

Palliative Care Chat - Episode 28

Celebration of National Spirituality Week with Rev. Dr. Carla Cheatham and Ret. Spiritual Advisor Katrina Scott

Dr. McPherson: Hello, this is Dr. Lynn McPherson and welcome to Palliative Care Chat, the podcast brought to you by the online master of science and graduate certificate program at the University of Maryland. I'm very excited. We have two guests today helping us celebrate Spiritual Care Week, which is October 20th to 26th of this year. Our first guest is Reverend doctor Carla Cheatham who said, please call me Carla, and our second guest is Katrina Scott, a recently retired spiritual provider. Ladies, welcome.

Dr. Cheatham: Thank you. Glad to hear your voice Lynn. Glad to be with you.

Dr. McPherson: Thank you. Thank you. So today we're going to be talking about Spiritual Care Week. So what the heck? Maybe a good place to start would be. What the heck is spirituality? And is this the same thing as religion? What do you think?

Dr. Cheatham: Oh, well this is Carla. I'll jump in and begin with that one, because this topic's near and dear to my heart. A lot of folks misunderstand the role of spiritual care counselors or spiritual care providers. So one of the reasons we're grateful for this week is because we can highlight what it is we do, and what we don't do. Many people hear spiritual care and or they hear a chaplain, which is what we've commonly been called, and they assume that we're going to come in and try to impose some sort of beliefs on them, judge them, try to get them converted, and that is the last thing that a clinically trained ethical healthcare chaplain is supposed to be doing. We come in and say, what do you believe, and how can we help you access your beliefs to find as much peace, meaning and comfort as possible? But when we talk about beliefs, we're not meaning just religious beliefs. We have the view that everyone has questions of existence, meaning how do we make sense of suffering? Why are we here? How do we find comfort?

Where do we turn for direction? How do we carry on after the time that we die in this world, with leaving the legacy, and do we believe in a life after this one? If so, what does that look like? Those are questions of existence. Those existential questions everyone has. Some respond to those questions by turning to nature, and the arts, and sciences and humanities, the greater good of human consciousness and love. Others answer those questions and find comfort and connection through a spiritual community, a spiritual path. And still others turn to a dedicated religion with practices and rituals of their own, and scriptures and texts and songs of their own. So however it is that people answer those existential questions, we want to help them access their beliefs to find, again, peace, meaning, comfort, and direction. That ends on their terms, without us imposing our views at all. But spiritual cares about the existential

questions and struggles, and we get to show up and help them find whatever they use to answer those questions to find their own support.

Dr. McPherson: And how's that different from religion?

Dr. Cheatham: It's differs from religion simply because in religion, there is a faith leader, of a faith community who is tasked with upholding the doctrines, the views, the standards of that particular religion. And promoting in many cases that religion, not always. There are some religions that are not even [biblical 00:03:17] meaning trying to proselytize others to their way of seeing. But others are. In religion though, there's one dedicated viewpoint, and healthcare, and spirituality, there's a lot more openness to different ways of being and seeing. And so a spiritual care provider wants to help people find ways to access things of spirit, something greater than or beyond themselves that may or may not fit into a traditional religious structure. So Katrina, any other thoughts about that.

Dr. McPherson: Well I was going to ask Katrina, do you think we've reached the tipping point, where more people are concerned about spirituality than a specific religion?

Ms. Scott: You know, that's a great question, and I hate to say this, but it really kind of depends upon where you live in the United States. The deep south Bible Belt is a lot different than the Pacific Northwest, especially in practices, values and how those practices and values enter into our daily lives. So the Pew Report, which is a great place to look, has a lot of information that people over the age of 65, 90% of those people still identify with their spiritual traditional religion of birth, whether they attend temple or church or not. Whereas right now, currently more than half of the people under the age of 30 do not identify with any organized religion, nor are they looking to do that. So their support system, where churches and temples and houses of belief, brick and mortar structures are now being replaced by, I hate to say it, digital media. I think most people get their support systems through Facebook now. [crosstalk 00:05:11].

Dr. McPherson: And you know, coming at this as a pharmacist, and certainly my head is not in your game particularly, but it would seem to me that people with an advanced illness facing death would be more concerned about the big question of, you know, did my life make a difference? Why is this happening to me, that seems to be more of a spirituality question than a religion-focused question. What do you all think about that?

Ms. Scott: There are three major components or needs of people facing a life threatening illness, and especially at end-of-life. And this person would be meaning making, you know, the meaning of my life, the meaning of this illness in my life, if it's earlier through the trajectory of illness. The second is the value of me, given this disintegration of who I was, and where I am now, a time when people should be loved and cherished versus feeling burdens to their family. And the third part is always that meaning of reconciliation, of reaching out to others, and to kind of being at peace. Being at peace with God, being at peace with family, feeling that

you've tried your best to make amends for things that you possibly regret or have left undone in your life.

Dr. McPherson: Wow. Big job you guys have. I would think that you would encounter a lot of people, for example, the end stage COPD-er who smoked all of his or her life, and the feelings of guilt that I brought this on myself. Is that something you all confront?

Ms. Scott: Oh, yeah, all the time.

Dr. Cheatham: Yeah, we experience really kind of the range of emotions. There are some who are the most religiously devout, who have struggled the most, and then there are others who are not really well connected with spirituality, who have had the most peace. And it kind of runs the gamut. And vice versa. People of deep faith who have a deep and abiding peace, and who can find a source of forgiveness, and people who, even who are non-theistic atheists, agnostics, humanists and such, who also can find a great deal of peace. It really depends upon how they make meaning as Katrina was saying, how they make sense of things. So a lot of it though, the things that we suspect people will experience by the time they come to us in palliative care, and then later into hospice, very often they have wrestled with those things.

They've been living with this disease nonstop, not able to get away from it for weeks, and months, and sometimes years. So oftentimes by the time they come to us, they may be dealing with more a bout of grief around not wanting to leave the persons that they love, or they may be dealing with struggles around... There may be some questions about wanting to clean things up, but sometimes we see that by the time they get to us, they've really done a lot of that, and hospice especially, one of the things we see more often than not is not why is God letting me die, but why is God not letting me die? Why am I being allowed to linger and suffer? Why is this being allowed? Why Can't I just die? So it really runs the gamut, but the tricky thing is just helping them identify how they make sense of things.

At one point in time, I had a person who was atheist, another who practiced a lot of Celtic and native spirituality, but no defined religion, just a very spiritual path, and some elements of Buddhism as well in his belief system. And another who was a devout evangelical Christian from the Worldwide Church of God and Christ. Each of them were struggling with some of the very same things. The person who was an atheist, he turned to the sciences, and the poetry of Robert Frost, and the music of Bob Dylan for meaning and comfort. For the person who was spiritual, he practiced Native American Smudgings, and he read Celtic prayers, and he turned to Buddhism and meditation and letting go of desire as a way of accepting suffering. And the person who was the evangelical Christian turned to prayers and scriptures and expressions asking for forgiveness of sin and seeking pardon for things she felt she had done wrong. So same concerns, same struggles. They just found their own ways of dealing with them and tending to them.

Dr. McPherson: So you've got to have quite a few tools in your toolbox I think to take on all comers.

Dr. Cheatham: Well one would think, but I would argue you, I'll be curious to hear Katrina's thoughts. I think the more I've become comfortable at just being present with people as they are, where they are, without needing them to be any place different, I need to know less about different viewpoints, and more about how to just hold open space for them, to sit and talk long enough with a supportive, caring presence, until they can hear themselves, and find their own answers. As they find the truth and sense of connection inside of them, I am just that sounding board and a place to be. In fact, when people ask me for answers, I won't give them. I reflect back to them and ask them to tell me what they think and believe. And I'm really more, and as a theme as you were telling us, Lynn, earlier, the theme being about holding space, I do a lot more of holding space rather than providing answers, or even having a lot of tools in my toolbox.

Dr. McPherson: Katrina, maybe you could address that. The theme same of this year is Cultivating Space. What does that mean?

Ms. Scott: Well, space comes in a whole forms, right? It comes from the space within our bodies, inside of ourselves without a way from us as well within us. And I think that given serious illness and end-of-life concerns, space seems to quite often not expand, but contract, especially given limitations on a person. I think one of the roles that we have as spiritual care providers, AKA chaplains, is to open up that space, and to help that person remember, I call it remembered wellness, who they were at the top of their game, what their and dreams have been and will continue to be, and to hold... I'm sorry I'm getting flustered here, but I always describe my job is that I am a sponge. My job is to hear the thoughts, dreams, wishes, hopes, fears of the person, to let them know that I have heard their suffering, and that I understand that they are suffering. Or I've heard their joy, and I'm replenished by being in the presence of that. But it really is basic companionship, and companionship means being in the same space as that person. Not above, not below, but with them.

Dr. McPherson: Okay. So obviously you are both faculty in our master of science program, and you both know that I am pretty fervently wish that all people in our program are transdisciplinary to an extent. So what would you say is the minimum skillset for anyone in our program in this realm?

Ms. Scott: I would say when faced with a patient saying to you, "Why is God doing this to me?" The number one thing that is most imperative at baseline is to acknowledge their suffering. If somebody said their foot hurts, you'd ask them where it hurts. Oh, that's really hard. Why is God doing this to me? And you have to acknowledge it by saying, "Oh, that must feel so hard to feel that way. I cannot imagine how difficult that must be for you. Please tell me more." You want to find out what their suffering really is. And it could be something that you think it is, but it could be anything. It's their belief system, and their worldview, and where it's butting heads with what they are actually

experiencing. So acknowledging suffering, a personal spiritual suffering is number one. You don't want to lose it.

Dr. Cheatham: I would definitely agree. And I would add to that letting go of the need to fix. Megan Devine is a writer in grief and bereavement, and she says some things cannot be fixed. They can only be carried. And so we show up to sit beside them. Herbert Adler talked about compassionate listening as being analogous to hemodialysis, in that as the person speaks their suffering, and it's received by the compassionate listener, by the time it passes through, as he says, and I love this term, the compassionate equanimity of the caring listener. And by the time it then comes back to the speaker, it's been dialyzed of just a bit of its pain.

Dr. McPherson: That's great.

Dr. Cheatham: So you were talking earlier. Yeah. So you're talking earlier about the tools in the toolbox. I would say as we are acknowledging that suffering, and holding that space, and affirming them, as Katrina was talking about, I say that these days, the biggest three tools I have in my toolbox, where I mostly live as a spiritual care counselor is, first to say this sucks. Just without, you know, any proper language, but just to acknowledge this sucks, and they relax, and drop the language that sometimes they feel like they have to put on when the spiritual care counselor's in the room. That they acknowledge yeah. Yes it does. And then they tell me what really, really is going on and how they feel. The second is, of course you feel that way. A lot of people do. Of course you feel that way. That kind of validation can alleviate people of a lot of the guilt and fear and shame and judgment, or fear of other's judgment about some of the things that they feel. So validating and normalizing how they feel.

And the third is teaching their loved ones how to put the bedrolls up and down so that they can get as close to their loved one as they want to. And then how to put them back up when they leave. To model that it is okay to be close to your loved one. If it's bothering them, they'll let you know. But otherwise to not let that sterile environment that we've put up, oftentimes people stand there in the corner not wanting to touch them. Like, you're paying for this room. If you want to crawl up in that bed with your, you know, whoever this person is to you, you go right ahead. And if anybody complains, you have you come get the chaplain, and I'll put the fear of God in them. I've even stood vigil at a door in an acute inpatient facility, hospice facility when there was a couple who had been back and forth to MD Anderson as her cancer was back, and multiple treatments and tests, and it had been weeks and weeks and weeks.

And finally it was clear that she was not going to be able to recover from this time. And so it had been months since they had had any time alone, having been back and forth to different hospitals. So they're in the IPU, and it was very clear that they adored each other. But he had his hand woven through the bars of the hospital bed, and contorted himself to try to reach over and hold her hand. And I finally, as part of my assessment, asked how long it had been since they'd been able to have, well, private time together, and I kind of waggled my

eyebrows. And they kind of, he kind of turned beet red and she said, "Way too long."

And I said, "Well, you know, these doors can't lock for safety reasons, but I have about, oh, two hours worth of paperwork to do. And if I sit about five feet down the hallway away from your door, and it's closed, I can guarantee you nobody will get past me to come in and bother you. Just remember to come open the door at some point, I can get home to my family for supper." And they said, "Really?" And I said, "Yeah. And I might suggest keeping the bed rails up, just for safety's sake." And yeah, it's, you know, talk about palliation, sometimes helping people find ways to connect and to help them get past some of the barriers we put up in our minds about thing, yeah, you can be close, is the most powerful thing we can do.

Dr. McPherson: You're a rascal Carla Cheatham, I don't care what they say. You do what it takes. Get her done.

Ms. Scott: We had do not disturb signs in my hospital.

Dr. McPherson: Had on the door knob or a tie or something?

Ms. Scott: We would actually employ, ask the nurses to use a Hoyer lift to move the patient over it so their loved one could get into bed next to them.

Dr. McPherson: Oh, that's... wow.

Ms. Scott: Yeah.

Dr. McPherson: This is a layman's question too, you hear so many labels about people in your line of work. What's the difference between a pastoral care counselor, a chaplain, a spiritual care coordinator? Are these all labels for the same kind of professional, or are they really differences? Are there differences?

Ms. Scott: Well, it depends. Most large hospitals now would love to have what are called board-certified chaplains. People that have a graduate degree in theology, that have done minimum of 1,600 hours of clinical supervised education, clinical pastoral, CPE, and then have to be endorsed by a religious or endorsing body, whether it be through ordination, or endorsement for healthcare chaplaincy, and then you go in front of a committee, to be certified where you do a lot of paperwork and a lot of work. And then above and beyond that, there are specialty certifications in palliative care. So, that's the standard. There are other associations who are offering board certification that aren't as strenuous and as robust as some organizations. There are associations that you pay a hundred bucks and you get a chaplain card. So yeah, and some faith-specific hospitals might have clergy of their own, assigned to be with patients and families. But hopefully they're more multi-faith faith than just a particular faith. Does that make sense?

Dr. McPherson: It does.

Dr. Cheatham: So that's the board certification where the true term chaplaincy exists, a board-certified chaplain. There are others though who perhaps have been in the field for 25 years, did not have access to clinical pastoral education, or where they went to university, to seminary. They didn't have access to it, or it's not where they thought they were headed. They thought they were into parish ministry, working with the faith community for instance, and then and then found themselves working in healthcare instead. But they have not gotten fully board-certified. And the term chaplain over the years, we humans put together baggage with language, and the word chaplain over time collected some baggage by many people as being seen as decidedly Christian. When there are chaplains who are Buddhist, Muslim, Jewish, Bahai, Sikh, every different flavor of Christianity that you can imagine and Catholicism, there are Pagan chaplains and Wiccan chaplains. There are even agnostic and humanist and atheist chaplains. And so we run the gamut. But because of the fear, the baggage that term collected, there were many people who would not see the chaplain because they feared a certain stereotype, and they feared judgment and proselytizing.

And so in order to help alleviate some of this fear, we started trying to talk more about we're not about religion, we are about your spiritual support. How's your spirit holding up, and what does that mean to you? So we've been playing around with different language. In the previous days, in a lot of the faith-based hospitals perhaps for instance, because so many of the hospitals began as faith-based institutions, like the Sisters of Mercy and the Franciscans, etc. As they were supported by persons of faith, and faith communities, and religions, religious groups. So they would talk about it as pastoral counseling. But as we've expanded and as Katrina was talking earlier about the rise of persons who consider themselves spiritual rather than religious, and those who consider themselves neither spiritual nor religious, but they still have existential questions.

We try to make available rabbis and the moms, and priests, and clergy of all of types. We try to coordinate connection with them. But at the end of the day, ideally, a clinically-trained healthcare chaplain, or as we're calling them now, spiritual care providers, spiritual care counselors. You may even hear the term spiritual care coordinator. It all is really trying to say, we're there to help you access your beliefs, and find support. And to connect you with your clergy if you do have some, or want connection with a clergy from a particular religious group. So all saying essentially the same thing in different ways. But at the end of the day, it's we're wanting to show up for people, and offer them that support.

Dr. McPherson: That's great. So just as you said, a good spiritual care coordinator or provider would be able to determine when a patient does want to see their particular religious leader, what advice would you have for the rest of the team as an indicator of you really need to talk to a spiritual care person, like when it gets

above what a nurse or a doctor or a pharmacist can provide, beyond what Katrina described as the basic skills we should all have as transdisciplinary providers. What are some flags to say, I really think we need to bring in the rest of the team here?

Dr. Cheatham: What used to be as a hospice, oh, go ahead.

Ms. Scott: No, no, go ahead.

Dr. Cheatham: It used to be the hospice chaplain, as soon as someone cried, they would call for me. And when I would ask, so what is it that they're needing? Well, they're crying. Okay, and are there words to those tears? No, no, no. They're just crying. We need you to come. And so it took some time to educate them that tears may just be a sign of them expressing what they need to express. And I certainly am not averse to coming to see them, but we started letting people know that if they were listening just specifically for religious language or spiritual language about God or a deity or something along those, or heaven or hell or forgiveness, if they were listening for those, spiritual and religious terms, they might be missing it.

Anytime people are expressing again, those questions of meaning, how do I make sense of this? How do I understand this? What should I do? How will I carry on? Will my kids remember me? How do I cope? As they're looking for any of those kinds of, any sorts of existential distress or angst or suffering, that's when it's a really good time to bring in the spiritual care coordinator.

Dr. McPherson: Absolutely. Katrina, anything else on that?

Ms. Scott: The members of the team might want to be presented with some standard spiritual distress forms, there are a whole bunch of tools out there that patients, especially clinicians, to look at to see what are the types of distress that people are having. But for me, the big thing is fear, that people are scared to death of dying. And what is that fear about? Is it the actual dying process? Is that the fact that you're just, this loss is too much for you to leave your family? What is your fear? What is your anguish? What is your suffering, the disintegration of who you were and hopefully a chance or space to maybe mend that a little bit before the end. So I think a smart thing would be to give those forms to the team.

Dr. McPherson: That's a good idea. I would imagine that sometimes you have your hands full. I mean, I was raised Catholic, and boy, we are painted a pretty graphic picture of what hell looks like forever and ever and ever, and it's going to be really hot. So I can imagine somebody being very fearful of roasting in the eternal fires of hell forever.

Dr. Cheatham: Yeah, we do come across that sometimes. Yeah. And so we help them think through and talk through what they think about love, and forgiveness, and meaning. You talk about the interdisciplinary and the transdisciplinary

approach, and we're so grateful for that because in spiritual care we speak on they're being spiritual care generalists, but you're all members of the team, who we believe have an ethical and some cases really even a regulatory responsibility to screen for spiritual distress, and then to respond and intervene in the moment as needed, within appropriate bounds. And then to know when it's time to refer to a spiritual care coordinator or a spiritual care provider who will then come in as the spiritual care specialist, and do a deeper assessment beyond the screening and then deeper interventions in plan of care. Now to be clear, that's much more the model in the hospital setting, and the palliative care setting, and community-based setting. But for hospice, the reqs are much different.

There's to be a spiritual care or other counselor who is part of the interdisciplinary team that takes part in the comprehensive assessment, to put together the plan of care within the first five days. Where the standard in hospice is that a spiritual care practitioner gets out there to see patients and families and assess within the first five days. And that be the one to introduce themselves to patients and families. And then to help be part of developing that plan of care. But we spend a lot of time in training other staff, and that's a lot of what we do in the, definitely in the basic psychosocial and spiritual course. And the program is to help them find that sweet spot. We don't want them to abandon or neglect people's spiritual needs because they're uncomfortable and skiddish about knowing how to tread that line, and how to be present with that topic for people.

But we also don't want them to go to the other extreme and overstep those boundaries and become unintentionally that religiously and spiritually abusive by bringing their own belief into that process, and even a bit opportunistic, of taking advantage of someone being weak and scared, and usually that's an opportunity to present their own beliefs, well-meaning, well-intended, loving people, but who haven't been trained in how to hold that boundary, will look for an opportunity to bring what they believe into that care relationship. And it happens all the time. We help them learn how to hold that sweet spot without going in either direction of spiritual malpractice, how to not abandon or overstep. And it can be a tricky needle to thread, but we spend a lot of time helping those that are scared get more comfortable, and those that are way too comfortable, having a little more awe and trembling about the way they approach the ethical boundaries.

Dr. McPherson: I think that's so important. When you were speaking, it reminds me of Dame Cicely Saunders definition of total pain and certainly as a pharmacist, and I'm all about the drugs, I have had to learn to say to a patient, what's one thing I can do for you right now? And very often it has nothing to do with the physical discomfort. It's not a morphine moment. So I think your words are very true. Katrina, anything you want to add to what Carla just said?

Ms. Scott: I just want to go back as a race in the Catholic tradition, although I no longer practice that there is, I'm in the Boston area, which heavily, is very, very heavily

Catholic. Where I worked, we had priests who were sacramental, because there was such a shortage of priests that ended up hospital over a thousand beds. The, you know, someone would say, oh, I'd like to see a, would you like to see one of our chaplains? Yes, I'd like a priest. And that was the common refrain. And so then I would walk in, and as it turned out, I've explained, no you're not we have one priest for a thousand people, and we would talk. But the most lovely thing is that sacrament of the sick, which my Roman Catholic colleagues sometimes referred to as the get out of jail free card, right? At end-of-life, because it's absolution, you get absolved of your sins, which can be really profound.

And for me it's when I'm with a family, and the person receives sacrament of the sick and then the priest leaves, and then we talk, we pray. We just continue in that space, and it's like the air is back in the room, especially for family members that are still very, very traditional. It's the bow on the package.

There's something comforting about those rituals, and for those who do practice a spiritual path or religious tradition, and even though to begin, let me be clear, those who are non-theistic, meaning they don't believe in a deity or follow a spiritual or religious path. We all have our own ritual, hello and goodbye are rituals. So there are rituals that we practice for persons who are non-theistic, either giving away ceremony, or a goodbye ceremony, but those rituals, those things that are familiar and give us a great sense of meaning and contact and reassurance, can be so powerful.

Dr. McPherson: Well said Katrina.

Ms. Scott: I was just thinking, we have have the Quran CDs and for our Muslim patients, just to have that recitation happening in the room, it's just, it's like an enormous blanket in the world.

Dr. Cheatham: All those little tricks, the Quran Explorer is an app on iPhone that assign to the patient, help me bookmark the surahs or the chapters that would be similar to in Judaeo Christianity, the 23rd Psalm. And I would hit those surahs, and then mom would recite the Quran, and it was a beautiful experience, in a way that I as a non-Muslim and as a female could bring the Holy recitations to a patient. So yeah, those are some of the tools that we do like to have in our toolbox.

Dr. McPherson: So it sounds like you both subscribe to the get her done theory, no matter what it takes. Good to know.

Ms. Scott: Yeah. And I can make that space, right?

Dr. McPherson: I think all of us in hospice and palliative care are kind of able to do that. We're all excellent at what we do individually, but I think it's our strengths and our overlap and it's that transdisciplinary nature that makes us an awesome force. And I know that both of you teach that in your teachings in our program, and I

am so delighted when I see the social worker, the chaplain talk about, I remember one of our chaplain students saying something like, I know when I go to visit a patient, and it's obvious to me from my assessment, they're having physical discomfort. So it's hard to work on your soul when you're really uncomfortable. And he would say, "I'm going to go get the nurse to see if she or he can give you a dose of your medication, and I'll be back in an hour." I think that's so important. I assume you both do as well.

Dr. Cheatham: Very much so. I'm a big fan of double dating, of disciplines going together to see patients, to better hear and understand what it is that the other does. And as I grow from being around physicians, nurses, social workers, et cetera, I then can then, not overstep my bounds and go out of my scope and try to play nurse, physician or social worker. But I can reaffirm the education and the languaging that I know that those other disciplines have used, and I can reinforce it and support that and know better of what I'm looking for, so that I know how to better know when to reach out and refer to them and vice versa. They then get more comfortable at knowing when to reach out to me. It's a great, great experience.

Dr. McPherson: Yep. I think-

Dr. Cheatham: Katrina, you were starting to say-

Dr. McPherson: Go ahead.

Ms. Scott: I would just say the, you know the math, I use this a lot. Maslow's Hierarchy of Needs. There's a great revamping of that for hospice and palliative care, but the foundation in order to get to that apex of transcendence, or self-awareness is pain and symptom management. Where I used to work, if somebody was in physical pain crisis, we would not see them. We would wait for the team to come in and to see what was going on before walking in and even trying to converse. That's kind of just basic 101.

Dr. Cheatham: And it's a constant case of triage, because there are times when I've been called by a nurse at two o'clock in the morning, and to have her say, "I've been doing continuous care in hospice in this patient's home for nine hours. They're wailing and moaning and thrashing, but not responsive. And I've given them enough meds to knock out a horse. I think this pain is spiritual, not physical. Everything's been said that we know of that needs to be said. Everyone's been here. We can't find anything, can you please come? We think this pain might be spiritual." And so the nurse being willing to notice and see and recognize and reach out to realize, and we know that when a person's emotional, mental and spiritual suffering is tended to properly, they have fewer symptoms. They're rating other symptoms as less a perception.

Other symptoms can be lowered. Their need for medication can be lowered. Their sense of calm and wellbeing and anxiety goes down. So they both work

hand in glove, I know you've talked quite a bit about team body, and team soul, and I've actually tried in my patients, my other students and said, go back to Lynn and tell her we're going to talk no, because we don't want to push that dichotomy. We really want to talk about team whole person, because that's what we do. And so it can be a useful way to see both. And yet I think we've got to pay attention to where the physical is impacting the spiritual and emotional, and where the spiritual emotional is impacting the physical and how we all work together to provide that palliative.

Dr. McPherson: Absolutely. Well that sounds like a lovely note to end on. Ladies, thank you so much, and happy Spiritual Care Week to you, and to all of our patients and the rest of our teams. I'm so grateful you took a half an hour to join us today. Again, this is Dr. Lynn McPherson, and this presentation is copyright 2019, University of Maryland. For more information on our completely online master of science and graduate certificate program in palliative care, or for permission requests regarding this podcast, please visit Graduate.UMaryland.edu/Palliative. Thank you.

Dr. Cheatham: Thank you Lynn.Katrina, it's an honor.

Ms. Scott: Thank you Lynn.