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Hospice patients' attitudes regarding spiritual discussions with their doctors

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Abstract

The purpose of this study was to assess hospice patients' attitudes regarding the discussion of spiritual issues with their physicians. We conducted in-depth interviews using open-ended questions on living with illness, spirituality and religion, and physician-patient relationships. The interviews were audiotaped, transcribed, and analyzed for dominant themes. The following dominant themes were identified: (1) treating the whole person, (2) treating with sensitivity, (3) favorable attitudes toward religious or spiritual discussions with doctors, and (4) no "preaching." Our

findings suggest that patients do not expect physicians to be their primary spiritual advisors; however, physicians should be aware of and comfortable communicating with patients about religious or spiritual issues. More training in this topic may enhance the care physicians provide to patients near the end of life.

Key words: spiritual, religion, hospice patients, physician-patient relationships

Introduction

Spirituality is important to the patient-provider relationship because spiritual and religious beliefs can guide patients' coping choices¹ and can help define their illness or disease.² Unfortunately, discussion about spiritual issues is infrequent in the clinical setting.^{1,3-5} Increasing discussion of spirituality with patients may be an important aspect of patient care. Provider awareness of patients' religious beliefs and perceptions of illness may be valuable for patient management because of the impact these beliefs and perceptions may have on

treatment choices and medical compliance.¹ Further, inquiry about a patient's spirituality may help develop a positive patient-physician relationship because of the personal nature of the conversation.⁶ Studies suggest that some patients favor this type of dialogue with physicians.⁷⁻⁹ In a study of 135 family practice patients in Vermont, 40 percent of those surveyed stated that physicians should discuss religious issues with their patients.⁸ Some patients have even indicated that they would like their physicians to pray with them.^{7,9}

Understanding patients' needs and attitudes regarding dialogues with providers on spiritual discussions is important. Most research on this topic, however, has been conducted in the Midwest and southeastern United States.⁷⁻¹⁰ Our study is among the first to be conducted in the Pacific Northwest. Further, to date there have been no studies published that assess hospice patients' attitudes regarding spiritual discussions with physicians in the medical setting. Hospice patients compose a unique population in that they face looming mortality and are

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all offered the opportunity for spiritual counseling. We purposely chose this population for our study because we believed that these circumstances may influence these patients to be reflective about spiritual issues and thus provide a setting in which we could obtain more in-depth information.

Based upon research by Maugans and Wadland and others,⁷⁻⁹ the objectives of our study were threefold: (1) to explore the desires of hospice patients in the Northwest to discuss spiritual issues with their physicians, (2) to explore the type of spiritual issues hospice patients may want physicians to address, and (3) to explore the appropriate time and setting for spiritual discussions to be initiated by physicians.

Methods

Design

We used the principles of ethnography, a qualitative research method used by social scientists and anthropologists, to describe and analyze patient attitudes and beliefs.^{9,10} The language of the informant generated the framework for investigation in response to open-ended questions and probes for in-depth information.¹¹ The ethnographic approach was iterative and reflective and involved the use of recorded dialogue, field notes, or both. Through this process, the researcher examined the meaning of the dialogue in the culture or environment in which it was generated.¹² The process of interviewing and analysis continued until recurrent themes emerged and the researcher was able to formulate a hypothesis or hypotheses.

Study population

Sixteen terminally ill patients enrolled in two Seattle area hospice programs were interviewed. Patients

were excluded if they had impaired hearing, speech, or cognition or were too frail to be interviewed. Participants were included regardless of their religious or spiritual beliefs, affiliations or preferences, race, ethnicity, age, or gender.

Social workers and nurses at the participating hospice centers approached potential subjects. If patients agreed, nurses or social workers made referrals to the study coordinator, who contacted the principal investigator. Patients were then contacted by phone, and the research project was explained in further detail. If patients agreed to participate, their physicians were faxed a letter explaining the project and asking for their support as part of our Institutional Review Board (IRB) protocol. None of the physicians approached refused to pledge his or her support. Once we received the physician's support, the patient was called, and arrangements were made to conduct the interview. Each participant signed a written consent form prior to the interview.

This study was approved by the IRBs of the University of Washington, Evergreen Medical Center, and Providence Seattle Medical Center.

Data collection

Eleven patients were interviewed in their homes, two were interviewed in Evergreen Hospice Center, two in convalescent health centers, and one in a convent infirmary. The interviews took place between December 1998 and April 1999. The length of time for the interviews ranged from approximately 15 minutes to 2 1/2 hours. Patients were asked open-ended questions in the broad categories of living with their illness, religion and spirituality, and patient-physician relationships. During the interviews, areas that appeared to be sources of vital information were probed by more in-depth questions. Questions were revised for

subsequent interviews to allow for more open-ended discussions of the aforementioned categories.

Data analysis

Interviews were audiotaped and transcribed. Subsequently, transcripts were reviewed with the audiotapes to ensure accuracy. Transcripts were reviewed and coded by the principal investigator.¹² During coding, key words and concepts were identified from the text, and these initial codes were then applied to subsequent transcripts. New codes were generated as the transcripts underwent multiple evaluations as part of the iterative process.¹³ Transcripts were downloaded into QSR NUD*IST (Non-numerical Unstructured Data Indexing Searching and Theorizing), a computer software program, to continue the search for dominant themes.

Trustworthiness

Trustworthiness, an ethnographic concept akin to reliability and validity, was assured by the following: (1) review of data and interview techniques with a medical anthropologist; (2) review of a sample of transcripts, with two independent readers to verify generated themes;¹⁴ and (3) review by colleagues in a work-in-progress session.

Results

Patient characteristics

We identified 39 potentially eligible participants, but 23 declined participation due to poor health. Of the 16 interviews, we excluded one interview from our analysis because a hospice worker participated in the interview. There were six males and nine females, and all were Caucasian. The participants' ages ranged from 63 to 86 years (mean, 74.5).

Major themes

Four major themes were identified: (1) treating the whole person, (2) treating with sensitivity, (3) favorable attitudes toward religious and spiritual discussions, and (4) no preaching. These themes are exemplified in the following quotations. (Names in these quotations have been removed to ensure confidentiality.)

Treating the whole person

Most of the patients interviewed were concerned about receiving holistic treatment by physicians. In general, participants expressed a strong dislike for being treated as a statistic, object, or thing. The following quote illustrates one patient's perspective on being treated as a whole person:

[T]hey treat the person like there isn't life [or] thoughts in them. It's a disease and they're going to diagnose it ... the whole person doesn't count. But I feel a lot better with a doctor that shakes my hand and says, "How are you doing today? Are things going okay?" At least he's made me a person. I'm not a statistic.

For our study participants, a crucial aspect of being treated as a "human being" was having physicians take time to know them through nonmedical dialogue. Participants indicated that if doctors made an effort to know what makes them "tick," it indicated that doctors were making an effort to know them as a person. As one patient expressed:

A patient goes into your office and you have a nice painting on the wall and the patient comments on it and says "you know I really like that painting." That should trigger something up here in the doctor's mind. Doctors should listen to

them—the patient is telling you something. [The patient] is telling you that he likes this, that maybe he likes art. [The patient is telling you] what he or she is interested in, and what gives them pleasure or displeasure in life [and] I think [it] should be a part of the element of treating the patient. Because you're treating the patient as a whole being.

Treating with sensitivity

Physician sensitivity was a common thread among the comments made by eight participants. The concept of physician sensitivity was strongly linked to knowing the patient as a person and included discerning the patient's emotional state. One patient stated the following:

Maybe what we should be using is [the] word sensitivity . . . we're sensitive to how people feel . . . how they react to things. And so maybe that's what we're asking doctors to be . . . sensitive to how [we] feel.

Participants wanted physicians to be more empathetic and to be aware of more than just their physical and medical needs. They also suggested that sensitivity might play a role in helping doctors know whether patients are spiritual or religious and whether they want to discuss those issues in a medical setting.

Favorable attitudes toward religious and spiritual discussions

Eleven of the 15 patients interviewed favored physician inquiry about their spiritual beliefs; however, only two said their physicians engaged them in a dialogue on this topic. Participants believed that sensitive doctors would know when and where to discuss religious or spiritual concerns with their patients.

One patient stated:

If you take the time to get to know a patient, you will get to know that this person is a spiritual type person or not. And I think you'll be able to figure out whether this person is a type of person who wants intervention, who wants you to come in and talk about this. And I think you'll know when it's appropriate and when it's not appropriate.

Another participant expressed the following in the context of the physician-patient relationship:

And if you've got a personal relationship, then I think the spiritual side will just fall in. In which case they could speak one on one, even though you may have a Buddhist for a physician.

When asked how physicians can become more sensitive to spiritual issues, one patient's responses included the following:

I think a doctor who is very close to his patient would have a pretty good idea where a patient stands religiously.

Participants provided various reasons why doctors should address patients' spiritual beliefs. Two believed it would help strengthen patients' religious beliefs. Two others believed it could provide an opportunity for pastoral or chaplain involvement, and one felt involving clergy was especially important for a physician who is not comfortable talking about religious issues. One patient stated that it made her feel great when her physician contacted her pastor during a hospitalization. The other participants did not state specific reasons why doctors should address patients' spiritual beliefs.

No preaching

Although a majority of the patients interviewed were in favor of doctors asking patients about their religious or spiritual beliefs, they strongly emphasized that they did not want to be forced or pushed into a religious discussion or have physicians preaching to them. Patients believed that if doctors are going to talk about religion or spirituality, it should be done in a nonaggressive manner. One religious patient, when asked if she would have been comfortable with her doctor bringing up religion or spirituality, said:

That wouldn't have bothered me . . . I think they should [bring up] religion to a certain extent . . . [but] not preach it!

Discussion

The data presented here are consistent with previous research by suggesting that some patients favor spiritual discussions with doctors in the clinical setting.⁸⁻¹¹ For example, in a study by Woodard and Sowell, HIV-infected women responded favorably when asked whether healthcare providers should have spiritual discussions with patients.¹⁵ Hebert and colleagues conducted a study using focus groups made up of seriously ill patients to elicit their perspectives regarding the discussion of religious and spiritual beliefs in the patient-physician relationship.¹⁶ Patients in this study recommended that physicians allow spiritually centered discussions to occur naturally by asking patients whether they feel comfortable or stressed out. Hebert and colleagues termed this type of questioning psychosocial inquiry. Our study seems to support these findings by showing that our sample of patients wanted their doctors to ask about religious or spiritual beliefs and felt that "sensitive

C	Do you <u>c</u> onsider yourself to be a spiritual or religious person?
A	Are you <u>a</u> ctive in any religious or spiritual community?
R	Are there any spiritual or religious practices/beliefs that <u>r</u> elate to your views about health and/or your healthcare needs?
E	Are you experiencing any religious or spiritual conflicts that might be affecting you <u>e</u> motional health? Are you concerned about religious or spiritual matters in your <u>e</u> veryday affairs?

physicians" would know when to discuss spiritual issues with their patients. Table 1 shows some questions clinicians can pose to help identify patients' spiritual or religious beliefs, connections with a spiritual community, beliefs that might affect medical decision making, and possible religious conflict. This table is based upon recommendations by Dr. Harold Koenig in his recently published book titled *Spirituality in Patient Care: Why, How, When, and What*.¹⁷

One goal of this study was to discover the type of spiritual issues patients might want doctors to discuss. Patients who, by the end of the interview, had not described specific spiritual issues they might like to discuss with their doctors were asked a more targeted question to obtain this information. Very few patients gave specific responses to this question, and those who did answer gave responses that varied in content. Therefore, no major themes emerged about the kinds of spiritual issues these hospice patients wanted their doctors to discuss. It seems these patients are more interested in building meaningful relationships with their doctors than focusing on the content of religious or spiritual discussions; however, if physicians are willing to inquire about patients' spiritual beliefs, patients may be more inclined to share other personal aspects of their

lives that may contribute to better patient care.

Patients in this study are not expecting physicians to be their primary spiritual advisors, nor do they expect physicians to be theologians or to know the details of a particular religion. Instead, patients expect physicians to respect their beliefs without preaching to them. Therefore, doctors should let patients set the agenda if patients indicate they want to discuss spiritual issues. Furthermore, physicians should not be intimidated by the idea of addressing spiritual issues and should feel comfortable engaging in such discussions without thinking they must have expert knowledge. Physicians should also be aware of the appropriate spiritual resources available in patient care settings and make referrals when appropriate. Patients in the study conducted by Hebert and colleagues suggested that physicians submit referrals to clergy if they are uncomfortable with spiritually centered discussions.¹⁶

Our study has limitations, including those inherent to the ethnographic method. This research methodology is designed to create rather than test hypotheses. Therefore, our study is inadequately powered to prove theories, only to generate them. We attempted to enhance the trustworthiness of our data by using processes

accepted in previous qualitative research;¹² however, our study participants did not review the results to help ensure trustworthiness, in part because many had rapidly deteriorating clinical conditions. Finally, although we gained internal validity by using a relatively homogeneous patient sample, our results may not generalize to other patient groups (i.e., patients not faced with impending death).

Future research may expand on the patient-physician relationship and how it addresses spiritual and religious issues. This research could lead to training opportunities that will help physicians become more comfortable engaging patients in religious or spiritual discussions and, in turn, enhance the care physicians provide to patients.

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