RESEARCH ARTICLE

Assessment of the spiritual and religious needs of patients by healthcare personnel. A model based on spiritual accompaniment.

Author:

Marcelo Fonseca Canteros

Department of Burns and Plastic Surgery, Dr. Ernesto Torres Galdames Hospital, Iquique, Chile

Email: mfon777@hotmail.com

Summary

During the past decades, spirituality and religion have regained their importance in health care, not only as a way of respecting the decision-making autonomy of the patient but as an element that influences the clinical evolution and quality of life of the sick patient and allowing to provide comprehensive health care. The latter has resulted in many countries guaranteeing spiritual care during hospitalizations by law. However, on the one hand, attention to spiritual and religious needs is usually reserved only for terminal cancer patients and/or patients with catastrophic diseases. On the other hand, attention to these needs has gradually become considered part of the obligations of the health teams, not without their reluctance and without a clear indication of how this task must be carried out. This work aims to present the importance of spirituality and religion inpatient care and a care model based on spiritual accompaniment.

Know all the theories, master all the techniques, but as you touch a human soul be just another human soul. Carl Jung

Keywords: Spirituality, Religion, Spirituality and health, Religion and health, Spiritual care

Introduction

Spirituality and religion have become a topic of interest in health. Multiple studies examine the relationship between them and their potential to prevent, cure and help deal with diseases[1-3]. These two terms are not synonymous. The first is related to the search for meaning, purpose, and connection with oneself, others, nature, and what is sacred. The second is associated with a set of dogmas and beliefs that include rituals and practices related to the divine[4-7]. Spirituality and religion are fundamental aspects of the daily life of many people. Spirituality is difficult to measure, but in the Western world, according to a study by the International Social Survey Program, 40% to 100% of people believe in God[8]. However, it is still not clear how the spiritual needs of patients should be managed and by whom. Even though patients increasingly demand this attention, the health team avoids this responsibility. They justify this by claiming that it is not a part of their obligations, that they do not have enough time, and they are not trained for this. They avoid discussing uncomfortable topics, and this responsibility usually falls on the chaplains, pastoral teams, and spiritual guides. However, doctors, nurses, and health professionals play equally essential roles in detecting, referring, and caring for these needs [9,10]. The importance of spiritual and religious needs in health care and a model of care based on spiritual accompaniment is the focus of this paper.

Historical context

If we review history, at the dawn of medicine, illness was considered a punishment from the gods instead of health, which was a gift from them. Treatment was a magical rite, and the doctor performed a priestly task. Characters such as shamans, healers, and sorcerers combined spiritual leadership and health care for their communities. This magical-religious interpretation of the health-disease process gradually changed in Greece, with the beginning of so-called scientific medicine. A rational explanation of the disease was adopted, and medicine became progressively separated from spirituality and religion. However, in the Middle Ages, the Christian Church declared the indivisible union of the body and soul in man. Priests also cared for the sick and met the most distinguished doctors within the religious orders. During the Renaissance, in the Western world, a dichotomous and antagonistic vision developed once again: religion and science, spiritual versus material; in other cultures, mainly oriental, did not occur[11-13]. In the dualistic, historical vision of a man (body/spirit), spiritual assistance is delivered separately from the assistance of the body, with the doctor taking care of one part and the priest of the other, with the only function of spirituality being to comfort and intervene when scientific and technological medicine can do nothing more to cure the disease[14].

In 1910, the British Medical Journal invited Sir William Osler - for some the most influential physician of the 20th century [15] - to write an editorial about people who relied on faith and prayer rather than on medical professionals to treat and cure their illnesses. Osler concluded this editorial titled "Faith That Heals" with the comment, "the entire subject is of great interest to me. I feel that our attitude as professionals should not be hostile "[16].

Definition of disease

Currently, the disease is defined by medicine as "*a structured clinical entity, characterized by a combination of symptoms and signs that define and differentiate it from others*," but perceived by patients as "*something alien and from which they would like to get rid of, something that frightens and disturbs them*

and prevents them from doing what they want to do "[17]. As a necessary experience, the disease causes a loss of control over various situations and a search for meaning, significance, transcendence, and supernatural cures, which generates greater interest and attachment to what is spiritual and also religious. New concepts such as healing appear, which refers to the "*ability of a person to find solace, comfort, connection, meaning and purpose amid suffering, angst, and pain "*[18], and spiritual suffering related to the "*impaired ability to experience and integrate the meaning and purpose of life through connection with self, others, art, music, literature, nature, or a power greater than oneself* "[19]. The prejudice and dichotomy between the sciences and the humanities are highlighted and the pressing need to cure the disease versus just alleviating suffering. On the other hand, the World Health Organization (WHO) provides the classic and well-known definition of health as "a state of perfect physical, mental and social well-being and not only the absence of disease." [20] Although this is true, it is beneficial to understand health as a complex reality. As the years go by, it becomes obsolete when it is understood that other components, such as spirituality, affect health and contribute or prevent the state of perfect well-being[21]. By adding the spiritual aspect to the definition of health, the bio-psycho-social-spiritual model appears, describing different dimensions of the person, and none can be separated. According to the circumstances, they emphasize that medicine is being dehumanized mainly due to the incomplete or undignified care of people[22-25].

Clinical Experience

Most of the publications that show a relationship between spirituality, religion, and health are oriented to mental health, understanding that there is a substantial overlap between spiritual and emotional needs, and the attention of spiritual needs usually includes the latter. However, concerning physical health, it has been suggested that greater spirituality and religion are associated with lower mortality, less pain, lower levels of blood pressure, better functioning of the immune system, and more outstanding quality of life[26-29].

On the one hand, exploring and paying attention to spiritual and religious needs allows one to obtain information that may eventually alter the course of the disease. Nevertheless, it may have an implicit or explicit impact on the relationship dynamics between the patient and health professionals[30]. On the other hand, it must be considered that for many people, religion can: a) provoke the feeling that illness is a divine punishment for sins that have been committed; b) prevent accepting medical help and c) the existence of a desire to solve the disease exclusively through spiritual and religious means.

a. User satisfaction: *The Joint Commission* carried out a user satisfaction study on 1,732,562 patients between January 2001 and December 2001, which revealed a strong relationship between the degree to which health personnel took care of emotional/spiritual needs and the general satisfaction of the patient. The study emphasized the following: a) the staff's response to patient concerns/complaints; b) staff effort to include patients in the decisions about their treatment; and c) the sensitivity of the staff to the inconveniences caused by health problems and hospitalization[9]. Alternatively, poor interpersonal care increases the risk of negligence and medical lawsuits in which the main complaint is abandonment, lack of answers to the

patient's questions, and poor treatment. From the financial point of view, hospitalized patients who develop symptoms of depression have more extended hospital stays, use more hospital resources, and generate a subsequent increase in costs[31].

b. Religious participation: religiosity has been linked to a higher quality of life in terms of health, not just in the Western world. Alzahrani et al. found a positive correlation between religiosity and quality of life in Muslim patients from Saudi Arabia diagnosed with a diabetic foot[32]. Strawbridge et al. conducted a prospective mortality study on 5,286 people, with a 28-year follow-up, to analyze attendance at religious activities and mortality. They divided the study into two groups: 1) frequent attendees (at least once a week); and 2) infrequent attendees (less than once a week). Frequent attendees had a lower mortality rate (RR: 0.64), and during follow-up, they were more likely to quit smoking, exercise more, increase their social contacts, and remain married[33]. Another similar study, with a follow-up of 8,450 people and excluded confounding variables (socioeconomic, demographic, and health), demonstrated a significantly lower risk of death for those who attended religious activities more than once a week versus those who never attended (RR: 0.77)[34]. The magnitude of the possible impact of religion on survival is equivalent to abstinence from smoking, adding 7 to 14 years of life[35].

c. Prayer: Prayer can be defined as a form of communication with the Creator's Divinity, perhaps being the most frequent form of religious expression. The Bible guides its believers in its use: "*Are any among you sick? Call the elders of the church, and pray for him, anointing him with oil in the name of the Lord. The prayer of faith will save the sick, and the Lord will raise him*" [36]. It is currently classified as a complementary and/or alternative therapy. A study conducted by the *Centers for Disease Control and Prevention* and the *United States National Center of Health Statistics* found that prayer for health reasons was the most common complementary or alternative therapy (45.2% in the last 12 months and 55.3% during life)[37].

d. Cancer: a cancer diagnosis changes the lives of patients, friends, and family forever, raising questions about meaning and purpose more often than other long-term illnesses. From the moment of diagnosis, through treatment, survival, recurrence, and death, cancer patients are faced with spiritual issues that can cause suffering or help them cope with their disease. Spirituality and religion have been considered tools that help deal with cancer and as positive forces that help patients rethink their disease, find greater meaning in life and recognize what is ultimately essential to them[38]. Choumanova et al. interviewed 27 Chilean women with breast cancer and found that the use of religion and spirituality was manifested in 1) prayer, 2) dependence on God to guide them through their disease, and 3) the social support of other people who shared their faith. Half of them recognized that the disease had brought about greater importance to spirituality and religion in their lives. An increase of faith in God demonstrated this, and almost all patients (26/27) supported the idea that faith can assist patients in their recovery[39]. In men, studies have been

carried out on prostate cancer patients, observing that greater spirituality is associated with a more outstanding health-related quality of life in patients with terminal cancer[40]. Less spirituality is related to less sexual function and greater urinary discomfort[41].

e. Conversely, unresolved spiritual distress can lead to a poorer quality of life and poorer health outcomes. For example, this spiritual anguish (for example, feeling abandoned by God) is prevalent in cancer patients. Hui et al. evaluated 113 advanced cancer patients admitted to the acute palliative care unit of the *MD Anderson Cancer Center*, who, on admission, were subjected to – as per their usual protocol - the Edmonton Symptom Assessment Scale by a chaplain. 44% reported spiritual distress, mainly associated with young patients with pain and depression[42]. A hostile spiritual confrontation with a cancer diagnosis - expressed as an insecure relationship with God, an unsettling view of the world, and an incessant search for meaning - has been linked to increased depression and anxiety[43]. It should be noted that dying in peace with God is the second most important factor, after dying without pain, for patients and relatives with terminal cancer[44].

Ethical aspects

For Puchalski, the doctor has an ethical obligation to attend to the spiritual needs of his patients because this is the only way comprehensive care can be achieved. The principles of beneficence, autonomy, and dignity must be respected and also described are the ethical requirements for proper care in the field of health, which Salas summarized: a. prevent any act of proselytism, b. respect the emotional and spiritual limits of patients, c. respect the confidentiality and intimacy of the doctor-patient relationship, d. respect the doctor-patient intimacy and confidentiality, refer patients with spiritual problems to the chaplain, e. respect patients' requests to pray or participate in religious acts with their doctors[45,46] (Table 1).

Table 1. Ethical requirements for proper spiritual and religious healthcare. Salas et al. [23]

Prevent any act of proselytism
Respect the emotional and spiritual limits of patients
Respect the confidentiality and intimacy of the doctor-patient relationship
Respect professional boundaries and refer patients with spiritual problems to the chaplain
Respect the request of patients to pray or participate in religious acts with their doctors.

Table 1. HOPE questionnaire: Source Anandarajah et al. [55]

H: Sources of hope, meaning, well-being, strength, love, and connection
What gives you inner strength?
What are your sources of hope, strength, comfort, and peace?
What do you hold on to during challenging times?
What sustains you and keeps you going?
For some people, their religious or spiritual beliefs act as a source of comfort and strength in difficult times in life. Is that true for you?
If the answer is yes, go to questions O and P. If the answer is, consider asking: was it ever? If the answer is yes, ask: what has changed?

O: Organized religion
Do you consider yourself part of organized religion?
How important is it to you?
What aspects of your religion are helpful for you?
Are you part of a religious or spiritual community?
How does it help you with your illness?
P: Personal spiritual practices
Do you have spiritual beliefs outside of your organized religion? Which ones?
Do you believe in God?
What kind of relationship do you have with God?
What aspects of your spiritual practices are most helpful to you? (For example, prayer, meditation, scripture reading, attending religious services, listening to music, going on a hike, communing with nature)
E: Effects of medical care and end of life problems
How has your illness, or current situation, affecting your ability to carry out activities that help you spiritually?
How has it affected your relationship with God?
As a doctor, is there anything I can do to help you access the resources or activities that usually help you?
Are you concerned about conflicts between your beliefs and your medical situation/care/decisions?
Would it be helpful for you to speak with a chaplain or spiritual leader from your community?
Are there any specific practices or restrictions that I should know about concerning the provision of health care? (food restrictions, use of blood products, etc.).
If you are terminally ill: how do your beliefs affect the type of medical care you would like to receive in the coming days/weeks/months?

Legal aspects

In most countries, the reception of spiritual and religious care is a right guaranteed by law. The WHO guidelines recognize the right to spiritual care as a dimension of quality of life and suggest to regulate, through various norms, spiritual assistance in health care; guaranteeing that every person who requests it has the right to receive, promptly and following the law, religious or spiritual counseling and assistance. If able, the treating medical team should suggest religious and/or spiritual assistance for patients subjected to special circumstances[47,48].

Spiritual needs

The main problem of spiritual needs is the difficulty that the health personnel has to recognize and detect them, the lack of tools, and the ignorance of their impact on health care. Various studies show that most hospitalized patients think spiritual health is as important as physical health and that healthcare professionals should consider spiritual needs as a part of medical care[49-51]. For terminal cancer patients, in

particular, Taylor described seven general categories: (1) the need to relate to others; (2) the need for positivity, hope, and gratitude; (3) the need to give and receive love; (4) the need to review beliefs; (5) the need for meaning; (6) the need for religiosity; and (7) the need to prepare for death[52].

The evaluation and identification of these needs can be carried out informally during daily treatment by actively or formally listening with specific questions to determine if spiritual and religious aspects play a role in the disease, therapeutic alternatives, and recovery. The following must be performed to explore these needs: a. ask open-ended questions (do you have any idea why this happened?), b. encourage the patient to explain more in-depth (tell me more about that), c. recognize and normalize the patient's concerns (many patients ask these types of questions), and d. use emphatic comments (how do you feel about ...?)[53]. It is essential to point out that as the patient gains more confidence in the healthcare team, they are more likely to discuss these needs and that the right moment for this should occur, taking into account Maslow's hierarchy of needs (physical, mental, spiritual)[54]. Several surveys allow healthcare personnel to evaluate and objectify these needs, making it possible to discuss other important issues, such as the Functional Assessment of Chronic Illness Therapy-Spirituality (FACIT-sp), Spiritual Care Needs Inventory (SCNI), Patients Spiritual Needs Assessment Scale (PSNAS) and the HOPE survey. However, most must be adapted to the specific cultural reality [55-58]. The HOPE (hope) survey has not been validated as a research survey, but it allows an initial approach to the issues of spirituality and religion (Table 2).

Table 2. Stages to start spiritual accompaniment. Benito et al.[60]

a. Establish a relationship of trust and a therapeutic bond
b. Identify suffering
c. Identify the causes of suffering
d. Try to solve or disable threats that can be solved
e. Explore the resources and ability of the patient to transcend their suffering
f. Human intervention, guiding the patient towards the search for a transcendent vision of what he /she perceives as a threat.

Spiritual accompaniment

The aphorism of "no talking about politics, football and religion" aimed at maintaining and fostering harmonious relationships between people often seems to guide the doctor-patient relationship. Nevertheless, just as the in-depth exploration of sexuality was demystified in past decades, it is vital today to consider spirituality and religion as essential aspects in patient care[59]. Spiritual accompaniment is a model proposed for this purpose. The etymology of the word *accompany* comes from Latin, and it is composed of two terms: *cum* and *panis*, which mean to eat the same bread. The latter was a sign of being part of a community - that shared bread - which created and renewed this bond in ancient times.

On the other hand, the spiritual belongs to or relative to the spirit, and the word spirit comes from the Latin word *spiritus* and means breath. The classic story that reflects what spiritual accompaniment means is the one that occurred on the road to Emmaus. In this story, two sad people were slowly walking, talking about their problems, when a third person joined them

on the road, with whom they shared their sorrows. After listening to them, this third person clarified their doubts and guided them to search for meaning and purpose. After arriving at their destination and sitting at the table, he took the bread, broke it, and gave it to them, disappearing from their sight.[36]. Although this story is taken from the biblical account, as mentioned above, religion is not synonymous with spirituality, and religious accompaniment is not the same as spiritual accompaniment.

Benito defines spiritual accompaniment as "*the practice of recognizing, welcoming and giving space to the inner dialogue of those who suffer so that he can voice his questions and give life to his answers*," proposing a model for the healthcare personnel that accompanies based on hospitality, presence, and compassion[60].

a. Hospitality: is translated from the Greek word *philoxenia*, which means love (affection, kindness) to strangers, with the main idea being that the host responds to the needs of people who are temporarily away from their homes. This allows patients to have a space of serenity and trust, where fear is lost while transcending and giving meaning to the disease process.
b. Presence: the healthcare professional has therapeutic power with his / her mere presence but must also develop an empathic connection to facilitate the narrative process of the patient.
c. Compassion: refers to an act in favor of the other to alleviate their suffering. It is not an emotion but an action. The patient must be made to feel that they are not alone in the process.

The ideal companion must not only possess the three characteristics mentioned above, but they must also reflect a genuine interest in the other, no discrimination, disinterested help, respect, recognition of the other, and the commitment not to abandon, among other things. The steps to start spiritual accompaniment are: a. establish a relationship of trust and a therapeutic bond, b. identify suffering, c. identify the causes of suffering, d. attempt to resolve or disable threats that can be resolved, e. explore the patient's resources and capacities to transcend his/ her suffering, f. intervention with compassion, guiding the patient towards the search for a transcendent vision of what he/she perceives as a threat (Table 3). This is why healthcare professionals need academic training that not only focuses on the control of physical symptoms within the framework of a relationship that is increasingly specialized, impersonal, and only contractual, but also need to learn and develop skills that allow them to generate relationships of trust; an understanding that allows, at a basic level, to detect spiritual needs and refer them for their attention[61].

Units of spiritual accompaniment

Historically, spiritual care in hospitals, marked by religious predominance, fell exclusively on the chaplains, who over the years faced a complex model of transition towards a plural and ecumenical model[62,63]. In many countries, units of spiritual accompaniment are born, which are created to coordinate spiritual and religious assistance activities within hospital facilities, emphasizing their ecumenical nature, with the primary mission of channeling and assisting the spiritual needs of the sick, their relatives, and healthcare officials[64].

Conclusions

Comprehensive medical care requires recognizing the physical, mental, social, and spiritual dimensions. The omission of any of these aspects results in incomplete care that can generate a feeling of frustration and interfere with the healing

process of patients. Coincidentally, spirituality and religion are a fundamental part of many peoples' lives, so the healthcare team must consider them for the therapeutic process, not only for ethical and legal reasons but also for the implications in morbidity, mortality, and quality of life, and even economic aspects. It is not the obligation of the healthcare team to attend to spiritual and religious needs, but it is their responsibility to identify them, respect them and make the referral so that they are taken care of by the most suitable people (chaplains, spiritual guides, among others.). Spiritual accompaniment provides comprehensive and holistic healthcare, which generates multiple clinical benefits, humanizing and dignifying health care. As the Eastern aphorism sums up, to heal, you have to accompany and accompany is to cure. Moreover, spirituality should be considered one more component of the definition of health.

References

1. Ellison C, Jeffrey S. Levin. The religion-health connection: Evidence, theory, and future directions. *Health Educ. Behav.* 1998; 25.6: 700-720.
2. Fonseca M. Importancia de los aspectos espirituales y religiosos en la atención de pacientes quirúrgicos. Rev Chil Cir. 2016, 68(3), 258-264.
3. Fonseca M. Atención de las necesidades espirituales y religiosas de pacientes por personal de salud. Un modelo basado en el acompañamiento espiritual. *Rev Chil Cir*. 2021, 74.3.
4. Koenig H. Religion, spirituality, and health: The research and clinical implications. *ISRN Psychiatry*. 2012:1-33.
5. Puchalski C, Ferrell B, Virani R, Otis-Green S, Baird P, Bull J, et al. La mejora de la calidad de los cuidados espirituales como una dimensión de los cuidados paliativos: el informe de la Conferencia de Consenso. *Med Paliativa.* 2011;18:20-40.
6. Real Academia Española. Diccionario de la Lengua Española. 22.a ed. Madrid, España: Espasa; 2001.
7. Koenig H, King D, Carson V. Handbook of religion and health. 2nd ed New York, NY, USA: Oxford University Press; 2012.
8. Lehmann C. ¿Cuán religiosos somos los chilenos? Mapa de la religiosidad en 31 países. *Estudios Públicos.* 2002;85:21-40.
9. Clark P, Drain M, Malone M. Addressing patients' emotional and spiritual needs. *Jt Comm J Qual Patient Saf, 29*(12), 2003; 659-670
10. Oliver, E. Conferencia inaugural. I Jornadas de humanización y ética en Atención Primaria, fml. 2012; 16 Supl1:51p
11. Piñera B. El médico y la muerte. *ARS Méd*. 2000;2:59-63.
12. Guirao-Goris J. La espiritualidad como dimensión de la concepción holística de salud. *Rev ENE Enferm*, 2013; 7.1.
13. Masiá Clavel, J. Cuerpo, mente y salud en el budismo CHIH-I (o ZHI-YI, autor chino del siglo VI). *Filos Thémata.* 2007. 39, 387-389.
14. Young P, Finn B, Bruetman J, Emery J, Buzzi A. William Osler: el hombre y sus descripciones. *Rev Méd Chile*. 2012;140:1218-27.
15. Osler W. The faith that heals. *Brit Med J*. 1910;1(2581):1470.
16. Magliozzi Pietro. De la salud biológica a la salud biográfica. Humanización y salud. Ediciones Universidad Católica de Chile. 2006. Santiago, Chile.
17. Goic A. ¿Qué es enfermedad?. En: Goic A. El fin de la medicina. Santiago, Chile: Editorial Mediterráneo Ltda.; 2000. p. 76-83.
18. Puchalski C, Ferrell B, Virani R, Otis-Green S, Baird, P, Bull J. et al. Improving the quality of spiritual care as a dimension of palliative care: the report of the Consensus Conference. *J. Palliat. Med. 12*(10), 2009; 885-904.
19. Herdman T, Kamitsuru, S. Diagnósticos enfermeros: definiciones y clasificación 2012-2014. Barcelona: Elsevier, 2012.
20. Organización Mundial de la Salud. Constitución de la Organización Mundial de la Salud (1948) [Documento en línea]. Disponible: http://www.who. int/gb/bd/PDF/bd46/s-bd46_p2.pdf.
21. Moreno, G. La definición de salud de la Organización Mundial de la Salud y la interdisciplinariedad. *Sapiens. Revista Universitaria de Investigación. 2008*; 9.1: 93-107.
22. Lorenzo David. La espiritualidad en la humanización de la asistencia sanitaria. *Rev. iberoam. bioét.*, 2018, Nº 8, p. 01-11.

23. Salas C, Taboada P. Espiritualidad en medicina: análisis de la justificación ética en Puchalski. *Rev. méd. Chile*,147.9 (2019): 1199-1205.
24. Sulmasy D. A biopsychosocial-spiritual model for the care of patients at the end of life. *Gerontologist.* 42.suppl_3. 2002: 24-33.
25. Ledesma A, Lena M. Ejercicio clínico y espiritualidad. *An. Psicol.* 2007, vol. 23, no 1, p. 125-136.
26. Puchalski C, Ferrell B, Virani R, Otis-Green S, Baird, P, Bull J. et al. Improving the quality of spiritual care as a dimension of palliative care: the report of the Consensus Conference. *J. Palliat. Med. 12*(10), 2009; 885-904.
27. Koenig H. Religion, spirituality, and health: The research and clinical implications. *ISRN Psychiatry*, 2012, 278730.
28. Koenig H, King D, Carson B. Handbook of religion and health (2nd ed.). 2012. New York, NY: Oxford University Press.
29. Duarte A, Lucchetti G, Teixeira P, Rigatto, K. Spirituality and religiosity are associated with quality of life in patients with lung disease. *J. Relig. Health.* 2018. 1-12.
30. Taylor D, Mulekar M, Luterman A, Meyer F, Richards W, Rodning C. Spirituality within the patient-surgeon relationship. *J Surg Educ.* 2011;68:36-43.
31. Hickson G, Wright E, Entman S, Miller C, Githene P. Whetten-Goldstein K. et al. Obstetricians' prior malpractice experience and patients' satisfaction with care. *JAMA* 272:1583–1587, Nov. 23–30, 1994.
32. Alzahrani H, Sehlo M. The impact of religious connectedness on health-related quality of life in patients with diabetic foot ulcers. *J Relig Health*. 2013;52:840-50.
33. Strawbridge W, Cohen R, Shema S, Kaplan G. Frequent atten- dance at religious services and mortality over 28 years. *Am J Public Health.* 1997;87:957-61.
34. Gillum R, King D, Obisesan T, Koenig H. Frequency of attendance at religious services and mortality in a US national cohort. *Ann Epidemiol*. 2008;18:124-9.
35. Koenig H, Hays J, Larson D, George L, Cohen H, McCullough M, et al. Does religious attendance prolong survival? A six- year follow-up study of 3,968 older adults. *J Gerontol A-Biol.* 1999;54:370-6.
36. De Reina C, de Valera C. La Santa Biblia: Antiguo y Nuevo Testamentos: versión Reina-Valera, revisión de 1960. Asunción- Bogotá-Buenos Aires-Caracas: Sociedades Bíblicas en América Latina; 1964.
37. Barnes P, Powell-Griner E, McFann K, Nahin R. Complementary and alternative medicine use among adults: United States, 2002. *Semin Integr Med.* 2004;2:54-71.
38. Puchalski C. Spirituality in the cancer trajectory. *Ann Oncol*. 2012;23 Suppl 3:49-55.
39. Choumanova I, Wanat S, Barrett R, Koopman C. Religion and spirituality in coping with breast cancer: Perspectives of Chilean women. *Breast J.* 2006;12:349-52.
40. Zavala M, Maliski S, Kwan L, Fink A, Litwin M. Spirituality and quality of life in low-income men with metastatic prostate cancer. *Psycho-Oncol.* 2009;18:753-61.
41. Krupski T, Kwan L, Fink A, Sonn G, Maliski S, Litwin M. Spirituality influences health related quality of life in men with prostate cancer. *Psycho-Oncol.* 2006;15:121-31.
42. Hui D, de la Cruz M, Thorney S, Parsons H, Delgado-Guay M, Bruera E. The frequency and correlates of

spiritual distress among patients with advanced cancer admitted to an acute palliative care unit. *Am J Hosp Palliat Me*. 2010;28:264-70.
43. Boscaglia N, Clarke D, Jobling T, Quinn M. The contribution of spirituality and spiritual coping to anxiety and depression in women with a recent diagnosis of gynecological cancer. *Int J Gynecol Cancer*. 2005;15:755-61.
44. Steinhauser K, Christakis N, Clipp E, McNeilly M, McIntyre L, Tulsky J. Factors considered important at the end of life by patients, family, physicians, and other care providers. *JAMA*. 2000;284:2476-82.
45. Salas C, Taboada P. Espiritualidad en medicina: análisis de la justificación ética en Puchalski. *Rev. méd. Chile*. 147.9 (2019): 1199-1205.
46. Puchalski C, Vitillo R, Hull SK, Reller N. Improving the Spiritual Dimension of Whole Person Care: Reaching National and International Consensus. *J Palliat Med*. 2014; 17 (6): 642-56.
47. Ministerio de Salud de Chile, Sub Secretaría de Salud Pública. Ley Nº 20584, que regula los derechos y deberes que tienen las personas en relación con acciones vinculadas a su atención en salud. 2012.
48. Ministerio de Salud de Chile. Reglamento sobre asistencia religiosa en recintos hospitalarios. Decreto 94, 2007. Publicado en el diario oficial 17.09.08.
49. Muñoz A, Morales I, Bermejo J, Galán J. La Enfermería y los cuidados del sufrimiento espiritual. *Index Enferm*, 2014; 23(3), 153-156.
50. King DE, Bushwick B. Beliefs and attitudes of hospital inpatients about faith healing and prayer. *J Fam Pract* 1994;39:349-52
51. Williams J, Meltzer D, Arora V, Chung G, Curlin F. Attention to inpatients religious and spiritual concerns: Predictors and association with patient satisfaction. *J Gen Intern Med*. 2011;26:1265-71.
52. Taylor EJ. Spiritual needs of patients with cáncer and family caregivers. *Cancer Nurs*. 2003;26(4):260–266.
53. Lo B, Ruston D, Kates L, Arnold R, Cohen C, Faber-Langendoen K. Et al. Discussing religious and spiritual issues at the end of life: a practical guide for physicians. *JAMA*, 2002; 287(6), 749-754.
54. Seddigh, R., Keshavarz-Akhlaghi, A. A., & Azarnik, S. Questionnaires measuring patients' spiritual needs: A narrative literature review. *Iran. J. Psychiatry Behav. Sci.* 2016; 10(1).
55. Anandarajah G, Hight E. Spirituality and medical practice: Using the HOPE questions as a practical tool for spiritual assessment. *Am Fam Physician*. 2001;63:81-8.
56. Peterman AH, Fitchett G, Brady MJ, Hernandez L, Cella D. Measuring spiritual well-being in people with cancer: the Functional Assessment of Chronic Illness Therapy–Spiritual Well-Being Scale (FACIT-Sp). *Ann Behav Med*. 2002;24:49-58.
57. Hermann C. Development and testing of the spiritual needs inventory for patients near the end of life. *Oncol Nurs Forum*. 2006;33(4):737– 44.
58. Galek K, Flannelly KJ, Vane A, Galek RM. Assessing a patient's spiritual needs: a comprehensive instrument. *Holist Nurs Pract*. 2005;19(2):62– 9.
59. Josephson A, Peteet J. Talking with patients about spirituality and worldview: Practical interviewing techniques and strategies. *Psychiat Clin N Am*. 2007;30:181-97.

60. Benito E, Barbero J, Payás A. El acompañamiento espiritual en cuidados paliativos. Una introducción y una propuesta. SECPAL. Madrid: Arán Ed. ; 2008.
61. Ortiz A, Beca JP, Salas P, Browne F, Salas C. Acompañamiento del enfermo: Una experiencia de aprendizaje sobre el significado de la enfermedad. *Rev. méd. Chile*, 2008. 136(3), 304-309.
62. Bernardo L. De la capellanía a la asistencia religiosa: el campo religioso portugués en los hospitales. *Soc. relig.* 2016. *26*(46): 181-200.
63. Irrazábal G. Procesos de institucionalización del servicio de capellanía y la asistencia espiritual no católica para hospitales públicos de Argentina. *Salud colect.* 2018. 14, 355-371.
64. Magliozzi P, Alvear J. Acompañar al enfermo en el proceso de su enfermedad. En: Vademécum para acompañar enfermos de modo perzonalizado (2008).

