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PHILOSOPHICAL EXPLORATION

The Relationship between Medicine, Spirituality and Religion: Three Models for Integration

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Abstract The integration of medicine and religion is challenging for historical, ethical, practical and conceptual reasons. In order to make more explicit the bases and goals of relating spirituality and medicine, we distinguish here three complementary perspectives: a whole-person care model that emphasizes teamwork among generalists and spiritual professionals; an existential functioning view that identifies a role for the clinician in promoting full health, including spiritual well-being; and an open pluralism view, which highlights the importance of differing spiritual and cultural traditions in shaping the relationship.

Keywords Spirituality · Medicine · Integration · Pluralism

Vigorous debate continues about whether and how medicine and spirituality or religion should be integrated. While palliative medicine explicitly includes spiritual care among its goals (National Quality Forum; Puchalski et al. 2009a, b, c), there have been questions about how to accomplish this integration. These questions have to do with limited time for deep discussions in a busy clinical setting, what clinicians can do if they do identify spiritual distress when there are not enough trained chaplains to treat the spiritual distress, the need for more training in spirituality and clinical care, and ethical concerns about the risk of patient harm from proselytizing clinicians. This debate has important practical implications for the care of individual patients, as well as for the organization of care and the education of future clinicians. In order to help clarify the issues at stake, we distinguish

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here three viewpoints on the relationship of spirituality and medicine: a whole-person care model that identifies professional specialties, an existential functioning view, and an open pluralism view. While each of the three models agrees that spirituality and medicine should be integrated into the care of the whole person, they represent different emphases and concerns requiring dialogue.

A Generalist Specialist Model of Whole-Person Care

The interprofessional model of spiritual care (Puchalski et al. 2009a, b, c) is premised on the ethical obligation of all caregivers to attend to the whole person as described in the biopsychosocialspiritual model (Sulmasy 2002). Physicians have an ethical obligation to attend to the psychosocial, spiritual, and existential distress of patients and not just to their physical pain (Lo et al. 1999). This holistic approach to a patient's care is also grounded in the World Health Organization (WHO) definition of whole health, which defines health as the "dynamic state of complete physical, mental, spiritual, and social well-being and not just the absence of disease or infirmity" (Üstün and Jakob 2005). The Institute of Alternative Futures reports on patient-centered care notes that patients' healthcare outcomes are improved if their values and beliefs are respected and integrated into their care (Institute of Alternative Futures 2004). Integral to this biopsychosocialspiritual model of care is the recognition that members of a clinical team have varying degrees of expertise; as part of their professional obligation, they should respect the expertise of others and recognize the limits of their professional expertise in certain areas. Thus, a physician might be a physical care specialist but a generalist in social care or spiritual care. The chaplain is a generalist in psychosocial care but an expert in spiritual care (Handzo and Koenig 2004) as well as in the tenets of person-centered care. Identification of spirituality as an equal, specialized domain of care is critical for several reasons. First, in the current reductionist model of care, spirituality and other humanistic aspects of care are often relegated to the category of optional, nonessential aspects of patient care. Identifying spiritual distress as deserving the same intensity of attention as physical pain makes spirituality a recognized domain of care. Secondly, this perspective emphasizes the importance of a team approach to care. The clinical team brings together experts in physical as well as psychosocial and spiritual domains of care, thus enabling the best possible care for the patient. Finally, this model aims to ensure that patients are protected from potential harm when well-meaning clinicians engage in areas of clinical care in which they have little or no training.

While palliative care includes spiritual, religious, and existential issues as a required domain, and patient surveys demonstrate that patients feel the need to have their spirituality addressed (Balboni et al. 2007; McCord et al. 2004), there have been questions raised by some clinicians about who should address those issues with patients and how patients' spirituality should be integrated. To address these concerns in 2009, a National Consensus Conference focused on developing a model with guidelines for how clinicians could best accomplish this task. In this model, the board certified or board eligible chaplain is recognized as the specialist spiritual care provider, while other members of the team are seen as generalists in spiritual care. However, everyone on the team is responsible for spiritual care, defined by the American Nursing Association as "interventions, individual or communal that facilitate the ability to express the integration of the body, mind, and spirit to achieve wholeness, health, and a sense of connection to self, others, and [/or] a higher power" (American Nursing Association 2005). Building on this concept, the 2009 National Consensus Conference defined spirituality as "the aspect of humanity that refers to the way

individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred" (Puchalski et al. 2009a, b, c). The model, definition, and recommendations emerging from this conference have been widely supported by numerous organizations including the National Consensus Project on Palliative Care (National Consensus Project 2004), the National Quality Forum (Ferrell et al. 2007), and the APC Standards of Practice (Lo et al. 1999). There are many hospital and other clinic settings doing demonstration projects using this model (Puchalski et al. 2009a, b, c).

According to these definitions of spirituality and spiritual care, each clinician is responsible to approach the patient as a whole person and to provide relational, dignity-based, compassionate care. Thus, interprofessional spiritual care is the foundation of whole-person or holistic care. This means that all members of the team assess the patient's physical, emotional, social, and spiritual well-being and identify distress in these domains. The spiritual care model is an integrated model in that none of these domains is addressed in isolation from the other domains. Within this relational model of care, patients as well as care providers have the opportunity to achieve their full authentic selves, to be respected, and to have their dignity honored at all times. The model calls for all care professionals to be other regarding and moving toward justice by encouraging clinicians to work together as a team to deliver service grounded in benevolence and altruism. It recognizes that spirituality or reflection should be part of a clinician's professional development, encouraging vocation and relationship-centered care. Thus, clinicians' self-compassion and self-care are essential to their provision of spiritually centered care (Fetzer Institute Global Gathering 2012).

Although spiritual care is provided by all members of the team, specialists also function to address physical, emotional, social, and spiritual issues outside the realm of their specialty Thus, a chaplain may address physical pain but look to the physician or nurse on the team to deal with determining the cause of the pain and its treatment. Similarly, physicians, nurses, and others may identify and even diagnosis spiritual distress as well as identify spiritual resources of strength of the patient, while the Board Certified Chaplain (BCC) is the expert who can further evaluate the spiritual issues and recommend how to treat spiritual distress or best integrate patients' spiritual strengths and resources. The chaplain is an equal and integral member of the medical team. Chaplains write assessments and plans with outcomes. They follow up with the patients along with the rest of the team. As the spiritual care leader on the medical team, the chaplain accepts referrals, but also models values such as listening and humility, facilitates communication, and serves as a resource for other members of the team. The chaplain confirms, corrects, or elaborates on the spiritual diagnosis made by the clinician. The chaplain also recommends to clinicians what interventions they might employ in the spiritual care of their patients. Whole-person care involves being present to the person and listening to his or her story—the physical, emotional, social, and spiritual story. All clinicians need to be present to the patient's suffering, listening for and diagnosing spiritual distress, and recognizing when spiritual care professionals need to become involved. The 2009 Consensus Conference recommended an implementation model for the assessment and treatment of spiritual distress (see Fig. 1) utilizing a list of spiritual distress classifications based in part on the NCCN (National Comprehensive Cancer Network) Distress Guidelines and outlined in the figure below Table 1 below—the diagnosis table.

As the patient moves through the system, clinicians who develop treatment or care plans obtain a spiritual history. There are currently three tools used for spiritual histories—FICA,

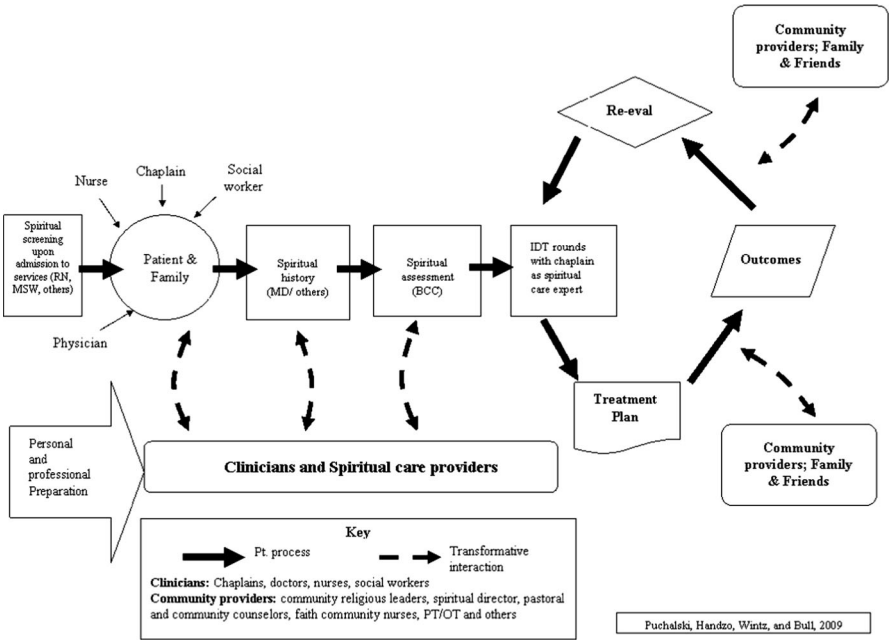

Fig. 1 NCC inpatient spiritual care model

Spirit, and Hope (Borneman et al. 2010; Maugans 1996; Anandarajah and Hight 2001). FICA has been validated as a clinical history tool (Borneman et al. 2010).

The first goal of the spiritual history is to invite the patient to share his/her spiritual, religious, or existential issues, concerns, beliefs, or practices. It also helps clinicians to identify spiritual distress or spiritual resources giving them strength. They can then integrate what they have learned about the patient's spirituality with the overall history and physical into a "Biopsychosocialspiritual assessment and plan" (Puchalski et al. 2009a, b, c; Handzo and Puchalski). This plan reflects the whole-person goals of this model. Ideally, the spiritual treatment plan is developed in conjunction with the Board Certified Chaplain as is often done in palliative care interdisciplinary teams (IDT). In the outpatient setting, spiritual care professionals include pastoral counselors, spiritual directors, clergy, and chaplains who work in the outpatient setting.

A critical concept in whole-person clinical care is the notion of healing as distinct from cure. Whereas cure has a mostly disease based focus, healing refers to the whole person and to how that person finds peace, a sense of coherence, solace, and meaning especially when dealing with serious or life threatening loss or disease. Healing occurs within the patient who may utilize his or her own resources, or that which he/she values most as a way to find inner peace. Anecdotal evidence suggests that healing is facilitated in the presence of a compassionate clinician, and in the context of that relationship. The Interprofessional Spiritual Care Model describes this process as the transformational potential of the healing relationship. (Puchalski et al. 2009a, b, c; Puchalski and Guenther 2012) But equally important to this model is the power of the relationship between clinicians and patients in healing. This is the "being" part of the clinical encounter where a clinician is fully present as an authentic person in a relationship with the patient in the midst of his or her suffering.

Table 1 Spiritual concerns or diagnoses

Diagnoses (primary)	Key feature from history	Example statements
Existential concerns	Lack of meaning Questions meaning about one's own existence Concern about afterlife Questions the meaning of suffering Seeks spiritual assistance	"My life is meaningless" "I feel useless"
Abandonment by God or others	Lack of love, loneliness Not being remembered No sense of relatedness	"God has abandoned me" "No one comes by anymore" "I am so alone"
Anger at God or others	Displaces anger toward religious representatives or others Inability to forgive	"Why would God take my child…it's not fair"
Concerns about relationship with deity	Desires closeness to God, deepening relationship	"I want to have a deeper relationship with God" "I want to understand my spirituality more"
Conflicted or challenged belief systems	Verbalizes inner conflicts or questions about beliefs of faith Conflicts between religious beliefs and recommended treatments Questions moral or ethical implications of therapeutic regimen Expresses concern with life/death or belief system	"I am not sure if God is with me anymore" "I question all that I used to hold as meaningful"
Despair/ hopelessness	Hopelessness about future health, life Despair as absolute hopelessness No hope for value of life	"Life is being cut short" "there is nothing left for me to live for"
Grief/loss	The feeling and process associated with the loss of a person, health, relationship	"I miss my loved one so much" "I wish I could run again"
Guilt/shame	Feeling that one has done something wrong or evil Feeling that one is bad or evil	"I do not deserve to die pain fee"
Reconciliation	Need for forgiveness or reconciliation from self or others	"I need to be forgiven for what I did" "I would like my wife to forgive me"
Isolation	Separated from religious community or other community	"Since moving to the assisted living, I am not able to go to my church anymore" "I have moved and no longer can go to my usual 12-step meeting"
Religious specific	Ritual needs Unable to perform usual religious practices	"I just can't pray anymore"
Religious/ spiritual struggle	Loss of faith or meaning Religious or spiritual beliefs or community not helping with coping	"What if all that I believe is not true?"

Within the context of the relationship, clinicians as well as the patients may experience vulnerability, emotions, and deep connection. In these moments within the clinical setting, the aim is not to fix but rather to accompany the patient as s/he shares his/her story. The model integrates the scientific and the spiritual to help actualize the scientific-spiritual

clinician, as described by Sulmasy (2002). The model describes how to engage in these dual aspects of clinical care in a way that brings about whole-person care—for the physical as well as psychosocial/spiritual. Therefore, the model calls for the formation of such a clinician to include scientific and intellectual as well as personal and spiritual development. Erby writes that this process of formation, of becoming a physician, includes "a deepening commitment to the values and disposition into habits of the mind and heart." (Irby et al. 2010) Thus, full formation calls for reflection in pre-professional education—reflection on one's call to a vocation of serving others, and of attending to the whole person in a committed and ethical way that honors and respects the diverse training and expertise of all the clinicians on the patient team. It also calls for training of clinicians in how to handle the professional intimacy that occurs with the patient—an intimacy with formality and the resultant boundaries that are necessary to protect the patient as well as the clinician. The hoped for outcome is a clinician who can quickly discern the diagnosis and bring together the best resources for the treatment while being fully present to the whole patient as a partner in supporting the patient in finding his or her own healing.

In summary, from a whole-person care perspective, care must be grounded in the biopsychosocialspiritual care model. This model requires varying degrees of expertise and requires that the chaplain as the spiritual care specialist be integrally involved in the medical care of patients. The clinician's role in providing generalist spiritual care is to (1) provide compassionate care by listening to the whole of the patient's story—the physical, emotional, social, and spiritual; (2) complete a formal spiritual screening or history, as part of the whole history of the patient; (3) assess for spiritual distress or spiritual resources for strength, aware that spirituality affects all other domains of care and may present as exacerbation of physical pain, social isolation, or emotional issues; (4) integrate spirituality into the biopsychosocial assessment and treatment plan; (5) integrate patients' resources for strength, including the spiritual, into the care of the patient; (6) work with the specialists in domains where the clinician is not an expert.(for spirituality that means working integrally with Board Certified Chaplains or other members of the team); (7) recognize that patients' healing arises within the context of the clinician–patient relationship; and (8) reflect on the clinician's personal and spiritual values and beliefs as inherent to their vocation of service to the whole person.

An Existential Functioning Model

Physicians and nurses concerned to promote full functioning of the whole patient—physical, emotional, and spiritual—sometimes find reasons and opportunities to go beyond screening and taking a history of their spiritual distress. Providing compassionate care may involve them in intimate aspects of their patient's emotional and spiritual lives, uniquely positioning them to help those who are experiencing existential distress to draw upon their spiritual traditions or practices in helpful ways (Table 2).

For example, patients struggling with identity in the face of a life altering illness stand to benefit from a spirituality that is engaged and transformative rather than static (e.g., the patient who still knows who he is because he feels loved by God or clear about his core values). Those who have lost hope as a result of trauma benefit from one that is integrated rather than fragmented. Patients struggling to find meaning and purpose benefit from a spirituality that is contemplative, rather than distracted (meaning-centered therapies address this). Those in moral distress benefit from a spirituality that is developmentally mature rather than primitive. And those struggling with autonomy in relation to ultimate

Table 2 Domains of existential functioning and the healthy self

Existential/clinical domain	Helpful spirituality	Healthy self
Identity	Engaged	Grounded
Hope	Integrated	Hopeful
Meaning/purpose	Contemplative	Visionary
Morality	Mature	Virtuous/Forgiven
Autonomy/authority	Loved	Intimate/Secure

authority benefit from a spirituality that is forgiving rather than rejecting (Cf. the positive vs. negative religious coping described by Pargament 2001).

Consider a few examples of these intertwined needs: A psychological process such as depression or trauma can have an important existential or spiritual impact ("I can no longer believe in a God who would let this happen to someone"). Loss of existential security, for example, occasioned by a damaged relationship with God or a trusted pastor, can also have an emotional impact ("I miss being able to pray"). And patients may confuse one dimension with another, as when they believing their hallucinations are from God, or spiritualize depression ("It's not that I'm depressed—God is punishing me").

In order to clearly understand their role, clinicians need to distinguish among the emotional (how they feel), existential (how they experience the world), and spiritual (how they are inclined to believe the world is) dimensions of their patients' distress. Table 3 illustrates this process using as an example the common problem of depression:

Specific interventions to help patients distinguish and address emotional and existential sources of their distress could include existential, insight oriented, and cognitive behavioral therapy, whereas interventions to help patients distinguish and address emotional, existential, and spiritual distress could involve spiritually integrated treatment (Peteet 2010). Consider two brief examples of engaging patient's spiritual concerns to deal with moral distress, as a clinician:

A patient in her 20's with severe anxiety revealed that her father had been sexually abusing her, but that she still believed what he and her church had taught that children should obey their parents. Her psychiatrist saw her as having impaired reasoning and emotional functioning and looked together with her at how she interpreted the scriptural

Table 3 Emotional, existential and spiritual distress in depression

Emotional (I feel…)				
as if I don't know who I am	despairing	directionless	guilty	lonely
Existential (I experience the world as if…)				
there is nothing special about me	my life is hopeless	my life is meaningless	I am guilty	I am alone
Spiritual (I'm inclined to believe…)				
God is punishing/ ignoring me	I am rejected by God/the universe	no ultimate basis for morality exists	No ultimate basis for hope exists	I am ultimately alone

command, so as to enhance her capacity to think for herself and make use of spiritual resources.

A recently widowed man in his 60's with prostate cancer was primarily concerned about an unresolved family split. His oldest son refused to speak with his younger brother because he had stolen money from the family when he was abusing drugs even though he was now clean and had apologized. Viewing his distress as related to the family's difficulty with forgiveness, his therapist asked whether they had considered the parable of the prodigal son.

What is the relationship between a clinician's role in promoting spiritual health and that of a chaplain? Both may find themselves addressing existential and spiritual concerns and offering a caring presence, but chaplains also carry the symbols of hope and healing can more easily incorporate a patient into a faith community and provide liturgical/sacramental resources (Evans 1999). Under certain circumstances, clinicians as well as chaplains may pray and read scripture with patients. Most clinicians will be less expert than chaplains in providing spiritual assessment and care, but they can learn to collaborate and consult with them, as they would with a medical specialist, e.g., both learning from a psychiatrist how to provide better emotional care, and asking the psychiatrist to do what only psychiatrists are credentialed to do.

The specialization and time pressures which have become characteristic of modern medical practice present significant obstacles to implementation of an existential functioning model. Yet clinicians who make it a priority to treat the whole person have opportunities to see and help distinguish among existential, emotional, and spiritual distress, and to try to formulate a plan to address the whole patient's intertwined, but distinct, needs in each of these areas. How much time they have to do so depends in part upon their specialty and practice settings; psychiatrists and palliative care physicians typically are better positioned to do so. Of course both psychiatrists and palliative care physicians need training in how to address existential and spiritual issues in greater depth and do well to regard their chaplain colleagues as valuable resources.

In summary, from a existential functioning perspective, the clinician's role in providing whole-person care is to: (1) recognize the dynamic relationships among emotionally related, existentially related, and spiritually related distress; (2) address processes causing distress and functional impairment; and (3) treat the person as an integrated whole, appreciating how he/she may need to draw on existential, spiritual, and emotional resources in order to acknowledge, bear, and put into perspective the issues that matter most to him/her.

An Open Pluralism View

Without contradicting the previous two models, an open pluralism model widens the frame from the patient–caretaker relationship to include the larger cultural and institutional contexts in which care is given. Open pluralism refers to a "commitment to explore, understand, and hear the voices of the particular moral communities that constitute our culture" (Kinghorn et al. 2007). It aims toward greater ownership of the role that the visions and commitments of particular communities that include religious, cultural as well as secular humanist perspectives have for institutional structures and social processes (We recognize that many people do not belong to formal spiritual or religious communities). If an openly pluralistic model were employed within medicine, then multiple spiritual and cultural traditions (e.g., Jewish, Buddhist, Secular humanist, Native American, Christian,

Table 4 Spiritual and non-spiritual plausibility structures governing the socialization processes and institutions of medicine

Field	Plausibility structures		Significance
	Spiritual	Non-spiritual	
Anthropology	Soul	Body	Human nature
Epistemology	Value	Fact	Rationality
	Religion	Science	Production of knowledge
Sociology	Private	Public	Space, time, and social interactions
	Church	State	Political
Theology	Sacred	Secular	Ontology
	Transcendent	Immanent	Divinity
	Supernatural	Natural	Causation/origin

etc.) would have equal opportunity to shape their own "plausibility structures" and their particular practices related to patient care. Consider here a sociological and philosophical argument for open pluralism, followed by some examples of its implications for practice.

The sociologist Peter Berger has shown that Western social reality is constructed on what he called "plausibility structures," defined as the systems of meaning that explain and justify embedded social structures and institutions (Berger 1967). Notable plausibility structures embedded within Western societies follow a repeating and overlapping pattern that dichotomizes the spiritual and non-spiritual (Table 4). This bifurcation of our social reality explains our contemporary social structures and concurrently justifies them as eminently rational. Thus, the separation of spirituality and medicine is rooted within a larger social system of overlapping bifurcations. Since Western culture prioritizes scientific, non-spiritual categories, these dominate the institutions and practices of medicine.

Without engaging and attempting to transform the current plausibility structures of Western society, attempts at integration may inadvertently reinforce the dualism that underlies the Western separation between medicine and spirituality. If clinicians see spirituality as having been "taken care of by the chaplain," they may be less likely to participate in the spiritual care of the patient. The result of having less interaction and collaboration with chaplains is that clergy and theological disciplines have less opportunity to offer constructive input into the provision of care (Pattison 2001). In the generalist–specialist model, clergy or culturally based healers are noted as being part of the team that might care for a particular patient if the patient desires that. But due to the socialization process, it may be difficult to implement that connection with a patient's clergy or other spiritual leader. One concern is that even if chaplains succeed in gaining additional resources, this socialization process will leave institutional structures untouched.

A related risk is that medical professionals, such as physicians and nurses, rather than being equipped and trained to be conscious of, able to identify, and willing to personally engage patients' spirituality in appropriate ways, will in practice perceive spirituality as outside of their sphere of interest or responsibility. As a result, they will be more likely to ignore patients' spirituality, or at best infrequently refer to chaplaincy (Vanderwerker et al. 2008). This is a lost opportunity because the medical workforce—who are themselves spiritual and/or religious (Phelps et al. 2012; Curlin et al. 2005) and who have the most regular contact with patients in various medical contexts—will remain a largely untapped spiritual care resource (Balboni and Balboni 2010).

A model of open pluralism suggests that current plausibility structures which contrast spiritual and non-spiritual be recognized as only one construction of our social reality, which needs to be considered alongside constructions of other cultures and moral communities which perceive spirituality, broadly defined, to be infused into all of life, including into the totality of medicine.

Curlin and Hall (2005) have described the implications of this spirituality of immanence for practice as valuing competence, autonomy, and neutrality over wisdom, respect, and candor. By contrast, open pluralism upholds the importance of multiple spiritual traditions, including spiritual, not religious, secular humanist, etc., expressing themselves on a social and institutional level. In a fully realized open pluralism, each spiritual or cultural tradition would shape the practice of medicine according to its own community's moral and spiritual ideals. Physicians would understand themselves as practicing biomedicine from within a particular tradition (e.g., Humanist, Hindu, and Native American). For example, a Christian's vision for a depressed patient's ideal state might be informed by the preferred virtues or ideals of love and grace, a Jew's by community responsibility and critical thought, a Muslim's by reverence and obedience, a Buddhist's by equanimity and compassion, a secularist's by respect for scientific evidence, and intelligibility (Peteet 2013). Precedent for this can be found in the plethora of hospital institutions that were created and operated primarily by religious communities in the past and today in various parts of the world (Rosenberg 1987; Ferngren 2009; Risse 1999). In most cases, these institutions expressed a given tradition's values without requiring either practitioners or patients to identify themselves with that tradition. Clinicians may choose to work in such settings because they perceive an alignment with their own personal values. However, in these, as in secular settings, there is always a recognition that imposing one's personal beliefs on patients is not appropriate.

Of course, in order for multiple spiritualities to be authentically integrated within medicine, pluralism needs to be upheld as an unmistakable characteristic of contemporary life, so that no one tradition or value systems dominates others. As summarized by Diana Eck: "The challenge of pluralism is not to obliterate or erase difference, nor to smooth out differences under a universalizing canopy, but rather to discover ways of living, connecting, relating, arguing, and disagreeing in a society of differences" (Eck 2007).

Open pluralism has a number of potential practical benefits: Clinicians who are more aware of how their spirituality shapes their practice of medicine will be interested in drawing upon their spiritual traditions and communities to form them professionally. For example, a secular humanist physician would draw on humanism as his/her source of meaning and value in medicine. A religious clinician might draw on religious beliefs as a source of professional meaning and purpose. Both would utilize their spirituality in self-care and perhaps use mindfulness practices rooted in their traditions as a way to practice compassion. In medical education students would be trained as reflective practitioners. Awareness of the student's spiritual, religious, cultural, or humanist values might inform that student of his/her professional call to serve patients. (Puchalski et al. 2014) This awareness would also help protect them from acting their commitments out unconsciously, in what has been termed "religious countertransference" (Abernathy and Lancia 1998). Instead, they would be encouraged to become more authentic (candid, rather than neutral, Curlin and Hall 2005) in responding to value-laden questions from patients. For example, they will be more aware of how their own beliefs or lack of them can cloud their vision of what a patient needs when he or she asks whether the clinician is willing to pray with them, or when a patient refuses treatment based on deeply held values. Clinicians more aware of the virtues of one another's traditions will be more able to learn from them (Peteet and

Peteet 2013). Patients who are interested in spiritual care from within their own spiritual tradition might be more able to identify resources within the healthcare system for doing so in an appropriate way that does not violate the boundaries of imposing beliefs or lack of beliefs onto patients.

Communities of clinicians and patients will be more free to design hospital spaces to reflect the values of healing and beauty rather than simply those of efficiency and disease modifying treatment. Hospital administrators and health planners will be more able to openly advocate for spiritual values, which transcend cost considerations, such as justice, access, and person-centered care. Further work is needed to better understand how different traditions (e.g., Buddhist, Christian, and Secular Humanist) may operate with integrity regarding their most treasured commitments within the same medical institutions.

The prospect of practicing more explicitly out of one's own particular tradition of course raises concerns about boundaries, including the risks of proselytization, undue influence and incompetent spiritual care. Yet all of the major traditions in an open pluralism subscribe to the basic principles of bioethics (beneficence, non-malfeasance, autonomy, and justice), and more open discussion of the role of one's commitments in dealing with value-laden clinical issues arguably offers the best protection for patients from inappropriate treatment (Balboni et al. 2011 p. 218–219; Bishop et al. 2007; Peteet 1994).

Discussion

We have contrasted these views for the sake of clarity, but view them as complementary rather than as competing models. The generalist–specialist model is a necessary practical step to organize spiritual care as part of whole-person care in the current culture of medicine and to integrate trained chaplains as equal members of the healthcare team. An existential functioning model supports the relational aspects of care highlighted by the generalist–specialist model, while offering clinicians a framework for going more deeply when there is the time, structure, and clear need for doing so (e.g., in psychiatry). And an open pluralist model, while it entails serious practical challenges, provides a way to think constructively about the limits of therapeutic neutrality in the care of individual patients and about the central problem of differing value commitments. Each model approaches the question of clinician involvement in the spiritual aspects of a patient's care. While even among these three authors there is some disagreement on some of the details and nuances of the models, there is agreement on these important points: All agree on the importance of defining spirituality broadly to be inclusive of all perspectives—spiritual, not religious, religious, secular, and cultural. All agree on the importance of ethical professional boundaries to protect vulnerable patients from undue influence by religious or non-religious clinicians and support the need for clinicians to recognize the importance of professional training in all areas of care including the spiritual. Clinicians need to work with trained spiritual care professionals such as chaplains, spiritual directors, pastoral counselors, clergy, and culturally based healers in the care of the whole person—body, mind, and spirit. All models address the role of spiritual or personal development as integral to professional development and important in medical, nursing and other clinical education.

The ultimate goal of integrated care is to provide the most holistic, evidence-based, person-centered care possible. It is essential to address both patient and clinician spirituality in achieving this goal because spirituality, broadly defined, is an irreducible dimension of every person regardless of their spiritual, cultural, religious, or other identification.

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