

Physicians and Patient Spirituality: Professional Boundaries, Competency, and Ethics

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Clinical studies are beginning to clarify how spirituality and religion can contribute to the coping strategies of many patients with severe, chronic, and terminal conditions. The ethical aspects of physician attention to the spiritual and religious dimensions of patients' experiences of illness require review and discussion. Should the physician discuss spiritual issues with his or her patients? What are the boundaries between the physician and patient regarding these issues? What are the professional boundaries between the physician and the chaplain? This article examines the physician-patient relationship and medical ethics at a time when researchers are beginning to appreciate the spiritual aspects of coping with illness.

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Spirituality, which pertains to ultimate meaning and purpose in life, has clinical relevance (1). Patients are especially concerned with spirituality in the contexts of suffering, debilitation, and dying. For some patients, these concerns may be taken up entirely within the context of human relations, values, and purpose (2); for others, their resolution involves faith in a higher being in the universe, one that is a source of reassurance and hope. A recently developed and clinically tested spiritual well-being scale delineates the amorphous term "spirituality" in broad categories, including such phenomena as belief in a power greater than oneself; purpose in life; faith; trust in providence; prayer; meditation; group worship; ability to forgive; ability to find meaning in suffering; and gratitude for life, which is perceived as a gift (3).

Spirituality as manifested by faith in a higher being is remarkably resurgent in the contemporary United States (4). But why address this form of spirituality now as a matter of serious medical and ethical concern? First, when patients feel that their spiritual needs are neglected in standard clinical environments, many of them may be driven away from effective medical treatment. This tendency is exemplified by a review of the medical records of 172 children who died after their parents relied on faith healing instead of standard medicine. The researchers found that most of the children would have survived if they had received medical care (5). More attention to patient spirituality in the clinical

context of standard medical care could attract more patients to proven interventions. Second, psychoneuroimmunology has established that such emotions as anxiety and hope (6-8) can be factors in illness outcomes (9). The keys to emotional coping with serious illness and disability are frequently found within the matrix of patient spirituality (10). Studies indicate that this matrix has clinical significance because it provides an interpretive framework for many patients in handling the stress of illness (11). For these two reasons, the physician's duty of beneficence requires respect for patient spirituality.

Deciding how best to respond to a patient's spiritual commitments, however, can raise professional ethical issues for physicians. For example, should physicians discuss spiritual issues with patients, and do patients want them to? Is it ever appropriate to try to encourage or discourage religious beliefs for the "benefit" of the patient? What should be the professional boundaries between physicians and chaplains, who can be clergy or nonclergy lay persons with clinical pastoral education? In 20th-century U.S. culture, Osler greatly appreciated the emotional and humanistic importance of belief systems. However, he delegated central responsibility for this aspect of patient experience to the chaplain (12).

But should an appreciation of patient spirituality also be expressed within the physician-patient relationship? If so, under what circumstances and to what extent? Physicians are often troubled by beliefs that may undermine the patient's medical care. Ultimately, however, case law allows treatment refusal in competent adults for religious or other reasons, and it sometimes requires what could be construed as overtreatment (13). This paper will not, however, focus on the well-discussed quandaries of treatment refusal or futile request; the main concern is the less widely discussed but broader issue of having clinical respect for patient spirituality as an important resource for coping with illness.

Although physicians remain uncertain about whether spirituality influences health, this topic is being increasingly studied. The first section of this article summarizes evidence for the claim that for many patients, spirituality that includes faith in a

higher being is important and beneficial. Attention then turns to the subsequent and primary task of addressing pertinent professional ethical issues.

Holism: Appreciating Patient Spirituality

Consensus panels have reviewed existing studies of the role of faith-based spirituality in coping with major illness and have found that the quality of data has improved over the last decade (14). As is true for any emerging scientific field, the later studies tend to be more methodologically sound than the earlier ones, and the evidence requires careful evaluation (14–17). The problems of chance, bias, and confounding variables have been critically analyzed in this literature. Despite the complex nature of spirituality as an epidemiologic construct frequently measured as a single item of religious commitment, statistically significant evidence seems to support a salutary association between these single items of religion and morbidity and mortality (16). A recent critical response to many published studies dating back several decades indicates that methods and reliability have improved over time; credible studies indicating health benefits associated with religious spirituality have been published in the best clinical journals (17). Research is showing that a patient's spirituality can play an important role in ameliorating the sequelae of severe illness (18, 19).

Well-designed studies generally revealing a beneficial relation of religious commitment, practices, and attitudes to patient well-being are emerging in several clinical areas, including stress reduction (20–22), recovery from illness (23), reduction of depression (24, 25), substance abuse prevention and recovery (26, 27), prevention of heart disease and high blood pressure (28), mitigation of pain (29), adjustment to disability (30, 31); and recovery from cardiac surgery in the elderly (32). In addition, results of a nationwide longitudinal study of elderly persons suggest that the noxious impact of living in dilapidated neighborhoods on changes in self-rated health over time is offset for older adults who rely heavily on religious coping strategies (21). Volumes of specialty journals have been devoted to research and literature reviews on the clinical relevance and importance of spirituality and religion as potential factors in coping with illness (33, 34). Medical educators have called attention to these data as studies have improved (35).

The focus on human hope is a good example of emerging data. Hope, which can be defined as a form of trust in the future, is often deeply enmeshed in a religious cultural matrix (36). A study conducted at the University of Michigan used a self-administered questionnaire with 108 women at

various stages of gynecologic cancer to better understand their perspectives on how they handled their disease; 85% of the patients identified themselves as having some connection with organized religion, 76% indicated that religion had a serious place in their lives, 49% felt that they had become more religious since having cancer (none reported becoming less religious), and 93% indicated that their religious lives helped them sustain their hopes (37).

When researchers in another study surveyed members of an American Cancer Society support group for women with breast cancer, 85% of respondents indicated that religion helped them to cope with their illness (38). A recent Sloan-Kettering study found that the religious beliefs of patients sampled provided a helpful active cognitive framework from which to face life-threatening malignant melanoma (39). A parallel Israeli sample showed similar results, noting that religion was found to be helpful rather than harmful in patient coping (40).

Because it can be particularly important to patients with terminal or chronic diagnoses, the support of hope should fall within the clinical purview of the skilled physician. In times of severe disabling illness, hope may be mediated through ritual, meditation, music, prayer, traditional sacred narratives, or other inspirational readings. Spiritual care in hospice skillfully redirects hope toward caring relationships and higher meaning (41). The hospice tradition provides an example of a health care team approach that integrates pain relief, emotional and relational well-being, and broadly defined spiritual care (42).

Spirituality in its religious form may be important to bereaved family members. In a study of Islamic patients, for example, bereaved persons were assigned to one of two groups. One group was given support for their religious beliefs, including readings from the Koran, along with standard psychotherapeutic assistance; the second group was given only the latter. The first group had more rapid recovery (43). This suggests the importance of assessing spiritual needs with the goal of optimizing therapeutic efficacy in the context of standard medical care.

Because patients often draw on religious beliefs in the context of their serious illness (44), physicians who have no such belief systems themselves must still consider how to best respect and, when appropriate, support patients' beliefs that may assist them in coping with illness (45). The beneficent physician who is committed to the patient's best interests (46) must consider how to support patient spirituality, if and when the patient deems it relevant; spirituality is also to be respected as an expression of patient autonomy. This ethical responsibility suggests the importance of attention to spirituality during rou-

tine clinical assessments, thereby engaging the patient as a unique person with a spiritual dimension and enriching the physician–patient relationship (47).

Spiritual Needs Assessment

Many physicians may still think that it is inappropriate to discuss spiritual matters with patients, either because they see the topic as falling outside their expertise or because they feel it would be an intrusion into the patient's private life. Many patients, however, would welcome such discussion. A study of 203 family practice adult inpatients at sites in urban Kentucky and eastern North Carolina (48) indicated that 77% of patients wanted physicians to consider their spiritual needs, 37% wanted physicians to discuss these needs with them more frequently, and 48% wanted their physicians to pray with them if they could. Sixty-eight percent of the patients said that their physicians never discussed religious beliefs with them (48). Although this study may reflect high regional religiosity and may therefore not be generalizable to the United States as a whole, it still reveals important data for clinicians. A 1993 survey conducted in an inpatient rehabilitation unit (49) indicated that 74% of patients considered their religious and spiritual beliefs to be important and that 54% desired pastoral counseling. Forty-five percent of patients thought that too little attention was paid to their religious and spiritual beliefs, and 73% said that no one from the health care staff ever spoke to them about spiritual and religious concerns. Of most concern was the fact that only 16% of the physicians on staff ever inquired about these matters. The authors concluded that rehabilitation personnel, particularly the physician team leader, should be educated about the diversity of patients' spiritual beliefs and should address these beliefs more fully (49).

The Association of American Medical Colleges Medical School Objectives Project states that physicians "must seek to understand the meaning of the patients' stories in the contexts of the patients' beliefs, and family and cultural values. They must avoid being judgmental when the patients' beliefs and values conflict with their own" (50). Many U.S. medical schools are conducting courses on spirituality to improve clinician knowledge, skills, and awareness (51). These developments may enhance overall communication with patients.

One review indicates that very few patients are offended at gentle, nonjudgmental questioning or clinical inquiry about such matters. In many cases, they may be more willing to explore their plans for living with serious or terminal illness in the supportive context of their beliefs (52). Forty percent of

patients in another study welcomed the idea of having their physicians explore spiritual issues with them, especially in the contexts of major life events (such as birth, death, major surgery, major illness, and terminal illness) (53). Self-administered questionnaires were completed by 177 ambulatory adult patients visiting a pulmonary office practice at a University of Pennsylvania teaching hospital (83% response rate) (54). Fifty-one percent of the study patients described themselves as religious, and 94% of the religious patients agreed or strongly agreed that physicians should ask them whether they have such beliefs if they become gravely ill. Forty-five percent of the respondents who denied having religious beliefs still agreed that physicians should ask about them. Only 16% of all respondents reported that they would not welcome a carefully worded inquiry into their spiritual or religious beliefs in the event of becoming gravely ill (54). Routine inquiry about patient spirituality can be included in the initial history and physical examination (51). Several potential screening tools (52, 55) exist; for example, an American College of Physicians–American Society of Internal Medicine End-of-Life Care Consensus Panel paper includes the screening question, "What are your hopes (your expectations, your fears) for the future?" in the context of providing palliative care to dying patients and counsels physicians to extend their caring by attentiveness to psychosocial, existential, or spiritual suffering (56). Such routine inquiry provides information on the clinical relevance of the patient's spirituality, can guide appropriate referrals to chaplains in the event that a patient becomes seriously ill, and may indicate beliefs that might interfere with therapy. One screening tool includes the following questions (57):

1. Do you consider yourself spiritual or religious?
2. How important are these beliefs to you, and do they influence how you care for yourself?
3. Do you belong to a spiritual community?
4. How might health care providers best address any needs in this area?

In addition to an initial screening, patients should be permitted to express their spirituality, should they wish to, in a respectful and supportive clinical environment. It would, however, be disrespectful and not beneficial or supportive of autonomy to encourage patients to "get" religious or spiritual beliefs if they do not have them.

Referrals to chaplains can be critical to good health care for many patients and can be as appropriate as referrals to other specialists (58). Because many clinicians do not routinely inquire about spirituality and do not appreciate its frequent patient relevance, such referrals often are not made (59). The lack of appropriate clinical spiritual referrals can constitute a form of negligence.

Professional Boundaries

The spiritual needs assessment and, when indicated, subsequent referral to a chaplain or pastoral care should be uncontroversial. A more serious ethical question surrounds the actions of physicians who also wish to act as pastoral caregivers.

Although it is true that, historically, some persons have been trained as both a religious clergy person and as a physician (for example, rabbi-physicians such as Moses Maimonides and the colonial American clergy-physicians), it is a general mandate of modern developed societies to keep professional roles separate. For example, one does not expect the clergy person who is also a licensed physician to wear his or her pastoral garb in the clinic when functioning as a clinician, nor the white physician's coat at religious service. (Yet the physician-minister or the physician who intends to proselytize, when serving in developing countries or in health care settings that are religious and clearly advertise themselves as such, may merge roles without controversy.)

Specialized independent professional organizations that function in societies in which the medical profession has been secularized regulate distinct spheres of activity to ensure competence and boundaries. Even in such societies, most religious traditions (and, therefore, many patients) still regard the physician as both the skilled agent of scientifically informed clinical interventions and as an instrument of a higher healing power. When the healer was less able to intervene in disease, the patient's knowledge of the physician's divine backdrop could enhance the potential placebo effect by increasing patient belief and confidence, thereby enabling some patients to heal themselves (60). Professional boundaries may appear somewhat artificial to the patient who believes that God is working through the physician. This does not mean that these boundaries are unimportant.

The pressure to blur the boundaries between the professions often comes from patients. For example, about half of patients indicate a desire to have physicians pray with them (48). If this finding is accurate, physicians might need to explain to patients why such activities usually better fall under the purview of competent pastoral care. Physicians might assert, for example, that professional boundaries ensure higher degrees of competency through specialized training and that there may be issues a patient will want to tell chaplains but not physicians, and vice-versa. Furthermore, the physician's potentially religious or "Aesculapian power" (Asklepios was the ancient Greek god of healing) might result in coercion of patients or the perception on the patient's part of an even greater power than would

occur without such religious sanction (62). Over the past three decades, biomedical ethics has focused on demystifying the authority of the paternalistic, "priestly" physician of old, thereby allowing greater patient empowerment through autonomy and self-determination (62).

Adding a sacred or religious mystique to the power of the physician is suspect. For example, we would not condone a Jesuit medical geneticist who maintains that it is appropriate and "nondirective" to wear his clerical collar when doing reproductive genetic counseling in a non-Roman Catholic health care setting. Nor would we want the clinician in a nonreligious health care institution to raise the question, "Have you accepted the Lord?" Many patients would be confused and rightly offended.

Clearly, it is important to delineate professional boundaries. The physician must, however, also be educated to understand spiritual concerns in the clinical environment. This can be achieved with course modules focusing on clinical studies of patient spirituality, spiritual screening tools, and chaplain referrals with patient consent. But what of the patient who requests that the physician pray with him or her?

Patient Requests for Physician Prayer

As stated above, we distinguish prayer as an alternative or substitute therapy from prayer as an adjunct to conventional medical therapy, and we strongly discourage the former. Many patients desire the adjunct model. For example, one national poll found that 48% of patients want prayer with their physicians and 64% of Americans think that physicians should join their patients in prayer if the patients ask (63). A study of religiously devout physicians revealed that most prayed privately for their patients. They reported praying aloud with only 13% of their patients; in these instances, physicians initiated prayers 53% of the time (64). A physician who initiates prayer without first being asked presents an ethical concern in that patients might easily feel coerced.

The guidelines suggested by T.F. Dagi, neurosurgeon and ethicist, would preclude physicians from praying openly with a patient without his or her explicit request and permission (65). Dagi, a Muslim, writes that "almost daily I see patients asking nurses and visitors to pray with them." When making surgical rounds, he has sometimes been asked by Christian family members or friends of the patient to engage in public prayer at the bedside. Given the right conditions, Dagi permits the surgeon or other physicians to pray publicly with a patient who desires this. He argues, however, that

the prayer should be led by an “identified religious leader distinct from the treating medical team whenever possible so as to avoid even an appearance of religious coercion.” This caution is valid. Physician-led prayer is acceptable only when pastoral care is not readily available, when the patient is intent on prayer with the physicians, and when the physician can pray without having to feign faith and without manipulating the patient. Under these circumstances, one recommendation that is acceptable to the secular physician is to simply listen respectfully as a patient prays.

Conclusions

Patient expressions of spirituality should be screened for and respected by physicians. Patient request for pastoral care should be implemented; those who frequently attend religious services will predictably ask for such referrals (66). The clinician who hopes to maximize therapeutic efficacy must respect his or her patients in this manner, especially when their spirituality is a critical life factor.

Immanuel Jakobovits, Chief Rabbi of the British Commonwealth of Nations, wrote that “disease forges an especially close link between God and man; the Divine Presence Itself, as it were, ‘rests on the head of the sickbed’” (67). Those standing around the sickbed—the patient’s family, physicians, and chaplain—will all relate to that presence in different ways. As the health care market presses providers in a more holistic direction (68) that includes attentiveness to patient spirituality, we expect that the ethical issues that we are beginning to address here will become even more significant in the standard clinical setting (69–71).

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