PRIMARY CARE REPORTS

The Practical CME Journal for Primary Care and Family Physicians

April 2021 VOL. 27, NO. 4

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Religion and Spirituality in Primary Care

Introduction

In 1999, the Association of American Medical Colleges (AAMC) drafted the "Contemporary Issues in Medicine: Communication in Medicine" report as part of their larger Medical School Objectives Project.[1] In it, the authors wrote that "spiritualty is recognized as a factor that contributes to health in many persons. It is expressed in an individual's search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism, and the arts. All of these factors can influence how patients and healthcare professionals perceive health and illness and how they interact with one another."

Recognizing that spirituality and/or religion may interact in a significant way with patients' health, the report calls for medical students to be made aware that "spirituality, and cultural beliefs and practices, are important elements of the health and well-being of many patients," and that they will need to "be aware of the need to incorporate awareness of spirituality and cultural beliefs and practices into the care of the patients in a variety of clinical contexts." This directive to medical schools to incorporate teaching around spirituality and religion was framed as a "contemporary" issue – as though it were somewhat novel. However, spirituality and religion have long been a part of medicine and of healthcare.

In the *Oxford Textbook of Spirituality in Healthcare*, Gary Ferngren writes, "to associate religion with healing seems to be an anachronism that is incompatible with scientific medicine.In fact, however, the two have had a close association 'since the earliest human attempts to heal the human body.'"[2] He goes on to provide examples of how, over time, people have looked to divine sources for healing and that priests and other religious figures often were sought out by people with illness for healing from their afflictions. The ancient view was that the various needs of the person were interconnected, and one could not attend to one need without knowing about and addressing the other. Out of this view of the close relationship between spiritual and physical health, and also because of the commitment held by various religious communities to attend to the needs of the sick and vulnerable, came the development of hospitals and clinics that were founded by religious organizations. In fact, many of the nation's first hospitals were started by religious organizations, and the Catholic Church, through their outreach, "is the largest group of nonprofit healthcare providers in the nation."[3,4]

Over time, there have been formal associations between medical societies and religion, with the most well-known example being the

EXECUTIVE SUMMARY

Religion and spirituality may interact in a significant way with patients' health. A genuine focus on the patient requires particular attention to their deeply held values, beliefs, and first principles. As physicians strive to provide care that is culturally competent and patient-centered, they must be careful to take into account their patients' deepest human commitments.

- Many patients continue to use their religion and spirituality to understand and address their health and disease states. This understanding may affect how they cope with, treat, and communicate about the disease.
- In 1977, George Engle explained that the widely accepted biomedical model of care was reductionistic and did not address key determinants of disease adequately. Engle concluded that the biopsychosocial model takes into account not only the illness, but patients' relationships with the physical, psychological, and social.
- Cicely Saunders recognized that the pain and suffering experienced by patients has physical, psychological, social, and spiritual components, describing it as the "total pain" experience.
- Providers may be less likely to address the spiritual and religious needs of patients if their own beliefs differ. This is in part because providers are concerned about offending someone or saying the wrong thing.
- Many physicians will encounter patients who pray during their medical encounter or ask the provider to pray with them. In these instances, if the physician chooses to lead a prayer, a nondenominational prayer is safest.

American Medical Association's (AMA) Committee on Medicine and Religion (CMR). In his paper "Back to the Future: The AMA and Religion, 1961-1974," Daniel Kim and his colleagues wrote that, "At its height, there were state-level committees on medicine and religion in 49 states … and there were county-level committees in over 800 county medical societies." The authors went on to explain that "thousands of physicians attended annual conferences for clinicians and clergy, and direct outreach to patients included a film viewed by millions."[5] The writers of this paper explained that the CMR arose out of concerns around declining humanism in medicine. The CMR came to an end in 1972, likely because of the AMA's internal debate on abortion.[6] By the late 20th century, the public called on the profession of medicine more broadly to approach medical care in a more holistic fashion, and in doing so, to incorporate spirituality and religion back into its purview.[7]

Since then, professional societies and regulatory bodies have recommended — and in some cases, required — addressing patients' religious and spiritual needs in the course of their healthcare. The Joint Commission requires a spiritual assessment for all patients admitted to a hospital or long-term care facility.[8] Professional societies, such as the American Thoracic Society and the American College of Critical Care Medicine, recommend addressing spiritual concerns in the provision of "comprehensive care."[9,10]

Additionally, many universities and medical schools now have programs in religion and spirituality. Examples include the University of Michigan Medical School Program on Health, Spirituality and Religion; Harvard's Institute on Health, Religion and Spirituality; Duke University's program on Theology, Medicine, and Culture; and the University of Chicago's Program on Medicine and Religion.

These programs have contributed to scholarship and consensus around important aspects of spirituality as it relates to education and patient care. For example, the director of the George Washington Institute for Health and Spirituality (GWish), Christina Puchalski, MD, along with Betty Ferrell, PhD, co-led the first national consensus conference, "Improving the Quality of Spiritual Care as a Dimension of Palliative Care," in 2009, which was attended by interdisciplinary experts in palliative care, clergy, and chaplaincy. The outcome of this gathering was an innovative model for interprofessional spiritual care.[11]

The medical profession is not the only group calling for increased attention to the spiritual needs of patients. Organizations dedicated to the patient experience also have recommended addressing spirituality in patient care. The Beryl Institute, a global organization dedicated to improving patient experience, released their own white paper on "The Critical Role of Spirituality in Patient Experience" in December 2015. That paper has become one of the most downloaded papers in the institute's history.[12]

Regardless of the formal or informal associations between organized religion and medical societies and hospitals, or the recommendations set forth by governing bodies and medical societies, many patients have spiritual and/or religious beliefs. Primary care physicians should make every effort to attend to the various aspects of patients' needs. Patient-centered care depends on the provider's ability to communicate effectively with patients regarding the values and beliefs that are important in their lives. For many patients and families, spirituality is not only a central part of their lives, it is a significant factor in their ability to find comfort and healing when undergoing medical treatment.

Religious/Spiritual Openness

Spirituality, religious practice, and ethical commitment often are at the core of the identity of many

Table 1. Kleinman's Eight Questions

1. What do you think caused your problem?
2. Why do you think it started when it did?
3. What do you think your sickness does to you?
4. How severe is your sickness? Do you think it will last a long time, or will it be better soon, in your opinion?
5. What are the chief problems your sickness has caused for you?
6. What do you fear most about your sickness?
7. What kind of treatment do you think you should receive?
8. What are the most important results you hope to get from treatment?

patients. A genuine focus on the patient requires particular attention to their deeply held values, beliefs, and first principles. Religious commitments (especially for those not from the developed West) are on the rise — but such commitments often are poorly integrated into the current practices of Western medicine. And it is not just the religious commitments of immigrant communities that are poorly integrated, but also those of religious patients at large.

Much has been written regarding the decline in religious beliefs among adults in the United States.[13] Although it is true that in the United States there has been a decline in formal religious service attendance and a decline in the number of U.S. adults who identify themselves as Christian, a large percentage of U.S. adults continue to express a belief in a "higher power." When one looks at the beliefs of minority populations in the United States and, more broadly, people across the globe, religious commitments still are quite prevalent. From these data, it can be inferred that the majority of the patients for whom physicians care likely have some degree of spiritual and/or religious beliefs.

In a recent survey, 36% of U.S. adults endorsed attendance at religious services at least once weekly, with first-generation immigrants having more religious attendance than second- or third-generation immigrants and Blacks endorsing more frequent weekly attendance than whites, Asians, or Latinos.[14-16] In particular, Blacks are more likely than non-Hispanic whites to indicate they are "both religious and spiritual" and less likely to indicate they are "spiritual only" or "neither spiritual nor religious."[17] Although the percentage of adults endorsing a formal religion has decreased over time, the percentage of U.S. adults who say they "believe in God with absolute certainty" still is the majority of U.S. adults, at 63%.[18]

Religious commitment is intrinsically connected to cultural, mental, spiritual, and societal aspects of wellness, and, thus, should be better recognized by the medical community, whose goal is to provide culturally competent, relationship-centered healthcare. Globally, both the world's Christian and Muslim populations have continued to grow.[19] Awareness of this is important because physicians are caring for increasingly diverse patient panels. As physicians strive to provide care that is culturally competent and patient-centered, they must be careful to take into account their patients' deepest human commitments. For many patients, their healthcare plan must engage their religious commitments if it is to be authentically whole-patient centered. How to do this will be addressed in later sections of this article.

The Intersection of Health, Religion, and Spirituality

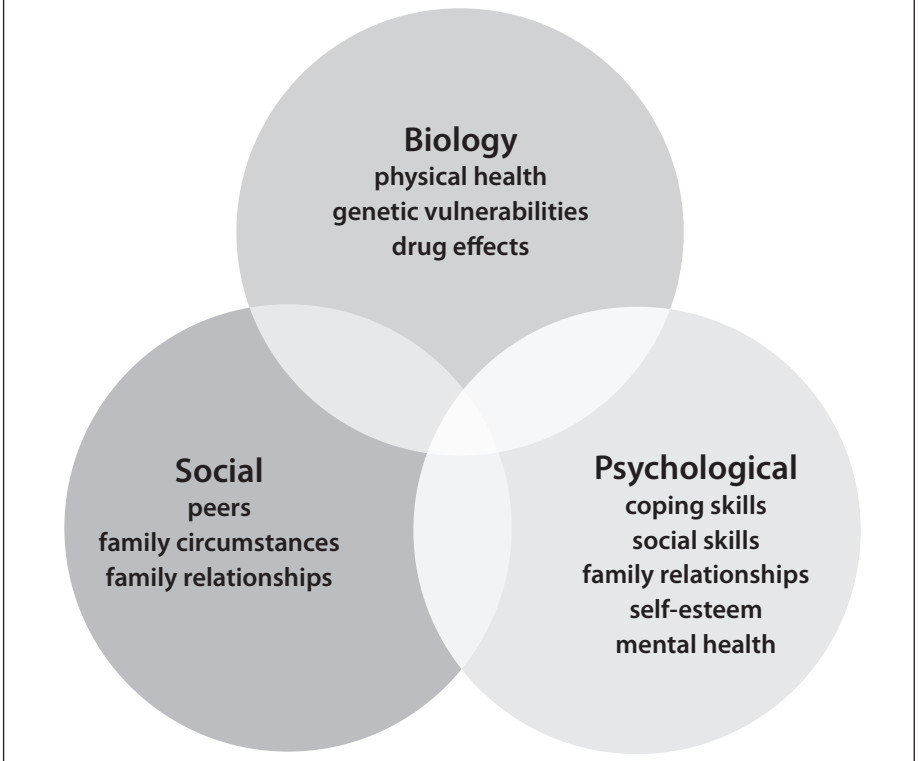
Scientific advances have significantly increased physicians' understanding of the various sources of pain experienced by their patients. With these advances, and an increased focus on what is observed, there has been increasing separation of the spiritual from the physical. However, many patients participate in activities that suggest their religion and spirituality are an important part of their lives, including their health and well-being. For example, a large number of them pray, meditate, read scriptures, or participate in religious education programs.[19]

For many, their beliefs and participation in spiritual and religious practices bring about a sense of spiritual peace and well-being. In essence, religion and spirituality remain a significant part of patients' lives. This includes the way in which patients interact with the healthcare system. There are many decisions, both simple and complex, that patients make after consideration of their religious or spiritual beliefs, or consultation with their spiritual or religious leaders. The decision to receive or reject a treatment, or the need to adjust a care plan, may hinge upon the patient's religious beliefs. Frequently encountered examples include Jehovah's Witnesses' refusal of blood transfusion or blood products and the observance of the holy month of Ramadan by Muslims, which requires intermittent fasting.

Many patients continue to use their religion and spirituality to understand and address their health and disease states. There may be significant variation in patients' understanding of a specific disease (for example, diabetes), depending on their religious and spiritual beliefs. This understanding may affect how they cope with, treat, and communicate about the disease. One may appreciate how religion and spirituality can influence the answers to the questions that Arthur Kleinman suggests as we seek to understand how patients see their disease.[20] (*See Table 1.*)

These questions are patient-centered and focus on the cognitive processes, perceptions, and emotions related to their disease. They allow physicians to gain insight into what is most important as they assist patients with the management of their health and disease. The

Figure 1. George Engle's Biopsychosocial Model of Care



answers to Kleinman's questions may leave healthcare providers perplexed if they do not have a knowledge and understanding of the patient's religious and spiritual background. For example, consider a patient who believes their illness is the result of sinful living or the devil, or a patient who believes the cure of their disease is a result of prayer or divine intervention. This understanding likely will lead to more meaningful interactions with patients and may allow physicians to use resources within the healthcare system and in the community as they provide comprehensive, compassionate care for their patients.

Toward a More Comprehensive Model of Care

Few would argue there has not been significant progress toward addressing patients' physical, social, and psychological needs. Areas of patients' lives that once were considered off limits now are addressed with regularity within medical encounters. For example, sexual history once was considered taboo by some, and this led to infrequent and inadequate discussion of this important part of patients' lives. Now, both patients and physicians view sexual history as an integral part of the patient's social history. Having an understanding of this history is essential to caring effectively for the patient. In addition, it was not until fairly recently that the medical community began to address mental health effectively and compassionately. We now know that mental health may have a significant effect on physical health. These two examples illustrate the appreciation for the interrelation of these different aspects of being human. This understanding led to George Engle's development of the biopsychosocial model of care.[21] (*See Figure 1.*)

In his 1977 article, Engle explained that the widely accepted biomedical model of care was reductionistic and did not address key determinants of disease adequately. Engle called on physicians to not only determine if a person is "sick" or "well," but suggested that it is the physician's responsibility to determine why the patient is sick and in which ways, and then to develop a treatment plan to restore and maintain health. Sickness may be described as the disruption of right relationships.[22] Engle concluded that the biopsychosocial model takes into account not only the illness, but patients' relationships with the physical, psychological, and social. For example, illness disrupts not only the relationships between molecules, cells, tissues, organs, and physiological processes occurring within the body, but it also interferes with relationships between family members, neighbors, friends, employers, and employees.[22] In other words, illness has an effect on relationships that people often rely on for coping. Engle's model allows the appreciation that patients may be suffering physically, psychologically, socially, or in each of these domains simultaneously. This certainly was an upgrade from prior models, but it did not adequately address the total person. Instead, it continued to reduce patients to that which is measurable. Unfortunately, the biopsychosocial model did not take into account what some patients deem the most important part of their being: the immeasurable — their spirituality, or their relationship with that which transcends the physical, psychological, or social.

Cicely Saunders, widely considered the founder of the modern hospice movement, recognized that the pain and suffering experienced by patients has physical, psychological, social, and spiritual components. She described this as the "total pain" experience. (*See Figure 2.*)

Saunders' approach emphasizes a holistic, whole-person approach to patient care. This allows one to recognize that, at the end of life, patients may ask questions such as "What will death feel like?" "Is there an afterlife?" "Have I done all I can in this earthly life?" "Are my finances

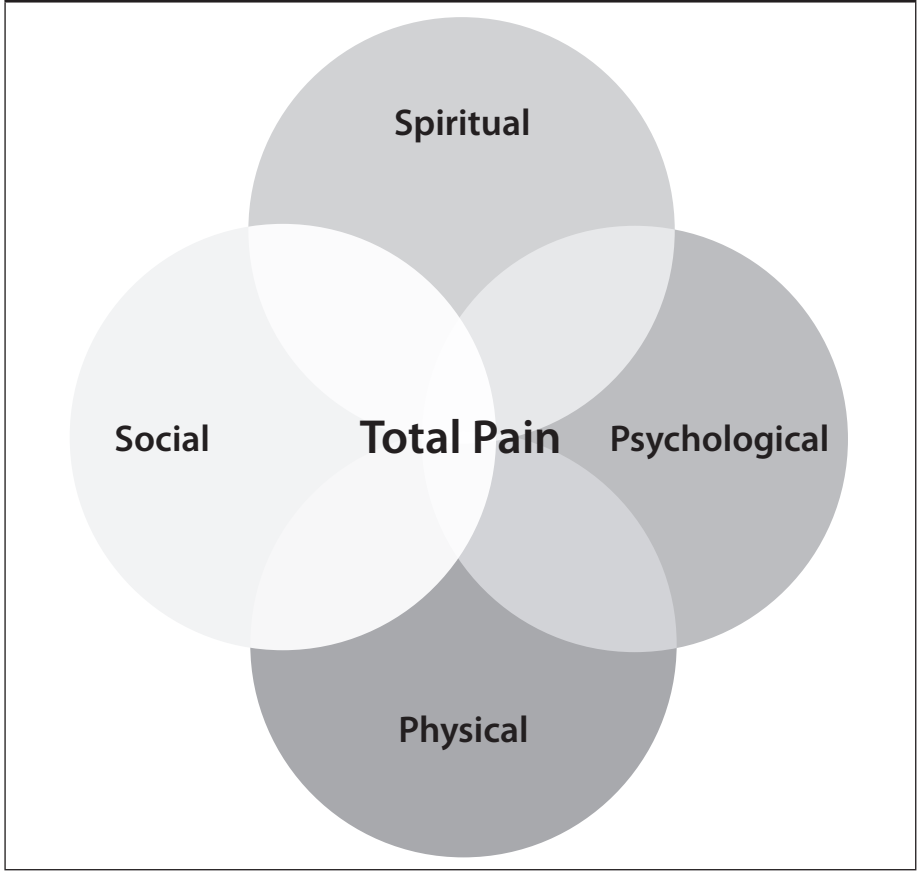
in order?" "Will my family be taken care of?" Certainly, this goes beyond the focus on the physical pain and suffering that patients may encounter at the end of life. Some of the issues that arise at the end of life or with life-threatening illness are examples of what is known as spiritual distress. Saunders helped healthcare providers to appreciate that patients' pain may not be relieved simply by administering analgesics. Instead, all aspects of patients' pain and suffering must be addressed with compassion.

Later, Onarecker and Sterling proposed expanding the biopsychosocial model to include spirituality, leading to the development of the biopsychosocial-spiritual model.[23] This more holistic model acknowledges the importance of spirituality, thereby addressing the totality of patients' relational existance.[24] The World Health Organization (WHO) recognized the importance of addressing the totality of a person's existence and in 1999 changed their definition of health from "health is the state of complete physical, mental, and social well-being and not the mere absence of disease or infirmity" to "health is a dynamic state of complete physical, mental, spiritual, and social well-being and not merely the absence of disease or infirmity."[25] This shift clearly demonstrates an appreciation for religion and spirituality as an important social determinant of health.

Religion and Spirituality and Health Outcomes

Spiritual beliefs and practices are not only highly prevalent in the lives of patients, and increasingly recognized in whole-person models of health, but their positive effects on health are broad and far-reaching. For example, in a study of women in the Nurses' Health Study, frequent attendance of religious services was associated with a decreased risk of all-cause mortality, cardiovascular mortality, and cancer mortality.[26] Another study by Wen and colleagues demonstrated decreased mortality in low-income Americans who attended religious services more than once weekly.[27]

Figure 2. Saunders' Model of Total Pain



Religion and spirituality also may have positive effects on patients' mental health. In a systematic review, Braam and Koenig demonstrated that religious service attendance and placing importance on religion decreased depressive symptoms in some patients.[28] Additionally, a study by Miller and colleagues showed a significantly decreased risk of experiencing major depression in adults with high self-report of religion or spirituality and a parental history of depression.[29] Furthermore, religious service attendance may protect against suicide.[30] A systematic review of the literature also showed decreased levels of anxiety in people with higher levels of religiosity.[31] Some authors even have proposed incorporating a patient's faith into their mental health therapy in a model known as "faith-integrated therapy."[32] Religion and spirituality also have positively affected outcomes in diseases, such as human immunodeficiency virus (HIV) and congestive heart failure.[33,34] For example, studies have shown that experiencing spiritual peace and adhering to a healthy lifestyle are better predictors of mortality risk than functional status and comorbidities in patients with heart failure, and greater spiritual well-being is significantly associated with less depression in patients with heart failure.[35] A systematic review by Hosseini and colleagues, investigating the association between religious and spiritual involvement and cognitive function in adults, showed that religion and spirituality had a protective effect against cognitive decline in middle age and older adults.[36]

Finally, religion and spirituality have long been known to be central to programs such as Alcoholics Anonymous (AA), which was founded in 1935 by two people (one of them a physician) with alcohol

use disorder. One of the founders has described being unable to stop drinking until he had a significant spiritual experience. This led to the strong spiritual foundation found in AA programs. Similar programs, like Narcotics Anonymous, also follow a 12-step, spiritually based process.

Studies have shown that feeling God's presence daily and believing in a higher power as a universal spirit is predictive of positive outcomes in patients struggling with addiction.[37]

There may be no other time during a person's life that they consciously consider their physical, psychological, social, and spiritual relationships more than at the end of life. Although the finitude of physical death brings about the end of many important relationships, many patients with a spiritual or religious background believe they also are spiritual beings, and that their spirits will live on after their physical death. For example, a 2015 Pew Religious Landscape study showed that about 72% of Americans believe in heaven.[38]

Prior to death, many endure a prolonged course with the challenge of an incurable or terminal illness. During this time, patients may reflect on religion and spirituality, or look to find meaning or peace from these sources. Others may experience spiritual pain because they perceive their relationship with the transcendent as broken. This makes discussing and understanding the patient's religious and spiritual background essential.

When caring for dying patients, healthcare providers must seek to understand how a person is coping religiously and spiritually. This is important because religion and spirituality have been associated with improved quality of life in patients with serious, incurable diseases, and at the end of life.

Much of the research in this area is related to patients with terminal cancer. For example, in a study by Vallurupalli and colleagues, patients receiving palliative radiation therapy not only relied on religious and spiritual beliefs to cope with their advanced cancer, but spirituality and religious coping led to a better quality of life.[39]

To quantify the degree to which people experience spiritual well-being and coping, scales have been developed for use in both clinical work and research. The Functional Assessment of Chronic Illness Therapy – Spiritual Well-Being 12 Item Scale (FACIT-Sp-12), one of the most commonly used scales to assess spiritual well-being in cancer patients, is a 12- item scale that evaluates a patient's feeling of "meaning/peace" and "faith."[40,41] Physicians also should be aware of the Brief RCOPE, one of the most commonly used measures of religious coping. The Brief RCOPE is a 14-item validated scale that may be used to comprehensively assess religious coping with major life stressors.[42]

Physicians Addressing Patients' Religion and Spirituality

Given the clear association between spirituality, religion, and health, it is imperative that healthcare providers know how to effectively inquire about patients' spiritual and/or religious beliefs if they hope to provide whole-person centered care.

Research confirms that patients are open to and would like their physicians to inquire about their religion and spirituality. A study by McCord and colleagues showed that 83% of patients wanted their physicians to ask about their spiritual beliefs at least in some circumstances. This was especially true when discussing life-threatening diseases, serious medical conditions, and the loss of loved ones.[43] In response to such research, in 2016, the AMA stated that it "recognizes the importance of individual patient spirituality and its impact on health and encourages patient access to spiritual care services."[44] Additionally, organizations such as The Joint Commission and the Association of American Medical Colleges, have called on physicians to not only address patients' religious and spiritual needs, but to begin training future generations of physicians to do so as well.

Although patients desire discussions about religion and spirituality, and the medical community has come to recognize the importance of these discussions, a gap remains between what is desired/recommended and what is done in practice. For example, a systematic literature review showed that physicians addressed religion and spirituality during medical consultations infrequently and inadequately.[45] There are many reasons for this practice gap. However, one of them is not that physicians believe that religion and spirituality are unimportant. A study by Smyre et al showed that 65% of physicians believed that it is important to address a patient's spiritual concerns at the end of life, and that it is essential to good practice. In the same study, 81% of physicians indicated that it is appropriate for a doctor to encourage patients to talk with a chaplain or pastoral care provider.[46] Another study by Monroe et al showed that 84% of primary care physicians thought they should be aware of patients' spirituality, but most would not ask about spiritual issues unless the patient were dying.[47]

Cost

As discussed, spiritual distress can occur in patients, especially those with chronic or life-threatening illness, and research has shown that patients would like their healthcare teams to be aware of their religious and spiritual needs. These data alone should provide adequate reason to address the needs of patients in this domain. However, for those who question if addressing spiritual needs leads to cost-saving for healthcare systems, there are data supporting the cost-effectiveness of spiritual care. In a study by Balboni and colleagues, among patients with advanced cancer, those who reported that their religious and/or spiritual needs were inadequately supported by the healthcare team were less likely to use hospice and more likely to die in an intensive care unit (ICU).[48] This translated into higher end-of-life costs, particularly among minorities and people identified as "high-religious copers." End-of-life costs

averaged $2,000 to $4,000 more per patient in the group of patients who felt inadequately supported vs. those who felt supported.

Although indirectly linked to cost, patient satisfaction increasingly has become an important metric that has the potential to influence hospital revenue. Patient satisfaction, or lack thereof, can affect hospital revenue through word-of-mouth recommendations or online reviews of a hospital (which may affect referrals, etc.) and is linked to reimbursement by some payers, such as Medicare.[49] For example, research has shown that patient satisfaction is higher after a visit by a chaplain and that patients are more willing to recommend the hospital, as measured by both the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey data and Press-Ganey survey data.[50]

Barriers to Screening for and Addressing Spiritual Needs

When asked, many healthcare providers believe a spiritual assessment should be completed and would be willing to do it, but in practice, few actually do.[51] Screening for and addressing the spiritual needs of patients requires many resources. These resources can be especially limited in the outpatient setting.

The most frequently identified barriers to addressing the spiritual needs of patients include lack of time, difficulty identifying patients who want to discuss spiritual issues, provider discomfort and lack of training on the topic, lack of chaplain support in the outpatient setting, and the belief that addressing spiritual concerns is not part of the physician's role.[52,53]

In addition, most electronic health records do not have built-in support either for prompting a provider to take a spiritual history or to document one efficiently.

Of the aforementioned barriers, adequate time particularly is challenging in the ambulatory setting. There are a number of tools that require only a few minutes to administer. For example, the FICA tool, developed by Dr. Christina Puchalski for use in primary care, is validated, is easy to use, allows efficient assessment of a patient's religion and spirituality, and should only take about two minutes to complete.[54] (*See Table 2.*)

Table 2. The FICA Tool

Faith	• Do you consider yourself spiritual or religious? • Do you have spiritual beliefs that help you cope with stress? • What gives your life meaning?
Importance/ Influence	• What importance does your faith or belief have in your life? • On a scale of 0 (not important) to 5 (very important), how would you rate the importance of faith/belief in your life? • Have your beliefs influenced you in how you handle stress? • What role do your beliefs play in your healthcare decision-making?
Community	• Are you part of a spiritual or religious community? • Is this of support to you, and how? • Is there a group of people you really love or who are important to you?
Address	• How would you like your healthcare provider to use this information about your spirituality as they care for you?

Other tools used in clinical practice for the assessment of patients' religious and spiritual needs include the HOPE, FAITH, and SPIRITual tools.[55] There are benefits and drawbacks to the use of each of these tools. Physicians should choose a spiritual assessment tool based on familiarity, comfort, and the needs of their patients.

Lack of training or education on how to take a spiritual history is another common barrier for this being done in clinical practice. In a study by Balboni and colleagues that looked at barriers to providing spiritual care at the end of life, the majority of nurses and physicians reported they had never received spiritual care training.[56] Even though most medical schools now have some curriculum in spirituality as it relates to healthcare, the curriculum varies widely in scope and most physicians still feel inadequately prepared to take a spiritual history.[57] In a study involving medical students in Brazil, the majority wanted to address spirituality and/or religion in their clinical practice and considered it relevant, but nearly one-half felt unprepared to do so.[58] There is evidence that dedicated education on taking spiritual histories in the outpatient setting leads to a change in practice, with more providers consistently inquiring about these questions.[59]

An insufficient number of available chaplains poses another challenge to fully addressing the spiritual needs of patients, especially in the outpatient setting. The Distress Management Guidelines of the National Comprehensive Cancer Network (NCCN) say that "distress should be recognized, monitored, documented, and treated promptly at all stages of disease and in all settings."[60] Since spiritual distress is a type of distress encountered by patients and is encountered in the outpatient setting just as in the inpatient setting, spiritual care resources should be available across all healthcare settings. Historically, chaplains have been involved in a limited capacity in the outpatient setting compared to the inpatient setting, but this is changing for the better. However, the historical lack of chaplaincy presence in the outpatient setting has meant that clinical staff and leadership in the outpatient setting are not as familiar with what chaplains do and how they can help support the needs of patients and families.[61] This poses an additional

barrier to the use of the outpatient chaplaincy staff, even in the cases when they are present and available.

Another barrier to adequately addressing the spiritual needs of patients involves discomfort with discordant views. A recent study suggested that providers are less likely to address the spiritual and religious needs of patients if their own beliefs differ from those of their patient.[62] In part, this was because providers expressed discomfort with beliefs that differed from their own and expressed concern about possibly "offending" someone or "saying the wrong thing." Therefore, this speaks to a larger barrier in our culture of insufficient contact and dialogue with those who believe differently than we do, and also speaks to a need for increased training in medicine around cultural competencies. As we work to overcome these barriers, many have continued to advocate for addressing spiritual care in patients. This is true especially in the realms of medical education and in professional chaplaincy organizations, which have been advocating for better integration of chaplaincy in the outpatient setting.[63,64] Regarding medical education, on the last national survey, approximately 90% of medical schools reported curriculum on spirituality and health, which is encouraging to see.[57]

The Role of Chaplains

Like any need outside of the scope of one's practice, spiritual distress often is best attended to by someone trained in pastoral care, such as a hospital chaplain or community faith leader. Patients may have many ailments that require physicians to enlist the assistance of consultants and other professionals in the medical community. Often, physicians consult with those in social work, behavioral health, mental health, or with a subspecialist when care outside of their expertise is needed. Similarly, as they seek to care comprehensively for their patients, if a spiritual need outside their scope of practice arises, the ability to consult with a spiritual care specialist should be in their toolkit of resources. In primary care, if the physician's goal is to provide whole-person care, then the physician has an obligation to ensure they are attendant to all aspects of their patients' needs. After they discover these needs, referring patients to the right provider to address them is paramount.

Some patients already may have a spiritual advisor from their local congregation, synagogue, or mosque to whom they can turn. Encouraging patients who are experiencing existential or spiritual distress to turn to their spiritual advisors is recommended. For patients who do not have a spiritual advisor, many health systems have chaplains who may be called upon, just as one would any other type of consultant. Hospital and healthcare chaplains are theologically educated, pastorally experienced, clinically trained, and certified by a professional chaplaincy organization. In the United States, healthcare chaplains who are board-certified have completed a minimum of four units of Clinical Pastoral Education (CPE) training through the Association for Clinical Pastoral Education, Healthcare Chaplains Ministry Association, the Institute for Clinical Pastoral Training, or the College of Pastoral Supervision and Psychotherapy. Some chaplains also may be certified by one of the following organizations: Spiritual Care Association, Association of Professional Chaplains, National Association of Catholic Chaplains, Neshama: Association of Jewish Chaplains, Association of Certified Christian Chaplains, or College of Pastoral Supervision and Psychotherapy.

Although, historically, the term "chaplain" has referred to someone from a Christian tradition, the term now often refers to people from any religious or philosophical tradition. Typically, certification requires a Master of Divinity degree (or its equivalent), faith group ordination or commissioning, faith group endorsement, and four units (1,600 hours) of CPE.[65] Many are embedded within palliative care teams or medical ICUs, but often are available to any patient who needs them, on any service in the hospital.

Many physicians erroneously believe that chaplains are needed only for end-of-life care, but their involvement can be considered appropriate at any stage in chronic illness, at the time of a challenging new diagnosis, or whenever existential distress may arise in the course of their healthcare. Chaplains can address spiritual distress, provide certain sacraments, and assist teams with difficult "goals of care" or end-of-life discussions.[66,67] They also are available to assist with the support of staff. Chaplains also can assist with spiritual distress in primary care settings and have been shown to be helpful with facilitating advance care planning.[68]

Unfortunately, many physicians are unaware of the role of spiritual care services or how to contact them when needed. In a recent study evaluating ICU physicians, many were unfamiliar with spiritual care services and reported lack of clarity regarding the process of contacting the spiritual care department and what services the department could provide.[62] However, when patients are treated by a member of the chaplaincy staff, they often report higher levels of satisfaction with their hospital stay and are more likely to endorse that their emotional and spiritual needs were met compared to patients who did not have a visit by a hospital chaplain.[69] Knowing how to properly use the expertise of chaplains in the healthcare system in which a physician works is an essential part of being able to attend to whole-person care and needs as they arise.

Prayer

In addition to being able to call on a chaplain or other member of a spiritual community to help patients, physicians should be aware that private prayer often is used by patients in the course of their healthcare and patients may even ask their physician to pray with them during a healthcare encounter.

Prayer is a common practice of people of faith. According to a Pew research poll, 55% of people in the United States pray daily. Even among U.S. Americans who identify as non-religiously affiliated, 20% say they, too, pray daily.[70] When people become ill, many patients turn to prayer as a source of comfort, to feel connected to the divine, ask for healing, and express gratitude.[71] Certain groups are more likely to turn to prayer than others, namely Blacks, older patients, and women.[70,71] Research has demonstrated a positive effect of prayer on many diseases and conditions. In a recent systematic review, which evaluated the effect of prayer as an adjunctive therapy for pain, prayer emerged as a preferred beneficial intervention for religious patients undergoing surgery or a painful procedure.[72] Prayer also has been found to have a beneficial effect on self-reported quality of life and psychological status for patients with cardiac disease, psychosocial adjustment, and symptom management in patients with breast cancer, and in patients struggling with their mental health.[73-75]

Given the prevalence of prayer among patients, it is unsurprising that many physicians will encounter patients who are praying during the course of their medical encounter or will tell their physician or team about their prayers regarding their illness. Some patients will even ask a healthcare provider to pray with them during a healthcare encounter.[76] How should physicians respond to this? Recognizing that the decision to pray with a patient is a personal one, most guidance written on the topic suggests that, because of the inherent power differential between the patient and healthcare provider, healthcare providers should not pray with the patient unless specifically asked to do so by the patient.[77] With this in mind, in one of the most recent guides provided by the *AMA Journal of Ethics*, physicians are asked to consider balancing their personal feeling regarding patient prayer requests with recognizing the need for the patient to feel legitimized in their faith practice. The authors write: "When a physician is comfortable praying with a patient, it is most appropriate to pray silently. If the patient requests the physician to lead the prayer, however, the physician should be cautious to avoid imputing specific beliefs to the patient, as even those of the same faith can differ in their beliefs. If the physician chooses to lead a prayer, nondenominational prayer is the safest; asking God for support is safer than requesting specific outcomes. "[78]

Healthcare providers' willingness to engage patients' requests for prayer is dependent on their own spiritual or religious life, since studies have shown that comfort with and respect for the prayer lives of patients is associated positively with the religiosity of the providers themselves. For example, nurses who self-reported a more robust personal prayer life were shown to respond more favorably to patients' requests for prayer. [79] Physicians who are more religious and/or spiritual report more positive perceptions regarding the link between religious beliefs/practices and patients' psychological well-being.[80] In one national survey of physicians, a majority of the physicians stated that, if asked, they would join the family and patient in prayer. Physicians' willingness to join ranged from 67% when there was concordance between the physician's and the patient's religious affiliation to 51% when there was discordance.[81]

Addressing the spiritual needs of patients may require an interprofessional approach. Although many physicians appropriately rely on their spiritual care colleagues to attend to the spiritual needs and prayer requests of their patients, patients still value their physician making it clear that their beliefs and practices are respected by all members of the healthcare team. However, knowing this, many hospitals have insufficient chaplains to meet the spiritual needs of their patients. This has been especially apparent during the COVID-19 pandemic. With limited in-person contact with other members of the team, including outside faith leaders, physicians need to be able to feel comfortable addressing some of these requests themselves, to the best of their abilities.[76]

Religious Accommodation

Lastly, patients with religious and/or spiritual practices may desire accommodation of various types while in the healthcare system. It is important to know what type of accommodation may be requested, and in some cases, required. When sick, patients often are separated from the communities, people, and practices that normally provide them comfort and support. This can cause further stress in addition to the stress of their medical illness. When patients are in the care of their

Table 3. Examples of Religious Accommodations in Patient Care

- Accommodating dietary needs (kosher, halal, etc.)
- Providing access to patients' identified religious or spiritual leader as requested
- Providing time and/or space as requested for prayer
- Incorporating the patient's spiritual and/or religious beliefs in medical decision-making as appropriate
- Providing access to sacraments or other religious or spiritual materials as requested for prayer and/or healing
- Honoring time that is identified as "sacred" as it relates to their religion, when possible (i.e., not asking patients who observe the Sabbath to fill out paperwork on the Sabbath)

physicians, the physicians should strive to accommodate their patients' needs — religious needs included.

Needs as they relate to religion and or spirituality often include dietary needs; offering of sacraments; space, time, and materials for prayer; and respecting one's faith and/or spiritual commitments, since they may intersect with healthcare decision-making.

Many physicians are familiar with providing accommodation for patients whose religious and/or spiritual commitments lead them to disagree with a standard medical procedure or intervention (such as an influenza vaccination, blood transfusions, or the acceptance of a definition of death that is solely neurological), but religious accommodation for patients and families also means having dietary options available to them, having space and time to pray, and considering needs at the end of life.[82-85] (*See Table 3.*) When patients are hospitalized, just as physicians would strive to accommodate a patient who has a dietary need around lactose or who may prefer a vegetarian meal, so too should they strive to accommodate a patient who requests halal food or a kosher option. Having available meal options that reflect a variety of preferences throughout a healthcare system demonstrates a commitment and respect for multiple, diverse needs.

Religious accommodation is not just something healthcare systems should do; it is something they must do according to The Joint Commission. The Joint Commission requires hospitals to be accountable for maintaining patient rights, including accommodation for cultural, religious, and spiritual values.[86] For example, respecting the Sabbath for people who observe it, and not asking observant patients to participate in activities on the Sabbath that would be in violation of keeping this time sacred, should be strongly considered if at all medically possible.[87]

Regarding space, many hospitals also are rightly considering the religious needs of patients when designing new buildings. For example, one healthcare system considered needs for prayer when they designed patient rooms, with privacy in mind for prayers and ways to include symbolic meaning derived from attributes such as color.[88]

The need for religious accommodation may occur at the end of life when, for example, it is recommended that a dying Muslim patient be placed in a position such that his or her feet are facing Mecca.[89] Many patients also desire having their spiritual advisor or leader participate in discussions with the healthcare team about goals of care or end-of-life discussions. Taking the time to understand who patients prefer to have involved in these conversations and taking the time to listen and incorporate such persons can help patients feel supported and can assist in complex decision-making. Having a healthcare staff that provides culturally competent care is patient-centered and can help prevent added distress to patients who already are under duress from their medical illness.

Summary

In conclusion, if physicians want to address whole-person care, then they need to recognize and attend to the spiritual needs of their patients. To do this, physicians need improved training in taking a spiritual history and recognizing spiritual distress, time to do so, and the resources available to help patients who may be experiencing spiritual distress.

Many barriers to whole-person care exist, and much work has yet to be done to overcome ongoing challenges to doing this well. Patients want this type of care, but in practice, their needs often go unmet.

Physicians also should strive to provide religious accommodation for patients who desire this, in accordance with physicians' respect for them as whole persons and their desire to provide culturally competent, patient-centered care.

To do all of this well will require ongoing efforts in medical education, faculty development, continuing medical education, and advocacy, and strengthened partnerships with colleagues in the community and professional organizations. In the meantime, physicians have an opportunity to reflect and improve upon their own individual practices with a hopeful desire to improve their skills in this domain as they continue to strive to be growth-minded healthcare professionals.

Patients deserve to be acknowledged in the entirety of who they are, and in physicians' efforts to do so, they must acknowledge spirituality as a component of whole-person, patient-centered care.

References

A complete list of references is available online: http://bit.ly/3eNw0Fx

CME Questions

1. Many tools have been developed and validated for use in taking a spiritual history. In particular, the FICA tool has been developed by primary care physicians for use in the outpatient setting. In the FICA acronym, the "C" stands for which of the following?
   a. Concerns about spirituality
   b. Caregiver burden
   c. Cost of healthcare
   d. Community
2. According to Pew Research Forum, which population in the United States endorsed the highest rates of weekly church attendance?
   a. Whites
   b. Blacks
   c. Asians
   d. Latinos
3. According to the Association of American Medical College's (AAMC) definition, spirituality is expressed in an individual's search for:
   a. meaning.
   b. security.
   c. religion.
   d. comfort.
4. In the United States, healthcare chaplains who are board certified have completed a minimum of four units of which type of training?
   a. Mindfulness Meditation
   b. Clinical Pastoral Education (CPE)
   c. Narrative Medicine
   d. Rite of Christian Initiation of Adults (RCIA)
5. According to the *AMA Journal of Ethics*, when providers are asked to pray with patients, it is most appropriate for the provider to pray:
   a. silently.
   b. on their knees.
   c. holding hands.
   d. on their own.
6. When the World Health Organization changed its definition of health, it included which of the following?
   a. Social well-being
   b. Spiritual well-being
   c. Psychological well-being
   d. Physical well-being
7. Which of the following tools may be used to assess a patient's religious coping?
   a. FICA tool
   b. HOPE tool
   c. SPIRITual tool
   d. Brief RCOPE
8. Among models of care, which model tends to take the most holistic approach to the care of patients?
   a. Total pain model
   b. Biomedical model
   c. Biopsychosocial model
   d. Psychosocial-spiritual model

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