Discussing Religious and Spiritual Issues at the End of Life

A Practical Guide for Physicians

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As patients near the end of life, their spiritual and religious concerns may be awakened or intensified. Many physicians, however, feel unskilled and uncomfortable discussing these concerns. This article suggests how physicians might respond when patients or families raise such concerns. First, some patients may explicitly base decisions about life-sustaining interventions on their spiritual or religious beliefs. Physicians need to explore those beliefs to help patients think through their preferences regarding specific interventions. Second, other patients may not bring up spiritual or religious concerns but are troubled by them. Physicians should identify such concerns and listen to them empathetically, without trying to alleviate the patient's spiritual suffering or offering premature reassurance. Third, some patients or families may have religious reasons for insisting on life-sustaining interventions that physicians advise against. The physician should listen and try to understand the patient's viewpoint. Listening respectfully does not require the physician to agree with the patient or misrepresent his or her own views. Patients and families who feel that the physician understands them and cares about them may be more willing to consider the physician's views on prognosis and treatment. By responding to patients' spiritual and religious concerns and needs, physicians may help them find comfort and closure near the end of life.

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As patients nearing the end of life grapple with their mortality, their spiritual and religious concerns may be awakened or intensified.[1-5] Such concerns may be the basis of patients' medical decisions, including decisions about life-sustaining interventions. Some patients may explicitly raise spiritual or religious issues with physicians,[6-9] whereas others may not discuss them but may be troubled by them or make medical choices based on them that physicians consider unreasonable. In these situations, physicians need to address patients' spiritual or religious concerns to provide better care. In addition, knowing these concerns helps physicians to understand patients' needs and to provide them with respectful, comprehensive end-of-life care.[1,10-15]

Many physicians, however, feel unskilled and uncomfortable discussing patients' spiritual and religious concerns[16-18] and therefore may avoid such conversations.[6] This article suggests how physicians might respond when patients or families raise such concerns near the end of life. Although chaplains and clergy typically help address these issues, in some cases they may not be avail-

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Box 1. Phrases to Help Elicit the Patient's Concerns

1. Use open-ended questions.
   Examples:
   - Does your trust in God lead you to think about cardiopulmonary resuscitation in a particular way?
   - Do you have any thoughts about why this is happening?
2. Ask the patient to say more.
   Examples:
   - Tell me more about that.
   - Can you tell me how you think she is suffering?
3. Acknowledge and normalize the patient's concerns.
   Examples:
   - Many patients ask such questions.
4. Use emphathic comments.
   Examples:
   - I imagine I would feel pretty puzzled to not know.
   - That sounds like a painful situation.
5. Ask about patient's emotions.
   Examples:
   - How do you feel about . . .?
   - How has it been for you with your wife in the intensive care unit for so long?

able or the patient may not want to talk to them. We analyze 3 cases in which responding to patients' spiritual and religious concerns helps physicians reach decisions about life-sustaining interventions and alleviate patient distress.

CLARIFYING RELIGIOUS STATEMENTS BY PATIENTS

When making clinical decisions about life-sustaining interventions, some patients refer to their religious or spiritual beliefs. In the following case, the physician regards these religious references as a distraction from her primary task of making a decision about cardiopulmonary resuscitation (CPR), thereby missing an important clue about what is important to the patient.[19,20]

Case 1

Case 1 concerns religious beliefs in a discussion of do not resuscitate (DNR) orders. Mr R is a 77-year-old, white, retired mechanic who has class II congestive heart failure and coronary artery disease that cannot be revascularized. After an emergency department visit for an exacerbation of congestive heart failure, his physician raises the issue of a DNR order. After checking the patient's understanding about his illness, the physician describes CPR.[19] The following conversation then occurs.

PHYSICIAN: In your situation, CPR is very unlikely to succeed. What do you think about what I have said?

MR R: Well, I want you to do what you can. I trust that God will decide when it's my time.

PHYSICIAN: Absolutely. Let me ask you, if you were to have a heart attack, your heart stopped, and you died, would you want us to try CPR?

This exchange is typical of DNR discussions.[19] This physician pursues her agenda of settling the issue of CPR, which seldom is a priority for the patient.[21] Pressing the patient to make a decision about CPR is unlikely to succeed, causing both the physician and patient to feel frustrated.[19] Mr R may feel that the physician is pushing him to make a decision that he has not had time to think through. Instead of pushing for an immediate decision about CPR, the physician might try to understand how the patient is thinking especially in light of his comment about God.[10,22,23] Many patients want to discuss spiritual and religious issues with physicians.[6-9]

PHYSICIAN: What do you mean when you say that you trust God?

MR R: Well, I place myself in God's hands.

PHYSICIAN: Tell me more about what it means to place yourself in God's hands.

MR R: God has a plan about how long I should live.

The physician may feel frustrated that she is no closer to her goal of clarifying Mr R's DNR preferences, even though she has tried to elicit his concerns and values (BOX 1).[24,25] Physicians vary regarding the techniques they find useful when probing for patients' values. For example, some physicians or patients consider a phrase such as "Tell me more about . . ." too psychologically oriented or forced. Another way to advance the discussion while following the patient's pace is to ask directly how his views of God are related to his decision about CPR.

PHYSICIAN: You mention trust in God. Does your trust in God lead you to think about CPR in a particular way?

MR R: If God calls me, I am ready. But when is he [God] really calling? I just don't know.

At this point, physicians might proceed in several ways. Some physicians might make an empathic comment such as, "I imagine I would feel pretty puzzled too about not knowing" or "That sounds like a painful situation." Such comments would be particularly useful if the physician believes that the patient's emotions are causing distress or impeding a decision. Other physicians might invite Mr R to say more about how his ideas about God relate to his preferences about CPR: "Do you have any ideas about that?" Still others might be more directive, summarizing the discussion and making the issue of CPR more explicit: "Let me be sure I've understood. It sounds like if you thought God was calling you, you wouldn't want us to try to revive you. But you're not sure when God is calling you. Is that right?" If the patient agrees, the physician might then say, "If I told you how likely it is that CPR would succeed in various situations, would that help you decide whether God was calling you?" or alternatively, "When you've known other people who have died, what do you think helped them to know when God was calling"? Through such discussions, the physician can help Mr R think through his preferences about CPR, based on what is important to him and the medical situation.

RESPONDING TO STATEMENTS THAT MAY INDICATE SPIRITUAL AND RELIGIOUS CONCERNS

In other situations, the spiritual or religious nature of a patient's concerns

may be less obvious than in case 1. Yet physicians need to become aware of these concerns to respond to them appropriately.

Case 2

Case 2 concerns questions about why an illness has happened. Mrs L is a 64-year-old woman undergoing combination chemotherapy for metastatic small cell carcinoma of the lung. She visits her physician 2 days after an emergency department visit for dehydration caused by nausea and vomiting associated with the chemotherapy.

PHYSICIAN: How have you been doing?

MRS L: I don't know. I keep wondering why all of this is happening to me.

PHYSICIAN: Well, as we talked about, chemo tends to make people feel down. Tell me, how much have you been able to eat and drink since you got home?

In this conversation, the physician presses forward with biomedical questions, assuming that Mrs L is asking why she became dehydrated. Although it is important to evaluate her hydration, the physician misses an opportunity to explore her concerns first.[20,26] Mrs L's question, "Why is this happening to me?" might have several meanings. She may be asking for scientific information. For example, why did severe vomiting occur after premedication with antiemetics? Or, why did the cancer occur after she stopped smoking? However, Mrs L may also be asking about psychosocial, existential, or spiritual issues. She may be trying to find meaning in tragic events, asking why bad things happen to good people.[13,15,27] The physician can distinguish these possibilities through an open-ended question.

PHYSICIAN: Do you have any thoughts about that?

MRS L: Well, I wonder why God would do this to me.

PHYSICIAN: Tell me more about that.

MRS L: I've been active in my church. I've tried to be a good wife and mother. I just don't understand it.

The physician may feel that this discussion has reached a dead end, despite his efforts to elicit the patient's perspective. However, continued attempts may help the physician understand Mrs L's concerns, which are apparently spiritual in nature, and thereby provide her some comfort.

PHYSICIAN: It sounds like you can't understand why this would happen given all that you've done to lead a good life.

MRS L: Yes, I sometimes feel that God is punishing me, even though I've tried to be a good person. Why else would God let this happen?

PHYSICIAN: It sounds like you're thinking about the past, trying to figure out what you might have done.

MRS L: Yes, that's it [tearful].

This dialogue is not a digression but an integral part of clinical care because it builds empathy and helps relieve distress. Empathic comments can be therapeutic, showing that the physician has understood the patient and cares about her.[28-31] Patients who believe that the physician has really understood them may no longer feel alone with their distress.[29,32]

The physician in case 2 avoids several pitfalls in responding to Mrs L's spiritual and religious concerns (BOX 2). First, he does not try to solve her problems.[10] Trying to relieve suffering is a compassionate human response and the goal of palliative care. Fixing problems is the focus of biomedical training. However, spiritual suffering cannot be "fixed" in the same way that pain may be alleviated with analgesics. The physician cannot answer the ultimate question of why good people have fatal diseases. Yet paradoxically, patients may feel comforted when another person is simply present or "walks with" them.[33]

Second, the physician does not step beyond his expertise and role.[15,17,18,34-37] Physicians should respect patients' religious and spiritual views and avoid expounding or imposing their own beliefs.[11,18,35,38] Unlike chaplains and clergy, few physicians have the training or expertise to engage in theological discussions about the nature of God, sin, and punishment.[15,18] Moreover, the roles of physician and spiritual counselor usually are best kept separated,[11,15,17,18,34,35,39] except perhaps when a physician has also had pastoral care or seminary training.

Box 2. Pitfalls in Discussions About Spiritual and Religious Issues Near the End of Life

- Trying to solve the patient's problems or resolve unanswerable questions.
- Going beyond the physician's expertise and role, or imposing the physician's religious beliefs on the patient.
- Providing premature reassurance.

Third, the physician does not offer premature reassurance. When a patient questions the worth of her life, compassion may impel the physician to say that cancer is not a punishment from God. However, immediate reassurance may seem superficial and fail to achieve its goal. It might also deter patients from disclosing other important issues and emotions.[24,26] As a result, patients may be burdened by unexpressed concerns and feel that the physician has not understood them.[24,26]

Physicians may find it difficult to refrain from attempting to alleviate the patient's spiritual suffering or from offering immediate reassurance. To overcome their skepticism, physicians might recall the last time they came home from work and said, "I had a terrible day." Was it helpful if your spouse offered advice about dictating notes after each patient or reassurance that the next day would be better? Or was it more helpful if others listened to your story, asked questions, and acknowledged, "It does sound like a terrible day?" Such reflections may help persuade physicians that they may not have answers to the patient's spiritual or religious questions, but they still can provide a supportive setting that helps patients to find their own solutions.

RESPONDING TO A PATIENT'S QUESTIONS ABOUT THE PHYSICIAN'S RELIGION

During discussions of the patient's spiritual and religious concerns, he/she may ask about the physician's religion or whether the physician believes in God or is born-again.[18] Patients may have various reasons for such inquiries. They may wonder whether it is safe to talk about spiritual and religious issues with the physician. They may prefer a physician who is sensitive to spiritual issues, is religious, or shares the same faith.[18,40] In social relationships, a disclosure by one person often leads to a reciprocal disclosure by the other. More problematically, some patients may be curious to know personal information about their physician or may want to engage the physician in religious discussions.

Physicians might respond in several ways to such questions. Many physicians may feel that their religion is a private matter and choose not to disclose it to their patients.[18] If they are of a different faith, they may be concerned about a rift with the patient.[18] Physicians have no obligation to answer questions about their religion. However, physicians need to consider how to decline without discouraging patients from voicing their spiritual or religious concerns. A physician might say, "I'd like to keep the focus on you rather than me."

Other physicians might simply disclose their denomination. However, in addition to answering the patient's factual inquiry, such physicians should also explore why the question is important to the patient.[24]

PHYSICIAN: I am Jewish, but I am curious about why you asked.

MRS L: I guess I was wondering if you could understand my questioning of God.

PHYSICIAN: I'll certainly try my best. Many patients question why bad things happen to good people. It is important for me to know that you are struggling with this and that religion is important in your life.

Physicians who disclose their denomination need to set appropriate limits. The question "What religion are you?" is not an invitation for physicians to explicate their spiritual and religious beliefs. If patients ask about details, it is appropriate to focus the conversation back on the patient.

RESPONDING TO RELIGIOUS REASONS FOR REJECTING THE PHYSICIAN'S MEDICAL RECOMMENDATIONS

Patients and their families may insist on interventions that physicians consider futile.[41,42] Such insistence may result from disagreements over prognosis, rejection of physician authority, distrust of the medical system, or a religious belief in miracles.

Case 3

Case 3 deals with belief that a miracle will occur. Mrs M is a 72-year-old black woman with chronic obstructive pulmonary disease who has been receiving mechanical ventilation for 2 months because of acute respiratory distress syndrome and multiorgan failure. Believing that Mrs M now has only a 1% chance of being successfully extubated, her physicians begin to discuss limiting life-sustaining interventions. Mrs M is unable to participate in these discussions. She had previously indicated that her husband should act as her surrogate but did not provide specific directives for her care. Mr M and their 2 children insist that mechanical ventilation be continued.

PHYSICIAN: Let me explain again how sick she is and that she has not improved, despite all our efforts.

MR M: We know that she is very sick.

PHYSICIAN: Yes, she is very sick. Her lungs are not healing. She is barely holding on.

MR M: God has stronger healing powers. He will answer our prayers and work a miracle.

PHYSICIAN: You know, miracles are rare. Most of the time they don't occur.

This exchange illustrates how physicians may seem to dismiss religious-based insistence on interventions they consider ill-advised. In these conversations, each party may feel frustrated and believe the other party is not listening. The physician in this case uses common but usually ineffective tactics to try to dissuade the family. First, she tries to provide more facts or arguments.[43] However, such insistence usually springs from different values, not factual misunderstandings or disagreements. Second, the physician argues that miracles by definition are unlikely. However, faith in miracles does not depend on their probability. Other physicians might try to reframe the concept of "miracle." For example, they might suggest that the miracle will not be Mrs M's recovery but rather the gathering of relatives to be with her a final time. Although the family might reach this reformulation on their own, they are unlikely to be persuaded by someone who does not believe in miracles. Furthermore, using the family's religious terms to get them to agree with the physician's plan can be manipulative. As tension mounts, physicians and families may become polarized, and disagreements may escalate into conflicts. Rather than reiterate her own position or press the issue of limiting interventions, the physician might do better to listen to the family and try to understand their views.[44]

PHYSICIAN: What would a miracle look like to you?

MR M: We know that he [God] will answer our prayers. The bible says that prayer can move mountains.

PHYSICIAN: I see that your faith is very important to you.

MR M: It is. Our faith is strong that God will work a miracle and she will come home with us.

PHYSICIAN: I also hope she can go home.

MR M: We just want you to do your best, so that God's will can be done.

The physician has defused the disagreement by listening to Mr M's views on miracles, acknowledging the importance of religion for him, and aligning with his hopes that Mrs M might recover. In turn, Mr M seems more accepting of the limits of medicine in this situation. "I wish" or "I hope" state-

ments by physicians can be particularly useful in such situations.[45] Stating a wish allows the physician to share the family's hope without reinforcing unrealistic expectations.[45] However, framing the statement in this way also implies that it is unlikely that these hopes will be realized.

After finding common ground with Mr M, the physician can explore whether his religious views have other implications for Mrs M's medical care.

PHYSICIAN: As you think about Mrs M's illness, what else do you hope for?

MR M: We hope, we know, that God will not let her suffer.

PHYSICIAN: Do you feel that she is suffering now?

MR M: She has all those needles and tubes, and she doesn't recognize us most of the time.

After listening to Mr M's belief in miracles, acknowledging the importance of religion to him, and aligning with his hopes, the physician may appropriately turn the discussion toward other hopes for that patient. However, asking about Mr M's other hopes as soon as he mentioned miracles might seem dismissive or disrespectful of his religious beliefs.

In addressing Mr M's religious concerns, the physician achieves several important goals (**BOX 3**). First, clarifying Mr M's belief in miracles helps the physician appreciate why the family wants to continue "futile" interventions and how faith is a source of support and hope to this family. Second, the physician connects with the family. Listening respectfully does not require the physician to agree with the family or misrepresent her own views. Once the family feels that the physician understands them and cares about the patient, they may be more willing to hear her views on prognosis and care.[44] Third, the physician works toward shared goals. After the physician acknowledges the importance of religion to Mr M, it is safer for Mr M to express his ambivalence about his wife's condition. Subsequently, the physician and Mr M might be able to agree on relief of suffering as a goal of care. In turn, this goal might help the physician and family agree on specific clinical decisions about ventilation, vasopressors, dialysis, and CPR. After such discussions, some families or patients may make choices that differ from the physician's recommendation. However, these discussions will at least reduce the conflict and ill will over such decisions.

When a patient cannot speak for herself, her physicians need to ascertain whether her own beliefs are consistent with those expressed by her family. In this case, the physician later learned that Mrs M had led prayer breakfasts and bible study groups and had expressed views similar to her husband's. The physician therefore felt reassured that Mr M was accurately conveying her beliefs.

Knowledge of their religious concerns and beliefs may help physicians mobilize support for patients and families. Many will welcome visits, prayers, scriptural readings, and religious rituals from chaplains or clergy of their own choosing. Equally important, however, other patients and families may not want ministrations from chaplains and clergy; their views should also be respected.

In conclusion, physicians responding to spiritual and religious concerns that patients raise near the end of life can keep in mind several guidelines. First, they should respect the patient's views and follow the patient's lead in exploring how these issues affect their decisions about medical care, cause distress, or provide comfort. Second, physicians need to appreciate the limits of their expertise, role, and training. It is appropriate for the physician to listen, ask clarifying questions, and explore the patient's feelings, as with any topic of importance to the patient. However, physicians should not try to convert patients and generally should not engage in theological discussions or invite patients to participate in religious rituals. Third, physicians should maintain their integrity and not say or do anything that violates their own spiritual or religious views. These guidelines may provide physicians with tools to help patients find comfort and closure near the end of life.

Box 3. Goals for Physicians When Discussing Spiritual and Religious Issues With Patients and Families Near the End of Life

- Clarify the patient's concerns, beliefs, and needs and follow hints about spiritual or religious issues.
- Make a connection with the patient by listening carefully, acknowledging the patient's concerns, exploring emotions, making empathic statements, and using wish statements.
- Identify common goals for care and reach agreement on clinical decisions.
- Mobilize sources of support for the patient.

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Everything ought to be beautiful in a human being: face, and dress, and soul, and ideas.
—Anton Chekhov (1860-1904)