What Do Family Physicians Think About Spirituality In Clinical Practice?

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OBJECTIVES To describe the context in which physicians address patients’ spiritual concerns, including their attitudes toward this task, cues to discussion, practice patterns, and barriers and facilitators.

STUDY DESIGN This was a qualitative study using semistructured interviews of 13 family physicians.

POPULATION We selected board-certified Missouri family physicians in a nonrandom fashion to represent a range of demographic factors (age, sex, religious background), practice types (academic/community practice; urban/rural), and opinions and practice regarding physicians’ roles in addressing patients’ spiritual issues.

OUTCOMES MEASURED We coded and evaluated transcribed interviews for themes.

RESULTS Physicians who reported regularly addressing spiritual issues do so because of the primacy of spirituality in their lives and because of the scientific evidence associating spirituality with health. Respondents noted that patients’ spiritual questions arise from their unique responses to chronic illness, terminal illness, and life stressors. Physicians reported varying approaches to spiritual assessment; affirmed that spiritual discussions should be approached with sensitivity and integrity; and reported physician, patient, mutual physician–patient, and situational barriers. Facilitators of spiritual discussions included physicians’ modeling a life that includes a spiritual focus.

CONCLUSIONS These physicians differ in their comfort and practice of addressing spiritual issues with patients but affirm a role for family physicians in responding to patients’ spiritual concerns. Factors that form a context for discussions of spiritual issues with patients include perceived barriers, physicians’ role definition, familiarity with factors likely to prompt spiritual questions, and recognition of principles guiding spiritual discussions.

KEY WORDS Spirituality [non-MeSH]; family medicine; medicine and religion. (J Fam Pract 2002; 51:249-254)

An emerging body of research supports the inclusion of spiritual issues in healthcare. Studies have correlated religious commitment with health. Many patients affirm the importance of spiritual factors in their lives. Recent studies demonstrate that many patients wish to have spirituality considered in their health care, especially during grave illness or emotional crisis. How to accomplish this objective...

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KEY POINTS FOR CLINICIANS

- Family physicians differ in their views regarding the appropriateness of addressing patients’ spiritual issues, but they widely support a patient-centered approach to any spiritual assessment that is performed.
- Physician barriers to spiritual assessment may include upbringing and culture, lack of spiritual inclination or awareness, resistance to exposing personal beliefs, and belief that spiritual discussions will not have an impact on patients’ illnesses or lives.
- Facilitators to spiritual assessment may include communicating a willingness to have these discussions and the physician’s modeling a life of balance and spiritual maturity.

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is less clear. Although physicians possess spiritual assessment tools, broader issues such as physician attitudes, roles, and varied ways of dealing with spirituality have not been widely studied. Understanding this context is crucial if physicians are to include spiritual assessment in patient care.

Two studies of Midwestern family physicians found strong support for addressing patients' spiritual concerns. In one survey, family physicians in Illinois (n = 210) believed that strong religious convictions positively affect older patients' mental health (68%) and physical health (42%). These doctors supported physicians' pursuing spiritual issues at patients' request (88%) and when patients faced bereavement or impending death (66%). Similarly, Missouri family physicians (n = 231) affirmed that spiritual well-being is an important health component (96%) and that hospitalized patients with spiritual concerns should be referred to chaplains (86%). A far smaller percentage of these physicians, however, felt they should personally address patients' spiritual questions (58%).

Despite acknowledging the importance of spiritual issues, the Missouri physicians seldom engaged patients in conversations about death and dying, meditation or quiet reflection, prayer, forgiveness, giving and receiving love, the role of a deity in illness, and the meaning or purpose of illness. They reported such barriers to spiritual discussions as lack of time (71%), inadequate training for taking spiritual histories (59%), and difficulty in identifying patients who want to discuss spiritual issues (56%). The gulf between physicians' attitudes and practice of spiritual assessment suggests an incomplete understanding of their role in spiritual health.

A study by Craigie and Hobbs14 of 12 family physicians who are themselves deeply spiritual represents early progress toward understanding this role. These physicians perceived that their spirituality enabled them to experience sacredness in patient encounters, to view medicine as a mission, to maintain centeredness, and to serve as instruments of healing. They described themselves as facilitators and encouragers of patients' spiritual values and resources. We reasoned that unlike the deeply spiritual respondents in the Craigie and Hobbs study, family physicians in general are likely to have a broad range of attitudes and practices regarding spiritual assessment. We sought to better understand the spectrum of views about the physician's role in spiritual encounters, to describe family physicians' approaches to addressing spiritual issues, and to further explore barriers to spiritual discussions and facilitators of these discussions.

**METHODS**

We conducted semistructured interviews6 with 13 family physicians. Participants assessed their frequency of addressing patients' spiritual issues and provided demographic information and practice characteristics. Interview topics included spirituality in the doctor-patient relationship, the practice of addressing spiritual issues, and perceived facilitators and barriers to discussing spiritual issues. Interviews were conducted by one of the authors (either A.D.B. or D.H.) or by a research assistant trained in qualitative investigation techniques. Interviews averaged 45 minutes in duration.

To guard against bias in advocating a particular stance toward spiritual assessment, we stressed to respondents that we wanted their honest observations and confirmed their statements throughout the interview. Before analyzing the data, we noted our preconceptions toward spiritual assessment. We consciously sought to avoid these biases while reviewing the data. To further reduce the likelihood of bias, we selected a research team whose members represented multiple academic disciplines and religious backgrounds.

Qualitative research aims to uncover new information and perspectives rather than to draw definitive conclusions from a representative study sample. Study participants were deliberately selected to represent a range of demographic factors (sex,
age, religious background), practice types (academic or community practice; urban and rural), and practice regarding physicians’ role in addressing patients’ spiritual issues.

All study participants were board-certified family physicians in Missouri. Three participants were white women; 10 were white men. They ranged in age from 37 to 63 years. Three were in full-time community practice; all others were medical school or residency faculty. All but 1 faculty member reported previous community practice experience. Two participants practice in rural locations; 2 in community health centers; 1 in a metropolitan community practice; 4 in metropolitan community-based residency clinics; and 4 in a metropolitan university-based residency clinic. Subjects’ religious affiliations were Jewish (1), Christian (6), “Unitarian Universalist with Muslim leanings” (1), “Unitarian Universalist with Buddhist leanings” (1), “Unitarian” (2), “none” (1), and agnostic (1).

Interviews took place in participants’ offices. We informed them of the use of audiotapes during the telephone recruitment and obtained verbal consent before audiotaping. An Institutional Review Board approved our study.

Study staff transcribed the interviews verbatim. Investigators verified interview content through comparison with interviewers’ notes and entered the text into Ethnograph, a computer database program designed to organize textual material. Investigators used an iterative process to make an initial template for organizing and coding data. Our multiple readings of interviews led to further code revisions until consensus was reached regarding salient issues or themes. We solicited respondents’ views of the validity of the final codes and themes and of the accuracy of illustrative quotations.

RESULTS

Six respondents reported regularly addressing spiritual issues with patients. One respondent reported an intermediate level of involvement; 6 reported that they do not regularly address spiritual issues. One physician was opposed to physicians’ addressing spiritual issues with patients.

The themes that emerged from the coded interviews were associated with 5 issues: (1) the appropriate role for physicians in addressing spiritual concerns; (2) situations in which physicians focus on spiritual issues (the nature and setting of these discussions); (3) how physicians address spiritual issues; (4) barriers to addressing spiritual issues; and (5) facilitators of spiritual assessment.

Physician’s Role

Physicians who regularly discussed spirituality believed that the scientific evidence linking spirituality and positive health outcomes justified their actions. One study participant stated, “Every physician ought to be dealing with [patients’] spiritual issues. [For example] how can you justify not talking about spirituality to a patient with depression when you can prove scientifically that strengthening faith commitment helps them? It really comes down to a quality of care issue.”

Some respondents believed that the primacy of spirituality in life provided a justification for addressing spiritual issues with patients. As one stated, “These values . . . get at the core of who you are. I would hope that I would be respectful and supportive” [whether or not I was a physician].

The respondents universally viewed themselves as supportive resources for patients through listening, validating spiritual beliefs, and remaining with patients during times of need. One expressed that healing occurs as physicians and patients connect as people, stating, “I don’t have to be a spiritual master. I can be a human being, trying to connect with another human being. That is a healing experience.”

Although several participants seldom addressed spiritual matters, only one strongly opposed the initiation of such discussions, out of concern about role definition and invasion of patients’ privacy. This participant felt that spiritual matters were “no more in the physician’s domain than questions regarding patients’ finances or their most evil thoughts.”
Nature and Setting of Discussions
Respondents reported specific patient illnesses and stressors that are likely to prompt spiritual discussions. These included terminal illness; chronic illness; specific conditions, such as heart disease, cancer, or miscarriage; depression, anxiety, or other psychiatric illness; pregnancy; and life stressors, including traumatic illness in the family. Other patient situations associated with spiritual discussions included the presence of symptoms without an explanation (e.g., pain, insomnia, anorexia), loss of a bodily function, role change within the family, or an illness that erodes one’s self-concept.

Physician respondents also reported factors that often prompt them to ask spiritual questions. These included intensive care unit admission, new diagnosis of terminal illness, treatment failures, patients’ dissatisfaction with progress of treatment, and discussion of advanced care directives. The respondents who regularly address spiritual issues use screening questions that they tend to ask in response to a patient’s cues or crisis (Table 1).

Some respondents asserted that patients’ spiritual questions arise from their unique reactions to life stress and illness. One physician stated that patients’ questions have “more to do with their view of their illness than what the illness really is.” Spiritual questions commonly asked by patients covered a wide range of spiritual themes (Table 1).

Manner of Addressing Spiritual Health Issues
The physicians in our study believed that in most circumstances, patients should initiate spiritual discussions. One said, “It’s one of those areas where you need a small amount of the patient’s permission to get started and a lot more of the patient’s permission to finish.”

Those who regularly address spiritual issues reported using a variety of techniques and approaches (Table 2). These physicians allow for an inclusive definition of spirituality; they try to normalize spiritual discussions and to integrate spiritual discussions into the ongoing doctor–patient relationship. One said that “bringing [spirituality] to the table” along with other potentially sensitive issues helps patients know “what you’re interested in and gives them the option of deciding to pursue it or not.”

The physicians who address spiritual issues follow principles of spiritual assessment (Table 2). All respondents affirmed that spiritual discussions should be approached with sensitivity and integrity to avoid imposing their own belief systems on their patients. One said, “I can’t even describe how negative it [would be] for me to impose my spiritual beliefs on [my] patients.” Another respondent agreed, but also described a tension between faith-based and profession-based thoughts: “[Discussing one’s faith with a patient risks being] an abuse of power; yet if a patient dies tonight and I haven’t shared the Good News that I have . . . I’m neglecting something that’s very important. . . . How do we do this . . . with both gentleness toward the patient and reverence toward God?”

Respondents expressed divergent viewpoints concerning routine spiritual history taking. Although some considered this to be an essential skill, those who seldom addressed spiritual issues found it less pressing and more time consuming than medical concerns. None reported the routine use of currently available spiritual assessment tools. A respondent opposed to initiating spiritual discussions noted a Judeo-Christian bias in these tools, calling their use “cultural imperialism.”

Barriers to Spiritual Assessment
Our respondents noted significant barriers, including
physician barriers, mutual physician–patient barriers, physician-perceived patient barriers, and situational barriers (Table 3). An example of a physician–patient barrier is the mutual feeling that neither wants to raise issues of spirituality for fear of alienating or causing discomfort in the other.

**Facilitators of Spiritual Discussions**

Respondents noted that characteristics facilitating patients’ discussions of sexuality and other sensitive issues also facilitate conversations about spirituality. These characteristics include communicating a willingness to engage in (and having the time for) such discussions and assuring patients that spiritual confidences will be received in a nonjudgmental fashion.

Physicians who are more spiritually inclined may be more likely to address spiritual issues with patients. As one respondent stated, “When I have conversations about spiritual issues, it’s [sic] usually been at my initiation . . . because I’m more concerned about religious sorts of things than many physicians.”

A final theme expressed by respondents is that physicians who model a lifestyle characterized by balance and spiritual maturity can facilitate patients’ spiritual growth. One stated, “My patients perceive something about my balance and spiritual strength that makes them believe they can do anything. It allows me to move to the next level with them . . . [by showing them how to foster] that strength in themselves with the help of family, community, and God.” Other facilitators are listed in Table 3.

**Discussion**

The relationship between religiosity and positive health outcomes does much to justify spiritual assessment. Other justifications include enhanced coping in chronic illness states, providing patients with hope in illness-coping and recovery, the possibility that neglect of spiritual needs may drive patients away from medical treatment, and evidence that some patients desire physicians to raise spiritual issues.

We sought to explore the context of spiritual assessment rather than to further justify such assessments. The context of spiritual assessment refers to the philosophical question of whether physicians should address spiritual questions and to practical questions of how spiritual matters arise, how physicians approach them, and what barriers and facilitators they perceive with regard to discussing spirituality. Our study adds to knowledge about this context in several important ways.

We found variance of opinion concerning the physician’s role in spiritual assessment. Respondents reporting infrequent spiritual assessment expressed the view that spiritual issues have lower priority than other medical concerns. Yet those who regularly address spiritual issues justified this with scientific evidence associating spirituality and health. They also proposed a justification not found in previous studies: that spirituality is central to life and therefore important for its own sake rather than simply as a means to a medical end. These findings support and augment previously cited justifications for physicians assisting patients with spiritual health issues.

Our study results add to the list of categories that prompt discussions of spiritual issues. Respondents affirmed a role for physicians in discussing end-of-life issues and advanced care directives, as in previous studies. In addition, they observed that patients’ spiritual questions arise from their unique responses to chronic illness, terminal illness, and life stressors. They identified 2 new categories prompting spiritual discussions: unexplained symptoms and treatment failure.

All respondents affirmed a role for physicians in supporting patients who initiate spiritual discussions. As in a previous study, they viewed themselves as facilitators and encouragers of patients’ spiritual values and as resources rather than as spiritual counselors. The most reticent physicians believed in responding to patients’ questions rather than initiating discussions, an approach that may fail to identify spiritual issues. All respondents supported a patient-centered approach to spiritual assessment in which physicians act with integrity and take care not to abuse their position.

Many physicians saw value in spiritual history taking, though none reported routine use of spiritual assessment tools. The potential Judeo-Christian bias in assessment questions noted by one respondent highlights the need to use culturally sensitive, generic assessment tools and to work toward further development of such tools.

We identified new barriers to spiritual assessment, including a physician’s upbringing and culture, lack of spiritual inclination or awareness, resistance to exposing personal beliefs, and belief that spiritual discussions will not influence patients’ illnesses or lives. Respondents also postulated patient barriers, including fears that their physician might judge them for their spiritual views or consider their raising spiritual questions inappropriate.

We identified facilitators of spiritual discussions, such as communicating a willingness to have these discussions. One respondent noted that physicians whose lives are characterized by spiritual maturity might serve as agents of patients’ spiritual growth,
consistent with a previous study’s themes of caregiver spirituality and physician vocation and mission.14

Limitations
Because qualitative research aims to uncover new perspectives rather than to make generalizable assessments, our findings may not apply to all physicians or to all family physicians. Although our respondents did not represent all major world religions, ethnic groups, and cultures, they did offer a diversity of spiritual and religious perspectives. Finally, our study gives only physicians’ perspectives. We are currently studying patients’ perspectives of situations that elicit spiritual questions and of potential barriers to spiritual assessment. We will use themes from our patient and physician qualitative studies to frame questions for a national patient questionnaire regarding physicians’ spiritual assessment.

Conclusions
Physicians differ in their comfort and practice of addressing spiritual issues with patients, but affirm a role for themselves in responding to patients’ spiritual concerns. Perceived barriers, physicians’ role definition, familiarity with factors likely to prompt spiritual questions, and the recognition of principles guiding spiritual discussions form the context for family physicians’ discussions of spiritual issues with patients. This context is important to consider when training medical students and residents in spiritual assessment. Careful attention to this context will also enhance the practicing physician’s skill in providing patient-centered assistance with spiritual health concerns.

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