

CME 1 (for physicians)

Part 1, Section 1

Hello. I'm Dr. Harold Koenig. Welcome to Spirituality in Patient Care. This educational series provides the rationale for assessing and addressing the spiritual needs of patients **and** provides training for physicians and other team members to do so efficiently and sensibly.

I began my career as a registered nurse in the late 1970's. Soon, though, I entered medical school at the University of California, San Francisco. After graduating from medical school, I trained as a family physician at the University of Missouri, and then went on to complete a 3-year geriatric internal medicine fellowship at Duke University. During this time, I began to realize how important religion was to older adults as they wrestled with health problems. Because of my interest in this area, I sought further training in psychiatry so that I could focus on the patients' emotional problems and conduct research on religion, spirituality and health. I am now on the Duke faculty as professor of psychiatry and associate professor of medicine, and also teach and do research in the department of medicine at King Abdulaziz University in Jeddah, Saudi Arabia.

In this introductory overview, Part 1, we will learn why physicians should integrate spirituality into patient care and what exactly this involves. In Part 2 we will take a close look at the research justifying this integration, and in Part 3, examine clinical applications in detail. Parts 4 and 5 will focus on the spiritual care team whose primary role is to support the physician in the assessment and addressing of spiritual needs.

In Part 1, I will first **define** terms that are important in this discussion, such as religion and spirituality. Then I will describe what "integrating spirituality into patient care" **means** for the physician. Next, I will examine **why** take the time and make the effort to do this, and **review** the scientific research justifying it. Finally, I will discuss **how** to integrate spirituality into patient care, examining (a) what is involved in a spiritual assessment, (b) what types of patients does this apply to, (c) what other activities might the physician do to address spiritual needs, (d) what are the barriers that physicians face and how to overcome them, (e) role of the "spiritual care team" in backing up the physician, and finally, (f) boundaries which physicians should not cross.

Part 1, Section 2

Let's begin by defining the terms "religion", "humanism", and "spirituality":

Religion. Religion involves beliefs and practices related to the Transcendent. In Western traditions, the Transcendent may be called God, Allah, HaShem, a Higher Power, or in Eastern traditions, may be called Vishnu, Krishna, Buddha, or Ultimate Reality. Religions usually have *rules* to guide behavior here on earth and *doctrines* about life after death. Religion is often

organized as a community, but can also exist outside of an institution and may be practiced alone and in private.

Humanism. Secular humanism views human existence **without reference to** religion, God, the Transcendent, a higher power, or ultimate truth. The focus is on the rational self, science, and the human community as ultimate sources for meaning and purpose. Physicist Stephen Hawking says "Humanism rejects religion. It attributes nothing to the so called 'supernatural'. In this there is an awakened liberty that releases us from the **shackles and servitude mentality** of old superstitions so that we may realize our full potential."

Spirituality. According to the traditional definition, spirituality is the core of what it means to be religious. This term used to describe those who were deeply religious and lived a life dedicated and surrendered to the Divine. The modern definition of spirituality, however, has become much broader, including not only those who are deeply religious, but those who are not deeply religious and those who are not religious at all. In fact, spirituality has become largely *self-defined* and can mean almost anything, depending on what the person wants it to mean.

The main points to take away from these definitions are that Religion is more specific and has a definition that is usually agreed upon. Therefore, it is more easily measured and quantified. Religion is more useful when conducting research aimed at identifying specific characteristics that prevent disease or alter disease course. Spirituality, on the other hand, is an ideal term to use in clinical settings where talking to and engaging with patients is the goal. Patients should be allowed to define what spirituality means to them and clinicians should address it in that way.

Part 1, Section 3

What does “integrating spirituality into patient care” mean **for the Physician?**

Practically speaking, it means (1) conducting a brief “spiritual assessment”, (2) identifying spiritual needs related to medical care, (3) ensuring that someone meets those needs, and finally, (4) being willing to discuss this subject with patients in a supportive manner, recognizing the health benefits of doing so.

Part 1, Section 4

Next, WHY integrate spirituality into patient care? Here are 7 reasons:

- (1) Many patients have spiritual needs related to illness that influence satisfaction with care and healthcare costs
- (2) Religious beliefs influence coping with illness and may affect the patient’s emotional state and motivation towards recovery
- (3) Religion affects important health-related behaviors and likely influences medical outcomes

- (4) Religious beliefs of patients influence their medical decisions, **AND** religious beliefs of physicians influence the medical decisions they make as well
- (5) The “standards of care” established by JCAHO require that providers respect patients’ cultural and spiritual beliefs ((RI.01.01.01 EP 6; RI.01.01.01 EP 9; PC.01.02.01 EP 4; PC.01.02.11 EP 5; PC 01.02.13 EP3),¹ and assessment is the only way to know what those beliefs are
- (6) Involvement in a religious community may affect health by increasing patient monitoring and thereby improving compliance with treatment
- (7) Finally, addressing spiritual issues may also benefit the physician. By this I mean, the intrinsic rewards experienced when practicing “whole person” health care.

Part 1, Section 5

Besides the 7 reasons just mentioned, is there any scientific research on spirituality and health that justifies the time necessary to address these issues? I will briefly review some of that research here.

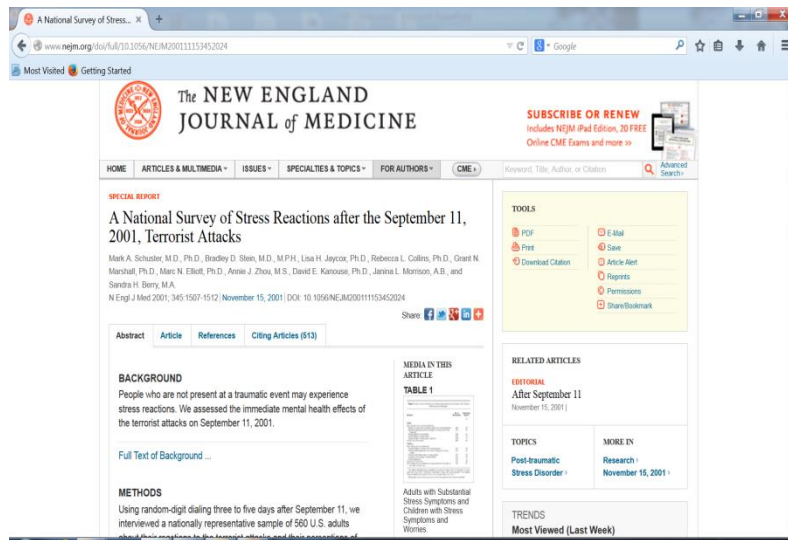
I begin by describing research on **Religion and Coping**. We think that the single greatest impact that religion has on health is its ability to help patients cope with medical illness.

Not long ago, a younger patient of mine suffering from severe chronic pain, family problems, and a deep depression, who was near suicide, gave me a picture to describe how he was feeling.



¹ Information contained here on the standards are based on a series of communications between Dr. Koenig and JCAHO staff, particularly Doreen Finn (DFinn@jointcommission.org), Senior Associate Director, who works under Mark Pelletier (MPelletier@jointcommission.org), Executive Director, JCAHO, Hospital Accreditation (January 6-12, 2012)

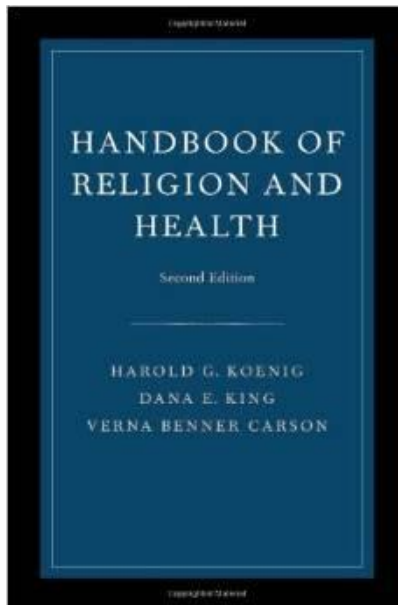
A large volume of research indicates that many individuals turn to religion for comfort when they are stressed. In 2001, after the September 11th terrorist attacks, a random survey of the U.S. population published in the *New England Journal of Medicine* found that 9 out of 10 Americans coped by turning to religion.¹ It was the most common form of coping, second only to talking with friends and relatives about the attacks.



Religious beliefs are especially likely to be used to cope with health problems. Medical illness is often accompanied by uncertainty, fear, pain, disability, and loss of control. If illness is prolonged, this can quickly lead to discouragement, loss of hope, and depression. Systematic research indicates that one-third to nearly half of hospitalized patients experience depressive disorder. Not surprising, then, over 90% of hospitalized patients in some areas of the U.S. rely on religious beliefs to cope. Religious beliefs give meaning to illness and strength to continue to strive towards recovery.

Other than being used to cope, how is religious involvement related to **health more generally**? I will now summarize that research. The findings I'm reporting here are based on a systematic review of quantitative peer-reviewed studies. The studies cited here were published in academic journals listed in Medline and PsychInfo prior to 2010, when the last comprehensive review was completed. This research is documented in the second edition of the *Handbook of Religion and Health* published in 2012 (Oxford University Press). I will also point out some more recent studies.

¹ Schuster et al. (2001). A national survey of stress reactions after the September 11, 2001, terrorist attacks. *New England Journal of Medicine* 345(20):1507-1512.



Part 1, Section 6

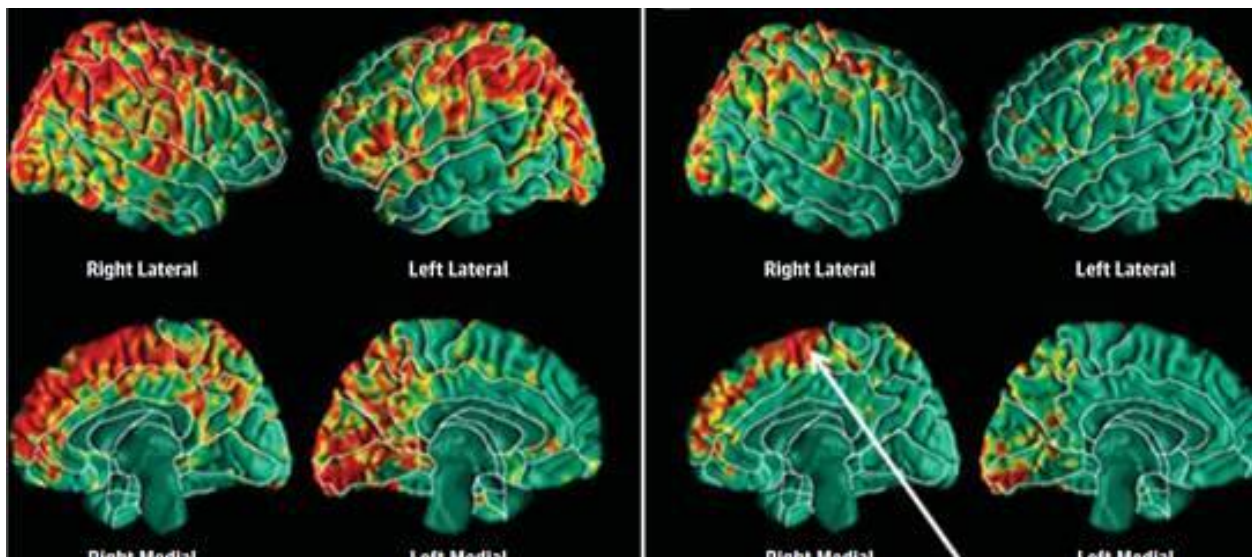
First, I review research on religion, **Mental and Social Health**, and then go on to review the research on health behaviors and physical health outcomes.

With regard to mental health, let's examine research on relationships with depression, suicide, and substance abuse, and then review the research on well-being, meaning and purpose, optimism, and hope.

Concerning religious involvement and **Depression**, nearly 450 quantitative studies have examined this relationship. These include designs that are cross-sectional, prospective, and about a dozen randomized clinical trials. Over 60% report that religiosity is associated with significantly less depression, faster recovery from depression, or a more rapid response to spiritual interventions compared to control groups. The percentage of positive findings increases to 67% in higher quality studies with more rigorous designs. In contrast, only 6% of those 450 studies report higher levels of depression in those who are more religious or spiritual.

With regard to more recent studies, consider a report published in January 2014 in JAMA. Columbia University researchers found that among those at high risk for depression there were multiple areas of the brain showing a reduction in volume based on functional MRI [see red areas in left panels].¹ Among those for whom religion or spirituality was very important [panels on the right], however, much less reduction in volume was observed.

¹ Miller L et al (2014). Neuroanatomical correlates of religiosity and spirituality in adults at high and low familial risk for depression. JAMA Psychiatry 71(2):128-35



With regard to **Suicide**, this tragic event often occurs when meaning and hope are lost in the setting of depression. Our systematic review found that 106 of 141 studies (75%) reported less suicide, fewer suicide attempts, or more negative attitudes toward suicide in those who were more religious. From a clinical standpoint, it is always helpful to know whether a patient is religious when assessing suicide risk.

Rates of **Alcohol and Drug Use** are also substantially lower among those who are more religious, especially among high school and college students when lifelong patterns of substance use are often established. Our systematic review found that 240 of 278 studies (86%) reported inverse relationships with alcohol use or abuse, and 155 out of 185 studies (84%) reported inverse relationships with drug use, abuse, or dependence. Studies with better research designs were even more likely to report inverse relationships.

Now, let's examine research on *positive emotions*. Positive emotions such as well-being and happiness exist at the other end of the spectrum from depression. Prior to 2010, there were at least 326 quantitative studies that had examined relationships between religiosity and **Well-Being**. Of those, 256 (79%) reported significantly greater well-being in those who were more religious or spiritual. Among the better designed studies, 82% indicated this finding. Less than 1% reported **lower levels** of well-being among those who were more religious, i.e., 3 of 326 studies.

Similar findings have been reported for studies of meaning and purpose in life, hope, and optimism. In studies of **Meaning and Purpose**, 42 of 45 (93%) reported significantly greater

meaning and purpose in those who were more religious. Many of these studies were conducted in patients with chronic medical illness. For studies examining **Hope**, 29 of 40 (nearly three-quarters) reported significantly greater hope, and for studies examining **Optimism**, 26 of 32 (81%) reported this finding.

As with mental health, relationships between religiosity and social health are overwhelmingly positive. Our systematic review identified 79 studies that examined associations with **Marital Stability** and marital satisfaction. Of those, 86% reported significant positive relationships. Likewise, of 74 studies examining relationships with **Social Support**, 61 (82%) reported positive connections, especially in older patients and in those with medical illness.

Part 1, Section 7

Next, let's review relationships between religiosity and **Health Behaviors** such as exercise, diet, sexual behavior, and cigarette smoking. This is a very important area, given that nearly 80% of all chronic disease is associated with health behaviors, and many such conditions could be prevented by healthy lifestyles.

Our systematic review found that those who were more religious were significantly more likely to engage in **Physical Activity** in 25 of 37 studies (68%). They were also more likely to eat a **Healthier Diet** in 13 of 21 studies (62%). **Extra-Marital Sex** and multiple sexual partners -- behaviors that increase risk of sexually transmitted disease -- were also less common among those who were more religious in 82 of 95 studies (86%).

Finally, we identified 137 quantitative studies that examined religiosity and **Cigarette Smoking**. Again, many of these studies were conducted in students and young adults. Ninety percent (123 of 137 studies) reported significantly less smoking in those who were more religious. Less cigarette smoking means less cardiovascular disease, less chronic lung disease, and less cancer.

Part 1, Section 8

Better mental health, better social health, and better health behaviors should translate into better **Physical Health** in those who are more religious. Let's review research that has directly examined relationships with physical health. In this section, I will review studies on religiosity and immune function, endocrine function, cardiovascular function, coronary heart disease, survival after open heart surgery, and all-cause mortality.

Immune Functions are the body's primary defense against outside invaders and internal pathological processes. Over two dozen studies have examined relationships with religiosity or spirituality. Of those, over half (56%) reported significantly better immune function in those who were more religious. Immune parameters examined included inflammatory markers such as IL-6, natural killer cell activity, T helper cell numbers, and response to immunization. These

findings are supported by numerous studies examining **infection rates** or viral concentration in blood, which found lower levels in those who were more religious. Many of these studies were conducted in patients with compromised immune systems, such as older adults or those with HIV.

Similar findings have been reported in studies of **Stress Hormones** such as cortisol, epinephrine, and norepinephrine. Our systematic review uncovered 31 such studies, 23 of which found significantly lower stress hormones in those who were more religious or in those receiving spiritual interventions (often studies of meditation).

Both immune and endocrine functions, then, appear to be healthier in those who are more engaged in religious or spiritual activity.

Heart Disease is the nation's number one killer and is the most common cause of functional disability worldwide. Relationships between cardiovascular disorders and religious involvement, then, are likely to have considerable impact on public health. I review here relationships with blood pressure, cardiovascular reactivity, coronary artery disease, and survival after open heart surgery.

With regard to **Blood Pressure**, our systematic review found that 36 of 63 studies (57%) reported lower blood pressure or less hypertension in those who were more religious. Similar findings have been reported for studies of **Cardiovascular Reactivity, Heart Rate Variability**, and blood levels of **C-Reactive Protein**, with 10 of 16 studies (or nearly two-thirds) reported better cardiovascular functions. Likewise, **Coronary Artery Disease** mortality and morbidity were lower in 12 of 19 studies (63%). Finally, at least one study has reported that 6-month survival rates after **Open Heart Surgery** were considerably greater among patients with high religious coping and high social support.

We end this section by reviewing studies of **All-Cause Mortality**, an outcome that estimates *the cumulative effect* of religious involvement on health across the lifetime. At least 121 of these were conducted prior to 2010. All were prospective cohort studies ranging in follow-up from several months to 65 years. Over two-thirds (68%) reported significantly greater longevity among those who were more religious. Of the 63 studies with the largest samples and longest follow-up, 75% indicated greater longevity. Only 6% reported shorter longevity among the more religious. One large nationally representative study found that among Whites, the average lifespan of those attending religious services more than once a week was 7 years longer than non-attendees, and in African-Americans the difference was 14 years.

In summary, more than 3000 quantitative studies worldwide -- all published in peer-reviewed academic journals -- have now examined relationships between religion, spirituality and health.

Of those, the vast majority have reported better health outcomes in those who are more religious or spiritual. This is true not only for mental health, social health, and health behaviors, but is also true for physical health.

Part 1, Section 9

In the past five years, increasing attention and research has focused on the **Spiritual Needs** of patients with medical illness. Of particular importance is a series of reports by oncologists at the Dana Farber Institute at Harvard who have been following a sample of 345 patients with advanced cancer. In their initial report in the *Journal of Clinical Oncology*,¹ they found that while 88% of patients said religion was important, 72% said their spiritual needs were minimally or not at all supported by the medical system, i.e., doctors, nurses or chaplains. Among those who indicated their spiritual needs were being supported, quality of life was significantly higher.

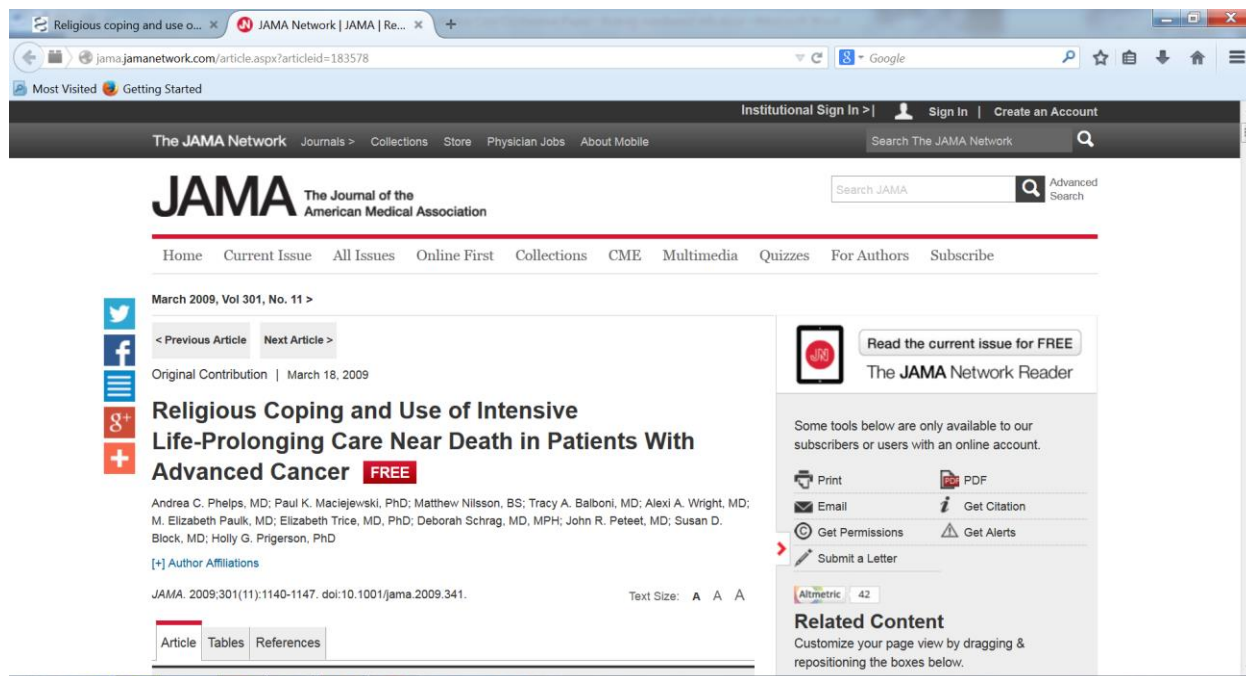


Next, in a 2009 report published in *JAMA*,² they examined the use of intensive, futile life-prolonging care requested by advanced cancer patients during the last week of life. Life-prolonging care included such treatments as mechanical ventilation or CPR. They found that such treatment was significantly more common in those indicating high levels of religious

¹ Balboni et al. (2007). Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. *Journal of Clinical Oncology*, 25(5), 555-560.

² Phelps et al. (2009). Religious coping and use of intensive life-prolonging care near death in patients with advanced cancer. *Journal of the American Medical Association*, 301 (11), 1140-1147

coping. This seemed counter-intuitive in that one would think that those who are more religious would be more accepting of death and less likely to demand aggressive treatment at the end of life. Apparently not so.



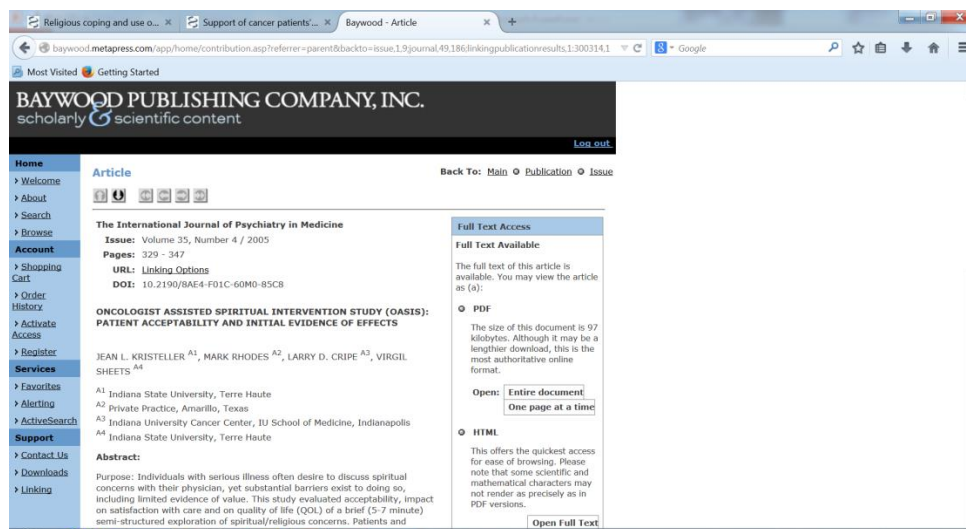
This finding caused researchers to explore why, and what they found was fascinating. They found that high religious copers using more intensive health services were primarily patients whose “spiritual needs were not being addressed by the medical team”. Among high religious copers whose spiritual needs were being met, the likelihood of receiving hospice increased 5-fold and aggressive care decreased by 72%.¹ Actual cost of care during the last week of life for those whose spiritual needs were being addressed was only about *one-half* the cost of patients whose spiritual needs were not, and among minorities, it was only about *one-third* the cost.²



¹ Balboni et al (2010). Provision of spiritual care to patients with advanced cancer: associations with medical care and quality of life near death. Journal of Clinical Oncology 28:445-452

² Balboni et al. (2011). Support of cancer patients' spiritual needs and associations with medical care costs at the end of life. Cancer 117(23):5383-5391

There has also been research on the effects of physician **Spiritual Assessment** on health outcomes. In the Oncologist Assisted Spiritual Intervention Study or OASIS, researchers alternately assigned 118 consecutive outpatients with cancer to either oncologists who took a brief spiritual history or those who did not.¹ While most of the patients were Christian, only 2 of the 4 oncologists were Christian, the other two were Sikh and Hindu. The OASIS intervention, which involved a bit more than taking a spiritual history, took an average of six minutes to administer. As a result, the total length of the outpatient visit increased by 1.7 minutes from 13.1 to 14.8 minutes. In 85 percent of cases, oncologists felt comfortable administering the OASIS interview, and in 76 percent of cases, patients said it was useful. At 3-week follow-up, compared to the control group, patients receiving the Spiritual Assessment reported significantly fewer depressive symptoms, significantly higher functional well-being, and significantly greater sense of interpersonal caring by the physician.



Section 10

Based on this systematic review, then, we **Conclude** the following:

- (1) Religion is commonly used to cope with medical illness.
- (2) Religious or spiritual involvement is associated with greater well-being, less emotional disorder, greater social support, and better health behaviors.
- (3) Religious involvement is related to less physical illness, better medical outcomes, and greater longevity.
- (4) Spiritual needs are widespread in medical settings, especially in those with serious, life-threatening illness.

¹ Kristeller et al. (2005). Oncologist Assisted Spiritual Intervention Study (OASIS): Patient acceptability and initial evidence of effects. International Journal of Psychiatry in Medicine 35: 329–347

(5) Assessing and addressing spiritual needs is related to great satisfaction with care, better QOL, less depression, fewer unnecessary health services, better functioning, and a better doctor-patient relationship.

(6) Much more research is needed to better understand these relationships. However, we know a lot already, and it's time to begin applying some of this knowledge to clinical practice.

Part 1, Section 11

So, what should physicians be doing differently than what they are already doing?

I now begin the transition in this training session from “the rationale” for addressing spiritual needs to “clinical applications”. The topics I will address are the following:

- (1) What do we mean by “spiritual assessment” and what does the physician do with this information?
- (2) What types of patients should have a spiritual assessment?
- (3) Besides a spiritual assessment, what else might the physician do?
- (4) What are some barriers to spiritual assessment and how to overcome them?
- (5) What is the role of the “spiritual care team”? And finally...
- (6) What are boundaries that physicians should not cross?

First, what do we mean by the “spiritual assessment”?

The spiritual assessment involves asking a few simple questions to identify spiritual needs related to medical illness. The purpose of the SA is to:

- (1) Become aware of the patient's religious background
- (2) Determine if the patient has religious or spiritual support
- (3) Identify beliefs that might influence medical decisions and compliance with treatment
- (4) Identify unmet spiritual needs related to medical illness
- (5) Determine if engagement of the “spiritual care team” is necessary, and...
- (6) Create an atmosphere where patients feel comfortable talking with physicians about spiritual needs affecting medical care

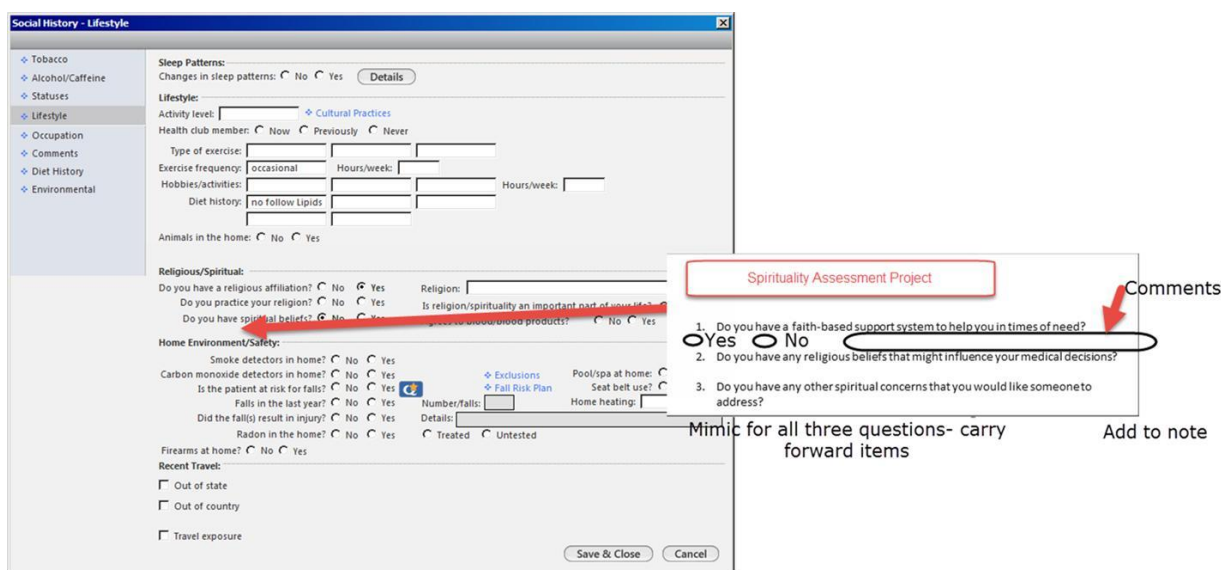
Part 1, Section 12

Assuming the receptionist or ward clerk has recorded the patient's religious affiliation in the EMR, and the physician has access to this information, the physician's spiritual assessment consists of the following three questions:

1. Do you have a religious or spiritual support system to help you in times of need?
2. Do you have any religious beliefs that might influence your medical decisions?
3. Do you have any other spiritual concerns that you would like someone to address?

When asking these questions, the physician should verbally and non-verbally **show respect** for the religious or spiritual beliefs of patients, regardless of what those beliefs are. This also involves showing respect for **the absence** of such beliefs.

What, then, should the physician do with the information from the spiritual assessment? **The physician should document the patient's responses in the EMR.** If spiritual needs are identified, the "spiritual care team" should be alerted so that arrangements can be made to address those needs. Finally, there should be **follow-up** down the road to determine if spiritual needs have been adequately addressed. Although the spiritual care team may assist in this regard, the physician should ensure that such follow-up occurs.



The spiritual assessment is NOT a one-time event. Whenever there is a significant change in the patient's condition, the physician will want to check whether any new spiritual needs have arisen that the patient needs help with.

Part 1, Section 13

Do all patients need a spiritual assessment by the physician? No. Who, then, does this apply to? There are five categories of patients where a SA is indicated. These are:

- (1) Patients with serious, life-threatening conditions;
- (2) Patients with chronic, disabling medical illness;
- (3) Patients with depression or significant anxiety;
- (4) Patients newly admitted to the hospital or a nursing home; and
- (5) Patients seen for a well-patient exam, when time is available to address social issues

Who does NOT need a Spiritual Assessment? These are:

- (1) Patients seen for an acute problem with no long-term complications
- (2) Patients seen for follow-up of a time-limited problem or a health condition without significant disability or challenges to coping
- (3) Children, teenagers or young adults without chronic illness, life-threatening or disabling medical illnesses
- (4) Patients who are not religious or spiritual, and so this topic is not relevant to them

Part 1, Section 14

The actions I've described above are the minimum expectation of physicians. Beyond the bare minimal requirement, what other activities might the physician do to address patients' spiritual needs? Such activities could include:

- (1) Listening to patients elaborate on their spiritual concerns;
- (2) Supporting patients' religious or spiritual beliefs;
- (3) Praying with patients if requested to do so; and...
- (4) Providing whole-person spiritual care

I will describe these activities in greater detail in Part 3 of this training series.

Part 1, Section 15

There are challenges, however, that prevent physicians from assessing and addressing patients' spiritual needs. Research indicates that only about 10% of physicians in the U.S. conduct a spiritual assessment.¹ What are some reasons for this?

The following 10 barriers stand in the way of spiritual assessment: lack of time, personal discomfort, fear of making patient uncomfortable, religion not important to physician, topic is too personal, spiritual assessment done better by others, patients don't want physicians to address this area, power inequality between physician and patient, beliefs of physician differ from patient, and spiritual assessment not physician's role. These barriers are based on research by the Harvard oncology group that I referred to in the research section.² They asked oncologists why they did not routinely assess and address the spiritual needs of patients. Let's now examine each of these barriers and how the physician can overcome them:

¹ Curlin et al. (2006). The association of physicians' religious characteristics with their attitudes and self-reported behaviors regarding religion and spirituality in the clinical encounter. Medical Care 44(5), 446-453

² Balboni et al. (2014). Nurse and physician barriers to spiritual care provision at the end of life. Journal of Pain & Symptom Management 48(3):400-10

(1) **Lack of Time.** A spiritual assessment is just one more thing that physicians are now being asked to do. We barely have enough time to perform our medical duties and document the results. Asking such questions could open Pandora's box. There is great temptation, then, to eliminate this "optional" activity.

Response: Doing a brief spiritual assessment must be a priority. It is not optional, but central to providing "whole-person" medical care. The SA can often **save time** in the long run, improve the doctor-patient relationship, and make the practice of medicine more rewarding.

(2) **Discomfort.** Many physicians are **not comfortable** addressing this topic, particularly if the physician is not religious him or herself. Few physicians have training on how to address this topic in a sensible and timely manner. Lacking expertise in this area, they don't feel comfortable asking questions about spirituality and don't know what to do about spiritual needs that are identified.

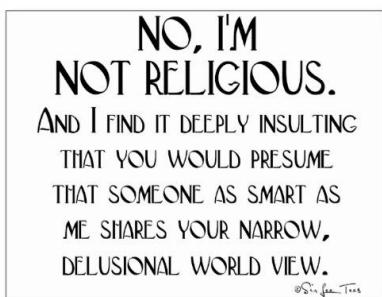
Response: Comfort comes with training and practice. This is why we are having this training session, and it is up to you to practice what you learn here.

(3) **Fear of making patient uncomfortable** or of not knowing what to say if the patient asks: "Why are you asking these questions?"

Response: Systematic research indicates that most patients are not offended or made uncomfortable when the physician performs a SA, and in fact, the majority is often quite pleased that the physician is doing so. If a patient asks why these questions are being asked, an appropriate response would be: "We are doing this routinely as a show of respect for the beliefs and values of patients, which may influence their medical care."

(4) **Spirituality is not important to the physician personally**, and is afraid that the patient will ask about his or her own beliefs.

Response: First, patients seldom ask physicians about their personal beliefs. If they do ask, then a brief or general response usually satisfies the patient. I wouldn't suggest the response in the slide below. The reason why most patients ask is worry about how the physician will treat their beliefs. Reassuring the patient that their beliefs will always be respected and honored usually allays this concern.



(5) **The topic is too personal** or there is no private space to discuss these issues.

Response: Physicians deal with sensitive areas **related to health** much more personal than asking about religious beliefs. Examples of sensitive areas include sexual behavior or personal health habits such as smoking, drinking, diet, and weight control. Fear that these areas are too personal does not prevent the physician from thoroughly assessing them.

(6) **The belief that spiritual assessment is done better by others.**

Response: The physician is the leader of the healthcare team and needs to know about factors that could affect the patient's health and their compliance with the medical care plan.

(7) **The belief that patients don't want the physician to address these issues.**

Response: Patient surveys indicate that only a minority of patients show resistance to such inquiry and prefer to keep medicine and religion separate (about 25%).

(8) **Concern that the power inequality** between patient and physician might lead to coercion.

Response: Realize that coercion in this area is a violation of civil rights, and so is never appropriate. I will discuss this boundary issue further in the next section.

(9) **Religious beliefs of the physician differ from those of the patient.**

Response: Realize that in this era of patient-centered medicine, the focus should always be on respecting and supporting the spiritual beliefs of the patient, whether or not the physician agrees with those beliefs.

(10) **Spiritual assessment is not part of the physician's role**

Response: Realize that providing whole-person care **IS** part of the physician's role and whole-person care involves addressing this area.

Part 1, Section 16

The physician is **NOT ALONE** in assessing and addressing spiritual needs. He or she is surrounded by a "spiritual care team" to help address spiritual needs that come up during the Spiritual Assessment. The spiritual care team is made up of nurses, social workers, chaplains, and office staff, and should be fully utilized. A primary purpose of the spiritual care team is to **minimize** physician time spent on this topic. As the quarterback of the spiritual care team, however, the physician's job is to do the Spiritual Assessment, which he or she cannot "hand off" to other team members.

Part 1, Section 17

Physicians must ALSO be aware of boundaries that limit their role in assessing and addressing the spiritual needs of patients. Here are five things that physicians should not do:

- (1) Don't prescribe religion to non-religious patients. The physician may think, "If religion is good for health, maybe non-believers should be encouraged to become religious." Not a good idea.
- (2) Don't force a spiritual assessment if the patient is not religious. In that case, quickly switch to ask about what gives life meaning and purpose in the context of illness and how this can be supported.
- (3) Don't pray with a patient before doing a spiritual assessment and unless the patient asks, or be ready for a lawsuit. While more than two-thirds to three-quarters of patients would like to pray with their physician and deeply appreciate the offer, others do not.
- (4) Don't spiritually counsel patients. Instead, always refer to trained professional chaplains or pastoral counselors. The only exceptions might be if the physician has pastoral care training, or if addressing spiritual issues is urgent and the patient refuses pastoral care or pastoral care is not available.
- (5) Don't do any activity that is not patient-centered and patient-directed. Remember, it's about the patient – not the physician. Addressing spiritual issues is like a ballroom dance. The patient leads and the physician tries not to step on his or her toes.

Part 1, Section 18

In **CONCLUSION**, here are 5 take-away points:

- (1) There are many reasons why physicians should **identify** spiritual needs related to medical illness by conducting a brief spiritual assessment.
- (2) Research, common sense, and good clinical practice justify taking the time to do so.
- (3) Many patients have spiritual needs related to illness and not addressing those needs is expensive, reduces QOL, and adversely affects the doctor-patient relationship.
- (4) The physician is responsible for conducting the spiritual assessment and following up, but is not alone.
- (5) The spiritual care team is there to help the physician ensure that spiritual needs are addressed and followed up appropriately.

For more information about **Research** on spirituality and health, I suggest the book *Spirituality and Health Research* (Templeton Press, 2011). For more information about clinical applications, I suggest the third edition of the book *Spirituality in Patient Care* (Templeton Press, 2013). A lot of information can also be found on our website at:

<http://www.spiritualityandhealth.duke.edu/>. Part II and III of this training series will address in greater detail both the research and the clinical applications.

