SPIRITUALITY AND MEDICINE

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Religious and spiritual beliefs and practices are important in the lives of many patients, yet medical students, residents and physicians are often uncertain about whether, when, or how, to address spiritual or religious issues. Physicians in previous times were trained to diagnose and treat disease and had little or no training in how to relate to the spiritual side of the patient. In addition, professional ethics requires physicians to not impinge their beliefs on patients who are particularly vulnerable when seeking health care. Complicating it further, in our nation’s culture of religious pluralism, there is a wide range of belief systems ranging from atheism, agnosticism, to a myriad assortment of religions and spiritual practices. No physician could be expected to understand the beliefs and practices of so many differing faith communities.

At first glance, the simplest solution suggests that physicians avoid religious or spiritual content in the doctor-patient interaction. As with many issues, however, the simple solution may not be the best. Research indicates that the religious beliefs and spiritual practices of patients are powerful factors for many in coping with serious illnesses and in making ethical choices about their treatment options and in decisions about end-of-life care (Puchalski, 2001; McCormick et al., 2012). This article inquires into the possibility that within the
boundaries of medical ethics and empowered with sensitive listening skills, physicians-in-training and physicians-in-practice may find ways to engage the spiritual beliefs of patients in the healing process, and come to a clearer understanding of ways in which their own belief systems can be accounted for in transactions with patients. Research shows that religion and spirituality are associated positively with better health and psychological wellbeing (Puchalski, 2001; Koenig, 2004; Pargament et al., 2004). Recent research also shows that patients involved in “religious struggle” have a higher risk of mortality (Pargament et al., 2001). Thus, physicians need to inquire about the patient’s spirituality and to learn how religious and spiritual factors may help the patient cope with the current illness, and conversely, when religious struggle indicates the need for referral to the chaplain.

How pervasive is religiosity in the United States?

Religious belief and practice is pervasive in this country, although less pervasive within the medical profession. Surveys of the US public in the 2008 Gallup Report consistently show a high prevalence of belief in God, 78% and an additional 15% who believe in a higher power (Newport, 2009). In an aggregate of 2013 polls, 56% claim that religion is important in their own lives and 22% claim it is fairly important (Gallup, 2013). Washington State is one of ten states claiming the least importance of religion, at 52% (Newport, 2009). In 2010, approximately 43.1% of Americans reportedly attended religious services at least once a week (Newport, 2010). 77% of Americans identified themselves as Christian, 5% with a non-Christian tradition, and 18% did not have an explicit religious identity (Newport, 2012).

One survey in Vermont involving family physicians showed that 91% of the patients reported belief in God as compared with 64% of the physicians (Maugans & Wadland, 1991). A 1975 survey of psychiatrists showed that an even lower number, 43%, professed a belief in God (American Psychiatric Association, 1975). These surveys remind us that there is a high incidence of belief in God in the US public. It also appears that physicians as a group are somewhat less inclined to believe in God. Whereas, up to 77 percent of patients would like to have their spiritual issues discussed as a part of their medical care, less than 20% of physicians currently discuss such issues with patients (King & Bushwick, 1994). Clearly, physicians are not inquiring about spirituality to nearly the degree that patients prefer (Puchalski, 2001; King et al., 2013).

Why is it important to attend to spirituality in medicine?

Religion and spiritual beliefs play an important role for many patients. When illness threatens the health, and possibly the life of an individual, that person is
likely to come to the physician with both physical symptoms and spiritual issues in mind. An article in the Journal of Religion and Health claims that through these two channels, medicine and religion, humans grapple with common issues of infirmity, suffering, loneliness, despair, and death, while searching for hope, meaning, and personal value in the crisis of illness (Vanderpool & Levin, 1990).

Definitions: Religion is generally understood as a set of beliefs, rituals and practices, usually embodied within an institution or an organization. Spirituality, on the other hand, is commonly thought of as a search for what is sacred in life, one’s deepest values, along with a relationship with God, or a higher power, that transcends the self. Persons may hold powerful spiritual beliefs, and may or may not be active in any institutional religion. Spirituality can be defined as "a belief system focusing on intangible elements that impart vitality and meaning to life's events" (Maugans, 1996). Many in the baby-boom generation who claim not to be religious, admit to a sense of “reverence” for life, similar to the concept championed by theologian-philosopher Albert Schweitzer.

Many physicians and nurses have intuitive and anecdotal impressions that the beliefs and religious practices of patients have a profound effect upon their existential experiences with illness and the threat of dying. Recent research supports this notion. When patients face a terminal illness, religious and spiritual factors often figure into their coping strategies and influence important decisions such as the employment of advance directives, the living will and the Durable Power of Attorney for Health Care. Considerations of the meaning, purpose and value of human life are used to make choices about the desirability of CPR and aggressive life-support, or whether and when to forego life support and accept death as appropriate and natural under the circumstances (Puchalski et al., 2009; McCormick et al., 2012; Ai, 2008). Many are comforted in the face of a health-crisis with an inner calm that is founded on their deep trust in God’s loving care for them in all situations.

On the other hand, Pargament’s research reveals that some patients in similar circumstances are involved in religious struggle that may have deleterious effects upon their health outcomes (Pargament et al., 2001). He identifies specific forms of religious struggle that are predictive of mortality. Patients who feel alienated from God, unloved by God, or punished by God, or attribute their illness to the work of the devil were associated with a 19% to 28% increased risk of dying during the 2 year follow up period (ibid). A study of religious coping in patients undergoing autologous stem cell transplants also suggests that religious struggle may contribute to adverse changes in health outcomes for transplant patients (Sherman et al., 2009). Referral of these
patients to the chaplain, or appropriate clergy, to help them work through these issues may ultimately improve clinical outcomes (Pargament, et al., 2001).

Further, the Joint Commission mandates that healthcare institutions ensure that patients’ spiritual beliefs and practices are assessed and accommodated (Joint Commission on the Accreditation of Healthcare Organizations, 2003). Handzo, a chaplain, and Koenig, a physician suggest that the physician’s role (as a generalist in spirituality) is to briefly screen patient’s spiritual needs as they relate to health care and to refer to the chaplain (a specialist in pastoral care), as appropriate (Handzo & Koenig, 2004).

How should I take a "spiritual history"?

Medical students are usually introduced to the concept of spiritual inquiry in courses such as "Introduction to Clinical Medicine." Medical students learn the various components of the doctor-patient interview, often beginning with topics such as the chief complaint, a history of the present illness, a psychosocial history which includes questions about religion and spirituality, and a review of organ systems. Students-in-training are often hesitant to ask questions that they regard as intrusive into the personal life of the patient until they understand there are valid reasons for asking about sexual practices, alcohol, the use of tobacco, guns, or non-prescription drugs. Religious belief and practice often fall into that "personal" category that students-in-training sometimes avoid, yet when valid reasons are offered by teachers and mentors for obtaining a spiritual history, students readily learn to incorporate this line of questioning into the patient interview.

Often, the spiritual history can be incorporated into what we may now want to call the "bio-psycho-social-spiritual" patient history. Students are taught to make a transition by simply stating something like the following: "As physicians, (or, as physicians-in-training,) we have discovered that many of our patients have spiritual or religious beliefs that have a bearing on their perceptions of illness and their preferred modes of treatment. If you are comfortable discussing this with me, I would like to hear from you of any beliefs or practices that you would want me to know about as your care giver." If the patient responds affirmatively, follow-up questions can be used to elicit additional information. If the patient says "no" or "none" it is a clear signal to move on to the next topic, although it is often productive to ask before leaving this topic if other family members have spiritual beliefs or practices in order to better understand the family context and anticipate concerns of the immediate family.
From years as a clinical tutor, I have observed students returning to my office to de-brief a recent patient interview with a sense of excitement and gratification in discovering that this line of questioning opened a discussion that disclosed the patient’s faith in God as a major comforting factor in the face of a life-threatening illness. One patient-family described gratitude for their church community who brought meals to their home in a period when one parent was at work and the other was at the hospital with a sick child, leaving no one to cook for the other siblings. Others spoke of a visit from a priest, a rabbi, or a minister during their hospitalization as a major source of comfort and reassurance. One patient, self-described as a "non-church-goer," described his initial surprise at a visit from the hospital chaplain which turned into gratitude as he found in the chaplain a skilled listener with a deep sense of caring to whom he could pour out his feelings about being sick, away from home, separated from his family, frightened by the prospect of invasive diagnostic procedures and the possibility of a painful treatment regimen. An older woman dying of metastatic cancer, whose adult children and grandchildren lived on the east coast, commented that although she was separated from her family as death drew near, she was sustained by the belief that “I will never be separated from the love of God, even in the moment of death.” An elderly patient with advanced COPD and heart disease explained that he would not seek aggressive treatment, but as a man of faith, was at peace with his imminent death. Most patients will be grateful for an inquiry about their spirituality and for the physician’s respect for their spiritual as well as their physical being.

Some find it helpful to have a clear approach or structure in mind when opening a discussion on spirituality with a patient or taking a spiritual history. A group at Brown University School of Medicine has developed a teaching tool to help begin the process of incorporating a spiritual assessment into the patient interview which they call the HOPE questions:

- **H:** Sources of hope, meaning, comfort, strength, peace, love and connection.
- **O:** Organized religion
- **P:** Personal spirituality and practices
- **E:** Effects on medical care and end-of-life issues

(Anadarajah & Hight, 2001)

So, for example, one might open this line of inquiry by stating that many patients have religious or spiritual beliefs that affect their choices regarding medical care, and ask, “I’m wondering,

(H) Where do you find comfort or hope in this time of illness? When things are tough, what keeps you going?
(O) Does organized religion have a place in your life, or in your family’s life?
(P) Are there spiritual practices or beliefs that are important to you personally?
(E) Are there ways that your personal beliefs affect your health care choices or might provide guidance as we discuss decisions about your care near the end of your life?”
(_ibid_)

One possible advantage of the HOPE questions is the fact that they begin with open-ended questions related to one’s support systems and are inclusive of those who may be nontraditional in their spirituality (ibid). As the interviewer’s skills develop it will become easier and more natural to recognize both verbal and nonverbal cues of the patient and to follow up appropriately.

How can respect for persons involve a spiritual perspective?

The principle of respect for persons undergirds our duties as health care professionals to treat all persons fairly, to safeguard the autonomy of patients, and to limit the risks of harm by calculating the burdens and benefits of the care plan. Such respect for persons is a guiding principle of the healing profession and flows from the profession’s fundamental ethical commitment in serving the sick and injured. Although respect for persons is a secular principle it may have a deeper meaning for physicians who hold a religious perspective as in most religions, the patient is seen as a part of God’s creation, or as created in the likeness of God (imago Dei). Likewise, it is reinforced in religious hospitals whose mission is to care for persons as "children of God," regardless of socio-economic standing. Such caring implies care for the whole person, physically, emotionally, socially and spiritually. Thus, our concern for the patient’s spiritual well-being is an integral part of health care and is a way of showing respect for the person who comes as a patient-suppliant.

How should I work with hospital chaplains?

It is heartening to know that the physician is not alone in relating to the spiritual needs of the patient, but can enjoy the team work of well trained hospital chaplains who are prepared to help when the spiritual needs of the patient are outside the competence of the physician. Most of today’s hospital chaplains are board certified and have undergone specialized training in listening to and talking with patients. Rev. Stephen King, PhD, Director of Chaplaincy at Seattle Cancer Care Alliance describes the requirements for chaplains as follows:

Board Certification Objective Requirements:
72 semester hours/108 quarter hours Masters in theological studies
1 fulltime year equivalent in clinical pastoral education (CPE) (ACPE residency)
Ordained or commissioned by a religious/spiritual tradition (accountability)
Chaplains play an important role in a team approach to caring for patients. The onset of serious illness or accident often induces spiritual reflection as patients wonder, "what is the meaning of my life now?" Others ponder questions of causation, "why did this happen to me?" As mentioned earlier, some patients in the midst of a health crisis may also face a religious struggle or feel angry with God for allowing this to happen. Still others are concerned as to whether the physician’s recommendations for treatment are permissible in the patient’s faith community. Practical questions concerning the permissibility of procedures such as an autopsy, in vitro fertilization, pregnancy termination, blood transfusion, organ donation, the removal of life supports such as ventilators, dialysis, or artificially administered nutrition and hydration, or employment of the Death with Dignity Act, arise regularly for persons of faith. In many cases, the chaplain will have specialized knowledge of how medical procedures are viewed by various religious bodies. In each case, the chaplain will first attempt to elicit the patient’s current understanding or belief about the permissibility of the procedure in question. The chaplain is also prepared to respond to patients experiencing religious struggle through expert listening and communication skills.

The chaplain is a helpful resource in providing or arranging for rituals that are important to patients under particular circumstances. Some patients may wish to hear the assurances of Scripture, others may want the chaplain to lead them in prayer, and still others may wish for the sacraments of communion, baptism, anointing, (formerly, the last rites), depending upon their faith system. The chaplain may provide these direct services for the patient, or may act as liaison with the patient’s clergy person. In one case, a surgeon called for the chaplain to consult with a patient who was inexplicably refusing a life-saving surgical procedure. The chaplain gently probed the patient’s story in an empathic manner, leading the patient to "confess" to a belief that her current illness was God’s punishment for a previous sin. The ensuing discussion revolved around notions of God’s forgiveness and the patient’s request for prayer. In this case, the chaplain became the "embodiment" of God’s forgiveness as he heard the patient’s confession, provided reassurance of God’s forgiving nature, and offered a prayer acknowledging her penitence and desire for forgiveness and healing. The conference with the chaplain opened the door for this patient to accept the care plan that she had refused earlier.
In another case, a neonatologist summoned the chaplain to the NICU when it became apparent that a newly born premature infant was not going to live and the parents were distraught at the notion that their baby would die without the sacrament of baptism. In this case, the chaplain was able to discuss the parent’s beliefs, to reassure them that their needs could be met, and to provide a baptism service with the parents, the neonatologist and the primary nurse in attendance before the baby died. The chaplain also notified the parent’s home-town pastor and helped make arrangements for the parents to be followed back home in their grieving process after the funeral. Sometimes, in the fast moving delivery of health care, the chaplain, by his or her job description, is the only one on the team with sufficient time to follow up on these important patient needs and concerns.

What role should my personal beliefs play in the physician-patient relationship?

Whether you are religious, or nonreligious, your beliefs may affect the physician-patient relationship. Care must be taken that the nonreligious physician does not underestimate the importance of the patient's belief system. Care must be taken that the religious physician who believes differently than the patient, does not impose his or her beliefs onto the patient at this vulnerable time. In both cases, the principle of respect for the patient should transcend the ideology of the physician. Our first concern is to listen to the patient.

Physicians are autonomous agents who are free to hold their own beliefs and to follow their consciences. They may be atheists, agnostics, or believers. It is clear that religious beliefs are important to the lives of many physicians. Medicine is a secular vocation for some, while some physicians attest to a sense of being "called" by God to the profession of medicine. For example, the opening line from the Oath of Maimonides, a scholar of Torah and a physician (1135-1204) incorporates this concept: "The eternal providence has appointed me to watch over the life and health of Thy creatures" (Internet Sourcebook Project, 2011). In a much earlier time in the history of the world, the priest and the medicine man were one and the same in most cultures, until the development of scientific medicine led to a division between the professions. After Descartes and the French Revolution it was said that the body belongs to the physician and the soul to the priest. In our current culture of medicine, some physicians wonder whether, when and how to express themselves to patients regarding their own faith. The general consensus is that physicians should take their cues from the patient, with care not to impose their own beliefs.
In one study reported in the Southern Medical Journal in 1995, physicians from a variety of religious backgrounds reported they would be comfortable discussing their beliefs if asked about them by patients (Olive, 1995). The study shows that physicians with spiritual beliefs that are important to them integrate their beliefs into their interactions with patients in a variety of ways. Some devout physicians shared their beliefs with patients, discussed patients’ beliefs, and prayed either with or for patients who requested such. These interactions were more likely in the face of a serious or life-threatening illness and religious discussions did not take place with the majority of their patients (ibid).

Obstacles to discussing Spirituality with Patients

Some physicians find a number of reasons to avoid discussions revolving around the spiritual beliefs, needs and interests of their patients. Reasons for not opening this subject include the scarcity of time in office visits, lack of familiarity with the subject matter of spirituality, or the lack of knowledge and experience with the varieties of religious expressions in our pluralistic culture. Many admit to having had no training in managing such discussions. Others are wary of violating ethical and professional boundaries by appearing to impose their views on patients. Nonreligious physicians have expressed anxiety that a religious patient may ask them to pray. In such instances, one could invite the patient to speak the prayer while the physician joins in reverent silence.

On the other hand, some physicians regularly incorporate spiritual history taking into the bio-psycho-social-spiritual interview, and others find opportunities where sharing their own beliefs or praying with a particular patient in special circumstances has a unique value to that patient. Certainly issues in modern medicine raise a host of value-laden questions such as whether or not to prolong life through artificial means, whether it is licit to shorten life through the use of pain medications in the provision of palliative care or to pursue “death with dignity” in the final weeks of one’s life. These and a myriad of other questions have religious and spiritual significance for a wide spectrum of our society and deserve a sensitive dialogue with physicians who attend to patients facing these troubling issues. Often, such questions are initiated in doctor-patient discussions and may trigger a referral to the chaplain.

How can we approach spirituality in medicine with physicians-in-training?

The UW School of Medicine was an early leader among medical schools in addressing the topic of patient-spirituality. In an elective course, originating in Spring, 1998, "Spirituality in Health Care," the range of topics goes beyond simply teaching spiritual history taking. Students are encouraged to practice
self-care in order to remain healthy as providers for others, and to give intentional consideration to their deep values and their own spirituality as components of their spiritual well-being. The purpose of this interdisciplinary course is to provide an opportunity for interactive learning about relationships between spirituality, ethics and health care. Some of the goals of the class are as follows:

To heighten student awareness of ways in which their own faith system provides resources for encounters with illness, suffering and death.
To foster student understanding, respect and appreciation for the individuality and diversity of patients' beliefs, values, spirituality and culture regarding illness, its meaning, cause, treatment, and outcome.
To strengthen students in their commitment to relationship-centered medicine that emphasizes care of the suffering person rather than attention simply to the pathophysiology of disease, and recognizes the physician as a dynamic component of that relationship.
To facilitate students in recognizing the role of the hospital chaplain and the patient’s clergy as partners in the health care team in providing care for the patient.
To encourage students in developing and maintaining a program of physical, emotional and spiritual self-care, which includes attention to the purpose and meaning of their lives and work.

(McCormick, 2011)

Until recently, there were all too few medical schools that offered formal courses in spirituality in medicine for medical students and residents. This situation is changing. When the University of Washington School of Medicine created the elective, “Spirituality in Medicine” (1998) there were few other such courses available in medical schools. In 2004, JAMA’s curricular survey showed that: “in 1994, only 17 of the 126 accredited US medical schools offered courses on spirituality in medicine. By 1998, this number had increased to 39, and by 2004, to 84 schools” (Fortin & Barnett, 2004).

In 1998, AAMC developed medical school objectives related to spirituality and cultural issues:

Association of American Medical Colleges (AAMC) Report III- Contemporary Issues in Medicine:
Medical School Objectives Project (MSOP III)
Learning Objectives
With regard to spirituality and cultural issues, before graduation students will have demonstrated to the satisfaction of the faculty:

**MSOP III**

The ability to elicit a spiritual history

The ability to obtain a cultural history that elicits the patient’s cultural identity, experiences and explanations of illness, self-selected health practices, culturally relevant interpretations of social stress factors, and availability of culturally relevant support systems

An understanding that the spiritual dimension of people’s lives is an avenue for compassionate care giving

The ability to apply the understanding of a patient’s spirituality and cultural beliefs and behaviors to appropriate clinical contexts (e.g., in prevention, case formulation, treatment planning, challenging clinical situations)

Knowledge of research data on the impact of spirituality on health and on health care outcomes, and on the impact of patients’ cultural identity, beliefs, and practices on their health, access to and interactions with health care providers, and health outcomes

An understanding of, and respect for, the role of clergy and other spiritual leaders, and culturally-based healers and care providers, and how to communicate and/or collaborate with them on behalf of patients’ physical and/or spiritual needs

An understanding of their own spirituality and how it can be nurtured as part of their professional growth, promotion of their well-being, and the basis of their calling as a physician.

(Association of American Medical Colleges, 1999)

Beyond the four years of medical school, residency programs, particularly those with a primary care focus and a palliative care focus, are incorporating education in spirituality training residents. In addition, Continuing Medical Education (CME) events are now offered to practicing physicians through a series of annual conferences on "Spirituality in Medicine," the first of which was hosted by Harvard Medical School with Herbert Benson, MD, as facilitator. Dr. Benson and Dr. Christina Puchalski combined efforts as co-directors of this conference for several years. Since 2008, Dr. Puchalski has directed an annual Spirituality and Health Care Summer Institute sponsored by the George Washington Institute for Spirituality and Health (GWISH) in Washington D.C.

Summary:

Patients facing serious illness, accident, or death often experience a crisis of meaning. Spirituality is often defined as “the search for meaning.” Spirituality may, or may not be accompanied by a particular religion. Some patients are
profoundly comforted by their spiritual beliefs. Others may encounter religious struggle or negative ways of coping with illness. It is important for patients that their cultural, spiritual, and religious beliefs be recognized and integrated in the development of a plan of care and in decisions that are made concerning end-of-life care. Respect for patient values and beliefs requires competent communication skills in health care professionals. In recent years, considerable effort has been made in professional training to foster patient centered communication that is cognizant and respectful of patients’ cultural and spiritual values and how these may be incorporated into optimal patient care. The American Association of Medical Colleges (AAMC) has developed medical school objectives (MSO) related to spirituality and culture that every student should achieve before graduating. Residency training programs and continuing medical education programs foster continued learning after medical school. However, there is room for improvement. In a recent survey of NW physicians, only 17% of responding physicians reported routinely inquiring about religion/spirituality with new patients, while in a crisis situation, 49% reported inquiry into the patient’s religion/spirituality. 83% of respondents agreed that doctors should refer to chaplains (King, et al., 2013). New resources are available for educators such as those developed by the George Washington Institute for Spirituality and Health (GWISH), including on-line materials that are easily accessible to both students and faculty. Research into the relationship between religion/spirituality and health outcomes and patient well-being is burgeoning. Health care professionals ought not to neglect their own psychological and spiritual well-being. Health care professionals work in an intense and stressful environment, frequently exposed to the suffering of others and to companying with the dying. Such work requires that we stay in touch with our own feelings and that which provides meaning and value within our own lives, while working in a profession dedicated to the care of others.

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References


Koenig HG. Religion, Spirituality, and Medicine: Research Findings and Implications for Clinical Practice. Departments of Psychiatry and Medicine, Duke University Medical Center. Southern Medical Association, Volume 97, Number 12, 2004:1194-1199.


McCormick, TR. Syllabus for BH-518, “Spirituality in Health Care” Department of Bioethics and Humanities, School of Medicine, University of Washington, 2011.


Personal communication with Stephen D. King (date?).


