In recent years, discussions about patients’ spiritual and religious beliefs have found their way into the most widely read medical journals. Assessments of the relevance of such beliefs to the practice of medicine have varied from supportive\(^5\) to cautious.\(^6\) There has also been discussion of the existence of patients’ spiritual needs, especially in care at the end of life.\(^7\)

This growing medical literature invites physicians to consider the value of incorporating spiritual and religious factors into their care for patients as whole persons.\(^8\)

The coping benefits of religious and spiritual beliefs are the focus of this column, in contrast to claims about the possible therapeutic or preventive health benefits of such beliefs. By coping I refer to the constructive impact that religious and spiritual beliefs can have on a patient’s ability to accept illness, participate in treatment, and experience personal growth in the midst of illness. The ability to cope is crucial because serious illness is a threat to our wholeness as persons—causing fear, social disruption, loss, suffering, or death. These burdens are likely to be prominent in conditions that involve disability, terminal disease, substance abuse, or depression.

Spiritual and religious needs relevant to patient care can be summarized by 4 domains:\(^9\): (1) meaning and purpose; (2) hope; (3) forgiveness; and (4) relationship with God (if belief in God is present). Especially in end-of-life care, the prevalence of such needs is clear: 89% of seriously ill patients want to be at peace with God; 88% want to have a physician who knows them as a whole person; 86% want to resolve unfinished business with family or friends; and 80% want to feel their life is complete.\(^10\) The ability to cope with illness and participate in the process of care might be impeded by unmet spiritual and religious needs. The more serious the illness and the more disturbed by illness the patient, the more interested physicians should be in identifying such needs and attempting to locate potential resources to help address them.

Physicians may have various reasons not to address spiritual or religious matters with their patients. Reservations may arise from concerns about straying beyond professional boundaries, awkwardness in broaching an unfamiliar topic, or lack of time. Some physicians will be understandably reluctant to inquire about spiritual or religious beliefs if they know of differences between their own spiritual or religious background and that of the patient. There also may be ethical concerns about allowing spiritual or religious dialogue into the physician-patient relationship, since the physician’s professional status might be misused to promote beliefs or values that are outside the physician’s professional domain.\(^11\)

However, spiritual and religious beliefs (and their affiliated communities) may be the most significant resources that some patients bring to their illness. Therefore, physicians have a pragmatic interest in identifying and understanding how such resources can be employed in the interest of healing and well-being. Acknowledging the spiritual and religious resources of our patients does not mean that physicians should pretend to be competent in domains external to their professional scope. Nor does it mean that physicians should agree with the beliefs or belief systems that patients profess. Indeed, some physicians with deeply held spiritual or religious beliefs of their own may justifiably feel their personal integrity compromised by engaging a patient in discussion about such beliefs if doing so gave the impression of condoning beliefs espoused by the patient but not by the physician. Acknowledging the existence of patients’ spiritual and religious beliefs implies the awareness that these beliefs are often profoundly important (and potentially ultimate) sources of meaning, purpose, hope, and comfort. These beliefs may provide patients with a conceptual framework that helps them put their illness or mortality within a context that makes sense of what otherwise may seem meaningless or cruel.

There are concrete questions that physicians can ask to determine whether spiritual or religious beliefs may be relevant to a given patient’s care: (1) Do you consider yourself spiritual or religious? (2) How important are your spiritual or religious beliefs, and do they influence how you care for yourself? (3) Do you belong to a spiritual or religious community? (4) How might your healthcare providers try to address needs you have in this area? A physician who choos-
es to make such inquiries must then decide how to respond to the patient's answers. In the context of serious illness, information about a patient's deepest beliefs may help explain their coping strategies or treatment choices. Depending on a patient's answers, the physician may decide to encourage that patient to seek help from members of his/her own spiritual or religious community, or may suggest referral to a chaplain or other spiritual counselor. If physician and patient have sufficient reason to believe they have similar spiritual or religious beliefs, it may be natural for them to discuss the impact of illness and rationale for decision making in the context of those shared beliefs. In such circumstances, empathy and trust are likely to be enhanced by mutual understanding.

Discussions about resuscitation status or advance directives provide an important opportunity to inquire about spiritual or religious beliefs. Such discussions are typically uncomfortable for patients and physicians, but have become an essential part of patient care. Part of the discomfort induced by code status and other end-of-life discussions may arise from the way these discussions are sometimes delivered—appearing suddenly and in isolation from a patient's wider and deeper context of belief and understanding. This conceptual isolation may increase a patient's anxiety and fear by dislocating the discussion from his or her underlying framework of meaning and value. If a patient holds spiritual or religious beliefs that provide comfort in the face of suffering or death, the physician would do well to know this and may be able to try to help the patient by placing the code status discussion within a supportive framework provided by the patient's most foundational beliefs. This way of framing the discussion perhaps can be thought of as the conceptual equivalent of making a house call: the patient is allowed to receive and interpret the discussion while feeling at home in the comfort of their own framework of beliefs and values.

We should not ignore the possibility that a patient's spiritual or religious beliefs may cause them discomfort. Such instances, when they become evident, must be handled with care. But, even this is the case, information gathered may be important to how the physician interprets the patient's treatment preferences. For example, in the setting of end-of-life care, fears or feelings of guilt may make it harder for a patient to accept the reality of impending death and, therefore, make it harder for the patient to forgo life-supporting interventions. In such a case, further discussions or referral for spiritual counseling may be appropriate, if desired by the patient. If a patient does not hold spiritual or religious beliefs, conversation nevertheless may be meaningful. A considerate inquiry should serve to strengthen the physician-patient relationship, since such discussion expresses an interest in the patient as a whole person and can communicate appreciation for the patient's individuality.

**CONCLUSION**

Ethics is about responding to reality in ways that are good and right. If we agree that spiritual and religious needs are intrinsic to human beings and inherently provoked by serious illness, addressing these needs should be viewed as an integral part of ethical patient care. Indeed, there are situations when it would be unethical not to inquire about spiritual needs. For example, it would be inappropriate to forget to ask a patient who is dying if he or she would like to speak with a chaplain or other spiritual counselor. How to find the time—and learn the skills—to address these matters with sensitivity and competence is a serious challenge that does not admit of brief bullet-point strategies. But healthcare providers who care for their patients as whole persons will likely see the value of learning how to inquire about their patients' spiritual and religious needs—and do what they can, in good conscience, to facilitate appropriate responses to those needs.

**References**


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