Health care Professionals' Reflections on Their Learning as Spiritual Generalists and Integration Into Practice

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Introduction: Meeting spiritual needs of patients is an important aspect of quality health care, but continuing professional development and training to provide spiritual care remains inadequate. The purpose was to identify participants' learning from simulation-based spiritual generalist workshops and application to practice.

Methods: Interdisciplinary participants completed self-report demographic questionnaires before the workshops and questionnaires after workshops that listed open-ended take-home learning. Responses were analyzed using qualitative content analysis. A subgroup was surveyed 3 to 9 months after training to examine whether and how participants had incorporated workshop learning into clinical work.

Results: Workshop participants 181/211 (85.8%) reported learning in four categories: core values and skills of spiritual generalists, understanding spirituality/religion and its role in health care, interfacing with chaplaincy, and interprofessional teamwork. Of the subsample, 73.5% (25/34) completed surveys 3 to 9 months after training. Of those, 25/25 (100%) reported drawing on what they learned in workshops, and 24/25 (96%) reported making clinical practice changes.

Discussion: One-day spiritual generalist simulation-based workshops can improve continuing professional development learning experiences to provide generalist level of spiritual care. Workshops offered valuable learning and resulted in applicable clinical skills across professional roles. At 3 to 9 months after training, participants reported improved spiritual screening, recognition of spiritual distress, and referral to chaplaincy.

Keywords: spirituality, religion, spiritual generalist, interdisciplinary education

DOI: 10.1097/CEH.0000000000000318

Clinicians have long appreciated the importance of spiritual care for their patients, particularly in the settings of chronic illness and end-of-life care. Research has demonstrated that spiritual distress is correlated with increased pain and depression, anxiety, drowsiness, and nausea.[1–3] In a study including over 1000 palliative care providers from 87 countries, clinicians emphasized the need for conversational tools for use in screening patients' spiritual needs and in providing spiritual comfort, and the necessity was identified to overcome staff reticence in providing spiritual comfort.[4] In its 2015 report on care at the end of life, the Institute of Medicine[5] emphasized that frequent assessment of patients' and families' spiritual well-being and spiritual needs should be a core component of end-of-life care, in all settings and among all providers.

Unfortunately, patients continue to report receiving minimal or no spiritual support from their hospital care team or religious communities.[6] The primary barrier in providing spiritual care seems to be lack of training, with most nurses and physicians reporting that they had not received adequate training in assessing spiritual needs or providing spiritual care.[7,8] In another study, hospice nurses described their own moral distress at not having the practical competencies to care for the evident spiritual needs of their patients, and further training was recommended.[9]

The range of spiritual care training programs for health care providers is broad.[10] Training is typically targeted at nurses,[10–12] medical students as part of medical school curricula,[10,13] or the members of a single caregiving team as in hospice,[14] although some trainings are interprofessional for students[15] or front-line clinicians.[16–18] Training programs range in size from fewer than 5 to more than 100 participants.[10] Content usually includes the role of spirituality in health care and some skills for providing a generalist level of spiritual care such as spiritual screening tools, identification of spiritual distress, and how to make referrals to spiritual care specialists (chaplains).[11–13,15] Some programs also build in increasing the participants' sensitivity to their own spirituality as an access point of clinical compassion, support for well-being, and pillar of the healing

Disclosures: The authors declare no conflict of interest. This study was generously funded by Good Samaritan, Inc and the Norman and Helene Rabb Cahners Fund. Boston Children's Hospital Institutional Review Board ethical approval granted.

Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal's Web site (www.jcehp.org).

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aspect of one's professional identity.[13,14,17,18] Increasingly, trainings include simulation as a teaching tool[11,12] or live interviews with patients or their caregivers,[15] to support clinically integrative learning. At one end of the intensity spectrum, most programs are offered in a single session.[12,15,16] At the other end, Clinical Pastoral Education for Health care Professionals involves a minimum of 100 hours of education in a small interprofessional reflection group and close individual supervision of up to 300 hours of spiritual care in the clinical setting.[17,18]

This article reports on part of a larger study undertaken to develop effective full-day workshops to promote continuing professional development for clinicians to enable them to provide generalist level spiritual care in the context of their practice and to collaborate with board-certified chaplains, the spiritual specialists.[16] As such, the article addresses the gap between the unmet spiritual client needs and clinicians' spiritual care competency by examining the qualitative learning experience of clinicians after attending the workshops.

METHODS

Design

Our overall design was a program evaluation of a spiritual care continuing professional development intervention. Our evaluation approach is consistent with the Kirkpatrick Model[19] for analyzing and evaluating training and educational programs. In this study, we focus on data from questionnaires administered after the workshops, where we evaluated participants' spiritual generalist learning (Kirkpatrick level 2), and from questionnaires administered 3 to 9 months after training, where we evaluated the learners' self-reported behavioral changes as a result of the educational workshops reflecting transfer to clinical practice (Kirkpatrick level 3).

The workshops were structured to create a safe learning environment, then to alternate didactic modules with a variety of opportunities to practice the material just presented, and finally to sum up and share important learnings from the day. The activities were diverse and multimodal to provide different pathways for different kinds of learners. In each of two generalist-level realistic scenarios, a volunteer—in their own clinical role—interacted with an actor while incorporating spiritual generalist skills into their practice. The rest of the group observed the encounter from another room. Then the faculty debriefed the experience with the volunteer, actor, and participants, all together, helping to integrate the learning. The third realistic enactment of the workshop had a board-certified chaplain—a spiritual care specialist—engage with two actors in a complex case, while the participants watched. This enactment was designed to help participants understand more clearly the boundaries outside of which they as generalists are not equipped to work and to familiarize them with the work of their chaplain colleagues to whom it is important to make referrals in such circumstances.

The 1-day workshops incorporated both didactic and simulation-based components to equip health care providers from a variety of disciplines to integrate basic spiritual caregiving into their own professional roles.[16] Twelve such workshops were held between October 2011 and November 2016, with an average of 18 participants in each. Educational objectives included screening for spiritual needs of patients and families using an adapted version of Faith, Importance, Community, and Address as a basic spiritual screen in worldview inclusive language[20]; identifying spiritual talk in both secular and religious language[21–23]; becoming familiar with ethical guidelines for spiritual care; building vocabulary to respond to spiritual concerns of both patients and families; recognizing the signs of spiritual distress in patients and families; and making referrals to chaplaincy (spiritual specialists) for more comprehensive, in-depth spiritual care. The workshop included four modules including The Basics; The Faith, Importance, Community, and Address Screening Tool and video; Spiritual Distress; and Collaboration and Resources. Please see workshop agenda, modules, and educational methodologies (see **Appendix 1**, **Supplemental Digital Content 1**, http://links.lww.com/JCEHP/A98).

The workshops adopted the approach of a learning team in which all participants—workshop faculty, participants, and actors—contribute to the learning environment by bringing their individual knowledge and experience to the setting. The three faculty members served as teachers of modules, knowledge experts, and discussion leaders. The first faculty member was a board-certified chaplain and career specialist in pediatrics. The second was a board-certified chaplain and an ACPE (www.acpe.edu) Certified Educator. Faculty taught the didactic modules and provided slides for a "Glimpses of Spirituality" presentation designed to help participants recognize religious and secular spirituality widely present in the health care environment. The third faculty member was a nurse psychologist with expertise in using realistic enactment in the teaching of communication skills for health care professionals. She facilitated conversation debriefing the realistic enactments and integrating the learning of the day. A total of four actors were specially trained not only to portray their scenario roles well but also to give constructive feedback to the volunteers with whom they engaged, to support the participants' integration of new learning.

Data Collection

On the day of the workshop, participants independently completed short preworkshop self-report questionnaires that gathered demographic data including age, gender, disciplinary affiliation, years since earning their degree, race, and religious identification. After the workshop, participants completed questionnaires that asked them to reflect on their learning experience by answering the question, "Name three take home points from today's session."

A subsample of 34 participants which was enrolled in the two most recent workshops was sent an additional follow-up email survey, at either 3 or 9 months after the training. The follow-up survey included three broad questions: "Have you found yourself drawing on what you learned in the program?" "Have you made any changes in your practice based on what you learned?" and "Have you had the opportunity to incorporate the spiritual generalist role into your clinical care? If yes, please provide us with an example(s)."

Data Analysis

Descriptive statistics were conducted on the demographic variables to describe the sample. Written narrative responses on "take-home learning" from the postquestionnaires were analyzed using content analysis to identify main categories of

learning.[24,25] Within qualitative content analysis, data interpretation may be at the descriptive level, developing categories from similar coded content, and this can be informative in areas where little is previously known.[26,27] Given the nature of open-ended survey question data (which does not allow for engagement with respondents for clarification or depth, in contrast to, for example, interview data), our analysis focused at this descriptive level of identifying categories of learning, based on the manifest, rather than latent, content of the written responses.[26,27]

Data analysis was undertaken by three researchers who had backgrounds in public health (E.E.K.), nursing and psychology (E.C.M.), and health services research (D.L.), who served as the lead qualitative researcher. D. Luff has over 20 years of qualitative research experience, E. C. Meyer has 18 years, and E. E. Kerr was mentored by D. Luff and E. C. Meyer. Based on the researchers' experience, a descriptive analysis was appropriate to the data set.

First, all of the responses were read by one of the researchers (E.E.K.) who noted emergent codes. Two of the researchers (E.E.K. and E.C.M.) then met to agree on an initial coding framework, and the larger team (E.E.K., E.C.M., and D.L.) met to review the coded data for emergent categories. The whole team subsequently met to review and refine the categories. As part of this process, each team member was assigned to look in depth at a particular category (to ensure that the response fit the definition of the emerging category and to identify any new categories and/or subcategories). All researchers met again to discuss their analysis and to perform a crosscategory comparative analysis leading to final refinement of the categories. Once final categories were confirmed, two members of the team (E.E.K. and E.C.M.) chose illustrative responses to report and presented them for team agreement.

For the subsample of participants who were sent the follow-up questionnaire, we also performed a content analysis, according to the process above, on the written responses to explore the persistence and impact of take-home learning from the workshop in practice.

Ethical Approval

The study protocol was reviewed by the Institutional Review Board of Boston Children's Hospital and determined to meet exemption criteria for research conducted in established educational settings involving standard educational practices. Each participant signed a consent form that granted permission for his/her questionnaire to be used for educational and research purposes.

RESULTS

Participant Demographics

A total of 211 interprofessional clinician participants voluntarily enrolled in 12, separate, day-long spiritual generalist workshops. Of the 211 participants, 181 (85.8%) completed and questionnaires before and after the workshops. The total sample was largely women (84.5%), Caucasian (78.2%), with a mean age of 46.26 (SD, 12.74) and clinically experienced, with a mean of 17.79 years of experience (SD, 13.81). Table 1 depicts the full demographic characteristics of those who completed the questionnaires before and after the workshops (n = 181), and of the subsample (n = 25) which also completed 3-month or 9-month questionnaires after the training. Because of the small number of follow-up questionnaires distributed and collected, statistical comparisons of the demographics between the total group and the subsample were not possible; however, the groups were comparable overall. The subsample group had higher proportions of unspecified responses in some categories (gender, discipline, and ethnicity) than the total group, and the proportional response from some disciplines (nurses and social workers) differed somewhat between the groups.

Content Analysis

Results from the content analysis of take-home points from the questionnaires after the workshop and from the 3-month to 9-month follow-up questionnaires on longer-term application in practice are described below and presented with illustrative quotes in Table 2.

Take-Home Learning (Kirkpatrick Level 2)

Analysis of participant take-home learning data identified four primary categories. First, core values and skills of spiritual generalists is a category that encompassed attitudes, abilities, and tasks that support the spiritual generalist role. Second, understanding spirituality/religion and its role in health care is a category that covered the relationship between religion and spirituality, and how deeply a person's experience of them may impact how they cope with illness or injury. Third, interfacing with chaplaincy is a category that focused on participants' learning about when and how to team with chaplains in their role as spiritual specialists. Fourth, interprofessional teamwork is a category that described learners' awareness that spiritual care at a generalist level is shared across all team members, making interprofessional communication about patient and family spirituality essential to good care.

Follow-Up Behaviors (Kirkpatrick Level 3)

Of the participants who were sent the follow-up email survey, 73.5% responded (25/34). Of these, 100% affirmed that they had drawn on what they had learned in the workshops. Nearly all of the responders, 24 of 25 (96%) reported making changes to their clinical practice as a result of the workshops. Finally, 20/25 (80%) of the respondents affirmed having incorporated the spiritual generalist role into their clinical care. The respondents then offered examples of the spiritual generalist activities from their clinical work. Content analysis of these responses identified the same categories as the postworkshop questionnaire analysis.

DISCUSSION

This study extends previous work on the efficacy of interprofessional spiritual generalist continuing professional development workshops offered in a quaternary pediatric hospital setting,[16] by exploring and identifying core categories derived from qualitative responses from participants' immediate postworkshop learning, and from 3-month to 9-month postworkshop examples of how the skills had been incorporated into clinical practice. The continuing professional development delivered through the innovative simulation-based workshops

TABLE 1.

Spiritual Generalist Workshop Participants' Demographics

	Before and After Workshop Questionnaire Group n = 181	Before, After, and 3–9 mo After Workshop Questionnaire Group n = 25
Age (mean, SD, range)	46.26 ± 12.74 (21–76)	41.44 ± 10.25 (23–63)
Age group, n (%)		
≤30	26 (14.4)	5(20.0)
31–40	43 (23.8)	5 (20.0)
41–50	41 (22.7)	5 (20.0)
51–60	50 (27.6)	7 (28.0)
>60	21 (11.6)	3 (12.0)
Gender, n (%)		
Female	153 (84.5)	20 (80.8)
Male	23 (12.7)	1 (3.9)
Unspecified	5 (2.8)	4 (15.4)
Discipline, n (%)		
Physician	21 (11.60)	3 (12.0)
Nurse	62 (34.3)	2 (8.0)
Social worker	46 (25.4)	10 (40.0)
Psychologist	9 (5.0)	0 (0)
Child life specialist	2 (1.1)	0 (0)
Others	37 (20.4)	6 (24.0)
Unspecified	4 (2.2)	4 (16.0)
Years of experience (mean, SD, range)	17.79 ± 13.81 (0–43)	16.64 ± 13.81 (0–36)
Years of experience groups, n (%)		
0–1	14 (7.7)	2 (8.0)
2–5	30 (16.6)	6 (24.0)
5–10	26 (14.4)	3 (12.0)
10–20	34 (18.8)	3 (12.0)
20–30	48 (26.5)	6 (24.0)
30+	29 (16.0)	5 (20.0)
Ethnicity		
Caucasian	140 (78.2)	20 (76.9)
Hispanic	16 (7.9)	2 (7.7)
African American	3 (1.7)	0 (0)
Asian	9 (4.3)	0 (0)
Others	4 (2.0)	0 (0)
Multiracial	2 (0.9)	0 (0)
Unspecified	7 (4.0)	4 (15.4)

focused on individual learning (Kirkpatrick Level 1) and behavioral clinical practice change (Kirkpatrick Level 2) aimed at successfully preparing capable, confident interprofessional spiritual generalists. It therefore offers a useful perspective about which topics from the training clinicians found most applicable and logistically feasible to incorporate into their own practice.

Two of our four identified categories overlap clearly with common core themes identified in Paal and colleagues' systematic review of spiritual care training programs provided to health care professionals[10]: increased integration of spirituality into clinical practice (understanding spirituality/religion and its role in health care), and positive changes in communication skills with patients (core values and skills of spiritual generalists). Similar to Costello et al[11] and Galloway et al,[12] our findings demonstrate that simulation-based learning in spiritual care education was effective in the opening of participants' attitudes toward patient spirituality, identification of spiritual needs, and communication skills. Such as Lennon-Dearing et al,[15] our findings demonstrate the efficacy of training practitioners from medicine, social work, and spiritual care through an interprofessional model and increased the range of disciplines participating to acknowledging allied health professions' appropriate role in generalist level spiritual care.[25] Significantly, our study also expands the participant base from students[13] to an interprofessional group with *a* wide range of experience. Unlike the work of Daudt et al,[14] the present training is constructed for its setting, allowing the instructors to build community in each training group across diverse religious and religious/secular differences. This study is unique in highlighting participants' reflections on their learning experiences in workshops using simulation-based learning, including an understanding of spirituality incorporating both religion and secularity, and embodying the teamwork of generalists and specialists[26] essential to quality spiritual care by having the training is interprofessional. In addition, our training program encourages its participants to comment on an additional level of clinical integration of their learning: increased interdisciplinary teamwork with colleagues and referrals to chaplains in serving the spiritual care needs of their patients and families.

TABLE 2.
Categories of Learning and Impact

Category	Illustrative Responses	
	Take-Home Learning	Follow-Up
Core values and skills of spiritual generalists	Just because someone does not identify as religious/spiritual does not mean I should not approach it and ask about it	I always inquire about religious/spiritual beliefs and supports as part of my social work assessment now. It has been so helpful.
	Instead of ignoring the spiritual needs, try to identify and relay	I have dedicated more time during assessment to exploring spiritual questions with parents and adolescent patients.
	Emotional and spiritual distress can be more difficult than seen	The concepts of being a spiritual generalist have been integrated into my conversations when I speak to [patients] one on one, especially when I ask them what really matters to them.
	Distinction between generalist and specialist	I have tried to incorporate more discussions of faith while exploring support systems
	Compassionate curiosity	Better assessment of spiritual needs of patients and families
	Listen with my whole body all the time	Better assessment of spiritual needs of patients and families
	General vocabulary to approach patients' spiritual needs	Asking more specifically about religious/spiritual beliefs
	Therapeutic use of silence	
	Patients' rooms hold clues, be sure to look for them	
Understanding spirituality/religion and its role in health care and illness	Recognize what is something greater than oneself (SGTO) (as taught in workshop), an important component of one's spirituality	When disclosing a difficult diagnosis or unclear prognosis, I encourage the family to think about their sources of spiritual strength
	Difference between spirituality and religion	In working with (patients) who are facing end of life, incorporating questions about "what really matters" and from where they get their strength and support.
	Spirituality is complex and completely individual	Greater awareness of their importance
	Spirituality plays an essential role in health care	Asking about sources of spiritual strength/meaning when patients (are) facing decline/health challenges and trying to facilitate these needs being addressed with full supports
	As clinicians (and) spiritual generalists (we) have a huge impact on patients well-being	
	Role of spiritual strength in recovery	
Interfacing with chaplaincy	Being present (and)inviting patient collaborating with chaplaincy	I have referred more patients to chaplaincy over the last few months including a mother who presented with postpartum depression and a teen with a new eating disorder
	Importance of chaplaincy resources (which I already appreciated)	Exploring referrals to chaplaincy early on.
	Many resources/people to assist with patient care	I am an interpreter, so I work with lots of different providers and now I understand more about (chaplains') work
	Better understanding of chaplaincy vs. (community)clergy	Referring more often to chaplaincy.
Interprofessional teamwork	Engagement to continue to facilitate this work with other disciplines at my hospital	I actually used (this material) in helping coach a staff member. I wrote my exemplar on it.
	The work is a team effort	I had the chance to present what I learned at our monthly staff meeting.
	Drawing from team members as entry point to spiritual care	

Although spirituality training programs for nursing students[11,12] have demonstrated the efficacy of simulation methodology, the interprofessional nature of this study's training is core to its pedagogy and makes possible the emphases on interfacing with chaplaincy and interprofessional teamwork. Although intradisciplinary exploration of integrating spiritual care into practice has its place, expanding the conversation to include the perspectives of practitioners of other health professions and of professional chaplains is essential for maximizing the quality of care received by a patient/family.[28] Similarly, by including clinicians with a range of experience levels in the participant groups, this training model distinguishes itself from most others by encouraging broad peer-to peer-learning. Those newer to their professions are exposed to the depth of practice of more experienced clinicians. Those with more experience are offered perspectives from which they can approach coaching and teaching roles in their own practices.

This training was designed specifically for the interprofessional pediatric staff community at Boston Children's Hospital. Within the workshop take-away comments, several participants demonstrated learning about the presence of spirituality expressed in secular language and discovering a vocabulary for how to approach these issues with a person in their care. In the 3 to 9 month follow-up data, this learning was retained, as reflected in comments about having learned to ask what really matters to a person and from where patients summoned their strength. Presenting this broad framework for secular spirituality was a conscious choice of the course developers, reflecting not only professional chaplaincy's perspectives,[21–23] but the trending changes in America's religious demographics as reported by the Pew Research Center.[29] The careful incorporation into this training of didactic and case material representative of the hospital community's diverse religious and cultural perspectives, including secular spirituality, addressed the learning barrier reported in another interprofessional setting in which the privileging of one religious/spiritual approach in the curriculum led to conflict rather than enhanced learning in the participant community.[14] Participants found in the current study's workshops a useful frame of reference for spirituality/religion and a vocabulary for clinical application of the concepts.

In fact, the follow-up data reveal a sense of growing confidence and positive meaning in the learners' acquisition of the spiritual generalist role. There was evidence that the workshop learning extended beyond the clinical care provided, to

educational leadership efforts on the part of the budding spiritual generalists.

The study was limited by its focus on interdisciplinary spiritual generalist training in one pediatric setting. The specificity of a pediatric quaternary hospital, where questions of meaning arise intensively in the context of seriously ill or suffering children, raises questions about the direct transferability of the training. The workshop participants were largely women, Caucasian, and quite professionally experienced. The data were gathered from self-report questionnaires and subject to the limitations of such. The voluntary nature of participation in the workshops may have influenced the findings, in that clinicians who were particularly interested in spirituality/religion may have registered. Follow-up data were limited and only available for the last two workshop cohorts because of limited resources to disseminate and monitor the follow-up questionnaires. The follow-up group had a small n and included some missing demographic data which precluded formal statistical comparison with the overall sample from the workshops. Our analysis focused on learning and behavior (Kirkpatrick levels 2 and 3). Future evaluation of such training should address benefits to organizational performance (Kirkpatrick level 4).

Further study might explore how such educational workshops can be adapted to the needs of different health care specialty hospitals and settings. Future studies might examine how the take-home learnings impact actual clinical duties and what the supportive and limiting factors are in the translation of learning from the workshop to patient care. Similarly, it would be valuable to examine the outcomes of spiritual generalist training when such training is offered in new hire orientations and under similar mandatory circumstances, rather than when offered on a voluntary basis. Future research might also explore how participants' genders and spiritual/religious identities impact their experience of spiritual generalist training. Considering the impact of the religious affiliation of the institution on the workshop's perceived effectiveness for participants would be worth exploring, as would the degree of religiosity of its geographical location. How the curriculum might be helpfully adapted to front-line staff with less academic education would be worthy of study, as well. For ease and feasibility of replicability, examining whether similar effectiveness in learning is achievable if the simulations are presented in a prefilmed format, rather than live, would be worthy of study.

CONCLUSION

Lack of training hampers clinicians' ability to provide spiritual care to their patients and families. In this study, we undertook a program evaluation of a novel, interprofessional spiritual care continuing professional development intervention. Our key findings were that the spiritual generalist workshops provided valuable education and an enduring skill set to interprofessional health care providers including an understanding of spirituality/religion's presence in many patients'/families' experience of illness; integration of core values, ethics, and skills in providing generalist level spiritual care; increased interfacing with professional chaplains; and appreciation of the interprofessional teamwork involved in spiritual support of patients and families. The workshop can be a helpful resource for clinicians, filling a gap in training around addressing the spiritual needs of patients and families. We believe the model is worthy of replication and adaptation to other clinical settings.

Lessons for Practice

- One-day simulation-based workshops can improve continuing professional development learning experiences of health professionals in providing a generalist level of spiritual care.
- Integrating Kirkpatrick's Model in evaluating continuing professional development provides an educational strategy for better program development.
- Continuing education regarding the role of spiritual care within health care can include spiritual screening, empathic listening, referral to chaplaincy, and ways to integrate spiritual care support into everyday clinical practice.

ACKNOWLEDGMENTS

The authors acknowledge the valuable contributions of Anderson Lamberto, B.A., for his coordination and technical support of the workshops. The authors also thank workshop participants.

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