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SPIRITUALITY WITHIN THE COMPREHENSIVE GERIATRIC ASSESSMENT PROCESS

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In this chapter, Ellingson argues that the comprehensive geriatric assessment (CGA), which is used in the development of treatment plans for elderly individuals in poor health, has failed to acknowledge the import of some aspects of the elderly patient's life experiences. Ellingson uses case study analysis to demonstrate the significance of spiritual and religious beliefs and practices and suggests that the CGA model should be expanded to include explicit coverage of spirituality and religious issues.

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In recent years, health care researchers have drawn attention to the particular needs, preferences, and abilities of elderly patients. The elderly are the fastest growing segment of the U.S. population, with elderly women comprising the majority of this group (Allman, Ragan, Newsome, Scoufos, & Nussbaum, 1999). Older patients are likely to have fragmented care, seeing a different specialist for each chronic or acute condition and greatly increas-

ing the need for coordination of care and treatment (Beisecker, 1996). As with the general population, the content of communication between physicians and older patients is largely medical, often with little time given to psychosocial issues (Adelman, Greene, Charon, & Friedmann, 1992). Mishler (1984) argued that physicians are more comfortable with and attuned to the "voice of medicine" and often exclude or minimize the "voice of the life-world," or the context of the patient's life experiences. Yet attention to this lifeworld is critical to the care of the older patient because of the unique biopsychosocial, financial, and relational factors that often confront people in their later years (Estes, 1981).

The comprehensive geriatric assessment (CGA) is intended to facilitate the gathering and consideration of patients' biopsychosocial status as well and their medical history and current diagnoses (e.g., Extermann, 2003). Although the CGA addresses a range of biopsychosocial issues, it does not specify spirituality as one of the domains for assessment. Recent research has demonstrated how vital spiritual and/or religious experiences can be for patient quality of life and recovery (e.g., Bessinger & Kuhne, 2002; Eisenberg et al., 1998; Koenig, George, & Peterson, 1998). This case study of patient attempts to integrate their spiritual experiences into the CGA process is part of a larger ethnographic study of an interdisciplinary geriatric oncology team and their patients. This chapter explores exemplars of patients weaving talk about spiritual and religious experiences into interactions with health care providers from a variety of disciplines, including medicine, social work, dietary, pharmacy, and nursing. After exploring the CGA model and definitions of spirituality used in health care, I briefly review research on religious and spiritual beliefs in geriatric patients. I then introduce the setting of my ethnographic case study and provide an overview of my methods. I discuss the importance of spiritual and religious beliefs and practices for geriatric patients as they make sense of their illness experiences in dialogue with health care providers, using exemplars from my data. I conclude by arguing that the CGA model should be expanded to include explicit coverage of spiritual issues, and I offer specific suggestions on how to do so.

SPIRITUALITY AND GERIATRIC CARE

Defining the Comprehensive Geriatric Assessment

The CGA is "a multidisciplinary diagnostic process intended to determine a frail elderly person's medical, psychosocial, and functional capabilities and limitations in order to develop an overall plan for treatment and long-term follow-up" (Rubenstein, Stuck, Siu, & Wieland, 1991, p. 8s). The CGA

process involves the use of a variety of "standardized instruments to evaluate aspects of patient functioning, impairments, and social supports" (Wieland & Hirth, 2003, p. 455). The team I studied utilized the Geriatric Depression Scale, the Activities of Daily Living (e.g., bathing oneself), the Independent Activities of Daily Living (e.g., housekeeping), the Mini-Mental State Examination (detects cognitive processing and memory deficits), and body mass index score (BMI; screens for malnutrition). Such assessment and coordination of treatment and services is especially important for older patients because this population is more likely than others to have both multiple health needs, and complex interactions of medical, psychosocial, and material circumstances (Satin, 1994; Siegel, 1994; Stahelski & Tsukuda, 1990). CGAs help detect unknown or suboptimally treated medical conditions in geriatric oncology patients (Extermann, 2003), and they also uncover relevant information that affects patient care, such as the patients' financial resources and insurance coverage, their preferences for types of care in various situations, and the availability (or lack) of family members to provide home care (Elon, Phillips, Loome, Denman, & Woods, 2000). Ideally, CGA also improves diagnostic accuracy and the development of appropriate, comprehensive treatment plans for patients (Mosqueda & Burnight, 2000).

The use of an interdisciplinary or multidisciplinary health care team to conduct the CGA is standard practice in geriatric settings (Osterweil, Brummel-Smith, & Beck, 2000; Wieland & Hirth, 2003). Geriatric teams are designed to meet the needs of elderly patients; they may be multi-, inter-, or transdisciplinary in organization. Geriatric evaluation teams have been found to be extremely effective at assessment and intervention (Applegate et al., 1990; McCormick, Inui, & Roter, 1996), and correlate positively with a range of desirable outcomes, such as increased patient satisfaction (Trella, 1993); better coordination of patient care (McHugh et al., 1996); improved functioning in activities of daily living (ADLs; Rubenstein et al., 1984); fewer nursing home admissions following hospitalization (Wieland, Kramer, Waite, & Rubenstein, 1996; Zimmer, Groth-Junker, & McClusker, 1985); decreased mortality 1 year after discharge (Langhorne, Williams, Gilchrist, & Howie, 1993); and, decreased prescribing of psychotropic drugs among nursing home residents (Schmidt, Claesson, Westerholm, Nilsson, & Svarstad, 1998). Members of different disciplines work together to provide geriatric care, and programs such as the one discussed here were set up to make the illness experience as positive as possible for these patients by more effectively addressing their health and illness management needs (Stahelski & Tsukuda, 1990). Teams commonly include professionals from medicine, nursing, social work, and dietary, but may draw from a wide range of other disciplines, including pharmacy, psychiatry, physical therapy, and occupational therapy.

Defining Spirituality

Some health communication scholars now acknowledge the centrality of spirituality to the experience of patients, their loved ones, and the health care providers who care for them (e.g., Gonzalez, 1994; Parrott, 2004). Scholars agree that spirituality is not synonymous with religion and that it includes a range of dimensions (Doswell, Kouyate, & Taylor, 2003). Nonetheless, spirituality is frequently couched in religious discourse, even when researchers are attempting to offer a broader conceptualization of spirituality (Henery, 2003).

Spirituality is difficult to define, and a number of definitions and models exist. Wills (Chapter 1, this volume) defines *spirituality* as "an active process engaging hope in the ongoing development of connection to self, to others, and to the universe." In their discussion of the burgeoning interdisciplinary field of medical spirituality, Bessinger and Kuhne (2002) defined spirituality as follows:

> that personal function which relates life's meaning to transpersonal reality. Spirituality is an element of a person's individuality and not necessarily defined by association with a certain tradition or by organizational affiliation. It is multidimensional and operates (to varying degrees) in acknowledgement of the unconscious self, the needs of others, and the realm of the sacred. (pp. 1385-1386)

Further exploring the multidimensionality of spirituality, LaPierre (1994) developed a model for describing spirituality with six dimensions, including journey (search for purpose and meaning), transcendence (encounters with a Higher Power, e.g., God, the universe), community (being part of a supportive group), religion (participation in organized religious groups), the mystery of creation (experiencing the beauty and wonder of nature), and transformation (profound personal change).

Spirituality remains largely outside the proscribed boundaries of conventional medicine (Barnes, Plotnikoff, Fox, & Pendleton, 2000), but increasingly is acknowledged as a critical component of patients' experiences with health, illness, and health care (Parrott, 2004). Religious practice can be considered an aspect of psychosocial experience and hence relevant to patients' health: "Religion is akin to other psychosocial factors and falls squarely into the biopsychosocial model" (Robinson & Nussbaum, 2004, p. 68). Moreover, some contend that beyond organized religion, spirituality "is the integrating factor that holds together the physical, psychological and social components of care" (Wright, 2002, p. 125). Spiritual assessment could therefore be instrumental in understanding and, ideally, improving patients' capacity, resources, and strategies for coping.

Elderly Patients and Spirituality

Patients often want to discuss spiritual issues, but physicians generally are reluctant to do so (Fletcher, 2004). Fletcher's study of nurses, social workers, physicians, psychologists, and chaplains in the Veteran Affairs health care systems found that these individuals had serious difficulties in addressing patients' spiritual needs due to time constraints, concerns about discussing religion and/or spirituality in inappropriate ways, lack of training, and concerns about addressing spirituality in an institutional (government run) setting. Yet all acknowledged that, particularly within the aging veterans population, complete care must involve attention to the spiritual. In fact, spirituality has been found to be a significant aspect of experiencing life-threatening illness (Albaugh, 2003), and hospice and palliative care programs openly embrace the central role of spirituality in end-of life care (Lin & Bauer-Wu, 2003; McClain, Rosenfeld, & Breitbart, 2003; Wright, 2002). One experienced physician argued that, "Plainly, it is no longer reasonable to compartmentalize human experience and health into separate dimensions. A mature understanding of human health recognizes that the spiritual aspect of our existence must be acknowledged and spiritual resources must be mobilized" (Genuis, 2003, p. 81).

Some researchers rightly caution that physicians must be very careful to support patients' existing spiritual or religious beliefs, attitudes, and behaviors, rather than in any way guiding patients towards a particular manifestation of spiritual experience (Koenig et al., 1999). Henery (2003) warned that "For patients, attempts to measure and assess beliefs, values and lifestyle in the name of an objectified 'spirituality' might only intensify the experience of alienation promoted by modern institutions" (p. 556). To do so would be a breach of ethics, given the physicians' powerful role in the ill patient's life, and Robinson and Nussbaum (2004) suggested that physicians let patients take the lead and refer them to clergy (Barnard, Dayringer, & Cassel, 1995).

ETHNOGRAPHIC CASE STUDY

As part of a larger ethnographic study of communication within an interdisciplinary geriatric oncology team and the patients they serve (Ellingson, 1998, 2002a, 2002b, 2003, 2005), I examined the data for evidence of patients' expressions of spirituality. In order to focus my inquiry, I posed the following research question: How do patients express their spiritual needs during the CGA process? Before addressing this question, I provide some background information on the oncology team and its clientele, describe my process of data collection, and provide an overview of my qualitative-interpretive approach to data analysis.

The Interdisciplinary Geriatric Oncology Team

The Interdisciplinary Oncology Program for Older Adults (IOPOA) team at the Southeast Regional Cancer Center (SRCC[1]) consisted of two oncologists (one of whom also is the director of the program), an advanced registered nurse practitioner, two registered nurses, a registered dietitian, a licensed clinical social worker, a clinical pharmacist, and an administrative assistant who worked in an office suite apart from the clinic and served a number of support functions. The team provided CGA and treatment recommendations to each new patient over the age of 70 who came to SRCC for treatment or for a second opinion. Patients underwent a thorough medical history, a physical examination, and a psychosocial evaluation. As part of the assessment, each new patient was screened for depression, cognitive processing deficits, risk of polypharmacy (overmedication or drug interactions), physical impairment or disability, and malnutrition. All of these assessments influenced the treatment plans that the oncologists developed. Moreover, each team member was empowered to make interventions to improve patient health and quality of life. For example, the pharmacist recommended altering medication schedules to avoid drug interactions, the dietitian recommended increased water consumption or augmenting food intake with nutritional supplement beverages, and the social worker recommended counseling or put patients in touch with programs such as home health care.

Data Collection

Study data included ethnographic fieldnotes, interaction transcripts, and staff interviews. For this case study, I drew on the fieldnotes and interaction transcripts only. Clinic observation was conducted weekly from September 1997 to December 1999. I spent 3 to 5 hours 1 day a week in the "new patient" clinic and 1 hour a week in meetings of the IOPOA team. With permission, I observed interactions between patients, companions, and team members; assisted with minor tasks (e.g., getting patient a glass of water); relayed messages from one team member to another; offered pieces of information if requested by a team member (e.g., explained where a team member was or who was with a particular patient); participated in discussions team members had about patients (e.g., listening to their opinions and offering my own opinions of patients' affect); engaged team members in discussions about their personal lives and careers; and spoke with patients and their companions, particularly when there was a long wait before the oncologist was available. While in the clinic, I kept a notebook on a "palm top" computer in which I wrote brief notes. Immediately after observing, I typed extensive fieldnotes detailing my observations, producing more than 300

pages of text. To supplement the fieldnotes, I completed and transcribed nine audiorecordings of initial patient visits from May to July 1999. Following an Institutional Review Board-approved protocol, patients were approached in the waiting room and invited to participate. The recordings included interactions between patients, their companions (e.g., spouse, adult child), and each of the geriatric oncology team members, for a total of seven interactions per patient (patients saw the registered nurse upon both arrival and discharge, and had one interaction each with the oncologist, dietitian, nurse practitioner, pharmacist, and social worker). The interactions were transcribed using transcription guidelines developed specifically for medical discourse by Waitzkin (1990).

Data Analysis

Using a case study approach (Stake, 2000), I reviewed the fieldnotes and transcripts for evidence of spiritual experience. Lindlof and Taylor (2002) advised adopting interpretive "tropes" or semiotic devices for deciphering the patterns that invest experience with meaning. I chose the models of spirituality developed by Wills (Chapter 1, this volume) and LaPierre (1994) as tropes to identify expressions of spirituality in the data. In particular, following Wills, I looked for patients' expression of an "active process" of sense-making; talk of hope; and expression of connection to self, others, or the universe. I also looked for evidence of the different types of spirituality as defined by LaPierre (1994): journey metaphors, transcendent moments, participation in religious or community groups, connection to nature, and experiences of personal transformation.

RESULTS: SPIRITUALITY IN THE IOPOA CLINIC

Using Wills' (Chapter 1, this volume) and LaPierre's (1994) broad, inclusive definitions of spirituality, I found numerous expressions of spirituality from patients in the data. In virtually all cases, the expressions did not fit neatly or exclusively into one category, however. Patients wove their spiritual concerns and explanations into larger stories of symptoms, treatment, social support (or lack thereof), family relationships, and requests to health care providers for assistance or information. Hence, patients spoke of multiple aspects of spirituality (e.g., connection, purpose, and meaning) within very brief comments or anecdotes and often touched on spirituality in many ways over the course of a longer interaction, such as a medical history or psychosocial assessment. Listing the individual components of LaPierre's and Wills' definitions of spirituality along with a brief, decontextualized

example for each fails to provide a sense of the complexity of spiritual experience and its importance to many geriatric patients. Thus, I have chosen to explore in depth three rich examples within which multiple aspects of patients' spirituality were addressed in conversation with one of the interdisciplinary team members during the CGA process. For each exemplar, I offer a brief segment of the patient–provider interaction recreated from my fieldnotes and audiorecordings as an ethnographic narrative (see Ellingson, 2005) and draw connections between the patient's experience and the previously mentioned models of spirituality.

Exemplar 1

The first example is of a widowed female patient, accompanied by her adult son, who sought a second opinion on her cancer treatment protocol. During the psychosocial assessment, Mrs. Davenport[2] reported that she had gone to support groups when her husband died, but felt she did not need a formal group to assist her in coping with her cancer diagnosis and treatment. In the following excerpt, the patient talks with the team's social worker, having just completed the Geriatric Depression Scale:

> "That's fine, you did great," says Joyce, taking the clipboard from Mrs. Davenport. "You don't seem depressed at all."
>
> "No, I'm not. I try to keep very active. I cook and take care of the house for my son and his family. My daughter-in-law works too, you know."
>
> "Wow, that's a lot of responsibility," offers Joyce.
>
> "Hmm, yes, well, I like it. Rick asked me to move in with them after my husband died a few years ago."
>
> . . . Joyce poses a few questions about her satisfaction with her living arrangements, and then asks, "Mrs. Davenport, would you be interested in support groups for cancer patients?"
>
> "No," says Mrs. Davenport slowly. "I don't think so. I tried a couple when my husband died, and I just think I do better by myself. I have a lot of support at home and at church. I don't think so."
>
> "That's fine. We all have our own ways of coping, and you seem to be doing just fine," says Joyce. (Ellingson, 2005, pp. 29-30)

Mrs. Davenport's response reflects at least three different aspects of spirituality in her daily life. First, being part of a supportive community—both within her church group and her son's family with whom she resides—gave

her meaningful relationships with others, corresponding to Wills' "connection with others" and LaPierre's "supportive community." Such relationships spared Mrs. Davenport the burden of loneliness and provided a sense of love, belonging, and self-worth. Spirituality is more focused on coping and healing than on curing (Wills, Chapter 1, this volume) which corresponds to the emphasis on coping in geriatrics, where curing is often not possible (Satin, 1994). Many communication studies on social support affirm the importance of having caring others to provide instrumental, informational, and emotional support to older adults facing cancer diagnosis and treatment (e.g., Arrington, 2004, 2005).

Moreover, one of those communities is a church where Mrs. Davenport attends services regularly and is involved in related activities, reflecting LaPierre's (1994) identification of participation in organized religions as one form of spirituality. Indeed, church attendance has been found to be important to many elderly persons, functioning as a vital form of social support (Robinson & Nussbaum, 2004). Engaging in religious rituals reaffirms her doctrinal beliefs and values and reinforces her connection with a group of likeminded individuals who share in her spiritual experience (i.e., the liturgy or service). Moreover, religious beliefs and participation may be beneficial and promote physical health as well (Larson & Larson, 2003). Encountering the sacred or a higher power affirms one's connection to the universe, an experience Mrs. Davenport framed within Christian theology. Such an experience may actually have fostered a sense of well being for the patient, despite her cancer diagnosis.

Finally, reflecting Wills' framing of spirituality as an active process, the patient indicates that helping to take care of her son and daughter-in-law, her grandchildren, and their home is very satisfying for her. Mrs. Davenport chose to enact an ongoing caregiving relationship with her family members. In daily service, she derived pleasure and satisfaction. If she were unable to serve in this chosen capacity, the patient might experience a spiritual crisis. Instead, her continued capacity to actively (choose to) serve as caregiver is a source of comfort, purpose, and meaning. Moreover, this work gives her a sense of purpose and connection to herself (Wills, Chapter 1), as she generated a very positive sense of herself in her current role. Mrs. Davenport's daily support of her son's family commenced with the death of her husband, a time of loss and upheaval for her. Her developing a new home and a new role for herself can thus be viewed as a journey toward personal growth and meaning (LaPierre, 1994).

Exemplar 2

The second example features a single older woman with a low, fixed income. Ms. Viola discussed her health with the team's nurse practitioner, Sandra:

Sandra proceeded down the list of common ailments with Ms. Viola repeating her mantra of "no" to all of them. "Any difficulty getting around?" asked Sandra next.

As though she had been waiting for just such a question, Ms. Viola took a deep breath and began, "Yes, I do. I have fibromylagia, and it is very painful in my hands. And I am so tired, and my back aches and so does my rib cage, and I can't work." Sandra nodded and Ms. Viola continued. "The pain is so bad I can't sit at my drawing table. I am a very creative person. That's who I am—I am a professional visual artist. If I can't do my work, I'm not *me*," she finished passionately. (Ellingson, 2005, pp. 44-45)

Ms. Viola's story clearly relates to Wills' (Chapter 1, this volume) idea of connecting to oneself as a fundamental component of spirituality. For this patient, doing creative work is the way she connects to and becomes herself; creativity is fundamental to her identity. Without this expression, Ms. Viola experienced a profound loss of meaning and purpose, as she was unable to continue her life's journey of creativity (LaPierre, 1994). Ms. Viola's wording of her problem was by far the most dramatic and explicit of the many instances of patients articulating a sense of loss of self that came at the point of diagnosis and/or onset of symptoms: "I'm not me!" she cried. This patient felt disconnected to the very essence of herself, reflecting a profound spiritual crisis.

Additionally, creativity is a process, and the longing to resume her artistic work reflects Ms. Viola's sense of spirituality as active rather than passive (Wills, Chapter 1, this volume). Interestingly, she makes no mention of producing a good piece of art or selling her work as her goal; it is in the *act* of creation that she feels spiritual satisfaction, not in the products she generates. This patient sought help from the geriatric team as much to cope with her spiritual loss of self as to address her specific biomedical diagnosis. In doing so, she actively participated in improving her own health and managing her health care. Active participation thus potentially had positive outcomes both spiritually and physically.

Ms. Viola also wanted hope that her present situation could be alleviated so that she could be herself again. Hope is fundamental to spirituality: "Viewed as an optimistic endeavor, spirituality is both a process *nurtured by* a positive outlook as well as one that fosters positive outcomes" (Wills, Chapter 1, this volume). Ms. Viola was experiencing despair, having coped with an intense level of pain that prevented her from engaging in her creative work. She sought an optimistic outlook from the health care team, to alleviate both her physical and spiritual crises. The health care team members' receptiveness to acknowledging Ms. Viola's physical and emotional pain was a crucial first step in fostering hope; to have had her concerns dismissed or

disconfirmed undoubtedly would have deepened her despair by lessening her hope of obtaining a solution to her physical problems and the spiritual deprivation they engendered.

Exemplar 3

In the final excerpt, the team's nurse practitioner is meeting with Mr. and Mrs. Davis for a brief follow up visit before Mr. Davis' chemotherapy treatment:

> Mr. Davis looks at the floor and continues, "I'm having chemo today, and I was wondering if it would be okay, if afterward I went to my cabin in the mountains of North Carolina for awhile. Is there any reason I couldn't do that?" He looks up and meets Sandra's kind eyes. Sandra smiles and touches Mr. Davis's hand. "Not at all. That's wonderful. Being there would do you more good than anything we could do here. It would be healing for you." (Ellingson, 1998, p. 498)

Mr. Davis responded very gratefully, clearly appreciating the nurse practitioner's understanding of his need to spend time with nature by being in the mountains, out of the city, and away from the stress he was experiencing during his cancer treatment. His wife, who was sitting next to him, commented, "See, I told you so!" when the nurse practitioner expressed her support. The nurse practitioner further honored this need by arranging a minor shift in the man's chemotherapy schedule to enable him to spend a few extra days at his mountain retreat.

At first glance, this patient most clearly illustrates LaPierre's (1994) expression of spirituality through enjoying the beauty of natural settings. LaPierre suggested that: "Persons may respond to different aspects of their environment—sunsets, mountains, the colors of autumn in the Northeastern United States, waterfalls, the Grand Canyon—as occasions when the mystery of creation is evoked and with it the presence of God" (p. 158).

Nature as a restorative has a long tradition in Western societies. By recognizing the call of the natural world, the nurse practitioner gave comfort and acknowledgment, thus honoring the patient's needs. When she does so, she increases the patient's ability to be hopeful in the face of his illness, an important component of Wills' model.

Hope is necessary for action. In this story, the patient is trying to move from a passive to an active role (Wills, Chapter 1) by making requests for permission to travel and for a more accommodating chemotherapy schedule. Mr. Davis had had to hire someone to manage his business while he was having treatment, and he disliked standing by passively, having surrendered

day-to-day control over his company. When the nurse practitioner praises his suggestion as being more helpful than the medical treatment she was offering, she affirms his active role in his managing his illness and treatment process. Hope and action reinforce each other, making a more optimistic view and the ability to maintain that view easier for the patient, despite all the difficulties with which he is coping. Research has found that terminal cancer patients feel more hopeful when their physicians offer action steps; that is, describing what can be done for the patient rather than focusing only on what cannot be done (i.e., finding a cure) (Clayton, Butow, Arnold, & Tattersall, 2005).

Mr. Davis' connection with his wife is another key element of his spirituality (see Wills' "connection to others"). Mrs. Davis accompanied him for his visit with a written list of questions and topics in order to make sure that all of his concerns were addressed. On the surface, her claim to have "told him so" about the appropriateness of a trip to his mountain cabin was an affirmation of her wisdom and a criticism of her husband's skepticism. However, the statement also provided evidence that she had taken it on herself to communicate with her husband about strategies to enhance his health and his ability to cope with treatment. She had urged him to make the request for travel, and the positive results not only were likely improved health outcomes for the patient but also an affirmation of the caring connection between the wife and her husband.

DISCUSSION AND RECOMMENDATIONS

In each of the exemplars explored in this chapter, the health care provider responded positively and supportively to the patients' expression of spiritual needs and/or experiences. Although not overtly labeling them spiritual, the patients and providers nonetheless expressed and validated spiritual dimensions of the patients' lives. Of course, many opportunities for affirming and exploring patients' spirituality doubtlessly are missed due to patient reticence, health care provider resistance or disinterest, and/or structural constraints on clinical communication (e.g., time pressure). In order to facilitate the incorporation of spiritual experiences more broadly in the CGA in all geriatric settings, spirituality should be explicitly defined as an area of psychosocial assessment. By invoking the spiritual as an official aspect of assessment, space is created for discussion that may seem extraneous or even inappropriate during the CGA under current models. Of course, such legitimating of the domain of spirituality offers no guarantee that patients will be forthcoming and health care providers receptive about spiritual issues. At the same time, evidence suggests that the CGA model is quite successful in

integrating a greater level of attention to patients' emotional, financial, and social support challenges and resources than physicians who individually see patients (e.g., Elon et al., 2000). Hence, it is not unreasonable to posit that designating a spiritual domain is likely to increase attention to spiritual topics that arise in the CGA process.

I now turn to suggestions for integrating such a discussion of spirituality into the CGA process. When done thoughtfully and respectfully, inclusion of spiritual dimensions of patients' lives in the CGA could benefit the ability of patients and health care providers to meet patient needs. I recommend that practitioners and theorists specify spirituality as a domain in assessment models and assign it to someone in the team CGA, or better yet to everyone, with specific strategies for addressing spiritual needs and experiences. Of course, health care providers should take seriously the need for caution against promoting their own religious perspectives or agenda (e.g., Koenig et al., 1999). At the same time, supportive, professional assessment can include careful discussion of spirituality in the same way that health care providers (should) refrain from expressing unprofessional, judgmental attitudes about other elements of patients' psychological and social lives in which they might not personally believe (e.g., sexual orientation, pre- or extra-marital intercourse, family relationships).

First, to ensure that spiritual assessment does not fall through the cracks, I recommend that at least one health care provider have the official responsibility for inquiring into patients' spiritual needs. Robinson and Nussbaum (2004) suggested that physicians should interview patients regarding religious values, beliefs, and practices. Because the social worker is likely to address psychosocial needs within an interdisciplinary geriatric setting that employs the CGA model, she or he may be a logical choice. I suggest that health care teams discuss the matter among one another and develop a consensus as to which member of the team will take primary responsibility for this domain, including asking a short series of prepared questions.

Such questions on spirituality would need to be inclusive and open-ended. Maizes, Koffler, and Fleishman (2002) provided a range of suggested questions for an "integrative" health history. In addition to social, physical, and medical issues, they offer the following questions for exploring spirituality: "Where do you derive your strength during difficult times?" "How do you feel connected to life, to humanity?" "What gives your life purpose and meaning?" (p. 33). Such questions are good models for formulating open-ended questions that transcend specific religious doctrines while focusing on issues most relevant to patients' health, such as coping styles and resources, and beliefs about the meaning of life and suffering. Similarly, Wills' definition of spirituality as active, hopeful, and involving connection suggests a battery of questions on spirituality conceptually organized around these

three elements. In particular, I contend that at least one question should address the patient's understanding of and experience of hope. For example, "How do you define hope for yourself?" "How have you experienced hope and the loss of hope since your diagnosis?" Mentioning LaPierre's (1994) list of domains might help reticent patients to feel comfortable sharing details of nonreligious spiritual experiences. If patients are not forthcoming or have difficulty articulating their sense of spirituality, health care providers could follow up broad questions (such as those from Maizes et al., 2002) with an invitational comment such as the following:

> Many people find that spending time alone in the forest or by the ocean, playing with their grandchildren or pets, or spending time with their friends helps them to feel better. Have you found any places or activities that help you feel better during this difficult time?

Such a question could indicate to patients an openness to move beyond the realm of organized religion to activities that patients find meaningful but may not think to label as spiritual matters per se.

A second recommendation for health care teams is that all providers involved in the assessment process should respond openly if patients (or their loved ones) raise a spiritual topic on their own initiative. The crucial step is to go beyond responding to patients' comments on an efficient or pragmatic level and invite discussion of issues specifically as elements of the spiritual life of the patient. In the example of Mr. Davis, arranging schedule changes to accommodate a trip to the mountains was a pragmatic issue, but it has spiritual implications that could be more fully explored. Health care providers also could use patients' mentioning of enjoyable activities (e.g., golf, attending parties) at other points in the CGA as points of departure for exploring spirituality by inquiring as to the meaning of the activity for the patient (e.g., "It sounds like playing shuffleboard at your community center is really important to you. What makes that so enjoyable for you?").

Third, health care providers should maintain lists and offer referrals to spiritual resources, such as hospital chaplains or local religious organizations. They could even work to help explore options for those whose spirituality is best expressed in other ways, such as recommending local settings for those who enjoy nature, or community groups for active seniors who seek involvement with social or volunteer activities. Many hospitals and care centers have psychosocial departments or other patient support programs; a list of support groups, counseling services, meditation classes, informational packets or lending libraries; or other resources available at the institution could be offered to geriatric patients to help them to enhance their spiritual well-being, in addition to their medical needs.

Finally, discussions of spirituality in health care must move beyond focus on one discipline at a time, usually nursing or medicine (e.g., Robinson, & Nussbaum, 2004). In the field of geriatrics, social workers, nurse practitioners, dietitians, and others address psychosocial issues with patients (e.g., Extermann, 2003). Yet research overwhelmingly focuses on physician–patient interaction and de-emphasizes other health care providers, although patients spend much more time with nurses, technicians, and other providers of health and social services than they do with physicians (Ellingson, 2002a). Research on spirituality in the CGA must be as comprehensive as the process it studies, exploring not just physicians, but the wide range of health care providers who work with patients. Specifically, I recommend more studies of health care teams. In the field of geriatrics, interdisciplinary team care is standard practice, yet interdisciplinary teams are studied generally in terms of correlations of team intervention with quantifiable patient outcomes rather than with the team members themselves as the objects of scrutiny (e.g., Wieland et al., 1996). As a result, much of the research on team functioning is "anecdotal, exhortatory and prescriptive . . . there is an absence of research describing and analyzing teams in action" (Opie, 1997, p. 260). Spirituality is yet another domain that should be studied by focusing on the everyday discursive practices of health care team members as they provide care to patients (see Ellingson, 2003, for a discussion of researching mundane interactions of teams). Through documentation and analysis of communication between patients and the health care professionals who care for them, scholars can gain insights into the actual challenges and opportunities of discussing spiritual issues in the course of conducting the CGA. Such observational data has advantages over self-report data from interviews with health care providers or surveys of patients because it enables direct access to provider–patient interactions, the complexities of which are difficult to capture outside of their experiential context (Lindlof & Taylor, 2002).

CONCLUSION

In closing, I contend that spirituality is implied in the term *comprehensive*, which modifies and describes the geriatric assessment process. In this chapter, I suggested that the subtleties of inclusion must be replaced with conscious acknowledgment of the importance of spirituality and overt strategies to elicit—gently and respectfully—patients' perspectives on this crucial aspect of their lives, particularly as it relates to their strategies for coping with illness. By acknowledging and accommodating patients' spiritual needs, health care practitioners who serve geriatric patients will enhance both patient treatment outcomes and patient satisfaction with care.

NOTES

1. Both IOPOA and SRCC are pseudonyms.
2. All patient and staff names are pseudonyms.

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