Taking a Spiritual History Allows Clinicians to Understand Patients More Fully

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ABSTRACT

Dr. Christina Puchalski is an internist and geriatrician who has recently designed a Spiritual Assessment consisting of four basic questions that physicians or others can integrate into patient interviews. The assessment is remembered by the acronym FICA, for the four domains it touches on: Faith, Importance, Community, and Address. In this interview with Innovations associate editor Anna L. Romer, Dr. Puchalski explores how she came to develop the spiritual history, how she sees it as distinct from a careful psychosocial history, and what she has learned as she has trained physicians across the United States to incorporate it into their medical interviews. This interview is excerpted from a thematic issue, “Spirituality and End-of-Life Care,” Vol. 1, No. 6, 1999 of the online journal Innovations in End-of-Life Care at http://www.edc.org/lastacts/.

First, let’s review how you understand spirituality and the context for using the spiritual history or assessment.

I see spirituality as that which allows a person to experience transcendent meaning in life. This is often expressed as a relationship with God, but it can also be about nature, art, music, family, or community—whatever beliefs and values give a person a sense of meaning and purpose in life. So, a spiritual history is a beliefs or values history that explicitly opens the door to a conversation about the role of spirituality and religion in the person’s life.

This conversation is extremely important for patients who are gravely ill and for dying patients. Spiritual questions that come up for these patients include: What gives my life meaning? Why is this thing happening to me? How will I survive this loss? What will happen to me when life ends?

We as clinicians don’t know the answers, but I do see it as our role to support and encourage people as they search for their own answers to these questions. Their spiritual beliefs, religious faith and values are resources, and it is also important to see this work as a team effort and to refer patients to chaplains and spiritual directors as needed.

How do spirituality and healthcare intersect?

Patients learn to cope with and understand their suffering through their spiritual beliefs, or the spiritual dimension of their lives. It is also through that dimension that I think the compassionate, caring part of the doctor/patient relationship is enacted. We don’t normally think of it that way, but to me, it’s a very spiritual interaction. Physicians are called to a service profession—our job is caring for people—I think that in and of itself is spiritual work.

What has happened over the last 30 years is that science has really led medicine, and a lot of the nontechnical aspects of medicine have been neglected. The spiritual assessment brings us back to those compassionate, caregiving roots of the patient-doctor relationship. Doing the spiritual history also helps healthcare providers understand the role that spirituality plays in the patient-clinician relationship itself.

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Can you say a little more about that?

Let me speak specifically about doctors because that’s the group I’m part of and that I work with the most. Every profession has some differences; however, I believe this applies to all the healthcare professions. For physicians, we are so burdened by time, stress, and the enormous amount of technical knowledge that we have to learn that many of us come out of medical school not very well trained to communicate with patients about things like end-of-life decisions or nonphysical suffering. So we tend to rely on what we’re most comfortable with, which is our technical training. But in fact, patients are very dissatisfied with that sort of patient-doctor relationship because they want doctors to be caring, in addition to being technically skilled. A Gallup survey was done in 1997, which looked at what people said they would want if they were dying. Having warm, caring relationships with their physicians was one of the responses. These same respondents also reported that doctors are lacking in these relationship skills. I think that part of the reason for this gap is that, as physicians, we don’t take that time to get to know the person in the patient. We walk into the office, act very quickly, focus on the things we’re comfortable with, i.e., medications and prescriptions, and then leave.

When you get involved in a discussion with a patient about his or her spirituality, you enter the domain of what gives that person meaning and purpose. When you begin to find out about why the person is suffering, and to listen to that person, you can’t help but notice a change in the quality of the relationship. Physicians who have incorporated the spiritual assessment write back and tell me about it. They say that the nature of the patient-doctor relationship changes—as soon as they bring up these questions, they feel that it establishes a certain level of intimacy in terms of really understanding who that person is at a much deeper level than they are accustomed to. The relationship feels less superficial.

How would you distinguish between a very careful psychosocial approach to an interview and what you are referring to as a spiritual approach?

I think traditionally in a psychosocial approach, what people ask is, “How are you coping with this illness? What are the stresses in your life? Are you fearful about dying? Do you have any fears of the future? How do you think your family is coping with all this?” Those are very important and relevant questions, and some spiritual aspects may emerge from those questions, but these questions are more targeted at psychological or social issues, such as how the person is feeling, financial pressure, or physical well-being.

The spiritual domain includes more than questions about how a person is coping. The questions I’m interested in are: Are there issues of despair? Meaning? Purpose? Belief in a god or an afterlife? People often feel, particularly when they’re dying, that their life has no meaning. A patient might be able to answer all of those psychosocial questions by saying, “My family helps me cope,” or “I have a social worker that works with me to resolve my financial problems.” Although a person may be able to answer these questions, still, at a very deep place inside himself or herself, the person is despairing. The patient might feel that life has lost its purpose, which might not come out in a psychosocial interview. Certainly belief in God, belief in an afterlife, all those kinds of things probably won’t come out in a typical medical interview, and yet we’re seeing from a number of surveys that spiritual issues are very important to a lot of people. Oftentimes they need permission to talk about those kinds of issues. Without some signal from the physicians, patients may feel that these topics are not appropriate or welcome.

In a spiritual assessment, my opening question is about the presence of faith or belief (“F”) so I ask, “Do you consider yourself spiritual or religious?” I find this is a very different opening from “What helps you cope?” I open the interview up to however that person wants to answer it. I don’t have an agenda and that’s very important. Religious people will right away feel an affinity for that question. People who are not religious, but who are spiritual will understand it that way. Occasionally, I’ve had someone say that they’re neither, and then I ask, “What gives your life meaning and purpose?” However, following a question that talks about spiritual or religious beliefs, then the meaning or purpose question takes on a different tone. Then, I take the patient’s lead.

I have a patient who feels that nature is very important, and she said something like, “I’m a naturalist, and looking at trees makes me feel really centered and with purpose.” In fact, one of the things she said was that if she were dying,
she would want me to refer her to a hospice with a window next to some trees, because that’s what gives her meaning and purpose in life. Now, I don’t think I would have gotten that kind of information out of a strict psychosocial type of interview.

Many of my patients are very religious, so they welcome the opportunity to not be laughed at, but to be able to talk about those issues. Answers vary from “I go to church every day, or every week, and my belief in God is central, it’s really important to me, it’s the way I cope with things. I use prayer every day.” Or, “I have rituals, or I meditate, or I do yoga.” There are a lot of ways people will answer that question.

However, it’s not enough just to know whether a patient is spiritual or religious. In the past, spiritual assessment has been rather simplistic or lim-
ited, merely asking patients about their religious denomination. So I developed the second domain where I am striving to get to how a person’s spiritual beliefs—if it’s nature, music, art, or a particular religion—how these beliefs influence that person in the way that that person cares for him or herself. This is the domain I refer to as “I,” in the acronym for “importance,” or the influence of those spiritual beliefs on the person’s life. So, with a dying patient, the question would be, “How do these beliefs influence the ways you are coping with dying? How do they influence the ways you are making end-of-life decisions?”

People have intrinsic spiritual beliefs, but they may also have extrinsic ways of expressing these beliefs. The third domain, known as “C,” refers to the person’s community. The community aspect may be what’s important and that may be a formal religious community or some other sort of community. A lot of our religious or spiritual beliefs are expressed intrinsically. Meditation. Prayer. Relationship with God. Nature. Whatever. But there’s also an extrinsic element that has to do with how a faith is practiced in the context of a community. That could be church, temple, or mosque. It might be a group of like-minded friends or an alternative spiritual group. This question about community has important practical implications because many times those are the people who will help a patient.

For example, I have a patient who is 88 years old and her husband is 93. He’s dying, and she’s not strong enough to lift him and do all of the caregiving. People from her church come almost every day and help them. This kind of community is a phenomenal resource. A fellow in geriatrics working with me was presenting the case to me, and he told me, “They have no support! They don’t have a social worker coming in. The home health aide comes maybe once a week. How is she managing?” So I said, “Well, have you asked about their spiritual history?” Well, he did that and he came back and said, “You know, in fact they’re Catholic, and people from their church come in every day. It’s an incredible support!” Now, if he hadn’t asked that question, he wouldn’t have known that. Plus, the belief system is a support, too.

The fourth part of the assessment, which I call “A,” for application or address, leads to the part where I think, “How is it that I can intervene in this situation or address these issues?” For example, when patients are healthy and come in for a regular physical examination, they may tell me briefly about their belief systems. But spiritual issues don’t really seem to be important, then I may not do anything with that content. But if someone comes in and says something that I hear as a warning sign, I might want to refer to a trained chaplain to help sort that out. For example, a person may see God as punitive and spiritual assessment may allow me to make a link between this attitude and the patient’s not wanting to take medicines, or not taking care of him or herself. Or if someone’s dying, spiritual concerns may be the only thing we talk about. I may bring a patient back the following week just to talk about these issues of life and death and how his or her spiritual beliefs affect any suffering the person may be feeling.

I think the whole issue with end-of-life care is that many people say they do good palliative care, and what they define as good palliative care is being able to give narcotics and manage pain and other symptoms appropriately. While that’s extraordinarily important, that’s not the only aspect of suffering. Again, we tend to focus on the physical suffering—what we see in front of our eyes. But it is crucial to attend to the spiritual dimension of suffering, and it’s distinct from emotional suffering.

Can you give an example to clarify that distinction?

A patient may be depressed, or may have anxiety, and while that may be related to spiritual suffering, it’s not the whole picture. I have many people who are healthy emotionally, but who suffer tremendously spiritually. Here’s a good example. A patient with several children was dying and the staff thought she was depressed, so they gave her medication for her depression, which only created new side effects. The medication didn’t help alleviate her mood as they described it. I was called in to consult and went to go talk to her. I didn’t find her depressed at all. She was just feeling that her life had no purpose and that she had nothing more to do in whatever time she had left. Her biggest concern was, “My 2-year-old is not going to remember me.” So we talked about what she could do to help her youngest daughter remember her. One tool is to write a legacy or a document where the patient articulates the things that are important to her and that she hopes to give to her daughter. What
are the kinds of values she wants to impart to her daughter? So, for the next months, that’s what she worked on. She wrote a legacy for her daughter which included things like, “These are my hopes and dreams for you.” In addition, one of the nurses videotaped her. This document and videotape then became a legacy, something her daughter could have as she grew up. With all of these activities to address her concerns about the meaning of her life, the “depression” lifted right away, without any medication.

There are other examples. I have patients in the nursing home who are not depressed or anxious. Yet there’s something unsettled that you wouldn’t necessarily be able to pick up on. But when asked, “How are you doing?,” they’ll say, “You know, I don’t know.” When I take a spiritual history, what comes out is, “You know, I really believe in God, I’ve believed in God my whole life, but I’m really wondering if He’s here for me right now. I’m feeling very abandoned by Him.” But that doesn’t necessarily result in a depression or an anxiety. It’s just part of a spiritual journey, but it nevertheless causes spiritual distress. So with people like that, either I talk to them, or I refer to a chaplain who comes and works with them every day or every other day on those kinds of issues to help them sort it out. There’s no magic fix. You can’t give a pill for that, nor can you tell them, “Oh, sure, God’s there for you. Don’t worry about it.” You can’t even give people an answer. However, you can listen and support them, and you can call on people who have particular training in this domain, such as trained chaplains, or spiritual directors, who can help patients work through this issue of God not being there for them and come to some kind of resolution.

How did you get involved in thinking about spiritual issues as a physician?

I was a biochemist at the National Institutes of Health (NIH), where I did a lot of basic research, which I found personally unfulfilling. So I started volunteering at a state mental hospital here in Maryland on the weekends. I worked with people with chronic mental illness. I saw a lot of spiritual distress, which was being overlooked. People who were able to find some sort of peace were the ones who were able to tap into that spiritual dimension in their lives. So when I went to medical school, I thought, “Well, obviously, I’m going to learn a lot about this.” And I didn’t. I saw nothing on spirituality. Even with something similar to alcoholism, there was nothing on 12-step programs. Nothing. It was all very biomedical. I was amazed by that absence. In my own life, I also experienced the death of someone close to me, and so took part in bereavement groups and observed how other people deal with loss. I thought, “Hmm. Nothing on that. Nothing on death and dying.” So I started an elective course on spirituality and medicine back then, as a medical student at George Washington University. The other students loved this course. I remember one classmate of mine, who was Jewish. We rotated through Holy Cross, a Catholic hospital here in the Washington D.C. area, and he mentioned that at first he was very anxious about going to a Catholic hospital. He had this image of nuns and priests walking down the hall and of Catholicism being imposed on him. So he was delighted when, in fact, that wasn’t his experience at all. Instead, he found that it was his favorite hospital because he experienced a sense of hope there.

We have since integrated the content of that course into the required curriculum at George Washington University. Now there are about 61 medical schools in the country that include some teaching about spirituality and medicine. Most of them have required courses on spirituality in medicine, based on the same model of integrating it throughout different courses.

What about the issue of time? We continue to hear about how physicians are hard pressed to spend time with patients, and this spiritual history seems to add one more thing to the litany of topics doctors are expected to ask about as they do a medical interview.

There is a lot that’s being thrown at doctors, even more now because in the standard history that we’re teaching, we really want you to do a good social history. There are questions about domestic violence, there’s a sexual history, everything is in there. All of that is important, but you have to use your judgment. So clearly, if someone comes in with chest pains, I’m not going to sit there and ask him or her a spiritual history. If the patient is clutching his or her chest, I’m going to do a quick electrocardiogram and figure out what’s going on. The patient may need rapid
intervention. On the other hand, if someone comes in for a regular physical, I would suggest addressing all these issues. It can be done in a brief amount of time. The FICA takes about 2 minutes. Spirituality is central to the care of the dying. When people are dying, the spiritual history is essential. I think if we don’t address these issues with someone who comes in with a sore throat, that’s okay. But if we don’t ask about spiritual beliefs with someone who’s dying, I think we’re being really remiss in our duties.

Are you training physicians around the country to do this spiritual assessment? And are you targeting that training toward end-of-life care because it seems to be such a vast area of need?

Yes. I don’t want to say that I’m only targeting it to end-of-life care because it’s so important across the whole spectrum. My interest is in end-of-life care, so I tend to be in that circle of people. When I do give a presentation to clinicians working in end-of-life care, I present the spiritual history as something appropriate to do across the lifespan. A good analogy is with advance care planning, which we know shouldn’t be done at the very end, either. Many advocates of advance care planning talk about doing advance care planning early on when the person is “healthy.” The nature of the conversation changes over time. So, too, for spiritual assessment. It may be for your 25-year-old, perfectly healthy person on a routine physical, you ask a couple of questions, you jot it down, maybe it’s an issue, maybe it isn’t. But it’s probably going to be the case if that person is suddenly faced with a diagnosis of human immunodeficiency virus (HIV), or cancer or a chronic illness, those discussions are going to become more frequent.

And these topics are related. I’ve found that when doing advance care planning, even under difficult circumstances with a patient I don’t know well, that if I start by taking a spiritual history, the conversation changes. If a patient can’t talk, I do a spiritual history with the family. Once I’m engaged in that conversation, it is so much easier to go into what gives that person meaning and purpose in life and how the patient might want to die, or under what circumstances. Most people are much more comfortable talking about end-of-life decisions in that context. So we focus a little more on spiritual concerns when I talk with people on end-of-life issues.

Please describe the training you do.

Ideally, the workshop lasts about 1½ to 2 hours, because that gives people a time to role-play and discuss and work in small groups, but I can do it in 45 minutes as well. I give a brief presentation on the assessment tool. I talk about why we do it; what the key issues are; how you look for what I would call “positive” versus “negative” spirituality. It’s not that any spirituality is negative, but let me give you an idea of what spiritual symptoms might be. For example, if a patient has a concept of God as punitive, that might be linked to not being willing to continue treatment. Then I would discuss ways to deal with that issue.

Then, I give some case examples, and I have people role-play with each other. If we have the longer period of time, we break up into smaller groups and discuss how that experience was and ways that they might integrate it in whatever their particular professions are. I do this with physicians, nurses, social workers, and others. Interdisciplinary groups are my favorite, because this kind of care doesn’t belong in any one person’s domain. So, the best workshops I’ve had included chaplains, physicians, nurses, social workers, licensed practical nurses, and home health care aides. When this happens, people across all of these roles end up interacting together, and particularly in the small-group discussion, they see how it might be different in each of their different professions as well as what they share. Then we come back into a large group and address issues about how the interview went and maybe share in the large group. That usually works pretty well. I try to follow up with people. I give a handout. Most people find that helpful. I’m now working in more detail on checklists that people can take back with them, because sometimes people forget the specifics.

Can you give me another example of what you’re calling “negative spirituality?”

Some people have less mature relationships with God—similar to a four-year-old’s relationship with a parent. What I mean here is that they have a very concrete and quid pro quo relationship. “If I pray, God will cure me.” If that doesn’t happen, then their faith is challenged and
they can feel abandoned and despairing. I would suggest that spiritual support might allow a person to develop a more mature faith.

*It sounds as though your own spirituality has been central, even though you haven’t explicitly said so, to your being in this place and doing this work. Do you address the participants’ spirituality in your workshops, in terms of what their values are and what gives their life purpose?*

What happens in the small group is that when people pair up to do a spiritual assessment, they come to recognize their own spirituality. I have some questions targeted to that experience in the small-group exercise. One of the things people often say is that you can’t address a patient’s spirituality until you address your own. I believe that. I don’t think it’s a “prerequisite,” because I think people are addressing it unconsciously. But I think it is important to be in touch with our own spirituality. It doesn’t have to be formal, but there needs to be an awareness. There’s actually been a lot done on this. Dr. Daniel Sulmasy, whom you may know, has written a book on spirituality and the healthcare provider.²

Dr. Rachel Naomi Remen is coming out with a book on the call to service. She spoke at one of my conferences, and observed that in California where the managed care rates are the highest in the country, the physician suicide rates are also the highest, as well as the physician dropout rates for medicine. As a profession, one of the things we have to reclaim is our own spiritual roots, the calling to be a physician. It’s not just a job. We’re coming back to the beginning of the conversation where I said that bringing spirituality into the history changes the patient-doctor relationship. Once a physician starts engaging in these conversations with patients, he or she immediately becomes aware of that aspect inside him or herself, and, I think, becomes a more open and compassionate doctor as a result. I don’t have data for that, but I can tell you from what patients and physicians have told me. Physicians become more open and more compassionate. Patients also become more open and trusting. Often, opening up this conversation about purpose and meaning touches that part of the doctor that made him or her want to be a physician in the first place. I see being a physician as a spiritual calling. We put our patients’ needs above our own, that’s one of the first things. We give of ourselves, we’re available. We hold someone’s hand or we walk through that journey with them, and unfortunately, the systems of healthcare right now are mitigating against that. But I think the profession really wants to recapture a lot of that domain. This is one of the reasons that spiritual assessment is so popular right now.

*So it doesn’t sound as though you’ve met much resistance from physicians to this training. Do you think that’s because you’re preaching to the converted?*

Resistance is an interesting word. There is some resistance, and the resistance is when people have a preconceived notion that this is a Christian, right-wing kind of endeavor, which it isn’t. When clinicians think that the spiritual assessment is going to be a platform for evangelizing doctors, to proselytize, then I sense resistance. Once I get beyond that, and they see that I’m not talking about a specific belief system, I think the resistance falls. Clearly the fact that there’s some data now to suggest that spirituality is helpful, as well as the fact that there are so many courses, makes a big difference. Right now many medical schools offer courses on spirituality or faith and medicine.³ The Association of American Medical Colleges (AAMC) cosponsors a conference with the National Institute for Healthcare Research on spirituality and medicine every year, called Spirituality, Culture, and End-of-Life Care, which I have cochaired. Having the AAMC support work in this area gives it more credibility, too. I think the most important part is that, as a profession, we are beginning to recognize that the patient-centered approach is vital. Attending to patients’ meanings and life purposes fits into the patient-centered model of care.

*Do you have any idea how many people you’ve trained so far?*

I’ve directly trained roughly 4,000 people to do the spiritual history. It is a train-the-trainer model because these people then take the tool back to their settings and they may train others. In addition, many of the courses at medical schools are using the spiritual history (FICA) tool, so it’s hard to make an exact estimate.
Are you evaluating your efforts in any way?

We are now. I’m doing a study where I’m looking at whether the FICA assessment itself makes differences in the things people say it does, like the patient-doctor relationship and some patient outcomes. I’m looking at depression as well as a spirituality index.

How are you measuring these outcomes?

I have different instruments for each of those. I have a patient satisfaction instrument, a depression scale, the Brief Depression Inventory, and the Spirituality Index is a 12-item part of FACT/SP; it’s a subscale of the FACT quality of life measurement scale. And we’re using a five-item religiosity scale. We’re just beginning these studies, though.

Are you going to be doing any interviewing?

Absolutely. I’m changing the study a little bit because I found that these instruments weren’t sufficient to measure what I’m interested in. So, we are going to do some focus groups. People want to share stories much more than they want to give a specific answer to a forced choice question.

What kind of feedback have you gotten about the usefulness or the effects of this training?

Some people say that they’ve been addressing spiritual issues all along, but that this simple set of questions has made it easier. Part of the problem is that people don’t know what’s spiritual and what isn’t. What the FICA does, albeit it’s a little simplified, is to clarify the topic. I’ve heard people say, “This makes it approachable. This makes sense.”

Just last week I gave a presentation, and someone said at the very beginning, “This is fine, but I bet it’s going to be too long to do.” Afterwards, he said, “You mentioned you could do it in a short amount of time, and I was really surprised, but when I did it here, I could do it in 2 minutes. Then obviously, just like anything else, if there are issues, you deal with it.”

This tool is geared to a time-constrained setting. I wanted to create something doctors or others could use at the beginning of the examination, something that would not constrain patients from leading the conversation into any area that was important to them. I see the spiritual assessment as opening up the conversation and making it permissible for patients and healthcare providers to include this domain in the medical interview.

Have you gotten any feedback from psychiatrists or psychologists in terms of how they feel this dovetails with what they do?

Actually, a lot of psychiatrists are involved in this themselves. At the National Institutes for Health Care Research, we give awards to psychiatry residency training programs for developing spirituality in medicine curricula. People involved in these programs have felt that it’s very useful. I’ve also spoken at the American Psychiatric Association (APA) several times, and each year they keep accepting the workshop. In fact, when I first presented at the APA, I had some trepidation, because I thought, “They’re doing this already. This is going to be oversimplified for them.” But in fact, it wasn’t, and they found this short tool quite useful because it’s not that easy to bring spiritual beliefs up in that context. Some psychiatrists have the luxury of time to go into these things in a lot greater depth, so they might use this to open up the conversation, and then they have other kinds of things they use to address spiritual beliefs in more detail, related to psychodynamic issues.

Do you think this tool would be applicable internationally or cross-culturally?

Yes, because the principles are general. You don’t have to use the exact words in the assessment tool. The first question is an open-ended question, asking the person if they consider themselves spiritual or religious. And respect for the patient’s belief system is integral to doing a spiritual history. You don’t impose your own belief or culture on it. The patient is really educating you.

Here is a twist on your question: Some healthcare providers have modified the FICA spiritual assessment tool to do a cultural assessment. So instead of the first question being, “What is your faith or belief or do you consider yourself spiritual or religious?” they have transformed it to, “What’s your cultural background? Tell me about it.” The second question then becomes “How im-
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important is it? How does it influence you?” So the tool seems quite flexible and adaptable to other domains such as cultural identity.

On the other hand, if someone were to say, “Do you have a specific religion? How many times do you go to church?” that would be a misreading of my tool. Those kinds of questions could lead the clinician to miss out on a wide range of beliefs. That’s why I specifically kept the spiritual assessment rather open-ended.

What are the lessons you’ve learned so far? Where are you going with this?

One thing I’d like to get involved in is defining spirituality better. What does spiritual care mean? What do practitioners mean by spiritual care? What are the different types of spiritual care that one can offer? Right now off the top of my head I can list a few things: listening, being present to the person, allowing the time and space for ritual, guided imagery, prayer, meditation, and a referral to chaplains as an acceptable part of care.

I think we need to assess what we’re doing. In addition to looking at patient outcomes, I’m starting to do follow-up surveys with people who have attended my conference. I think we need to get a little bit more analytical, even though I resist being analytical about spirituality because I think some things just can’t be measured. I really do. Having been a researcher in the past, I think that there are some aspects of the spiritual interaction between the physician and the patient that maybe cannot be measured. You can measure denomination; you can measure church/tem-

ple/mosque attendance, but certainly the intensity of a person’s own spirituality, I think, is very difficult to measure.

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