

# By Intuitions Differently Formed: How Physicians Assess and Respond to Spiritual Issues in the Clinical Encounter

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In a salutary contribution to debates about spirituality in medicine, Kuczewski (2007) raises the question of whether “hard and fast rules” are suited to the subject of dialogue about spiritual matters. Those who argue that physicians should not engage patients’ spiritual concerns still suggest physicians should at least consider those concerns, and those who encourage physicians to assess and address spiritual issues have developed and published an array of practical tools to help in that task. Yet little has been known about how physicians actually assess and respond to patients’ religious and spiritual issues. This commentary relates Kuczewski’s analysis to empirical data about what physicians themselves report.

We recently conducted semi-structured interviews with 21 physicians from a range of different religious and non-religious worldviews to explore their perspectives on the intersection of religion, spirituality and medicine. Prior reports described participants’ perspectives on how religion and spirituality influence patient health (Curlin et al. 2005a) and on religiously-mediated conflict in medical decision-making (Curlin et al. 2005b). We here report the themes from what participating physicians said about how they assess and respond to patients’ spiritual concerns. These themes are illustrated with direct quotations from study participants.

Participants described intuitive, patient-centered, case-by-case approaches to spiritual issues in the clinical encounter. They said they were more likely to inquire about spiritual concerns in contexts such as end-of-life care, communication of a grim prognosis, making decisions about pregnancy, and responding to symptoms of depression. Yet, physicians avoided strict rules or guidelines regarding when and how to inquire. Instead they talked about being “spiritually tuned in” to notice and respond to cues that suggest patients may have spiritual concerns that merit further attention.

Verbal cues from patients included angry or anguished tones of communication, spiritually laden words such as “guilty” or “lonely,” and explicitly religious language. Visual cues included Bibles or other religious literature on patient’s bedside tables, religiously symbolic jewelry, and

seeing a patient praying or in tears. By paying attention to these cues, physicians passively assessed whether spiritual issues might be pertinent to a particular patient, and identified starting points from which to begin more active inquiry. One physician commented, “There are lots of little clues that make me ask additional questions.”

Physicians asked additional questions to better understand patients, to identify their specific spiritual needs, and to communicate that the physician was willing to discuss spiritual issues if a patient so desired: “I ask open-ended questions that I believe are non-threatening, non-judgmental, non-proselytizing, that allow people to talk about their faith.” Physicians described starting with general questions, such as “Do you have anyone to talk to about this?” and “Is religion important to you?” before progressing to more specific questions, such as “Do you belong to a church or religious group?” Other than this trend from the general to the specific, participants did not describe following any consistent pattern, and several eschewed the idea of using a routine approach—“I don’t think there’s one set pattern [of] questions; life is really too fluid for that.” None reported familiarity with or use of any of the spiritual assessment tools that have been published in the medical literature.

In this fluid and non-formulaic way, physicians try to understand the patient’s viewpoint to establish rapport, express support, and attempt to match the patient with appropriate spiritual resources: “I try to tease out what the issues are, to understand what the needs of the patient are, and to make sure that they are met.” The simplest form of resource matching was for physicians to empathetically offer their presence and conversation, in hope that they could in some way encourage and comfort the patient. Physicians might talk about ideas, tell stories, or even offer counsel that they believe will be of benefit to the patient: “If I have something to offer—some ideas or some thoughts, ways to think about things, to ease their suffering—that’s my goal and that’s what I’ll do.”

When patients appear to need support that the physician cannot provide, then physicians said they would try to match patients to other resources. If the patient needs

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extended time with someone who could listen to and support them, the physician might help the patient establish contact with a pastoral care professional. If the patient needs more family support, the physician might encourage the family to be more involved. If the patient needs the sacraments, the physician might call a priest. If the physician believes that the patient would benefit from prayer, he or she might pray with the patient or, if uncomfortable praying, might refer the patient to a pastoral care provider.

The heuristics that seemed to guide physicians most were to be patient-centered and to take care not to impose one's own views. Physicians honored these rules of thumb by asking questions in an invitational rather than presumptive way, by starting with general and nonreligious inquiries before moving to specifically religious questions, and by dropping the subject if patients' body language or words suggested they did not want to discuss spiritual issues further. With respect to prayer, one commented, "If the doctor's going to pray with the patient it should be from the patient's point of view and the patient's religion, not the doctor's."

Overall, physicians described their role more as one of listening and making connections than one of trying to provide sophisticated spiritual care or counsel. Physicians were hesitant to tell patients what to do, although one noted, "If they seem to want to engage, I'll say more," and another added, "If [I want to share] my perspective I ask them for permission." Most often, it seemed, physicians refer spiritual care and counsel to those with more expertise. One physician said, "If [patients] were asking for guidance, then I would direct them to somebody who could guide them better than me." Another commented, "Once it becomes, 'tell me how to handle this spiritual dilemma that I'm having,' physicians ought to be very careful."

This qualitative study suggests that physicians share an intuitive, heuristic, case-by-case approach to assessing and responding to spiritual issues that emerge in the clinical setting. Yet, other data indicate that this intuitive approach generates widely varying approaches due in large part to differences in physicians' own religious and secular characteristics. In a mailed survey of 2,000 United States physicians (1,144 respondents) (Curlin et al. 2006), we found that physicians who are more religious and more spiritual, particularly those who are Protestants or Catholics, are much more likely to report that they inquire about patients' religious and spiritual concerns, that they encourage patients own religious and spiritual beliefs and practices, that they discuss their own religious and spiritual ideas with patients,

and that they pray with patients. They were also much more likely to say they spend too little time discussing religious and spiritual issues with patients, despite the fact that they are more likely to report spiritual inquiry and more likely to say they never change the subject when religious and spiritual issues come up. These differences appeared to be mediated in part by the fact that religious and spiritual physicians report less discomfort discussing religious matters and less concern about having insufficient knowledge and training. Yet, differences persisted in analyses that controlled for these and other relevant covariates.

In light of these data, physicians and ethicists are not likely to come to consensus about how to assess and respond to the spiritual concerns of patients. Physicians do not appear to apply hard and fast rules, and their intuitions, which are formed with reference to different religious and secular commitments, lead them to different conclusions about how to respond in given cases. This variation is not necessarily unwarranted so long as physicians follow the heuristics Kuczewski (2007) proposes—namely, to remain patient-centered and to be transparent when appropriate about the ways their own worldviews influence their counsel to patients. If physicians respond to patients with candor and respect, differences in worldview need not impose an obstacle to wise and compassionate care (Curlin and Hall 2005). ■

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