Spiritual care is integral to compassionate care

Speakers at a recent conference stressed the value of spiritual care.

By Hilda Johnson-Bogaerts

The annual conference of The Selwyn Foundation's Centre for Ageing and Spirituality, held in Auckland in September, explored spirituality in palliative care across cultures and belief systems, with a focus on older people. More than 80 people attended.

Opening the conference, the Ministry of Health's chief adviser for the health of older persons, Phil Wood, acknowledged the importance of spirituality in an holistic model of care. "We are very much a social, spiritual beast," he said. He spoke of adding "value to life" rather than "years to life" and confirmed the ministry is revising the Health of Older People Strategy to include more reference to spirituality.

In her *Spiritual Bodies* presentation, University of Melbourne associate professor Rosalie Hudson said that in a health-care environment which purported to provide holistic care, the spiritual component remained the least understood and was, therefore, the most neglected area of care, especially for older people. She spoke about the art of skilled spiritual companionship and the need for culturally informed practices. "Providing spiritual care is not about having all the answers, but about being there," Hudson said.

Buddhist view of spirituality

Managing director of Auckland's Amitabha Hospice and vice-chair of the New Zealand Buddhist Council, Ecie Hursthouse, presented the Buddhist view of spirituality and provided an overview of the Buddhist approach to end-of-life care. The Buddhist philosophy was to believe the purpose of life was to develop compassion for all living beings without discrimination and to work for their welfare and peace. Hursthouse spoke of the importance of giving spiritual support by listening and acknowledging without judgment and by showing kindness, compassion and empathy. As the dying process begins, we should support acceptance and contentment, encouraging the person to "let go" of everything, even unfinished business, plans and dreams.

Our lack of rituals around dying was one aspect of the presentation by author, transpersonal psychotherapist and teacher, Juliet Batten. In her presentation, *Pathways to grace-filled dying*, she discussed the importance of preparing for dying and displayed the very personal, meaningful items she would like to have around her as she dies. Dying was too important not to prepare for, or to leave to chance. Other cultures had particular chants and prayers for dying people, or formally passed on the mantle to the oldest son (or whomever), or blessed the family. Batten asked whether our society was overlooking something in this respect.

Research fellow with the University of Auckland School of Nursing Tess Moeke-Maxwell spoke on *Pae Herenga: An investigation of traditional Māori end-of-life caregiving customs*. She offered an insight into her research findings on Māori spiritual well-being at the end of life. Her research sought to determine the contribution traditional whānau care customs made to building whānau resilience during caregiving and bereavement, as well as to strengthen awareness of palliative care services and understanding of traditional care customs among the health workforce. She highlighted how projected Māori deaths of people aged over 65 are expected to increase from 51.9 per cent to 72 per cent of total Māori deaths by 2033, with deaths of those over 85 expected to more than double.

'. . . spiritual care should be integral to compassionate, person-centred health care. . .'

Nurse practitioner and a senior lecturer at the University of Auckland's School of Nursing and Freemasons' Department of Geriatric Medicine Michal Boyd's presentation examined palliative care in aged residential care and the effects on staff. The older people become, the less likely it is they will die at home. In New Zealand, 38 per cent of older people died in residential aged care and 34 per cent in hospital, Boyd said. She explored the barriers to palliative care for those with dementia, including that dementia was not recognised as a terminal disease; a lack of advance care planning; issues with symptom management due to communication difficulties; and a lack of skills and knowledge.

Palliative care education

Increased availability of palliative care education was necessary to improve the quality of care but was insufficient on its own, Boyd said. Evidence-based guidelines for palliative care should be developed, and advance care planning undertaken in the early stages of chronic illness and dementia. Consultation with specialists and multidisciplinary teams should also take place at the end-of-life stage, with continuity of care and collaboration between health-care professionals and families particularly critical.

A lecturer in health promotion at Otago University, Richard Egan, explored a health promotion approach to spirituality in later life. He looked at how public health and health promotion could help foster an environment where spirituality flourished and spiritual care was the norm in healthy ageing and end-of life-care. To embed spiritual care in public policy, "we should create supportive environments, strengthen community action, develop personal skills and reorient health services".

Spiritual care should be integral to compassionate, person-centred health care; all health-care providers should know about the options for addressing patients' spiritual distress and needs and health-care professionals should be trained in conducting a spiritual history, as part of routine patient assessment, he said. Providers should be trained in cultural sensitivity, and educated on the spiritual aspects of health and how this related to themselves, to others and to the delivery of compassionate care, Egan said. •

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