MEDICAL HUMANITIES REPORT

Barriers, Boundaries, & Blessings: Ethical Issues in Physicians' Spiritual Involvement with Patients

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Judging from the best-seller lists, television and newspapers, Americans' fascination with spirituality has grown dramatically over recent years. When pollsters ask, nine out of ten Americans consistently report that they believe in God, in the power of prayer in their lives, and even in miracles.[1] At the same time, spirituality and religion have come to be distinguishable in the lives of many people. Many have sought spiritual well being and enlightenment apart from religious traditions and institutions, and have turned increasingly toward more eclectic and personal spiritual practices.[2] Given this growing attention, perhaps it is not surprising that health and healing are central among the places that there has been a renewed interest in spirituality.[3]

Patients have generally seemed more interested than their physicians in incorporating spirituality into health care. When asked whether they would welcome inquiry regarding their spiritual or religious lives if they became gravely ill, two-thirds of patients in a recent study reported that they would welcome such a question, sixteen percent said they would not, and, significantly, only fifteen percent reported that a physician had ever made a spiritual inquiry.[4] These results are consistent with other studies that have indicated a significant difference between patients' wishes to include spiritual issues, resources, and information in their medical care and physician's practices regarding spiritual involvement with their patients.[5] At the same time that patients' interest in addressing spiritual issues in health care has become manifest, researchers have sought to assess the clinical relevance of spirituality in medicine. A mounting body of evidence suggests that religious commitment or spiritual practice may play a role in illness prevention, coping with illness, recovery from surgery, and improving treatment outcomes, among other indices.[6] A number of assessment tools have been developed to assist physicians interested in responsibly assessing spiritual issues in clinical care.[7]

In response to evidence that religious and spiritual beliefs and practices are clinically important in medicine, clinicians may wish to engage these issues in the lives of their patients. A careful consideration of some ethical questions that are sometimes perceived as barriers to spiritual involvement may help a physician choose *whether* and *how* to be involved in the spiritual life of their patients.

This paper addresses some of the ethical issues that may arise in a physician's spiritual involvement with their patients. Appealing to principles of medical ethics, some of the conceptual, methodological, structural and professional barriers to spiritual involvement are examined. Whether involvement is by spiritual assessment, through particular therapeutic interventions that are sensitive to patients' values and beliefs, or by referrals to other providers of spiritual and religious support, I consider what ethical difference the level of spiritual involvement makes. Finally, I examine some of the ethical concerns and pitfalls of spiritual involvement and how they might be addressed in practice.

Barriers to Spiritual Involvement

The threshold question for the clinician interested in involvement with their patients' spiritual issues is *whether* to address these concerns at all. In a recent study of family physicians in Missouri, Ellis and colleagues report on the barriers that physicians perceive that discourage them from discussing spiritual issues with their patients.[8] This useful work suggests that while these physicians do not discuss spiritual issues frequently, most recognize a role for physicians in addressing patients' spiritual concerns, and most believe spiritual health to be important. While previous studies had speculated about the reasons for physicians' apparent reluctance to address these issues, this study provides clear evidence of just what reasons are offered to account for the observed difference between patient interest and physician involvement in addressing spiritual issues.

Of the fourteen potential barriers that were identified, lack of time was cited most often (71%), while a range of concerns associated with lack of training or experience in spiritual assessment was identified by about half the respondents as a barrier. Other barriers included concern that the physician would project their own beliefs onto patients (53%), personal discomfort with the subject (42%), and a belief that spiritual concerns are not appropriate to the physician's role (31%). While not all of the perceived barriers reported by this study were ethical objections, some which have clear implications for the ethics of the physician-patient relationship bear further examination.

Autonomy Considerations

The primary area of ethical barriers to spiritual involvement involves a concern for patient autonomy. If respect for patient autonomy is taken as a central moral obligation of the physician, then some of the concerns expressed by physicians in the Ellis study can be identified as affecting this obligation in the physician-patient relationship. More than half of the respondents in that study (53%), for example, were concerned that they would project their own beliefs onto patients. Like other perceived barriers, this concern can bee seen as a spectrum of spiritual involvement. On the one hand would be the careful and respectful patient-centered perspective that guards against projecting one's own beliefs onto another and allows the patient to initiate any conversation about spiritual issues. At the other extreme would be the concern that some clinicians might take the opportunity to proselytize the patient, taking advantage of their power and authority in the relationship to forcefully try to persuade the patient to accept the clinician's beliefs or values. It seems clear that this latter kind of coercion has no place in a patient-centered relationship that seeks to respect the autonomy and dignity of the patient.

Whether the concern to avoid inappropriate proselytizing should be a barrier to any of a spectrum of spiritual involvement requires acknowledging the power differential in the physician-patient relationship and the coercive potential of the physician. This "Aesculapian power" of the physician can be turned to the patient's benefit or harm, and the potential for coercion is certainly to be resisted.[9] In their recent helpful analysis of this issue, Post and colleagues note that biomedical ethics has sought over the last three decades to demystify the authority of the old paternalistic, or "priestly", model of the physician in the interest of empowering patients through a respect for their autonomy and self-determination.[10]

A related concern that spiritual issues are not an appropriate part of the physician-patient relationship (a concern expressed by 31% of physicians in the Ellis study) seems to be belied by the consistently high interest that many patients express in having their physician be open to hearing about the spiritual concerns that impact their health and well-being.[6] Facilitating a model of patient self-determination might mean creating a safe space in the professional relationship

where patients feel comfortable addressing the important values and concerns in their lives, however sensitive those may be. Clinicians are used to creating that kind of safe space for the discussion of sexual concerns, for example, by expressing empathy and a non-judgmental interest in the patient's experience and values. In training new physicians, the Association of American Medical Colleges Medical School Objectives Project suggests that physicians, "must seek to understand the meaning of the patients' stories in the context of the patients' beliefs, and family and cultural values. They must avoid being judgmental when the patients' beliefs and values conflict with their own."[10] The same non-judgmental approach to spiritual issues might lead the compassionate and empathetic clinician to be able to allow the patient room in the relationship to raise those questions of value and personal meaning that are most important to them, rather than feeling compelled to leave them outside the consulting room or away from the bedside.

Beneficence and Nonmaleficence Issues

A second set of ethical concerns about whether to appreciate patients' spirituality in health care has been raised about the role and usefulness of health outcomes research which suggests a positive correlation between spirituality and various indices of health. In his recent critical response to outcomes research on religious spirituality dating back over decades, Sloan and colleagues note that methodological problems afflict many such studies and challenges the conclusion that religious activity will promote health or that illness is somehow the result of insufficient faith.[11] Addressing this concern, some have suggested that this research is still in its infancy and methodological sophistication has grown over time, yielding more subtle and nuanced results showing positive correlation.[10] Sloan's concern is that physicians may actively do harm by supporting claims that, in short, religion is good for your health.

Quite apart form the scientific and methodological debates about research which seems to indicate health benefits associated with spirituality, the threshold issue is whether this uncertainty about health outcomes research needs to be a barrier to spiritual involvement for physicians. It might still be possible for the sensitive clinician to appreciate a patient's spirituality appropriately, in ways that do not rely on utilitarian or instrumental expectations of better health. Sloan and colleagues acknowledge that there can still be an important role for addressing spiritual issues in medicine, suggesting that, "Irrespective of the practitioner's religion, respectful attention must be paid to the impact of religion on the patient's decisions about health care. . . . No-one can object to respectful support for patients who draw upon religious faith in times of illness."[12] Such a patient-centered perspective on spiritual involvement is entirely consistent with the approach suggested by some of the available spiritual assessment tools such as Maugans' SPIRITual History, which inquire about whether the patient wishes to make known any spiritual beliefs or issues that might impact their medical care.[13]

Professional Boundaries

For the clinician who decides that some level of spiritual involvement with some patients seems appropriate to their comprehensive care of the whole person, there remain important issues of *how* to address spiritual concerns. As in any other aspect of the physician-patient relationship it is important to recognize the appropriate limits or boundaries of that professional relationship.

One set of ethical considerations about professional boundaries is about professional competence to address spiritual concerns. Over half of the respondents in the Ellis study were concerned that they had inadequate training or experience in taking a spiritual history, were uncertain about how to identify patients who desired discussion of spiritual issues, or were

uncertain about how to manage spiritual issues that patients might raise. This concern for not overstepping the limits of their professional training seems to be addressed by the AAMC's approach to medical education, noted earlier. Training and assessment tools are available, and programs in spirituality are now part of the curriculum of many U.S. medical schools to improve clinicians' knowledge, skills, and awareness of these issues.[14] The side benefits of such training might well be to enhance the physician-patient relationship by emphasizing and developing better communication skills.

Another area of ethical consideration involves the appropriate limits of spiritual involvement. The clinician who might, for example, feel entirely comfortable inquiring about spiritual issues that could impact on medical care might well be discomfited by a subsequent request to pray with the patient. Once a clinician decides to engage in some level of spiritual involvement with patients, it is still appropriate and necessary to make referral to other sources of spiritual counsel, guidance, and support, as necessary. Whether referral is to professional pastoral care such as trained hospital chaplains or to a patient's own clergy or other spiritual caregiver, this is an important way of respecting the professional boundaries of medical and spiritual caregiving. A spiritual needs assessment and subsequent referral, when indicated, can thus be a normative part of responsible medical engagement with the patient.

The physician who desires to be actively involved in spiritual care for the patient raises a more difficult issue. T.F. Dagi, a neurosurgeon and ethicist, suggests, for example, that physicians not pray openly with a patient without the patient's explicit request and permission.[15] Even better, he suggests, is to facilitate prayer being led by an identified religious leader such as a chaplain, so as to avoid even the appearance of the kind of religious coercion discussed above.

Recommendations and Conclusions

Bioethics is sometimes accused of offering more analysis of ethical problems than practical advice about *what to do*. With this consideration of a few of the ethical barriers and boundaries to spiritual engagement between physicians and patients, I want to turn finally to offer some brief constructive suggestions of ways to avoid the kinds of ethical pitfalls and problems addressed here.

- Develop spiritual self-awareness: The clearest hedge against unwitting bias or projecting your own beliefs on others is some clarity and understanding of just what you do believe and where you are in your own spiritual journey. This is also a matter of self-care for the physician.

- Avoid value imposition: Being clear about respect for the patient's values and experience will help avoid the problems of coercion or proselytizing.

- Create a safe place in the physician-patient relationship: This safe space will allow the patient to initiate discussion of spiritual issues if they feel that the physician has indicated it is an appropriate topic by raising the question of whether spiritual or religious beliefs are important to the patient. Expressing empathy and understanding for the patient's ultimate values and personal meanings encourages trust and communication in the relationship.

- Accept your naivete of others' faith traditions and spiritual life: Don't assume that because the box for religious preference says "Catholic" or "Muslim" or "None" that you know anything about how this patient is engaged with a religious tradition or community. Let them tell you about their own spiritual life, or how they interpret the religious traditions of which they feel

a part. This helps avoid the problem of stereotyping a patient according to the tradition they identify with and may lead to encounters with others that promote growth and discovery.

- Refer to pastoral care providers: Patient requests for pastoral care should be referred to an appropriate caregiver, and pastoral care professionals can be called on for consultation in situations where the physician feels uncomfortable or unprepared.

- Remain flexible in selecting the appropriate involvement, if any: If the answer to an initial question about whether spirituality is important can be "yes," then it can also be "no." Not closing the door on the subject after that patient's initial demurral can allow a subsequent interest to be expressed, as at a time of serious illness.[5]

- Build on the patient's strengths: Assessing and being willing to engage the patient's spiritual values, hopes, and beliefs may allow the physician and patient together to identify sources of spiritual support, comfort, or tools for coping or recovery.[7]

Not every physician will choose to be spiritually engaged with patients. Those who do might well encounter some of the challenges to professional boundaries addressed here. As this brief assessment of some of the ethical issues that might be perceived as barriers or boundary issues to physicians' spiritual engagement with patients suggests, the sensitivity and empathy of the patient-centered encounter of a patient's spiritual values need not fall prey to these pitfalls and objections. As health care continues to be concerned for the bio-psycho-social and spiritual well being of the whole person, the issues that have just begun to be addressed here will become even more significant for the caring and compassionate healer.

NOTE

Portions of this work were presented as part of a workshop, "Integrating Patients' Spirituality into Clinical Care," at the Society for Teachers of Family Medicine annual meeting, Orlando, Florida, in May, 2000. I am grateful to Drs. Dana King, Timothy Daaleman, Mark Ellis, Howard Brody, and Aron Sousa for their constructive engagement and discussion of many of these issues. The views and conclusions expressed here remain mine.

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InkLinks *is a regular column in which readers reflect on issues related to the lead article. For each issue of MHR I ask for short contributions, loosely related to the lead article. No topic in InkLinks has gotten the quick and energetic response that "spirituality" evoked. Some of the response was wary: isn't the concept, in a Christian culture, likely to be just Christianity in disguise? Is there such a thing as a generic spirituality? Arnold Werner asked why, after years of insisting that doctors stop playing God, we now ask them to play clergy. But the responses printed below show that the concept of spirituality has surprising breadth and resonance. I found Sarah Abood's to be particularly thought provoking: writing as a veterinarian, she finds spirituality in the human-animal bond. At first reading that startled me; I hadn't thought of that bond as spiritual. But I soon recalled that Buddhism embraces just such a perspective. As one writer put it, "If we can only see the cat on the fence, the child in the playground, and the old man on the park bench as [ourselves] there will be hope for the world."* [1] *Buddhism grounds spirituality in a "clear-minded and largehearted, all-inclusive Compassion" for all living beings. Below is a sampling from other perspectives on spirituality. Your own reflections, objections, and questions are welcomed. "InkLinks", we hope, will become a place for an inclusive and varied conversation.* — *J. A.*

1. Norm Phelps, "Buddhism and Animals," The Animals' Agenda; Vol. 19, No. 5 (Sep/Oct 1999) 37.

In Zimbabwe . . .

Barbara Sparks, RN
Department of Osteopathic Surgical Specialities

In Zimbabwe, spirituality profoundly effects many health care decisions. It is basic, for instance, to beliefs about the etiology of disease. Someone becomes ill if the ancestor spirits have become displeased with his or her behavior or thoughts, or that of their relatives. If one seeks care from a traditional healer (*n'anga*) the healer often intervenes with the ancestor spirit for forgiveness, as well as treating the patient with herbs. An example of this concerning birth complications is the belief that arrested labor is the result of the laboring woman's infidelity. Certain rituals are performed by the traditional midwife, the woman confesses, is cleansed, and labor is believed to progress normally.

It is not unusual for a patient to seek care from both a *n'anga* and a (western-trained) physician, to cover the issues of spirituality as well as formal medicine. Frequently a *n'anga* is called into hospital to address a patient's spiritual needs if a visit to the *n'anga*'s home is not possible. My research with chronically hypertensive women in Zimbabwe revealed that praying and attending church regularly is perceived to be an essential aspect of healing.

In the United States, I'm afraid, spirituality is woefully neglected as part of most health care encounters. This is particularly true in ambulatory care, even with profoundly ill patients.

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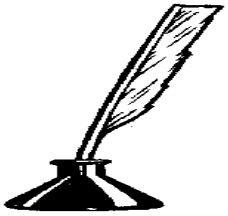

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In England . . .

Margaret Jones, PhD
Department of Pathology

While thinking over emerging concepts of spirituality that enrich the practice of medicine, I suddenly recollected the question our GP always asked, no matter what prompted our visit, during our sabbatical leaves in Newcastle-upon-Tyne and Edinburgh. URI or whatever, when I'd voiced my chief complaint, the rejoinder would be "And how are you within yourself, Margaret?" Within myself??? Indeed! I can remember being totally nonplussed by this question and mentally discarding possibilities from a familiar list of organ systems that might be involved with the "what" or "where" of the "within" that was being addressed. The question catapulted me into another orbit and my chief complaint receded in significance as my larger, untidy universe came into view. I mentally thanked him for caring enough to ask and said, "Fine!"

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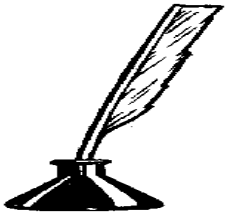

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In Nursing . . .

Georgia Padonu, R.N., Dr.P.H.
Department of Nursing

Spirituality in my professional life, as in my personal, is dominant. Spirituality encompasses three areas. Christianity, as a part of my spirituality, has been very troubling at times, and I have had to move to that particular interpretation that I know is the cultural part of my spiritual development.

Spirituality helps to shape my professional work ideas, dictates the tools and ethics. Spirituality helps guide choices for professional success. For example, my educational accomplishments are as much about a weapon of survival, a tool for change, and a means to service to the community as about pride and success. Spirituality is also a part of my physical, emotional, and economic endeavors. Spirituality dictates a sound body and mind, as well as good economic habits learned through tithing. I am a spirit, therefore my spirituality cannot help but influence all aspects of my being.

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In Veterinary Medicine . . .

Sarah K. Abood, DVM, PhD
College of Veterinary Medicine

I've never understood how my colleagues in veterinary medicine could argue the position held by agnostics or atheists. The mysteries, complexities, and simple beauties of biology and physiology have always been connected in my mind to a higher being. That's where my own personal spirituality first linked with my chosen profession—in my high school science class. But it didn't end there. With experience and age come an entirely different consideration of spirituality—the magical (and sometimes unexplainable) bond between people and the animals under their care.

I recently called a client to ask how his very sick cat was doing at home. It had recently been released from the MSU Veterinary Teaching Hospital with a stomach feeding tube in place. Things hadn't been going very well at all. After watching the cat's condition deteriorate rapidly over 5 days, and after much discussion, the owners had decided to have their cat euthanized. I happened to be the first person the owner spoke to about the decision, and although he admitted that this cat was not his favorite (they had 7 indoor cats), he was still choked up and cried during our conversation. I was reminded, once again, of the power of the human-animal bond—something that can bring strong people to their knees or lift up and encourage those that seemingly have no hope. If that isn't spiritual, then I don't know what is.

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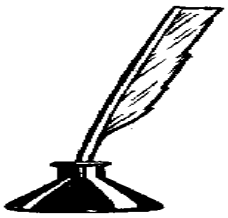

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As Respect Within the Hospital . . .

Brooke Purves and Allison B. Wolf
Doctoral Candidates, Department of Philosophy

Brooke Purves: After delivery, my first child, Ana, had breathing problems which forced her into the NICU. My partner, Steve, and I were unable to hold her or attempt breastfeeding for two full days. The separation and the images of her limp body, sustained by tubes in her nose, head, and arm, oxygen hood sequestering her delicately featured face and the blips on the myriad of monitors only enhanced the postpartum depression felt by all of us. When I was released from the hospital 48 hours after birth, the spiritual connection of mother to child had not had an opportunity to kindle. The experience had been surreal, as though she was not really my child, as though I had not really delivered.

Where I lived The Church of Jesus Christ of Latter-day Saints was the dominant religion. The head nurse asked me if I was a member of the religion, and I was. This nurse suggested that we call in some of elders of the church to administer a blessing of the sick to our ailing infant. "It really does help," she told us. We gave such a blessing, and two days later Ana was well enough to go home with us. I appreciate that nurse being so in tune with our needs that she suggested something we should have thought of on our own, but because we were in unexpected circumstances, did not.

Allison Wolf: When I was fourteen I came down with a mysterious illness, involving sudden weight loss, severe pain, and a recurring facial rash, that no one could diagnose. My experience

with the physicians was frustrating and disillusioning. They did not listen to me, sometimes did not even know my name, barged into my room at 6:00 AM and ordered me to tell the story of my illness to yet another specialist. I felt that they never actually listened to that story; rather they kept trying to fit me into the mold of the disease that they decided that I should have. They kept telling me that I was wrong in my descriptions, gave me tests and medication without informing me, and threatened me with further undesired treatments if I disobeyed their orders.

The nurses had an opposite reaction. They did not discuss medical conditions, tests, or diagnoses. Rather, they talked to me, about me. They asked me about who I was and what made me tick. They tapped into a part of me that could not be quantified or explained, but needed comfort, a part that no medicine could address. When they discovered that I was a Jew in a Presbyterian hospital, they offered to contact a rabbi in case I wanted to discuss spiritual and emotional matters in a religious, rather than secular, context. Though that was not something for which I felt a great need, I appreciated the fact that these nurses understood I had a spiritual side. Their sensitivity helped me use the time that I was ill to search for who and what I was, as fourteen-year-olds will do. Because of the way the nurses communicated with me, I always knew that someone thought I was more than a patient.

Neither of us claim that the spiritual dimension of our care made the difference in our recoveries. But the respect that was shown gave us spiritual comfort. Because we were set at ease, not only were we able to begin healing, but also the people around us, like Ana and Steve. "Spirit is the network of love by means of which we experience, communicate, learn, realize and grow. . . ."

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Center News & Announcements

Tom Tomlinson attended the 3rd International Symposium on Coma and Death in Havana, Cuba, this February to present a paper on "The Irreversibility of Death: Medical, Ethical or Metaphysical?"

Clayton Thomason was appointed by Governor John Engler to the Michigan Commission on End of Life Care, Lansing, MI. Thomason represents bioethical perspectives on the Commission, whose charge is to evaluate and improve training and curricula for health care professionals, develop resources for the public, examine state policies to remove barriers to effective pain control, and improve access to end of life care.

Judy Andre spoke on "Non-Doctors and Non-Nurses," for the Central Michigan University Philosophy Department.

Howard Brody did ethics grand rounds for the Dept. of Clinical Bioethics, Clinical Center, National Institutes of Health, Bethesda, MD, on February 2, and for the University of Texas-Southwestern Medical Center at Dallas, February 8.

Libby Bogdan-Lovis presented "Reaching the Underserved" on April 29 for the Michigan Midwives Association spring meeting in Lansing, MI.

Len Fleck held a seminar "Just Caring: Health Care Rationing and Rational Democratic Deliberation" this March. The seminar was for NIH faculty and fellows attached to Department of Clinical Bioethics, Washington, D.C. This was at the invitation of Dr. Ezekiel Emanuel, chair.