

Letters

A Response to Geriatric Oncology, Spirituality, and Palliative Care by Dr. Lodovico Balducci



To the Editor:

We first thank Dr. Balducci for writing on this most important topic.¹ It usefully explores the overlap of three relatively new but increasingly prominent specialties—geriatric oncology, spiritual care, and palliative care. Each of these specialties has its own independent complexities, but, together, they form a very interconnected web. We fully agree that spirituality frequently increases in importance as we age and that the geriatric oncology population often features multiple comorbidities, making those persons prime candidates to benefit from palliative care services. We submit that there is a need for specialist spiritual care to go along with it.

We would suggest that Dr. Balducci's generally excellent contribution could be substantially improved by correcting several issues that generally fall within the realm of spiritual care.

In recent years, all the research and published guidelines have followed the generalist/specialist model for spiritual care with a professional board-certified chaplain as the spiritual care specialist and the other disciplines on the palliative care team as spiritual generalists.² This model has been integrated into the palliative care guidelines of the National Consensus Project for Quality Palliative Care. In these guidelines, the chaplain is specifically named as the spiritual care specialist on the interdisciplinary team and described as being trained to address spiritual and religious concerns of all patients and caregivers regardless of their spiritual or religious beliefs and practices. The guidelines call for a salaried professional chaplain as a full member of the team, describe the spiritual assessment the chaplain should perform, and how the chaplain will document on patients with demonstrated spiritual distress.³ Likewise, the Distress Management Guidelines of the National Comprehensive Cancer Network support this inclusion of a professional chaplain and detail the spiritual diagnoses that call for a chaplain referral.⁴

Given the unanimity of guidelines, Dr. Balducci's statement that "As practitioners of medical and radiation oncology and palliative care, advanced practice professionals, nurses, and social workers, they are in the best position to provide spiritual care ..." is incorrect. Although nurses and social workers provide generalist spiritual care within their scope of practice, the professional chaplain is the member of the team in the best position to provide spiritual care by virtue of specialty training in this particular domain. Although Dr. Balducci's statement that "It is important to remember that when the practitioner to addressing spiritual issues (sic), he/she can count on the help of the chaplain team member who has received clinical pastoral training" is true, it could be read to imply that the practitioner should only refer when he/she is uncomfortable; that is, when the practitioner is comfortable, they can do the spiritual care themselves. Both of these latter statements are contrary to guidelines and current best practice. If the practitioner is uncomfortable with this area of inquiry, he/she should seek guidance from the professional chaplain to be able to conduct a spiritual history and then refer appropriately. Under any circumstances, the practitioner is a spiritual care generalist who should ideally inquire about the patient's beliefs and values and know when a specialist is required. There is a good bit of literature now in this area.^{5,6}

Language is very important in spiritual care as it is in any branch of medicine. Especially for those professional caregivers who are Christian living in a culture that is a majority Christian, it is sometimes difficult to recognize when we are using terminology that might not be inclusive of the widest number of patients and families we serve. For instance, "church" is a Christian term and "transcendence" does not include increasing numbers of our spiritual seekers communities. Chaplains are experts at using the most inclusive terminology. Another alternative is always to state clearly when we are speaking from a Christian perspective.

The paper is also unclear about what constitutes proselytizing. Although in religious circles, the word is generally used to mean trying to persuade another to adopt the religious beliefs of the provider of care, in professional chaplain practice, it tends to have a

broader meaning. Chaplains take the power inequity between patients and providers very seriously. For us, any attempt to impose one's own values, beliefs, or opinions religious or otherwise on a patient, unless that opinion has been actively solicited, is considered unethical and the same as proselytizing. The general practice of a professional chaplain is to help each patient articulate and use their own beliefs and values in their coping. Although we applaud Dr. Balducci's clear declaration that proselytizing is not allowed, the extended example that ends the article is clearly an example of imposing one's own values and opinions about how one should spend the end of one's life. It effectively constitutes proselytizing and is not good spiritual care.

In sum, as with many situations in this intersection between oncology care, palliative care, and spiritual care, this paper would have been much improved by consultation with the professional chaplain, who is the spiritual care specialist on the interdisciplinary team. We encourage any practitioners who are interested in teaching or writing in this domain to seek consultation from their professional chaplain, who we trust will be more than willing to assist.

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The Current Practice of Oxygen Therapy for Dyspnea in Terminally Ill Cancer Patients: A Nationwide Survey of Japanese Palliative Care Physicians



To the Editor:

Dyspnea is a frequent and distressing symptom among terminal cancer patients.^{1,2} Oxygen therapy is often used to alleviate dyspnea in this population. However, the efficacy of oxygen therapy for dyspnea in patients without hypoxemia has not been proven,^{3,4} and several guidelines are against its use in such patients.^{5,6} In addition, oxygen therapy may worsen the quality of life because of adverse events such as oral dryness and feeling of restriction.⁷ It is, therefore, important to explore the daily provision of oxygen therapy for cancer dyspnea by palliative care physicians and to determine the criteria for oxygen therapy for cancer dyspnea in patients without hypoxemia. We conducted a nationwide survey of Japanese palliative care physicians to assess the daily practice of oxygen therapy in terminal cancer patients in the presence or absence of hypoxemia.

Methods

We identified 536 certified palliative care physicians in Japan from the Web site of the Japanese Society for Palliative Medicine as potential participants for a cross-sectional survey. From the 536 physicians, we randomly selected 268 (50%) and sent them questionnaires. Because of the lack of an existing specific questionnaire, we developed an ad hoc questionnaire based on literature review,^{3–8} discussion among the authors—who are palliative care physicians—and the results of pilot testing. The questionnaire included several components of physician-reported practices regarding oxygen therapy for dyspnea at rest in terminally ill cancer patients (defined as those with an Eastern Cooperative Oncology Group performance status of 4 and with an estimated prognosis of a week or two). The first component examined physician-reported practices in a hypothetical scenario where a terminally ill patient with cancer continued to suffer severe dyspnea with or without hypoxemia. The following practices were evaluated:

1. Physician-perceived first-line therapy for cancer dyspnea: The options included 1) oxygen therapy alone, 2) administration of parenteral opioid alone, 3) administration of parenteral benzodiazepine alone, 4) a combination of oxygen therapy