Doctor, Will You Pray for Me? Responding to Patients' Religious and Spiritual Concerns

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Abstract

Religion and spirituality in the United States have been shifting, and physicians are treating patients with increasingly diverse beliefs. Physicians' unfamiliarity with these beliefs poses critical challenges for medical education and practice. Despite efforts to improve medical education in religion/spirituality, most doctors feel their training in these areas is inadequate. This article draws on the author's conversations with providers and patients over several years in various clinical and research contexts in which religious/spiritual issues have arisen. These conversations provided insights into how patients and their families commonly, and often unexpectedly, make religious/spiritual comments to their providers or question their providers about these topics, directly or indirectly. Comments are of at least 9 types that fall within 4 broad domains: (1) perceiving God's role in disease and treatment (in causing disease, affecting treatment outcomes, and knowing disease outcomes), (2) making medical decisions (seeking God's help in making these decisions and determining types/extents of treatment), (3) interacting with providers (ascertaining providers' beliefs, having preferences regarding providers, and requesting prayer with or by providers), and (4) pondering an afterlife. Because of their beliefs or lack of knowledge, doctors face challenges in responding and often do so in 1 of 4 broad ways: (1) not commenting, (2) asking strictly medical questions, (3) referring the patient to a chaplain, or (4) commenting on the patient's remark. Medical education should thus encourage providers to recognize the potential significance of patients' remarks regarding these topics and to be prepared to respond, even if briefly, by developing appropriate responses to each statement type. Becoming aware of potential differences between key aspects of non-Western faiths (e.g., through case vignettes) could be helpful. Further research should examine in greater depth how patients broach these realms, how physicians respond, and how often medical school curricula mention non-Western traditions.

In recent years, the roles of religious and spiritual issues in health care have received increased attention, but many questions, gaps in understanding, and challenges remain. Religion and spirituality in the United States have been shifting markedly,[1] and physicians are treating patients with increasingly diverse beliefs, with which doctors may be unfamiliar, posing critical challenges for medical education and practice.[2]

Patients often want to discuss religious and spiritual issues with their physicians and other providers but are usually disappointed.[3] A 2011 study showed that among inpatients, 41% wanted to discuss religious or spiritual concerns with someone while in the hospital, but only half of them did so.[4] Doctors infrequently discuss these issues.[5] Of ICU attendings, 79% thought that it was their responsibility to address patients' religious/spiritual needs, but only 14% and 7% said they frequently ask patients and families, respectively, about these topics.[6] About 18% of physicians never discuss these issues, even if the patient asks, even at the end of life.[5] Patients tend to almost always initiate these conversations,[7] and physicians generally do not make efforts to support or facilitate the patients' religiosity.[8–10] Moreover, physicians sometimes attempt to change the topic.[5]

Yet religious and spiritual issues can be important, affecting patients' disease risks and perceptions and physicians' and patients' treatment decisions. Religious and spiritual coping has been found to be associated with decreased risks of certain diseases, for example, hypertension in African American women.[11] Those patients who did discuss religion/spirituality, whether they had initially wanted to do so or not, have been more satisfied with their care ($P < .05$).[4] Physicians without religion are more likely to engage in invasive procedures.[12]

Although the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) decreed in 2001 that hospitals must administer a spiritual assessment,[13] most medical schools still provide only limited training.[14,15] Only 7% have a required course dedicated to the topic.[13,14] Even if provided funding and training assistance, only one-quarter of U.S. medical school deans thought that they would increase the amount of time on the topic.[5] A review of medical school curricula in spirituality found only 10 articles, most of which "failed to specify what particular aspects" of the topic were covered.[16] Few curricula have been described, and evaluations of them have been relatively rare.[17,18]

Not surprisingly, most doctors (62%) feel that their training in this area is inadequate. Physicians' discomfort with these topics remains a major obstacle to them being able to discuss religious and spiritual concerns with their patients. About half of physicians feel awkward discussing these subjects with patients whose views differ from their own, and 44% worry that patients will feel uncomfortable.[19]

Doctors say that lack of time and private office space is what most hinders them from discussing religious and spiritual

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topics with their patients. However, the small amount of spiritual care they provide is not, in fact, associated with these 2 factors, but instead with their personal discomfort talking about spiritual issues ($P < .001$), beliefs that patients do not want these conversations ($P < .002$), worry that patients will feel uncomfortable ($P < .003$), lack of training ($P < .04$), and feeling uncomfortable engaging with patients who have religious beliefs different from their own ($P < .05$).[20]

These challenges are of rising concern since the religious landscape in the United States is becoming increasingly diverse. Fewer Americans identify as "religiously affiliated" or Christian or attend church, and more are Muslim and Hindu.[1] In recent years, the proportion of individuals who, when asked to choose their religious affiliation on a form, indicate "none of the above" (so-called "nones") has doubled.[6,21] The beliefs of doctors and their patients also differ significantly. Physicians are more likely to be Jewish, Hindu, Muslim, orthodox Christian, or Mormon and less likely to be Protestant, Catholic, or none.[2] Moreover, within any faith tradition, patients also differ widely in their beliefs and behaviors.[22] These shifts in religious diversity can create additional tensions in doctor–patient interactions, especially given rising Islamophobia and other forms of xenophobia.[23]

Patients are asked their religion by many hospitals but often must select their response from only 4 or 5 choices. Spirituality and religion can, however, be difficult to describe or assess. Instruments designed to obtain patients' spiritual history have limitations,[21,24] measuring various aspects, but many complexities, doubts, struggles, conflicts, and experiences are potentially involved in these beliefs and difficult to capture on a form.[25–27]

Hospitals regularly employ chaplains who can help patients but who face challenges as well—they are often underresourced and thus able to consult only a fraction of the patients in a hospital.[4] Only about 60% of hospitals have chaplains, and this proportion has not changed in over 20 years, despite JCAHO requirements.[28] According to a 2015 study, only 6% of patients in intensive care units had seen chaplains.[29] Clinicians could ask patients, especially if severely ill and facing the prospect of death, whether they would be interested in speaking with a chaplain, but such referrals to chaplains may not occur.[29]

Thus, several critical challenges and limitations in the current literature remain concerning the details of doctor–patient discussions and medical school curricula: what, specifically, patients and doctors each say when discussing religious or spiritual subjects and what medical schools teach about these topics. This article draws on observations and conversations with providers and patients over several years in various clinical and research contexts (e.g., in-depth interviews I have conducted as part of various studies) in which these issues have often arisen. I have reported other data from this research elsewhere, focusing on several other issues.[30–34] Here, I present and highlight several aspects of interactions regarding religious and spiritual issues since they may contribute to discussions in the literature and inform and advance efforts to improve medical practice and training in this area. Specifically, in this article, I examine how patients and families can utter at least 9 types of comments and questions to which providers should be prepared to respond in some way. Overall, I have found that physicians' responses are of 4 broad types.

How Religious and Spiritual Comments May Arise

I have found that patients and their families commonly make religious or spiritual comments to their physicians or ask their physicians questions about these topics unexpectedly, either directly or indirectly, and that providers often misunderstand or misinterpret what's been said and/or struggle with how best to respond. Patients commonly mention God but do so in ways that have a wide variety of meanings. As shown in Figure 1, patients and their families may make at least 9 types of comments within 4 broad domains: (1) perceiving roles of God in disease and treatment (in causing disease, affecting treatment outcomes, and knowing disease outcomes), (2) making medical decisions (looking to God to help make medical decisions and to determine types and extents of treatment), (3) interacting with providers (ascertaining providers' beliefs, having preferences regarding providers, and requesting prayer with or by providers), and (4) pondering an afterlife. These categories may not always be rigidly distinct but rather can overlap, with a patient's or family member's comments reflecting more than 1 category at different points. Doctors face certain challenges in replying when these topics arise and appear to respond in 1 of 4 broad ways: (1) making no comment, (2) responding by asking strictly medical questions, (3) referring the patient to a chaplain, or (4) commenting on the patient's remark. Medical education should encourage students to recognize the potential significance of patients' statements about these topics and to be prepared to respond, even if briefly, by developing appropriate responses to each type of comment.

Perceiving roles of God in disease and treatment

Roles of God in causing disease. Many patients and their families, especially when receiving bad news, wonder about, and comment on, the possible roles of God in causing disease, saying, for instance, "This must be God's will" or "I guess there's a reason for everything" or suggesting that karma or divine justice may play a role. Patients may not understand the mechanisms or reasons involved but nonetheless hold such views.

Roles of God in affecting treatment outcomes. Patients commonly make statements regarding the roles of God in influencing treatment results and even in curing disease. Especially when receiving bad news, patients may ask if, or believe that, God will affect treatment outcomes, saying, for example, "Will God help me?" "Will God save me?" "I think a miracle will happen," or "I'm hoping for a miracle." Patients may feel that God's influence on treatment outcomes can affect, for instance, when one dies ("I guess God isn't ready for me yet").

Roles of God in knowing disease outcomes. Many patients and families feel that, given genetics, environment, and other biological processes that can affect disease course and treatment results, God does not necessarily directly alter disease or treatment outcomes but omnisciently knows what these outcomes will be. These individuals may say, for instance, "God knows what will happen," or "only God knows." They may invoke the word "God" as a stand-in for other, unpredictable

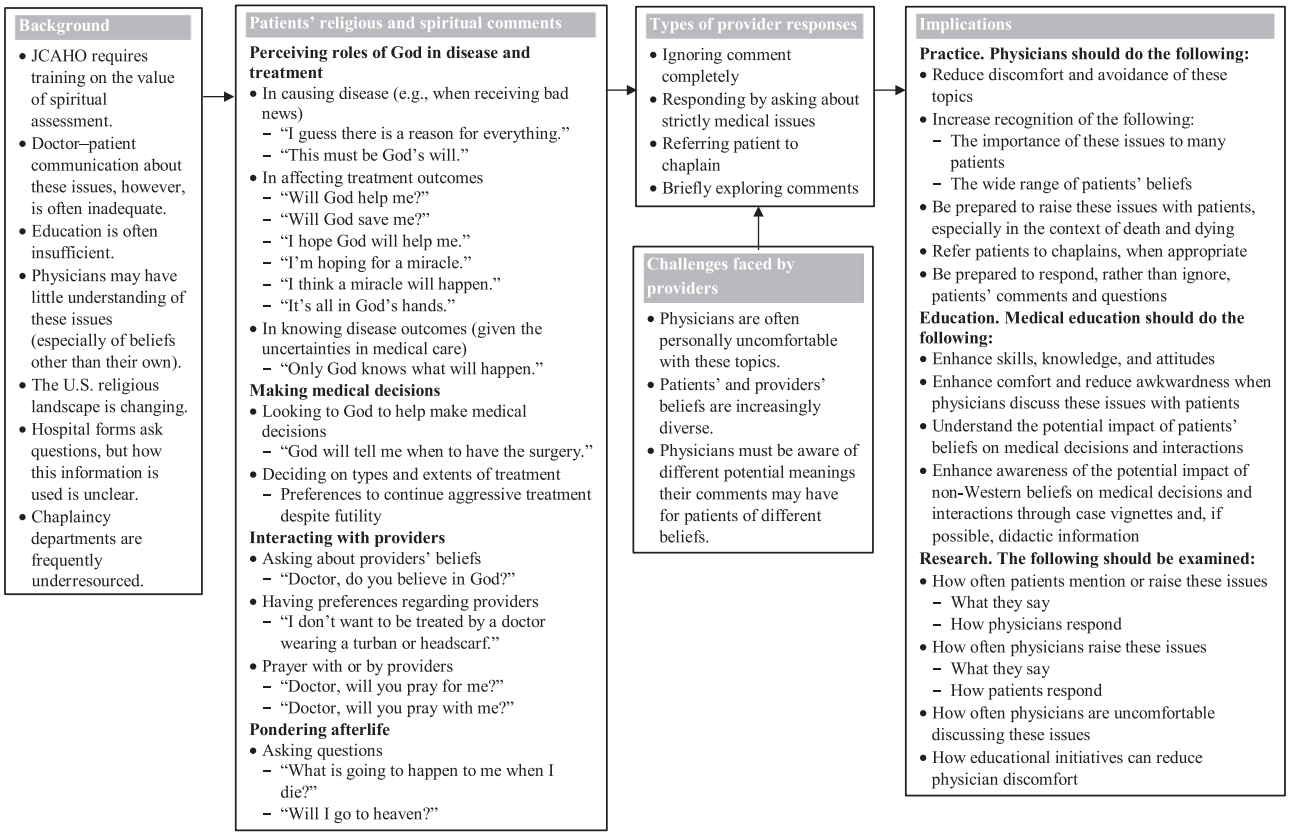

Figure 1 Types of religious and spiritual comments patients and their families may make and questions they may ask when speaking with their physicians. The 9 types of remarks are categorized into 4 broad domains (shown in the 4 boxes on the left of the figure). Implications of these observations are listed in the box on the far right of the figure. Abbreviation: JCAHO, Joint Commission on Accreditation of Healthcare Organizations.

factors that may play roles—both known unknowns and unknown unknowns.

Making medical decisions

Looking to God to help make medical decisions. Patients may seek assistance from God in making difficult treatment decisions, feeling that God will let them know whether and/or when to undergo certain interventions. A cardiologist, for instance, told me about a patient who "was a perfect candidate for a defibrillator…. Yet whenever I asked her about it, she said, 'I'm just not ready. God will tell me when to have it.'"

When patients are trying to make medical decisions and are grappling with the uncertainties involved, religion can thus provide a language and framework. Given the complex prognostic uncertainties regarding disease processes and outcomes if a patient does (or does not) undergo certain interventions, the patient may feel conflicted or uncomfortable and invoke God to try to grasp the complexities, anxieties, disappointments, bewilderment, dread, and other emotions he or she may experience about life and death. Patients may have difficulty saying, "I'm ambivalent and need time to weigh these emotional factors" or "I'm afraid I'll regret my decision." Religion can, however, provide a familiar framework for the uncertainty, with the patient saying, "God will tell me what to do or when I'm ready."

Deciding on types and extents of treatment preferences. Patients and families may also make religious and spiritual comments about treatment preferences. Challenges can arise, particularly regarding desires for aggressive care, despite physicians' perceptions of futility. A colleague told me, for instance, of a Muslim woman who wanted more aggressive treatment for her dying husband. The medical team considered such efforts futile. In the chart, the staff wrote that the wife was "in denial, has poor coping skills, and won't accept his situation." After several weeks of antagonism, a social worker arranged for a Muslim chaplain to visit the patient's wife, who, it turned out, believed that without the treatment, her husband wouldn't go to Heaven. The chaplain told her that God wouldn't want her dying husband to undergo more suffering, which additional treatment would cause. She then agreed to palliative care.

Interacting with providers

Asking about providers' beliefs. Patients and their families also occasionally ask a physician about his or her own beliefs. Doctors then face dilemmas of how to respond. Another physician described to me how a Muslim patient—who, at that point, was a recent immigrant to the United States—asked him, "Do you believe in God?" The doctor was perplexed, unsure what to say. This doctor sensed that the patient was wary and fearful of being treated in a foreign country. The doctor stammered out with hesitation, "Yes. I'm Protestant but believe in God," uncertain whether the patient knew about Protestantism and, if so, how much. The patient responded with relief, "Thank God!" and then seemed more assured. Patients may ask such questions to gauge whether and how much to trust their doctor. Genuine and authentic responses can potentially be beneficial. Providers may feel that disclosure of such information is unprofessional and too

personal, but in certain situations, it may strengthen provider–patient relationships and trust.

Having preferences regarding providers. Patients and/or families may state preferences with respect not only to particular treatments but also to providers of particular faiths. "Some patients don't want me to treat them," a Sikh physician who wears a turban recently told me. "They assume I'm Muslim. But I am not. I'm Sikh!" Other patients have said that they do not want to be treated by a Muslim physician or a nurse wearing a headscarf. Providers and their departmental and institutional leaders should be prepared to respond to such statements from patients—whether to try to accede to such patient requests or not—assessing the situation and avoiding discrimination against any patient or provider. Presumably, many institutions would not ordinarily grant such formal or informal requests but should be prepared to address such comments.

Prayer with or by providers. Patients and their families may ask doctors to pray with or for the patient. Providers may be caught off guard and feel unprepared, awkward, and unclear about how to respond. For example, one physician described how, before an operation on a young child with a very poor prognosis, the parents asked him to pray with them: "I'm Jewish and they were Catholic. So, I said, 'I'll leave you alone to pray together,' and left the room. But I felt very badly, unsure if I did the right thing."

Pondering an afterlife

Patients and their families also make comments regarding the possible existence of an afterlife, saying, for example, "What is going to happen to me when I die?" "Will I go to Heaven?" or "I'm going to go to Heaven!" Many providers are uncertain how to respond.

Types of Provider Responses

Overall, physicians appear to respond to these 9 types of comments in 1 of 4 broad ways.

The first 2 ways of responding are essentially sidestepping the issue, perhaps reflecting the physician's discomfort with the topic: Depending on the specific context of the patient's comment, the physician may ignore the remark completely by not responding, moving on as if the patient had not spoken, or essentially ignore the comment by giving a medical response. In the latter situation, the physician may purposefully change the subject, indicating that the topic is irrelevant, inappropriate, or of no interest. For instance, when a physician asks, "How are you doing?" and the patient answers, "I hope God is on my side" or "God won't let me down, will He?" some doctors may immediately make a medical comment (e.g., "Did you make your follow-up appointment?"). In ignoring such patient comments, however, physicians may miss important cues concerning the patient's coping and views of illness and treatment.

Third, physicians could respond to such comments by referring patients to chaplains, saying, for example, "If you'd like, we have chaplains who can talk with you about [this issue]."

Fourth, physicians could respond empathically in some way, even if very briefly in a single sentence. Doctors should not necessarily just immediately simply refer to a chaplain any patient who utters any religious or spiritual statement. Rather, following such a patient's remark, a physician might say, for instance, "What are your thoughts about that?" and, depending on the patient's answer, subsequently offer to refer the patient to a chaplain. Such seemingly small displays of empathy or caring can potentially strengthen doctor–patient relationships and communication. Doctors generally don't have time for lengthy conversations but should have appropriate scripts they're comfortable with in their repertoire, helping them to respond appropriately to each of the categories of comments listed above, respecting patients' and families' beliefs while avoiding insincere comments. Concerning requests for prayer, for instance, when asked by a Catholic family to pray with them, the Jewish physician mentioned above could presumably have said, for instance, "I'd be happy to stay here with you," or just remained standing with them in silence, out of respect.

Yet, the specifics of patients' or families' comments clearly vary widely and may require specific, not preconceived rote responses. In the case above, concerning the patient who thought God would tell her when to undergo defibrillation, the doctor reported the following:

> What could I possibly say to her in response? Who was I to argue against her God? But I had known her for several years, so finally I said, "I need to know what you mean: If it's just between you and God, where does that leave me, as the doctor?" She didn't know. "Do you think God is literally going to tell you? Or are you just afraid?" She said, "I'm just not comfortable doing it. I understand that it may help me, but I'm afraid."

This doctor was then able to address his patient's fears directly. Doctors can probe key underlying issues in such ways.

Challenges Faced by Providers

In determining how best to respond to each of these types of patients' comments, physicians can face challenges. Unfortunately, many physicians have limited knowledge or understanding of patients' beliefs that differ from their own. The physician may belong to 1 of at least 11 categories of beliefs (e.g., Catholic, Evangelical or mainstream Protestant, Jewish, Muslim, Hindu, Sikh, Buddhist, agnostic, atheist, spiritual but not religious, others), while the patient may also have any 1 of these 11 beliefs, producing 121 possible combinations. Doctors may, for instance, inadvertently make statements regarding disease course or treatment outcomes that patients and families may misinterpret due to differing beliefs. A Muslin chaplain told me, for example,

> Most non-Muslim doctors do not understand that Muslims believe that all events are due to the will of Allah. So, a doctor saying to a patient's wife, "Your husband has 2 months to live" rubs the family the wrong way, because the family believes that God, not the doctor, makes decisions about life and death. Instead, the physician should say, "Among patients with your husband's condition, 80% live for around 2 months."

In other words, the doctor should offer data about patients overall rather than about the specific fate of that patient.

Physicians should at least be aware of these potentially wide differences in beliefs and of misunderstandings that may arise from patients' and families' comments in the various categories described above.

Atheist and agnostic doctors may encounter additional dilemmas when a patient utters religious questions or comments because they may oppose the

notion of God and do not want to make statements in which they don't believe. An agnostic doctor reported that when patients ask her to pray with or for them, "Sometimes I lie and say 'yes.' But that doesn't feel right." Atheist and agnostic doctors should not tell religious patients, "I will pray for you" if that statement is insincere. In part, patients may sense the inauthenticity, which can generate its own problem. Physicians should be prepared to respond but in a secular way, saying, for instance, if asked to pray with or for a patient, "I will send you good wishes."

Atheist, agnostic, or religious providers should consider, too, what to say when patients inquire about or mention a possible afterlife. A colleague asked me, "How should I respond when a dying patient says to me, 'I'm going to die and go to Heaven, right?' I don't believe in Heaven but don't want to take away their hope." In such instances, providers could make statements that are supportive but not explicitly religious, saying, for example, "I hope your faith gives you strength and courage." Physicians should thus be as aware as possible of how both their own and their patients' beliefs can affect the meanings they may each assign to these terms. Both the patient and the physician may misinterpret each other's words because of their different beliefs.

Improving Providers' Abilities to Respond

Physician communication regarding religious and spiritual issues has received more attention in the last few years than previously, but several critical questions and challenges remain. Specifically, while much of the literature has focused on quantitative surveys of how often patients and physicians discuss religious and spiritual issues, this article explains how providers can face crucial challenges in knowing how exactly to respond when patients and families make several specific types of statements within the large realm of religious and spiritual topics. Patients and families may utter at least 9 types of comments and questions concerning religious and spiritual issues, and physicians may feel awkward, unsure, and unprepared in addressing remarks in each of these categories. Given increasing cultural shifts in beliefs, these comments can also have widening ranges of meaning for patients.

Efforts are thus needed to increase provider and trainee awareness and sensitivity regarding these issues, including these varied categories of comments. Attention to the categories outlined here can potentially improve medical practice, education, and research and thus doctor–patient relationships and care. Physicians should consider how they would respond to each of these sets of comments; doing so can enhance patient interactions and trust and inform providers about factors that may affect patients' views of the causes of, and optimal treatment for, disease and ultimately enhance patients' treatment, adherence, and care.

Critics have argued that physicians should not "prescribe religious activities,"[35] which is very different from questions of whether and how doctors should respond when patients themselves raise and want to discuss religious or spiritual topics. Rather than just ignoring such comments from patients because of personal discomfort, providers should arguably respond in whatever way they feel is appropriate. Education aimed at helping providers develop their own scripts and ways of responding is critical.

Expanding medical school curricula

Medical schools vary widely in how much they currently address these issues. All medical school deans should ensure that their medical curricula adequately cover these areas. Those schools that already attend to these areas relatively well may need less change than schools that devote relatively little time to these topics.

Medical school curricula should address not only knowledge but also attitudes and skills regarding these domains to reduce physician awkwardness, indifference, misunderstanding, wariness, or hostility when these topics emerge. With such knowledge and skills, providers would not be caught off guard by such statements and would know how to respond appropriately. Standardized patients and objective structured clinical examinations have been suggested as ways to prompt trainees to discuss religion and spirituality with patients in general,[36] but the specific categories of patients' questions and comments suggested here can help target and focus such educational endeavors.

Medical education should also heighten providers' appreciation of key relevant aspects of diverse beliefs, including non-Western traditions. Physicians won't realistically be able to gain in-depth knowledge about all religions, but they should at least be briefly exposed to relevant aspects of how the major religions, especially those they may see among patients, may differ. For example, they could discuss case vignettes involving challenges that can arise when they are working with patients of diverse faiths. Even one such lecture reviewing these topics is better than none. Clergy and/or patients from different religious traditions could also speak about their perspectives, underscoring both similarities and differences. Many efforts to improve physician communication and education about religion and spirituality have lumped together diverse religious and spiritual beliefs to form a seemingly unitary "spirituality" category. But the specific content of individual patients' beliefs, questions, and comments can play key roles in their health care, and physicians should, arguably, be aware of the potential differences in patients' religious and spiritual perspectives.

Additional areas for research

This analysis also suggests several vital areas for additional research on how often and in what specific ways patients and their families broach these realms. Studies have suggested that many patients want to have discussions about the religious or spiritual issues they are facing,[5] but research on the specific contents of their utterances—what exactly patients say and how providers respond—has been very limited.

Extensive literature searches have revealed no published reports on a number of topics related to patients' religious and spiritual concerns, including (1) how often and in what ways physicians use the information they collect about patients' beliefs; (2) how frequently, how much, and in what ways medical school curricula mention diverse, non-Western traditions (e.g., Islam, Hinduism); (3) which traditions various medical school curricula cover; and (4) how medical education can most effectively reduce physicians' personal discomfort in responding to specific types of patient and family comments about these topics.

Though this article has a potential limitation in drawing on conversations in varied clinical and research contexts over several years, future research can explore more fully, among larger samples

of patients in various inpatient and outpatient settings, how often patients and families make statements or ask questions that fall into these or other categories of comments, how providers respond, and how patients feel about their responses.

Appropriate Responses and Improved Patient Care

Additional targeted educational efforts to improve physicians' knowledge, attitudes, and behaviors are needed to reduce the awkwardness physicians may feel when responding to patients' religious comments and questions. With such education, physicians can increase their abilities to respond comfortably to at least 9 specific types of comments that patients and families may make concerning religion and spirituality. This ability is especially important when patients' and doctors' beliefs differ. Physicians who are able to reply appropriately, even if briefly, can enhance patient relationships and care.

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