Relationship with the sacred
- ❑ Ritual or dietary needs

Other Concerns: _____

N

Patient and Family Rights (PFR)

Standards

PFR.1 The hospital is responsible for providing processes that support patients' and families' rights during care. Ⓟ

PFR.1.1 The hospital seeks to reduce physical, language, cultural, and other barriers to access and delivery of services.

PFR.1.2 The hospital provides care that supports patient dignity, is respectful of the patient's personal values and beliefs, and responds to requests for spiritual and religious observance.

Joint Commission International Accreditation Standards for

Hospitals

Including Standards for Academic Medical Center Hospitals

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Joint Commission International

Challenges for Professionals

- Its too personal
- I am a Dr, Ns, MSW…
- I'm not an expert
- I am not religious myself
- It may raise problems
- I don't know how
- **Is there a scientific basis? What's the Evidence?**

Healthcare is personal

Speak appropriate to your role

Expertise is not expected, patient is the expert

Its about its significance in patient's life

Better to know about it now than later

Well…we can attempt to learn…