

AMA Journal of Ethics®

July 2018

Volume 20, Number 7: 607-674

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FROM THE EDITOR

Influences of Religion and Spirituality in Medicine

Danish Zaidi, MTS, MBE

Before medical school, I studied theology at Harvard Divinity School and served as a chaplain-intern at Boston Children's Hospital. Those experiences shaped the way I approach medicine and patients today. In particular, I acquired a newfound appreciation for how hospital hallways are places where values intersect and where profound decisions can be shaped by individuals' religious and spiritual beliefs.

Today, clinical chaplaincy remains an underutilized resource in health care, as patient spirituality continues to be an area that clinicians do not discuss as often as they should.¹ This finding is disappointing, given the potential benefits of integrating patient religion and spirituality into clinical practice by improving empathy, building trust, and understanding behaviors. In looking at the state of religiosity of America, a Pew Research Center report found that 70.6% of US adults identified as Christian in 2014²; the report also revealed trends toward religious diversity, with small increases from 2007 to 2014 in the percentage of the population identifying as Muslim and Hindu and a 6.7% increase in the unaffiliated or "nones,"² some of whom may identify as "spiritual but not religious."³ Acknowledging the moral underpinnings (spiritual or religious) that drive certain care-seeking behaviors—from end-of-life care to contraception—is critical in achieving a more holistic medical practice. Moreover, awareness of our patients' spiritual or religious beliefs helps us to be more aware of our own motivations, as spirituality and religion are important components that shape behaviors of many clinicians.

Educators across the country have noted the need to incorporate resources into the curriculum to help medical trainees better understand their patients' spiritual backgrounds. In recognition of the role that spirituality plays in the health of people, Christina Puchalski founded the George Washington Institute for Spirituality and Health (GWish) in May 2001 with the aim of bringing increased attention to the spiritual needs of not only patients and families but also health care professionals.⁴ In this issue, Aparna Sajja and Puchalski expand on the mission of GWish, writing about the importance of recognizing the role that spirituality plays in health and sharing [curricular steps](#) that Puchalski and her institution have taken to educate trainees about that role. This [interplay between medical and spiritual practices](#) is illustrated brilliantly by Ariana Ellis's drawing of a patient's hands: one holding pills and, the other, a rosary. And Karl Lorenzen's illustrations are aesthetic explorations of [spiritually relevant features of](#)

[embodiment](#)—fear and suffering—that are also considered through the lens of the four principles: beneficence, nonmaleficence, respect for autonomy, and justice.

Of course, religion and spirituality are important not just to patients but also to clinicians. Respecting the background of medical trainees when navigating discussions of morally sensitive aspects of medicine can be uniquely challenging. Louise P. King and Alan Penzias collectively share their experiences in and strategies for discussing morally or spiritually laden topics with students, particularly [conscientious objection](#) to cases of contraception or abortion.

The complexity of teaching religion and spirituality in health care practice speaks to the fact that patient and clinician values can sometimes intersect in a way that leads to conflict and moral distress.⁵ All three cases in this issue speak to that tension between patient and clinician. In the first case, a patient refuses postoperative pain medication prior to surgery to atone for some of his past sins. Benjamin W. Frush, John Brewer Eberly, Jr., and Farr A. Curlin respond to this case by distinguishing between the purpose of [medicine as health](#) and as a relief from suffering. The authors argue that clinicians can and should accommodate a spiritual response to suffering, as long as this accommodation does not undermine an ethical commitment to improving patient health. In a second case in which a patient asks her surgeon—an atheist—to pray with her before surgery, April R. Christensen, Tara E. Cook, and Robert M. Arnold offer [communicative strategies](#) for clinicians that address such requests in a respectful and supportive way, particularly when they don't share their patients' religious or spiritual views or are uncomfortable revealing their own. Jane Morris and Kavita Shah Arora respond to the final case, in which a physician employed at a Catholic health care organization prescribes contraception pills but wonders whether to code the prescription as acne medicine. The authors unpack the physician's [conflicting duties](#) to patient, employer, and state law, arguing that if she chooses not to prescribe contraception, she maintains a responsibility to transfer the patient and to notify future patients ahead of time of her inability to prescribe.

A shared thread in the first two cases is the role of the hospital chaplain. Chaplains are a valuable, yet underutilized, resource in situations in which spiritual or religious values create conflict or moral distress.⁶ One possible reason for this underutilization is the assumption that all types of clergy—including the laity—can perform the same work as hospital chaplains. However, professional medical chaplains are trained in ways specific to the health care setting, orienting their services more to the needs of the patient rather than their own interpretation of religion or spirituality.⁷ Susan Harris pulls from personal experiences to write about the unique [role of hospital chaplains](#) in mediating between patients' families and physicians when discussing goals of care, and in the podcast, Harris discusses specific [strategies for mediating](#) between these groups.

Finally, religion and spirituality encompass more than a single patient-clinician relationship. Important social movements and charitable organizations have drawn their inspiration from religion and spirituality. Medicine has a similarly rich history of partnership with faith-based initiatives, as many hospitals and service groups rely on the support of religious communities.⁸ Nadia Islam and Shilpa Patel share their experiences and offer best practices in [building partnerships](#) with ethnic minority-serving religious institutions to improve the health of Asian immigrants and Muslim women in New York City and New Jersey.

Religion and spirituality will continue to influence health care on both patient and community levels. It is up to the medical community to appreciate this fact and educate trainees on religion and spirituality's role in health care. On a macro level, a better understanding of patient and community values can help scale up the impact of faith-based health initiatives and improve hospital policies and medical legislation. On an individual level, recognizing the roles of religion and spirituality in medicine can help clinicians approach their patients with more empathy and trust and strengthen team-based collaborations between clinicians and chaplains. Further studying the impact of religion and spirituality (and openly discussing it) can then help to clarify why clinicians may feel moral distress when their values conflict with their patients'—and how they can address it.

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Citation

AMA J Ethics. 2018;20(7):E609-612

DOI

10.1001/amajethics.2018.609

Acknowledgements

I want to thank everyone who made this issue a reality—most importantly the authors, who contributed their time and effort to shed light on a neglected topic in medicine. I also wish to thank my mentor, Dr. Robert Truog, director of the Center for Bioethics at Harvard Medical School, for helping me in the planning stages of this issue. Finally, I would like to thank the editorial staff at the *AMA Journal of Ethics*, as well as my fellow theme issue editors, all of whom helped polish this issue into its final version.

Conflict of Interest Disclosure

The author had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

CASE WITH COMMENTARY

What Should Physicians and Chaplains Do When a Patient Believes God Wants Him to Suffer?

Commentary by Benjamin W. Frush, MD, MA, John Brewer Eberly Jr, MD, MA, and Farr A. Curlin, MD

Abstract

When physicians encounter a patient who gives religious reasons for wanting to suffer, physicians should maintain their commitment to the patient's health while making room for religiously informed understandings of suffering and respecting the patient's authority to refuse medically indicated interventions. Respecting the patient can include challenging the patient's reasoning, and physicians can decline to participate in interventions that they believe contradict their professional commitments. Chaplains likewise should both support and possibly respectfully challenge a patient in instances that involve desire to suffer for religious reasons, and physicians should draw on chaplains' expertise in these situations to attend to the patient's spiritual concerns. Finally, conversations involving spiritual and existential suffering might include members of the patient's religious community when the patient is open to this option.

Case

Mr. L is a 47-year-old father of 2 who has a history of alcohol abuse but has been sober for over a year. He was admitted from the emergency department, where he presented earlier this morning with acute abdominal pain. He was diagnosed with pancreatitis and biliary colic, indicating the need for a cholecystectomy (a laparoscopic procedure to remove the gallbladder to prevent gall stones, pain, and infection). However, before the procedure could take place, Mr. L stated that he did not want pain medication after the surgery because, as he said, "God wants me to be in pain." The medical team, unsure how to proceed, delayed the surgery.

Dr. J, a fourth-year surgery resident, met with Mr. L to discuss his request and quickly reach a resolution, as the medical team did not want to delay the procedure for more than 24 hours. After Mr. L explained why he did not want pain medication, Dr. J stated, "You are going to feel a lot of pain after this surgery. Sometimes the pain is so extreme that patients have difficulty breathing. So the pain medication helps you be able to take

full breaths, which reduces the likelihood of getting pneumonia.” Dr. J then asked Mr. L if he would be willing to speak with a chaplain about his ideas of what God wants for him, and Mr. L agreed.

Dr. J consulted with the chaplain on call, Mr. K, and explained Mr. L’s case. “We can’t, in good conscience, not give him pain medication,” she said. “It’s just bad care. I respect his beliefs, but I can’t be forced to give him what I know to be bad care because of his beliefs. We need to manage the pain to help him heal, if not to be compassionate.” Mr. K suggested, “I’ll speak with him to get a better understanding of his spiritual concerns. Why don’t we talk after I meet with him?”

Mr. K visited Mr. L. They spent some time getting to know each other and, eventually, Mr. K asked, “So would you tell me more about why you think God wants you to be in pain after your surgery?” Mr. L nodded his head and lifted his hand. “I’ve done a lot of wrong in my life and hurt a lot of people. I haven’t been a good father to my kids. And from the way I see it, God wants me to be in pain—God wants me to suffer through this so I can atone for some of my sins. And God’s right—I don’t deserve the pain meds and I don’t want the pain meds.”

Dr. J and Mr. K now meet and consider how to proceed.

Commentary

Recent research has indicated that religious identity and practice can impact health outcomes at the population level as well as individual clinical decisions of patients.^{1,2} This research has spurred discussion over how to properly attend to the religious concerns of patients, particularly when such concerns influence clinical decision making.² Although physicians often engage with patients’ religious beliefs to support clinical recommendations and to help patients cope with illness and the burdens of medical treatment, sometimes patients give religious reasons for resisting or refusing medical recommendations.³ Conflicts about medical decision making that involve religion and spirituality can be particularly fraught due to the seriousness and the deeply personal nature of religious belief and practice. The vignette involving a patient (Mr. L), his physician (Dr. J), and his chaplain (Chaplain K), offers such an instance.

Specifically, this scenario pits the patient’s desire to forego postoperative pain medication against the physician’s judgment that not treating postoperative pain constitutes bad medical care. For Dr. J, the proper course of action must conform to “good care,” which, in her judgment, entails administering [effective pain medication](#) after a major surgery. For Mr. L, the patient, the proper course of action requires refusing this pain medication under the religiously informed conviction that the pain to be suffered might “atone” for past sins. This commentary explores the conflict between the patient’s and physician’s views—first, through a reflection on the purpose of medicine, then

through an analysis of the particularities of accommodating religious belief in a clinical context, and finally by addressing the role of a chaplain and the wisdom of a community.

Suffering, Health, and Medicine's Purpose

First, this case raises a critical moral question: namely, what does good care entail for those who practice medicine? The traditional understanding of medicine holds that its *telos* ("purpose" or "end") is health, which Leon Kass famously defined as "the 'well-working' of the organism as a whole."⁴ This traditional delineation of medicine's purpose differs starkly from a contemporary vision that does not promote an objective definition of health as the end of medicine but rather champions the relief of suffering as medicine's purpose, an evolution whose roots lie in the philosophy of Francis Bacon.⁵ These two rival accounts of what medicine is for lead to different approaches with respect to the present vignette specifically and medical praxis and decision making more generally.

As the third author (F.A.C.) has argued elsewhere, preserving and restoring the health of the patient has been understood for centuries as the constitutive purpose of medicine.⁶ Under this traditional approach, physicians seek to relieve suffering, not as an end in itself, but insofar as the relief of suffering is part of attending to the patient's health. For example, the physician might readily prescribe narcotics for a patient whose health is diminished by wracking pain from metastatic cancer, but the same physician might refuse such narcotics for a patient suffering chronic pain when short-term relief of suffering is not proportionate to the long-term health-diminishing effects of dependence on narcotics. In the latter situation, the physician adhering to the traditional approach to medicine might prescribe an alternative regimen that is more conducive to the patient's health, even though doing so brings about less relief from suffering, at least in the short term. In contrast, a contemporary approach that champions the relief of suffering as the proper goal of medicine might struggle to distinguish between different types of patient suffering, potentially compromising the patient's health as a consequence. The authors contend that in order to discern when and how to relieve patient suffering, physicians need to maintain the profession's traditional orientation toward the patient's health.

Importantly, with respect to our analysis of the case, the traditional approach allows room for accommodating a [spiritual or theological understanding of suffering](#) as long as doing so does not contradict the physician's commitment to the patient's health, whereas the alternative approach leaves little room for such an understanding as it views suffering strictly as something to be eliminated.

Physician-Patient Accommodation in Engaging with Patients Who Invoke Religious Beliefs

On the traditional understanding of medicine as oriented toward the patient's health, the question is not, "How should Dr. J reconcile Mr. L's religious beliefs with her professional

beliefs?," but rather, "Does accommodating Mr. L's desire to forego pain medication compromise Dr. J's commitment to the patient's health?" Concern for Mr. L's health circumscribes which decisions are acceptable from Dr. J's point of view; it defines what can and cannot be done. Within the boundaries set by this professional commitment, Dr. J can search out with Mr. L a course of action that respects his religious concerns. What Dr. J is looking for is what Mark Siegler has described as "a physician-patient accommodation," a way forward in which both the physician and the patient are acting with integrity.⁷

In the current scenario, if evidence suggests that withholding pain medicine would unduly reduce the chances of a successful operation, compromise the patient's recovery, or otherwise threaten Mr. L's health, then Dr. J should refuse to offer this course of action, regardless of the religious rationale for such a request. Clearly, there are circumstances in which such refusals are warranted; Dr. J would have clear reason to refuse, for example, if the patient wanted surgery but would not consent to anesthesia.

Conversely, if Dr. J concludes that foregoing postoperative pain medication in this case would not otherwise unduly threaten the health of the patient, then she should feel free to accommodate Mr. L's religiously informed wishes, even if she disagrees with them. Once again, it does not matter so much whether Mr. L's refusal is religiously informed or not, although it is worth noting that physicians tend to be more accommodating of religiously informed requests, perhaps out of respect for the seriousness of religious convictions.⁸

Whatever Dr. J decides, she should explain her reasoning to Mr. L candidly and make clear that her rationale is based upon her professional judgment, not scorn for his religious ideas. If possible, Dr. J should take time to listen to Mr. L in order to better understand his reasoning and how his religious beliefs inform his desired course of action. Such listening opens up the possibility that Dr. J and Mr. L will find an accommodation that will allow Dr. J to do what she thinks is medically necessary. Instead of treating conversation about religious matters as out of bounds, Dr. J should freely inquire about how Mr. L understands the decisions he faces in light of his religious (or other) beliefs. This approach conveys respect, builds trust, and opens up the possibility of finding an accommodation that both patient and physician can pursue with integrity.

In the context of such respectful listening, Dr. J should also feel empowered to respectfully challenge Mr. L's beliefs about suffering. Indeed, as part of their professional commitment to the patient's health, physicians have some obligation to respectfully challenge [patients' refusals of medical care](#) that the physician believes is needed. A sincere discussion—even a respectful debate—in no way denigrates Mr. L's religious beliefs. Rather it treats religious concerns with the seriousness that Mr. L ascribes to them and so treats Mr. L with the respect he deserves. Such conversations do not

require physicians to get into theological arguments with patients. Simply asking patients whether there are alternative understandings within their faith tradition regarding the issue at hand might circumvent an impasse.

The Role of the Chaplain

We now turn to the role of Chaplain K in this dilemma. While chaplains are not health care practitioners per se, they are generally considered members of the health care team.⁹ Within that team, chaplains focus on the religious and spiritual care of patients, even when they are employed by secular institutions.^{10,11}

Ideally, Dr. J would involve Chaplain K early in this scenario—when it first becomes apparent that Mr. L's faith is important to him. In the course of these conversations, the chaplain, like Dr. J, may also seek to understand and potentially to challenge Mr. L's religious reasoning. He might, for example, encourage Mr. L to consider whether there are alternative understandings of suffering, guilt, or grief found within his religious tradition.

The chaplain should not, however, seek to bring about a predetermined outcome on behalf of the medical institution (such as changing the patient's mind about pain medication). The chaplain is not an instrument subordinated to the health care enterprise but rather a co-contributor to the flourishing of the patient. The commitment of the physician to the patient's health and of the chaplain to the patient's spiritual care are distinct commitments, but both should ultimately be expressed in a caring and respectful stance toward Mr. L throughout his treatment process. For Dr. J, this commitment means providing the best medical care possible within the constraints posed by what Mr. L is willing to consent to, all while exploring and even challenging his refusals. For Chaplain K, this commitment means continuing to attend to Mr. L's spiritual good and observing whether and how Mr. L's religious reasoning about his own suffering changes in the course of his treatment.

It is entirely possible that, in the current situation, no accommodation can be found. Dr. J might conclude that she cannot operate safely without knowing she can give adequate postoperative pain medication. Meanwhile, Chaplain K's presence, prayer, and conversation with Mr. L could result in Mr. L becoming more entrenched in his refusal of such pain medication. Such conflicts are sometimes inevitable, and respect for patients' authority means allowing them to refuse medical care that we believe they desperately need. However things turn out, the chaplain is there to provide spiritual care, not simply to persuade the patient to go along with medical recommendations.

The Wisdom of a Community

In the case of Mr. L, and in other related cases, it can be helpful to broaden the conversation beyond the confines of the hospital and the medical team. Toward this end,

Dr. J or Chaplain K might encourage Mr. L to invite his family, friends, and members of his faith community into further clinical discussions. Mr. L may decline to do so, of course, but, in our experience, many patients have more confidence in their own clergy or other religious counselors than they do in hospital chaplains, and inviting faith communities into these conversations can allow for more meaningful and effective spiritual care in such cases.

Inviting members of an outside religious community into clinical discussions is not without risk; in the present case, the faith community might fortify Mr. L's refusal of pain medication. However, the faith community might instead qualify or alter his understanding of suffering and atonement for sin while affirming the [theological truths](#) important to Mr. L's religious framework. For example, Mr. L's faith leaders might suggest that his refusal to accept pain medication will further burden his loved ones who will watch him suffer. They might help him explore the difference between pursuing suffering and patiently enduring suffering or how the work of reconciliation, repentance, and forgiveness can offer more peace than his current understanding allows.

Conclusion

Ultimately, when religious reasoning leads patients to disagree with or refuse their physicians' recommendations, physicians must seek to understand patients' reasoning and respectfully try to find an accommodation that neither undermines patients' authority to refuse medical interventions nor contradicts their professional commitment to patients' health.

In such encounters, the virtues of humility and patience are essential for physicians. They must have the humility to acknowledge the limits of their knowledge, expertise, and authority, and to ask for help from chaplains or religious leaders from the patient's community who have much more experience with spiritual concerns. They must have the patience to respectfully seek an accommodation with a patient whom they might be tempted to dismiss as simply irrational, and, even when it might not bring about the outcome they desire, they must give chaplains and clergy the freedom to do their work.

Such health care can be arduous and time consuming. However, if we are truly to respect and respond appropriately to patients' religious and spiritual beliefs, it is health care we must practice.

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Citation

AMA J Ethics. 2018;20(7):E613-620

DOI

10.1001/amajethics.2018.613

Conflict of Interest Disclosure

Dr. Eberly is a fellow of the Theology, Medicine, and Culture Fellowship at Duke Divinity School, of which Dr. Curlin is a co-director. Drs. Curlin and Frush had no conflicts of interest to disclose.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

CASE WITH COMMENTARY

How Should Clinicians Respond to Requests from Patients to Participate in Prayer?

Commentary by April R. Christensen, MD, Tara E. Cook, MD, and Robert M. Arnold, MD

Abstract

Over the past 20 years, physicians have shifted from viewing a patient's request for prayer as a violation of professional boundaries to a question deserving nuanced understanding of the patient's needs and the clinician's boundaries. In this case, Mrs. C's request for prayer can reflect religious distress, anxiety about her clinical circumstances, or a desire to better connect with her physician. These different needs suggest that it is important to understand the request before responding. To do this well requires that Dr. Q not be emotionally overwhelmed by the request and that she has skill in discerning potential reasons for the request.

Case

The night before a scheduled bypass surgery, Mrs. C meets with her surgeon, Dr. Q.

Mrs. C is calm and seems emotionally prepared for her morning procedure. Dr. Q discusses the procedure and briefly touches upon the postoperative care plan, assuring Mrs. C that she will have a more thorough discussion with her following the surgery. Dr. Q asks Mrs. C if she has any questions.

"None—thank you very much, Dr. Q. I'm ready for tomorrow morning and am looking forward to getting back home. But can we pray together before you leave?"

Dr. Q identifies as a secular Jew and as an atheist and finds no value in prayer. She knows Mrs. C is a devout Catholic and that prayer is important to her right now. Dr. Q considers "faking it" for the sake of just getting through the awkwardness of the request but decides against it since she feels that doing so would be disingenuous and disrespectful to Mrs. C.

"Would you like me to call the chaplain?" asks Dr. Q. "I know that Rev. P is in clinic today, and he can be here soon." Mrs. C looks visibly annoyed: "But Rev. P is not performing my surgery tomorrow morning. You are." Dr. Q wants to make sure Mrs. C feels well cared for but does not want to be insincere. She wonders what to do.

Commentary

Like Mrs. C, the majority of patients believe that spiritual care by physicians is important.¹⁻⁷ Approximately half indicate they would like their physicians to pray with them.⁷⁻⁹ Faith can play an even greater role in the lives of people facing serious illness, as patients turn toward religion for guidance or support.^{4,6-8,10} In the setting of severe illness, [religious and spiritual support](#) from the medical community significantly impacts patient-reported quality of life.^{6,11-13}

Despite the significance of religion in patients' lives, physicians often avoid engaging in these conversations.¹⁴⁻¹⁵ Believing the question is outside their expertise, worrying that they will say the wrong thing, or having discordant beliefs regarding religion, physicians are not sure what to say.^{3,7,16,17} Moreover, physicians do not want to lie or misrepresent their spiritual beliefs.^{8,16,17} Finally, physicians might even be reluctant to offer to refer to a chaplain, as Dr. Q does, because it might be heard by the patient as reflecting the clinician's discomfort and as attempting to avoid the topic. How can Dr. Q respond in a way that is true to her religious views and builds a stronger relationship with Mrs. C?

Here, we are going to suggest a nuanced way of dealing with a patient's request for prayer. First, it is important to understand why this request makes Dr. Q uncomfortable. A physician's capacity for understanding requires introspection.^{10,18,19} By practicing introspection, a physician is better prepared to pause and explore the many potential motivations behind the request. We show that once Dr. Q understands her discomfort and what Mrs. C is asking, she is better suited to respond. We will also describe Dr. Q's potential responses to Mrs. C's request for prayer. In general, a physician's responses to a patient's request for prayer will likely vary based on two factors: (1) the physician's comfort disclosing her religious beliefs, and (2) the physician's views about the role of prayer in health care.

Dr. Q's Discomfort with a Request for Prayer

When Mrs. C makes a request for prayer, Dr. Q's emotional reaction makes it hard for her to respond. Like Dr. Q, many physicians are often caught off balance when patients make a request to pray with them. Anxiety and discomfort could lead Dr. Q to want to avoid the topic. ("Would you like me to call the chaplain?") As patients can view discussion of their spiritual beliefs as a way to build a stronger relationship with their physician, Mrs. C might perceive this response as abandonment.^{3,8,20} The first step for Dr. Q toward overcoming her discomfort in responding to Mrs. C's needs is to understand her reasons for this reaction.

Several potential explanations for Dr. Q's discomfort exist.^{7,8,16,17} First, Dr. Q might be ill at ease because Mrs. C is asking her to reveal more about her private life than she is comfortable with.²¹ (*My personal life and beliefs are separate from my physician role. I don't want to talk about that.*) Second, Dr. Q could be afraid of upsetting Mrs. C because they

have different beliefs.^{16,17} This fear could be a source of discomfort even if Dr. Q was very religious. (*Mrs. C might not want a physician who is Protestant.*) In addition, Dr. Q could be uncomfortable because, as a scientist, she might not believe in religion.^{17,20,22,23} (*Ugh. I think religion is just a myth, but I can't say that.*) Finally, Dr. Q might not be accustomed to patients making religious requests of her; such requests could be heard as a challenge to her authority and training. (*What does this have to do with my doctoring ability?*)

Self-Reflection and Intentional Pause

There are two ways for Dr. Q to deal with her emotional reaction to her patient's request for prayer. First, Dr. Q can engage in anticipatory **self-reflection**.^{18,19,24-26} Second, after being asked to pray, Dr. Q can pause for a moment, internally acknowledging and dealing with her emotions.

Given the importance of religion in patients' lives, physicians should expect to be asked questions about prayer or their religion. Thinking about how she is going to respond to these questions ahead of time (ie, anticipatory self-reflection) would help Dr. Q to have a more considered response in future interactions. In addition, self-reflection has several demonstrated benefits for physicians, including increasing insight into personal feelings, increasing capacity for empathy, and enhancing the ability to differentiate between a patient's and a physician's needs.²⁵⁻²⁸

Following a request for prayer, an intentional pause could enable Dr. Q to process her initial emotional response, as otherwise her emotional response might cloud her understanding of Mrs. C's request.²⁸ Dr. Q can take a deep breath and consciously let it (and her anxiety) out. Rather than answer when she is off balance, she can internally acknowledge her anxiety and discomfort. (*Oh my... I did not expect that question... Breathe deeply and slow down.*) Then, rather than responding emotionally, she can slow the conversation down and try to better understand why Mrs. C is making this request. This approach would allow her to attempt to both build her relationship with Mrs. C and be true to her core beliefs, as has been found for other physicians.²⁹⁻³¹

Exploring the Request for Prayer

The request for prayer could be simply a question about whether Dr. Q will pray with Mrs. C. However, in our experience, these sentinel questions are more complex, with layers of emotions and underlying questions. For instance, Mrs. C could be scared or anxious about her upcoming surgery. She might also feel alone and vulnerable, lacking control of the situation.^{8,20} In these situations, prayer can be an important coping mechanism.^{8,32} Alternatively, Mrs. C might want to know that the doctor is a believer, as many patients believe that God acts through physicians³³ and view positively spiritual discussions with medical personnel.^{8,31}

To ensure that Dr. Q addresses the questions and emotions underlying the request for prayer, she should step back to understand exactly what is being asked. To investigate the above possibilities further, Dr. Q could say, "I see that it's important for me to be here with you; tell me more."^{29,30} This response both acknowledges the significance of Mrs. C's request and nonjudgmentally invites her to share her concerns.

Reflecting Mrs. C's Concerns

As Dr. Q learns more about Mrs. C's underlying reasons for request for prayer, she should reflect back what Mrs. C is saying. The request for prayer could be a request for a human connection that an empathic response might satisfy.³⁴ Listening respectfully in this manner does not require Dr. Q to agree with Mrs. C's religious beliefs.^{30,35,36} Rather, reflection tells Mrs. C that Dr. Q is listening and allows Mrs. C to feel acknowledged.^{29,37}

For instance, in response to Dr. Q's question, "I see that it's important for me to be here with you; tell me more," Mrs. C could say, "I am so afraid that I will not make it." Dr. Q should then acknowledge this fear. ("This is a scary situation.") Mrs. C might also specifically elaborate on the reason for her prayer request: "This is a big surgery; I've never been through anything like this before and need to know God will be with me." In this case, Dr. Q could reflect back, "I hear this is a lot to think about."^{29,30} In both responses, Dr. Q has empathized with Mrs. C's concerns, potentially strengthening the physician-patient relationship.

Responding to the Request for Prayer

After exploring Mrs. C's concerns and reflecting back her reply, Dr. Q will need to respond to Mrs. C's original request in the context of her concerns. This response should be guided by two principles. First, a clinician should not lie about her religious beliefs.^{8,35} Trust forms the cornerstone of the patient-physician relationship and is particularly important for views that are central to one's belief system, like religion. Hence, if Dr. Q were to misrepresent her beliefs to Mrs. C, it would severely undermine the relationship. Dr. Q does not need to explicitly state her beliefs regarding prayer to support Mrs. C. For example, her response could focus on addressing the psychological basis of Mrs. C's request for the physician's presence while she prays.

Second, to the degree possible, and while remaining truthful, a clinician should promote trust in the relationship.³¹ Building trust means reaffirming one's dedication to the patient's well-being and staying present.^{20,38,39}

Below are examples of how Dr. Q could respond to Mrs. C's request for prayer based on her comfort in talking about her religion and how well her religion aligns with Mrs. C's. In this case, Dr. Q identifies as an atheist, while Mrs. C is a devout Catholic. Dr. Q could respond, "I hear this is really scary, and your faith is an important source of strength for you. I will keep you in my thoughts and do everything that I can for you." This response is

also appropriate for those who are uncomfortable discussing religion further. Alternatively, if Dr. Q is willing to be present with Mrs. C, she could say, "I hear this is really scary, and your faith is an important source of strength for you. Let's spend a few moments of silence together."^{29-31,40}

For physicians who do not share the same faith or faith background with their patients or are not religious, such as Dr. Q, the above responses demonstrate how physicians can still support patients and meet their needs.⁴¹ Regardless of whether Dr. Q stays for Mrs. C's prayer, she has shown respect for Mrs. C, acknowledged the importance of prayer, and not abandoned Mrs. C. More generally, this type of response allows physicians to remain present with patients while also remaining true to their own beliefs by not committing to prayer.^{29,31,40,41}

One concern is that Mrs. C could respond by **questioning Dr. Q's beliefs**. ("But don't you pray?") In this case, Dr. Q could respond, "I see how important prayer is for you and am glad to be with you while you pray." For physicians who are uncomfortable discussing their beliefs, this response articulates both respect and returns the focus to the patient. In the rare case in which the patient persists, the clinician can either say "I do not, and I am more than willing to stay with you while you pray" or "I am uncomfortable talking about my faith. I will, however, be with you while you pray."

For physicians who are religious and comfortable talking about their beliefs, there are two possible scenarios. First, assume that Dr. Q is spiritual but does not share the same religion. (For example, Dr. Q is Southern Baptist and Mrs. C is Catholic.) Dr. Q could say, "I hear this is really scary. I am glad to silently pray with you." This response respects the fact that different religions pray differently and allows the patient to pray within the context of her faith.²⁹⁻³¹ Second, assume that Dr. Q has the same religion as Mrs. C. One way she could respond is this: "I hear this is scary. I can pray with you." When a physician is comfortable praying with a patient, it is most appropriate to pray silently. If the patient requests the physician to lead the prayer, however, the physician should be cautious to avoid imputing specific beliefs to the patient, as even those of the same faith can differ in their beliefs. If the physician chooses to lead a prayer, nondenominational prayer is the safest; asking God for support is safer than requesting specific outcomes, given (1) potential differences in beliefs regarding the purpose and practice of prayer and (2) risk of spiritual distress if the requested outcome does not occur.⁴⁰ For instance, Dr. Q could pray, "We ask God for support and for presence with Mrs. C during the surgery. May God ease her fears during this time of uncertainty."

Conclusion

Dr. Q's decision of whether to pray with Mrs. C is a personal decision. Introspection can enable physicians to offer a carefully considered response as opposed to an instantaneous emotional reply. In addition, a response that acknowledges and explores

Mrs. C's request for prayer can make her feel heard. While Mrs. C could still express disappointment depending on Dr. Q's ultimate response, following this approach both respects Mrs. C's emotional needs and Dr. Q's boundaries.

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Citation

AMA J Ethics. 2018;20(7):E621-629

DOI

10.1001/amajethics.2018.621

Conflict of Interest Disclosure

The authors had no conflicts of interest to disclose.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

CASE WITH COMMENTARY

Should Clinicians Challenge Faith-Based Institutional Values Conflicting with Their Own?

Commentary by Jane Morris, MD and Kavita Shah Arora, MD, MBE

Abstract

Catholic health care organizations generally prohibit their employees from prescribing contraceptives for the purpose of birth control. This restriction might go against a clinician's own beliefs and the explicit wishes of a patient. In this case, Dr. N is being asked by a patient, Ms. K, to code oral contraception as treatment for acne, a noncontraceptive benefit of birth control pills, although both parties know Ms. K's primary desire is to prevent pregnancy. We examine the legal and moral arguments surrounding contraceptive provision in this case and offer guidance for how Dr. N and Ms. K might work to find a tenable solution.

Case

Ms. K is a 19-year-old college student, home for the summer. Today, she is scheduled for a routine checkup with a new attending family physician, Dr. N. At the appointment, Ms. K presents as a healthy and energetic college student with minimal family risk of illness. Dr. N notes that Ms. K is sexually active and has had two partners in the last 6 months and asks Ms. K if she has been using contraception or protection from STIs during sex. "I use condoms every time. But I would be a lot more comfortable if I had birth control. Could you prescribe some for me?"

Dr. N agrees that she would benefit from an oral contraceptive but clarifies, "I'm not allowed to prescribe that for you here since this is a Catholic health organization."

Ms. K responds, "I know it's Catholic, but my friend comes here to get it, and her physician codes it as acne treatment." Dr. N considers that Ms. K's request for contraception is reasonable as a legal medical service and so prescribes the combined oral contraceptive pill (COCP) for Ms. K. Dr. N wonders whether to code it as acne treatment.

Commentary

Dr. N faces a difficult quandary: How should a clinician go about exercising her personal values when they clash with her employer's? Dr. N's choices fundamentally boil down to several possible options. She could choose not to prescribe at all, citing the *Ethical and*

Religious Directives for Catholic Health Care Services, established by the United States Conference of Catholic Bishops, which set rules for Catholic-affiliated health care organizations nationwide.¹ The Catholic Church views contraception as separating sex from the purpose of procreation within a marriage and therefore “cannot approve” contraceptive methods.¹ The *Directives* explicitly prohibit Catholic health institutions from promoting or condoning contraceptive practices, although such institutions “should provide, for married couples and the medical staff who counsel them, instruction both about the Church’s teaching on responsible parenthood and in methods of natural family planning.”¹ Dr. N could also choose not to prescribe COCP but instead refer Ms. K to a clinician outside the Catholic health system. Alternatively, Dr. N could opt to prescribe COCP, either for acne, as Ms. K’s friend’s doctor allegedly does, or for an alternative diagnosis for which Ms. K legitimately qualifies. Contraceptives, including oral contraceptive pills, are also appropriate therapies for a range of medical diagnoses including abnormal, irregular, or heavy menses; endometriosis; fibroids; and acne.² On the most extreme end of the spectrum, she could opt to prescribe COCP as contraception outright. Dr. N’s choice must balance respect for Ms. K’s autonomy as a patient, her own beliefs, and legal and moral considerations in executing her responsibilities as an employee of a Catholic health care organization.

Legal Considerations for Prescribing Contraception in a Catholic Health Care Institution

The United States Supreme Court clearly established a woman’s right to contraception as early as 1965 in *Griswold v. Connecticut*. This right was explicitly extended to unmarried women in *Eisenstadt v. Baird* in 1972 and to minors of at least 16 years of age in *Carey v. Population Services International*.³ These decisions hinged on the Court’s interpretation of a right to privacy, which, while not explicitly stated in the Constitution, extended primarily from the Due Process Clause of the Fourteenth Amendment.⁴

Despite COCP being a safe, evidence-based therapy and the American College of Obstetricians and Gynecologists (ACOG) supporting access to and reimbursement for all types of contraception, including COCP,² Catholic institutions can block clinicians from prescribing contraception through contractual obligations that fall outside the boundaries of professional organizations such as ACOG. According to the *Directives*, “Catholic health services must adopt these Directives as policy ... [and] require adherence to them within the institution as a condition for medical privileges and employment.”¹ Dr. N’s contract almost certainly prevents her from prescribing COCP for contraceptive reasons. Dr. N must then decide between protecting her job—a legitimate self-interest that also ensures her ability to care for future patients—and protecting the privileged relationship between physician and patient. The *Directives’* dictum is not an empty threat: Catholic health care organizations have terminated employees’ contracts for providing contraception.⁵ The *Directives* do not clearly state whether referring to a clinician outside their purview is permitted, but doing so would violate the spirit, if not

the letter, of the *Directives'* dicta given that the clinician would be complicit in the eventual provision of contraception.

Most of the extant policy regulating the exercise of individually held beliefs in the medical workplace focuses on [employees' right to refuse](#) to participate in activities that are incompatible with their values. Broadly, these laws prevent entities from discriminating against persons who refuse to perform certain services—such as end-of-life care, abortion, contraception provision, and sterilization—as a matter of conscience. In the years after *Roe v Wade* (1973), such laws were limited to employees of government agencies, but state laws now exist that allow employees of private institutions to refuse to provide services or prescribe birth control.⁶ Dr. N's case, on some level, represents the polar opposite: a clinician wanting to provide affirmative care but curtailed from doing so based on an institution's religiously derived policies. Unfortunately, case law and policy seem to be largely silent in this area, providing little legal protection for Dr. N should she attempt to defy her institution and openly prescribe contraception for the purpose of pregnancy prevention.

If Dr. N were to provide Ms. K her desired oral contraceptive under the false diagnosis of acne, the legal ramifications could result not from the provision of contraception itself but from the reason she gave for prescribing it. The US Code defines health care fraud as “knowingly and willfully execut[ing] ... a scheme or artifice—(1) to defraud any health care benefit program ... in connection with the delivery of or payment for health care benefits, items, or services.”⁷ By submitting a falsified diagnosis, acne, for coverage by an insurance plan, even when the treatment, COCP, would be covered under a different diagnosis, Dr. N would be committing fraud. [Health care fraud](#) is considered a federal criminal offense that can carry a federal prison term in addition to hefty fines.⁸

Moral Arguments for and against Contraception Provision

As mentioned earlier, the Catholic Church cannot approve contraceptives because they separate sex from reproduction.¹ In the Catholic Church's view, “[m]arriage and conjugal love are by their nature ordained toward the begetting and educating of children.”¹ Extramarital sex is not mentioned at all in the *Directives*, an omission which fails to take into account that over 90 percent of Americans have sex prior to marriage⁹ and that 40% of births in this country are to unmarried women.¹⁰ Even Catholic women and men in America, by and large, do not abide by this church decree in their own lives. The Guttmacher Institute reported in 2016 that 89% of US Catholic women at risk of pregnancy use some form of contraception and 68% use sterilization, hormonal birth control, or an intrauterine device (IUD).¹¹ Only 2% of US Catholic women use natural family planning, the Church's only approved form of birth control.⁹

As an employee of a Catholic health care institution, Dr. N has a duty to her institution to provide care in a manner consistent with its mission, despite the widespread use of

contraception among US Catholics. However, Ms. K is under no obligation to subscribe to the institution's moral principles. As an autonomous decision maker, she is seeking a reasonable, legal, and medically appropriate service within the realm of primary and preventative health care, which she is being refused due to principles she does not share. Dr. N must also examine the consequences of Ms. K not being able to attain her desired contraceptive method. In this case, a primary consequence could be unintended pregnancy, which would result either in abortion or in a pregnancy conceived, and a child possibly delivered, outside of wedlock—both options that the Catholic Church, which governs Dr. N's health care organization, opposes.

If Dr. N is unable to provide Ms. K with her desired form of contraception, she should refer Ms. K to a clinician outside the Catholic health care system. She could either do so explicitly, by formally transferring care to another clinician, or unofficially, by telling the patient about other health care organizations in the community that could provide more comprehensive care. ACOG states that referral is ethically necessary in cases of moral or religious objection.¹² The American Medical Association (AMA) states that a clinician "should offer impartial guidance to patients about how to inform themselves regarding access to desired services" if formal referral is unacceptable to the clinician—for example, in cases of "a deeply held, well-considered personal belief."¹³ However, referrals can impose burdens unjustly on those with fewer resources, particularly if the referral would put the patient outside his or her insurance network. Those patients with fewer resources and less health literacy will have greater difficulty in seeking and obtaining care from the referred clinician.²

It is unclear whether insurance or geographical constraints would prevent Ms. K from accessing another clinician outside the Catholic health care system. Groups such as Planned Parenthood provide a safety net for those with no clinician who can prescribe contraception but do not represent a feasible long-term solution, given attempts to defund Planned Parenthood and other reproductive health care organizations and that there are some states and many counties without access to Planned Parenthood or similar clinics.¹⁴ Thus, while referring to another clinician outside the Catholic health care system might be an expedient option for Dr. N, it fails to address the issue of contraception provision in a systemic manner.

The Catholic Church "does not consider at all illicit" use of medical therapies to cure diseases "even if a foreseeable impediment to procreation should result there from—provided such impediment is not directly intended for any motive whatsoever."¹⁵ It would be permissible to use birth control when the intent of the medication is for something other than pregnancy prevention if it is consistent with the principle of "double effect," whereby the effect of the action that is presumably "good" (eg, treating a medical condition such as acne) is intended and has more weight in justifying that action than does a consequence of the action that is merely foreseen and possibly "bad" (eg,

pregnancy prevention).¹⁶ To meet the standard of double effect, the good effect not must not only outweigh the bad effect but also come about as a direct consequence of the action—rather than as a secondary consequence of the bad effect—and the bad effect must not be actively willed.¹⁷ In fact, the double effect is only permissible if the bad effect cannot be avoided without failing to attain the good effect. However, in this case, since both Dr. N and Ms. K are well aware that the primary purpose of contraception is not treating acne, the principle of double effect cannot be used with sincerity to justify prescribing COCP.

Conclusion

As her physician, Dr. N has a responsibility to provide Ms. K with information adequate to make an appropriate, safe, and legal medical decision, which in this case is provision of birth control. In this case, Dr. N should probe Ms. K's medical history for an alternate but subjectively demonstrable diagnosis (such as abnormal uterine bleeding, dysmenorrhea, or acne) for which birth control is a medically accepted therapy so that she can prescribe Ms. K's desired contraception on the basis of the principle of double effect. If she is unable to make a diagnosis, Dr. N has a duty to inform Ms. K that she does not provide contraception for the sole reason of preventing pregnancy and to refer her to someone whose employer does not restrict prescribing patterns.

Outside of her encounter with Ms. K, Dr. N can also make some changes to facilitate the full range of care for all patients, particularly those who are socioeconomically vulnerable. For example, Dr. N could make sure that every patient is aware of her inability to prescribe contraception at the time the appointment is made, so that patients can choose to seek another clinician without first having to walk away from Dr. N's office empty handed.

The institution also has a responsibility to ensure that provisions are made to cover the full range of medically appropriate therapy, even if this means transfer to a non-Catholic institution if a medical service is not available.¹⁸ In this manner, Dr. N can balance her duty to her patient, her institution, and the values that govern her profession.

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Citation

AMA J Ethics. 2018;20(7):E630-636

DOI

10.1001/amajethics.2018.630

Conflict of Interest Disclosure

Dr. Arora serves on the American College of Obstetricians and Gynecologists Ethics Committee and the American Society of Bioethics and Humanities board of directors. Dr. Morris had no conflicts of interest to disclose.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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ISSN 2376-6980**

MEDICAL EDUCATION

Fostering Discussion When Teaching Abortion and Other Morally and Spiritually Charged Topics

Louise P. King, MD, JD and Alan Penzias, MD

Abstract

Best practices for teaching morally and spiritually charged topics, such as abortion, to those early in their medical training are elusive at best, especially in our current political climate. Here we advocate that our duty as educators requires that we explore these topics in a supportive environment. In particular, we must model respectful discourse for our learners in these difficult areas.

How to Approach Difficult Conversations

When working with learners early in their medical training, educators can find that best practices for discussion of morally and spiritually charged topics are elusive. In this article, we address how to meaningfully discuss and explore students' conscientious objection to participation in a particular procedure. In particular, we consider the following questions: When, if ever, is it justifiable to define a good outcome of such teaching as changing students' minds about their health practice beliefs, and when, if ever, is it appropriate to illuminate the negative impacts their health practice beliefs can have on patients?

These questions emerge for educators in obstetrics and gynecology most frequently with the topic of abortion. While we will focus our essay squarely on discussing abortion, it should be noted from the outset that our approach to this difficult topic can also apply to teaching other topics on which disagreement and divergent views persist. Our goal is to encourage all educators to create supportive space for open discussions on these topics.

Listen

First and foremost, our approach involves listening carefully so as to show respect for the views presented. Our students' beliefs, like our own, have developed over a great deal of time and are influenced by their unique experiences, their families, where they grew up, and so on. These beliefs are deeply held, can be defined as identity constituting, and require our respect and attention.

Showing respect involves not only careful listening but also ensuring that the student is given a safe environment in which to discuss ideas. Such discussions should typically not be held on rounds, as these are generally conducted in open spaces in hospital clinical care areas. If students (presumably a minority) are bold enough to share their views on rounds, they should be supported in speaking out and then later asked if time can be set aside in a neutral space to discuss their views further. Should students decline, of course, that is their prerogative. Our experience is that when offered the opportunity to discuss views on these difficult topics, students have welcomed it.

Similarly, all students present should be afforded a similar opportunity to discuss their points of view, assuming the views were shared in a group setting—which is rare. Group discussions of difficult topics can be fruitful but only with assurances ahead of time from all who wish to participate that they will engage with each other respectfully and without any specific goal except to hear and exchange views on the topic. Our experience is that difficult topics are typically raised by individuals and not in a group setting, which is indicative of students' desire to explore difficult topics in a safe environment.

Commit to an Open Discussion and Create a Supportive Environment

Assuming we have listened carefully and patiently, we can then reasonably request that our students also listen to our opinions and values on the topic at hand, informed by lengthy experience in practice. We talk about our years of experience not to set ourselves apart from or ahead of our learners but instead to emphasize and share that our own views have changed over time as we have experienced more of life and more of the practice of medicine. Students should understand that medical school and residency will almost surely change their views of many things—even if not the issue at hand. Keeping an open mind is essential to becoming an excellent well-rounded physician. To answer one of the questions posed earlier, we typically make clear that our goal is not to change students' minds but to ask instead that students remain always open to new perspectives, as we do ourselves.

The alternative would be to actively seek to change the minds of our learners on the topic of abortion (or another difficult topic). Given that there remains reasonable and active debate about the ethical permissibility of abortion, it would not be respectful for us as educators in a position of power to confront our students in this way. Certainly, we can present our point of view and how we've arrived at it; yet, we must at all times remain open to hearing our students' points of view. Our experience has shown us that the most successful approach is a mutual exploration of ideas and the literature surrounding them.

Thus, we find we must be open to discussion of all facets of the debate. We encourage our students to openly share what they have read on the topic along with any and all ideas that have come to them over time. There is nothing "off limits." We can commit to

each other that we believe each has the best of intentions in the discussion and in our work. In this way, our conversation can be wide ranging and hopefully without judgment.

As noted above, a wide-ranging discussion can't ensue on the wards or in the midst of a busy clinic. Instead, a neutral time and place can and should be set to fully explore the topic. We've found that most students who do not share our views on the topic of abortion—or any difficult topic—welcome the opportunity when offered to have an open conversation. Especially for those with viewpoints on one or the other extreme of the debate, it is rare to be able to safely explore counterpoints. Such conversations are essential for all of us in medicine. As educators, we must foster these conversations and thereby model a respectful mode of discourse.

Discussion Specific to Abortion

We can't cover in this short essay all the myriad points that can be explored in a discussion of the ethics of abortion or even [conscientious refusal](#) to learn to provide abortion care. Being willing to pull papers and compare our reads of various "debates within the debate" has been the source of rich and lengthy discussions with our students. Here, we can only briefly explore some key points that frequently arise and hope by that to encourage these types of discussion.

At the outset of conversations with those who conscientiously object to learning to provide abortion care, we typically acknowledge that asking anyone to perform an act they see as murder would be wrong, and thus we support a student's decision to refuse to participate. We likely also would fairly quickly agree to disagree about when "life begins" or when an embryo can be deemed to have moral status precluding provision of abortion services. This is not to say that this point does not merit an incredibly complex discussion, and we happily explore it with students. Yet, given a difference of opinion on this point, there is rarely a piece of evidence that would convince either of us to "come to the other side." Agreeing to disagree on this point is, in fact, helpful both for us and for students. Reaching an understanding that we can disagree on such a fundamental point—given that no dispositive evidence exists—yet still respect each other's points of view is an important step.

The bulk of our discussion then seems to focus on what a student's decision to conscientiously object to learning to provide abortion care will mean for their patients and for how they will care for them. We also discuss what it will mean for the broader community where they practice and for other clinicians who work with them or near them. For each student, depending on his or her intended medical specialty and practice setting—urban or rural—the answers to these questions will be very different. We remind our students that "health care providers with moral objections to providing specific services have an [equally important professional and moral] obligation to minimize disruption in delivery of care and burdens on other providers."¹

Thus, our answer to the question of whether we can illuminate the negative impact a student's health practice beliefs can have on patients, particularly those with limited options, is a resounding yes. In fact, this is our duty as educators. In making any health care decision that will close the door to a certain option for a patient, we as "gatekeepers" must explore what closing that door will mean to the individual before us and to the broader community where we practice.

Our students who conscientiously object to providing abortion services must take into account all that comes before and after their refusal to provide abortion services for their patients. This discussion of the patient's needs can be fairly wide reaching and might encompass discussions of religion, history, and the [law](#). Yet, primarily the focus is on lack of access to care, education, and services. We hope to put context into the discussion by exploring the patient's possible lack of access to preventative care, sex education, contraceptives, support services during pregnancy, support for young children, and subsidized childcare and by exploring recent trends in increasing maternal mortality.² This exploration of context might involve telling the stories of patients we've met over the years or reading papers about the current lack of access to care and what that means in terms of obstetrical outcomes and the general health of women in our country. Understanding the downstream and collateral impact of decisions we make as physicians is not something that we fully grasp upon admission to medical school. It is learned over time. As medical educators, bringing perspective to our discussions with learners is not limited merely to sensitive or charged subjects.

Again, we do not seek to change our students' opinions in exploring abortion or any difficult topic. Instead, we recognize that all the students we have encountered who conscientiously object to the provision of abortion services do so out a deep sense of care and responsibility. We know that this same commitment extends to their patients, so we must ensure that they fully understand the import of their refusal, just as they must fully understand the import of any action (or inaction) they take in medicine. Thus, we carefully explore what students feel is their responsibility to patients with respect to all these issues. If they are going to limit access to abortion services through their choice of specialty and conscientious refusal, then they must decide whether it is their duty to [ensure that women have access](#) to preventative care, contraceptives, family planning services, parental leave, and child care. Similarly, we explore the topic of referral and after care.

Given that we are engaged in a discussion, we do not tell our students what they must or must not do. That is not our purpose. We engage in advocacy in other arenas. Instead, we discuss with our students how all our patients, even those with whom we disagree, deserve our respect and care. This commitment will at times mean that we must refrain from burdening our patients with our own uncertainty or, potentially, with delays in care

should our decisions as physicians be difficult. We can't say definitively what this will mean for each student. It will depend on multiple factors related, as previously stated, to their choice of specialty and location of practice. Our hope is that they think not only of the issues related to the procedure itself but also of all the downstream effects on their patients and the community in which they practice.

Frequently, our conversation will stall a bit here. We typically do not reach a definitive answer during our first conversation. We always circle back to our deep respect for our students' views and our belief that our students should have the ability to refuse to participate in a procedure they find inherently immoral while still being a valued member of the medical profession. We always leave the door wide open to further conversations, and typically our students take us up on this offer.

By engaging our students in this way—by listening and creating a supportive environment for open discussion—we hope, ultimately, if nothing else, to foster a culture of respectful discourse essential to higher learning.

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Citation

AMA J Ethics. 2018;20(7):E637-642

DOI

10.1001/amajethics.2018.637

Conflict of Interest Disclosure

The authors had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

POLICY FORUM

Best Practices for Partnering with Ethnic Minority-Serving Religious Organizations on Health Promotion and Prevention

Nadia Islam, PhD and Shilpa Patel, PhD

Abstract

Faith-based organizations (FBOs) serve as effective sites for community-based health promotion, but there is a lack of research on this work in ethnic minority-serving religious institutions such as mosques, temples, and gurdwaras. This article will share best practices, challenges, and special considerations in engaging these sites through two projects: Racial and Ethnic Approaches to Community Health for Asian Americans (REACH FAR) and Muslim Americans Reaching for Health and Building Alliances (MARHABA). We also discuss the Consolidated Framework for Implementation Research and how we used this framework in the two projects to facilitate implementation of health promotion initiatives within ethnic minority-serving religious institutions. To successfully implement such initiatives within these sites, efforts should leverage trusted internal and external relationships through iterative engagement, include adaptable interventions, and address sustainability from the outset.

Faith-Based Community Health

Faith-based organizations (FBOs) serve as effective sites for community-based health promotion activities, especially among underserved groups, given their roles as community centers.¹⁻⁵ However, most research has focused on African-American and Latino community churches^{1,4}; a limited number of studies have engaged other ethnic minority-serving religious institutions in the US, including mosques, temples, and gurdwaras.⁶⁻⁹ Results of the few studies that have conducted health promotion activities within these sites^{7,10-12} suggest that these sites are “prime opportunities”⁷ for this work.

This paper will share best practices, challenges, and special considerations in engaging these religious settings in the US in health promotion programs and research through our experiences with two projects: Racial and Ethnic Approaches to Community Health for Asian Americans (REACH FAR) and Muslim Americans Reaching for Health and Building Alliances (MARHABA). Both projects were funded by the Centers for Disease Control and Prevention (CDC) and involved multiple community partners and sites (see

table 1). Project foci were guided by the grant and funder priorities and specific disparities faced by the target communities. The REACH FAR project uses a community-engaged approach to implement and disseminate culturally adapted evidence-based policy, systems, and environmental strategies to improve [hypertension prevention and management](#) for Asian Americans (ie, Asian Indians, Bangladeshis, Filipinos, and Koreans) in New York City and New Jersey. The MARHABA project evaluates the effectiveness of a culturally adapted lay health worker (LHW) intervention designed to increase breast and cervical cancer screening among Muslim women using a randomized controlled design.

Table 1. REACH FAR and MARHABA Projects

| Funding Source | Partners and People |
|----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CDC (2014-2018) | <p style="text-align: center;">REACH FAR</p> <p>4 CBO partners: Korean Community Services of Metropolitan New York, Inc. (serving the Korean community in New York City); UNITED SIKHS (serving the Sikh community across the US); Diabetes Research, Education, and Action for Minorities (DREAM) Coalition (serving the Bangladeshi community in New York City); and Kalusugan Coalition (serving the Filipino community in New York City)</p> <p>12 FBOs: 3 Asian Indian gurdwaras, 3 Bangladeshi mosques (including 1 senior center co-located in a mosque setting), 3 Korean churches, and 3 Filipino churches</p> <p>9 KOT Consultants: Individuals identified by CBO partners to train volunteers on the KOT program in faith-based settings. Consultants were contracted and trained by the New York City Department of Health and Mental Hygiene on KOT program implementation</p> <p>96 KOT volunteers: FBO volunteers and leaders identified in each setting to deliver the blood pressure screening program on a monthly basis to congregants</p> |
| CDC (2012-2014, 2015-2018) | <p style="text-align: center;">MARHABA</p> <p>14 mosques and community centers: eg, Baitul Mamur Masjid, Al-Iman Masjid, Brooklyn Islamic Center, Jamaica Muslim Center, India Home, Turning Point</p> <p>8 LHWs with networks and contacts in 5 New York City boroughs and South Asian, Southeast Asian, African American, African immigrant, and Middle Eastern Muslim communities</p> |

Abbreviations: CBO, community-based organization; CDC, Centers for Disease Control and Prevention; KOT, Keep on Track; FBOs, faith-based organizations; LHWs, lay health worker; MARHABA, Muslim Americans Reaching for Health and Building Alliances; REACH FAR, Racial and Ethnic Approaches to Community Health for Asian Americans.

Case Studies

REACH FAR. Building on a substantial collaborative history,¹¹⁻¹⁷ the REACH FAR project is guided by a multisector coalition consisting of a lead academic agency (NYU School of Medicine); 4 community-based organizations (CBOs) representing the Asian-Indian, Bangladeshi, Filipino, and Korean communities; and New York and New Jersey state and local health departments.⁷ Aided by technical assistance, training, and resources from NYU School of Medicine, coalition partners leveraged their roots in the community to engage 12 FBO sites, including 6 churches in the Filipino and Korean communities, 3 gurdwaras (Sikh houses of worship) in the Asian-Indian community, and 3 mosques in the Bangladeshi community. Given the high burden of heart disease among Asian Americans¹⁸ and the lack of culturally tailored hypertension management programs for this population, the project implemented a multilevel, evidence-based health promotion and hypertension control program that addressed organizational change (increasing access to healthy foods and beverages at communal meals) and individual behavior change (improving cardiovascular health through the implementation of blood pressure [BP] screening programs).⁷

Specifically, organizational nutritional policies were implemented to improve access to heart-healthy food and beverages during communal meals in each of the 12 FBO settings. At each site, we conducted a baseline survey with congregants to assess availability of healthy foods and beverages during communal meals prior to policy implementation. Leadership was engaged to discuss opportunities for introducing healthy meal options, and a social marketing campaign was developed and implemented at each site to promote organizational policy change. The project enhanced and promoted systematic linkages to culturally and linguistically tailored community-based resources by implementing the Keep on Track (KOT) program—a volunteer-led BP monitoring program sponsored by the New York City Department of Health and Mental Hygiene—at FBO settings. At each site, trained consultants offered a train-the-trainer program to the FBO. Volunteers then held monthly BP screenings for congregants, and congregants who participated in the program received a free screening, culturally tailored health coaching, and referral to care if needed. FBO volunteers tracked and monitored congregant BP readings at each event. In a period of 36 months, REACH FAR activities reached 6 876 congregants across the 12 sites.

MARHABA. The MARHABA project is guided by a coalition of a lead academic agency (NYU School of Medicine), primary care practice clinicians, mosques, and CBOs.¹⁹ The project grew out of research suggesting that Muslim women in the US have lower rates of breast and cervical cancer screening compared to the general population.²⁰ To address this disparity, the project implemented a culturally adapted LHW intervention designed to increase breast and cervical cancer screening among Muslim women in New York City. LHWs were identified leaders in the community and represented a variety of racial and

ethnic backgrounds. Using their social networks and mosque affiliation, LHWs recruited Muslim women who were not up to date on their breast and cervical cancer screening to enroll in the intervention. Participants were randomized into a less intensive or more intensive intervention arm. Women in both groups received a 1-hour educational seminar delivered by an LHW and culturally and religiously adapted health education materials. Women in the more intensive intervention arm received additional follow-up from an LHW to schedule and obtain needed screenings. The study, started in December 2016 and currently ongoing, has linked 7 LHWs with 186 Muslim women across New York City, providing tailored health education and referral to screening, with a goal of reaching 370 women by September 2018.

A Framework for Successful Engagement and Implementation of Health-Promotion Initiatives in Religious Minority-Serving FBOs

Implementation science frameworks provide important domains and constructs for identifying barriers to addressing gaps in the translation of evidence into policies and programs, particularly policies and programs in minority-serving FBOs that might be otherwise left out of larger population health efforts. The Consolidated Framework for Implementation Research (CFIR)²¹ identifies key constructs in 5 domains that influence the implementation and dissemination process and that are relevant to working in minority-serving FBOs in particular. These domains comprise *intervention characteristics* (characteristics of the intervention itself), *outer setting* (factors external to the organization), *inner setting* (characteristics of the organization implementing the intervention), *individual characteristics* (characteristics of the persons involved in implementation), and *process* (the processes of implementation). The CFIR framework was an integral aspect of project development for REACH FAR and MARHABA; the 5 domains guided project planning, implementation, and sustainability.

Intervention characteristics. Two key factors related to intervention characteristics led to successful project implementation. First, we culturally adapted the intervention to increase its relevance and acceptability for our FBOs. For instance, within Sikh gurdwaras, we incorporated the concept of *seva*, or service to the community without personal benefit, into promotion of healthy food to serve during *langar*, or shared communal meals offered to gurdwara participants. Specifically, the concept of *seva* was incorporated in messaging on healthy food programming and in working with gurdwara leadership to facilitate initiation of the project. This cultural adaptation helped to enhance the relevance and resonance of healthy food promotion strategies for congregation members and leaders. In the MARHABA project, we integrated ideas of collectivism, commitment to God, and the importance of maintaining individual health for the greater family health into education materials. While the adapted nature of our intervention was crucial to implementation success, a challenge related to this approach is the ability to replicate activities across different sites, as the intervention often had to be adapted at multiple levels, including ethnicity, site, and language.

Outer setting. The CFIR framework assumes that the outer setting of environments where program or policies are implemented will influence the implementation process. In our studies, we found that FBOs that had a history of working with the project's CBO partners were more likely to agree to project implementation because of the trust and shared history they had with the CBOs. In addition to leveraging [formal partnerships with CBOs](#), leveraging external FBO networks was crucial to facilitate project success. For example, in the MARHABA study, we were able to leverage LHWs' strong ties within both their congregation and their external social networks to rapidly recruit participants. Finally, we were able to facilitate FBO access to other external organizations and resources through our efforts. For instance, as part of the REACH FAR project, FBOs were incorporated in the New York City Department of Health and Mental Hygiene's BP screening program network and connected with other health department initiatives, thus expanding the reach of citywide efforts for underserved populations. The outer setting of FBO settings engaged in our projects, however, also created barriers to implementation, particularly with regard to navigating the political and social context of the community. For example, mosques that were part of REACH FAR and MARHABA were often faced with competing challenges and priorities, as the New York City Muslim community has increasingly been a target of negative media attention and discriminatory practices in the last decade.²²⁻²⁴

Inner setting. We employed 3 strategies relevant to the inner setting domain to help us successfully implement our programs. First, we leveraged existing organizational infrastructure. All of the FBO sites we worked with had some type of volunteer committee structure, although the formality of structures varied across settings. For implementation of the KOT program, which is designed to be a volunteer-led screening program, we built upon existing structures within each FBO setting in the REACH FAR project and trained volunteers who were already active in FBO activities. Another factor that drove successful implementation was adaptation of the intervention to the organizational capacity of each site. For example, in working with FBO sites in the REACH FAR project to implement nutritional policy changes that would increase congregants' access to healthy foods, we accounted for a variety of site structures—including sites with a kitchen that served their own food and those without a kitchen that received food from an outside source—in the policy language. Finally, we enhanced the internal capacity of each site by offering organizational incentives such as BP monitors and education materials. One specific challenge we encountered relevant to FBOs' inner setting was variations in leadership structures; each site had its own leadership structure, such as volunteer committee structures at gurdwaras or imams and board structures at mosques. For this reason, gaining approval for project initiation at each FBO site varied substantially, as did the frequency and method of engagement.

Characteristics of individuals. Taking into account the characteristics and types of individuals implementing REACH FAR and MARHABA interventions was critical to success. For KOT volunteers in REACH FAR and LHWs in MARHABA, we recruited and trained individuals who had existing trusted relationships with congregation members, which enhanced program success. We also found it was important to engage opinion leaders in the implementation process and champions at each site to initiate and sustain the project. A challenge faced in implementation was the need to account for gender balance in certain FBO settings. For instance, mosques often separate faith-based activities in their sites by gender. As such, we had to ensure that we trained sufficient numbers of male and female volunteers for programs like KOT. Similarly, there were variations in sociodemographic factors such as access to care and English proficiency across sites. To overcome this challenge, it was crucial for us to engage multilingual volunteers and FBO leaders in REACH FAR and multilingual LHWs in MARHABA.

Process. We employed a number of process-related strategies to facilitate project implementation. For example, we utilized a combination of social marketing, congregant-level education, and organizational-level training to ensure project activities were mutually reinforcing in both MARHABA and REACH FAR. Site engagement also concurrently focused on various FBO representatives (eg, leadership, congregants, meal prep staff), and partnerships were formalized by codeveloping memorandums of understanding with each site. Finally, we also allowed for reflection and evaluation in the process by providing and soliciting feedback about the projects throughout the implementation process. Specifically, we disseminated brief reports on the impact of the activities to congregation and leadership, held community forums to update FBO sites on progress, and created structured opportunity to engage FBO leadership in the implementation process. Two related challenges relevant to the process were site leadership time constraints and our dependency on these leaders to implement programs. For instance, in order to implement projects at the gurdwaras, we needed approval from gurdwara committee members, who were often volunteers and only available on weekends. As such, decision making and the process of obtaining feedback on project implementation were often delayed.

Best Practices

Using the CFIR domains to guide project implementation, we have distilled a number of best practices for partnering with ethnic minority-serving FBOs on health promotion and prevention.

Leveraging trusted internal and external relationships through iterative engagement. We worked with community partners to identify FBOs for health promotion activities based on their shared histories. A history of collaboration between CBOs and FBOs enhanced the likelihood that sites would be amenable to implementing health promotion activities (eg, increasing healthier food and beverage options at communal meals) or providing

access to such activities for congregation members (eg, allowing LHWs to host educational sessions and link women with screening services).

In addition to engaging external partners, engaging faith leaders, who are highly respected and serve as community gatekeepers, was critical. To this end, we developed guidelines to enhance faith leadership engagement. For example, a series of faith leader engagement meetings was conducted prior to implementation of health promotion activities at each site. Once faith leaders agreed to participate in projects, memorandums of understanding were jointly developed and reviewed by coalition partners and faith leaders. In addition to working with faith leadership, we worked closely with community members with informal leadership roles at the site. For instance, to ensure effective mechanisms for increasing access to healthy food at communal meals, the REACH FAR project engaged volunteers and people in charge of food procurement, preparation, and serving at FBO sites with kitchens as well as people in charge of purchasing food from outside vendors at sites without kitchens. Similarly, in order to ensure mosque participation in MARHABA, concurrently seeking approval from the imam as well as buy-in from female leaders at the mosque was important to project success.

Adaptation of intervention. Another best practice allows for the adaptation of protocols for health promotion program activities to address cultural and religious norms, the context of religious service and events, and FBO organizational structures. For example, REACH FAR BP screenings were adapted to accommodate Muslim women's modesty concerns by creating a separate station for female congregants in mosques. Similarly, MARHABA breast and cervical cancer educational materials were adapted to address [sociocultural considerations](#) in obtaining screenings by including imagery of Muslim women. For instance, all clinicians in the materials are female and all female patients are shown with their head covered (see figure 1).

Figure 1. MARHABA Educational Materials

“My faith is my strength, and my family is my foundation. Both guide me to take care of myself with regular screenings.”
 Khaleda Akhter
 Entrepreneur, Grandmother, Cancer Survivor

“إيماني وعائلتي هما أكثر قوة من مرض السرطان. فهما يمنحاني القوة للاعتناء بنفسني من خلال إجراء الفحص الدوري.”
 نعمت قاسم
 معالجة فيزيائية، جدة، نجت من مرض السرطان

TAKE CONTROL OF YOUR HEALTH.
 REGULAR BREAST AND CERVICAL CANCER SCREENING CAN SAVE YOUR LIFE.
 Here's what you can do:
 • Learn more about breast and cervical cancer.
 • Talk to your doctor or nurse.
 • Get screened for breast and cervical cancer.
 You and your family will be thankful that you did.

حافظي على صحتك
 الفحص الدوري لسرطان الثدي وسرطان عنق الرحم يمكن أن يكون السبب في إنقاذ حياتك.
 إليك ما يجب القيام به:
 • تعلمي المزيد عن سرطان الثدي وسرطان عنق الرحم.
 • تحدثي إلى طبيبك الخاص أو الممرضة.
 • قومي بإجراء فحص سرطان الثدي وسرطان عنق الرحم.
 سوف تشعرين بالامتنان أنك وعائلتك أنك قدتم بإجراء ذلك الفحص.

Why do I need to get screened?
 Breast cancer may not always cause symptoms, but it can be found early with a screening test called a mammogram.
 The risk for breast cancer increases with age. Talk to your doctor about when and how often you should be screened.

Cervical cancer does not always create symptoms, but there is a screening called a Pap test that can find this cancer early.
 Cervical cancer is the earliest gynecological cancer to prevent with regular screening tests and follow-up. It also is highly curable when found and treated early.

How is a mammogram done?
 1. You are given a gown to wear for the test.
 2. You will stand in front of an X-ray machine.
 3. A technician will place your breast between two plastic plates. (This will make your breast flat, and may feel uncomfortable at first, but it helps make any changes easier to see.)
 4. A female technician can be requested, if it makes you feel more comfortable.
 5. Results are discussed with your health care provider at a follow-up appointment or via phone call.

How is a Pap done?
 1. You are given a gown to wear for the test.
 2. You will lie on an exam table with your feet in stirrups.
 3. Your health care provider will gently open your vagina.
 4. Samples are taken from your vagina and cervix.
 5. Samples are sent to a lab for testing.
 6. A female health care provider can be requested, if it makes you feel more comfortable.
 7. Results are discussed with your health care provider at a follow-up appointment or via phone call.

HPV is a group of more than 150 related viruses. Some of these HPV types can lead to cancer, especially cervical cancer. A HPV test looks for the HPV virus that can cause cells to change to cancer.

You should start to get regular Pap tests every 3 years at age 21. If you are between the ages of 30 and 65 years, you should get a Pap test every 3 years OR every 5 years if you combine the Pap test with the HPV test. If you are older than 65 years, talk to your doctor about when you should get a Pap test.

Speak to your provider about these screenings as your regular/annual exams to determine if the frequency of screening is right for you.

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To enhance project success, a variety of mutually reinforcing education activities and social marketing strategies were implemented at the sites. For instance, to implement REACH FAR activities at Korean churches, we first held a workshop on hypertension awareness and then held a healthy eating food sampling event at which congregants

sampled low-sodium healthy recipes of traditional foods such as kimchi. In addition, staff displayed posters encouraging healthy eating at all events and provided nutrition education to congregants and kitchen staff.

Addressing sustainability from the outset. The organizational capacity of many minority-serving FBOs is at a nascent stage, although they serve large congregations. For example, leadership structures, though formalized, often shift in rapid cycles and might not be supported through salary or other means. Thus, the implementation of health promotion strategies should build organizational capacity. We accomplished this goal by tapping into natural leaders within each FBO (eg, individuals who led prayers groups or health screening events) and providing standardized and systemized training opportunities. Furthermore, we engaged these leaders in developing a protocol for health promotion programs that were realistic and sustainable within each FBO context. For instance, to increase access to healthy food and beverages at communal meals for the REACH FAR project, we offered a range of choices so that sites could choose the strategy that was the most feasible and relevant to their site and congregation. We also linked FBO settings and leaders to citywide resources and agencies that are otherwise disengaged from these settings to ensure continuance of the project. For example, REACH FAR sites were formalized into the local city health agency's BP screening program network, which situated these sites for other opportunities and resources available through government agencies.

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Editor's Note

MARHABA and REACH FAR research protocols were reviewed and approved by the NYU School of Medicine IRB.

Citation

AMA J Ethics. 2018;20(7):E643-654

DOI

10.1001/amajethics.2018.643

Acknowledgements

This publication is supported by grant numbers U58DP005621 and U48DP005008 from the Centers for Disease Control and Prevention (CDC), P60MD000538 from the National Institutes of Health (NIH) National Institute on Minority Health and Health Disparities, and UL1TR001445 from NIH National Center for Advancing Translational Sciences. The authors thank the following organizations for their partnership, collaboration, and dedication: Gulnihar Alam, our lead community health worker for MARHABA; all MARHABA lay health workers; the Diabetes Research, Education, and Action for Minorities Coalition; the Kalusugan Coalition; Korean Community Services of Metropolitan New York, Inc.; UNITED SIKHS; the New York City Department of Health and Mental Hygiene; the New Jersey Department of Health; the New York State Department of Health Office of Minority Health; APartnership; the Asian and Pacific Islander American Health Forum; and all faith-based organizations implementation sites.

Conflict of Interest Disclosure

The authors had no conflicts of interest to disclose.

This article is the sole responsibility of the author(s) and does not necessarily represent the views of the NIH or the CDC. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

MEDICINE AND SOCIETY

Training Physicians as Healers

Aparna Sajja, MD and Christina Puchalski, MD

Abstract

Spirituality is increasingly recognized as an essential element of patient care and health. It is often during illness that patients experience deep spiritual and existential suffering. With clinicians' care and compassion, patients are able to find solace and healing through their spiritual beliefs and values. This article chronicles a history of spirituality and health education, including the development of consensus-based clinical guidelines and competencies in health professions education that have influenced the curricular development.

Need for Spirituality in Medicine

Spirituality is defined as a search for meaning, purpose, and transcendence and a connection to the significant or sacred.^{1,2} Illness, because it raises questions regarding meaning and value, can be described as a spiritual event. As Hebert et al. note, "To ignore the spiritual aspect of illness, then, is to ignore a significant dimension of the experience."³ Yet medical training falls short of preparing physicians to help patients with the metaphysical needs of their illnesses.⁴ It is interesting that spirituality is not yet routinely addressed in clinical care, as most US adults believe in God or a universal spirit,⁵ patients can discover strength and solace in their spirituality, and data demonstrate the prevalence of spiritual distress.⁶ In this article, we chronicle the history of the field of spirituality and health, with its challenges, evolving definition, and integration into medical education.

Changing Roles of Spirituality in Medicine

Medicine, religion, and spirituality share a long history—as evidenced by the roles of healers such as priests and shamans. In the US, many hospitals were founded by religious organizations and espoused values of compassionate service. For centuries, medicine was a profession attending to both body and spirit, with patients often viewing physicians as "secular priests" who helped them grapple with the spiritual aspects of their illness.⁷ As medical science emerged, contemporary physicians no longer saw it as their role to care for patients' spirits. In 1910, the Flexner report sought to put medical education on a firm scientific footing by exposing its deficiencies.⁸ While the subsequent grounding of medical education in science resulted in tremendous advances in medicine, it also resulted in eliminating the humanistic and spiritual aspects of patient care. By the

late twentieth century, there was a greater outcry from the public for more [holistic and spiritual approaches](#) to medical care.¹

While more physicians are beginning to recognize that spirituality is a core patient need and has beneficial influences on health, some in the medical community think it “conflicts” with medical science.⁹ A major challenge in incorporating spirituality as a dimension of health stems from the difficulty in defining it. In attempting to define spirituality, one is discussing ways in which people view the purpose of their existence. Efforts have been made by consensus conferences on compassionate care to elucidate this concept.¹⁰ According to the 2013 International Consensus Conference on Improving the Spiritual Dimension of Whole Person Care, spirituality is defined as “A dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices.”¹¹ By this definition, spirituality is an inseparable aspect of humanity.

As we have entered an era in which patients suffer longer, traditional medicine’s goals of healing and relief from suffering become more pressing. As Egnew writes, “Suffering fills the chasm of meaninglessness that opens when the patient’s previously held meaning structures are destroyed.”⁴ Saving and prolonging life incur a duty to “accompany patients on their illness journeys, to care for their souls as well as their bodies.”⁴ This duty aligns with the World Health Assembly’s palliative care guidelines, which states that all healthcare professionals have an ethical obligation to address *all suffering* of patients—psychosocial and spiritual.¹²

George Washington University’s Spirituality and Health Course

The senior author (CP) recognized the need for addressing spirituality as part of whole person care while a medical student at George Washington University. CP and colleagues at George Washington University started the first fully integrated elective course on spirituality and health in 1992 as a way to begin to broaden our understanding of patients from a holistic viewpoint, and in 1996 spirituality became integrated into the required GW School of Medicine curriculum. In collaboration with the Association of American Medical Colleges (AAMC), we held a consensus conference in 1999 to develop a definition of spirituality, learning objectives aimed at improving whole person care and facilitating professional growth (see table 1), and methods for developing courses on spirituality and health. This conference issued in a report published as part of the AAMC’s Medical School Objectives Project (MSOP).¹³ Subsequently, in 2001, the George Washington University started the first university-charted Institute for Spirituality and Health (GWish).¹⁴

Table 1. MSOP III Learning Objectives Relevant to Spirituality and Cultural Issues

The ability to elicit a spiritual history

The ability to obtain a cultural history that elicits the patient's cultural identity, experiences and explanations of illness, self-selected health practices, culturally relevant interpretations of social stress factors, and availability of culturally relevant support systems

An understanding that the spiritual dimension of people's lives is an avenue for compassionate care giving

The ability to apply the understanding of a patient's spirituality and cultural beliefs and behaviors to appropriate clinical contexts (e.g., in prevention, case formulation, treatment planning, challenging clinical situations)

Knowledge of research data on the impact of spirituality on health and on health care outcomes, and on the impact of patients' cultural identity, beliefs, and practices on their health, access to and interactions with health care providers, and health outcomes

An understanding of, and respect for, the role of clergy and other spiritual leaders, and culturally-based healers and care providers, and how to communicate and/or collaborate with them on behalf of patients' physical and/or spiritual needs

An understanding of their own spirituality and how it can be nurtured as part of their professional growth, promotion of their well-being, and the basis of their calling as a physician

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The Evolution and Growth of Spirituality in Medicine Courses

The content and the basis of spirituality in medical courses have changed from 1992 to the present. Initially, courses responded to patient need as demonstrated in surveys. For example, McCord et al. found that 83% of patients in a family practice setting "wanted physicians to ask about [their] spiritual beliefs in at least some circumstances." Among those who wanted to discuss spirituality, 87% indicated "the most important reason for discussion was desire for physician-patient understanding."¹⁵

As research demonstrated the relevance of spiritual and existential distress and guidelines for physicians attending to all aspects of patient suffering were developed, courses began to emphasize the clinical aspect of spirituality.^{10,16,17} These courses, which became widespread, now teach patient need for spirituality, diagnosis of spiritual and existential distress, and development of spiritual treatment plans. More recently,

courses began to integrate the spirituality of the clinician as a way to help students identify with their role as healers.¹⁸ These courses also started integrating spirituality as a part of student wellness,¹⁹ particularly in response to the growing crisis of physician burnout, depression, and suicide.²⁰

From 1996 to 2008, the senior author (CP) and GWish led a medical school and residency Spirituality and Health Curricular Awards program, which contributed to the increase in the number of US medical schools incorporating spirituality in their curriculum from 13% in 1994 to 90% by 2014 and to spirituality curricular integration in psychiatry and family medicine residency programs.²¹⁻²³ To date, a total of 49 medical schools have received John Templeton Foundation funding for curricular development in spirituality and health.²⁴

Based on these courses, the National Initiative to Develop National Competencies in Spirituality for Medical Education (NIDCSME), convened by GWish in 2009 through a consensus process, established spirituality-related competency behaviors, teaching methods, and assessment strategies for medical schools.²⁵ The framework used was based on the existing Accreditation Council for Graduate Medical Education (ACGME) competencies.²⁶ The concepts of compassionate presence—a subset of compassionate care—and student wellness were determined to be essential to these courses. “Presence” refers to the contemplative aspect of our relationship with patients. While compassionate care can involve empathy, forming connections, helping patients with issues, and being respectful and caring, presence calls upon a unique set of skills in which the clinician moves to a more reflective and contemplative space with the patient.^{10,16,17} Accompaniment, discussed earlier, is the outgrowth of presence.

The NIDCSME recommendations led to the development of a national program in professional development called GWish-Templeton Reflection Rounds (G-TRR). G-TRR is a mentored small group program that “aims to integrate meaning, purpose and connectedness into the continuum of medical education” by nurturing physicians’ inner growth through an interdisciplinary reflection process.²⁷ These features relate to spirituality, broadly defined as finding meaning and purpose and experiencing connectedness to the sacred. Of the 33 participating medical schools in the G-TRR, 11 reported teaching more than 60% of competency behaviors,²⁵ with the highest prevalence in the compassionate presence domain. However, there are also barriers to implementing these behaviors in practice. Physicians’ most commonly cited barriers to initiating a [spiritual history](#) have been lack of an adequate framework during the clinical interview and perception of inability to offer time for such conversations.²⁸ In many ways, a spiritual history may not seem relevant in a routine appointment, but offering the space through genuine care beyond a problem list may provide an opportunity to heal in the most surprising of moments.

Despite these initiatives, physicians and trainees struggle with integrating spirituality into care, particularly into care near the end of life. In 2004, the National Consensus Project (NCP) for Quality Palliative Care developed 8 required domains of care, including spiritual, religious, and existential issues.²⁹ In this document, assessment of patient spirituality is required; however, there were no guidelines on how to assess patient spirituality or how to choose the clinical team member who should make the assessment. Thus, in 2009, Puchalski and Ferrell co-led another national consensus conference that emphasized interprofessional spiritual care (with clinicians functioning as generalist spiritual care professionals and trained [chaplains](#) as the experts on the care team). The conference addressed regular assessment by all members of the health care team and integration of spiritual issues into the medical plan as a fundamental component of quality palliative care.¹⁷ The guidelines motivated by this conference recognized spirituality not only as essential to care of the suffering but also as a fundamental aspect of preventative health. Spiritually-centered compassionate care should be key to any health delivery system.¹⁰

Last, the first global spiritual care train-the-trainer program—the Interprofessional Spiritual Care Education Curriculum (ISPEC)—will be launched in July 2018, led by GWish and the City of Hope in partnership with the Fetzer Institute.³⁰ This training program for teaching interprofessional spiritual care was developed by the senior author (CP), Betty Ferrell from the City of Hope, and colleagues. The program contains a level 1 online component and a more advanced level 2 leadership train-the-trainer component for clinician-chaplain pairs of leaders to use at their clinical settings.

Based on the above consensus conferences, 22 years of curriculum development in US medical schools, and the professional development program (G-TRR), the GWU components for a spirituality and health curriculum fulfill both clinical and professional development components (see table 2). The clinical component includes taking a spiritual history, identifying patient spiritual resources, diagnosing spiritual or existential distress, and integrating spirituality into the assessment and treatment plan of patients. These objectives are intended to provide all medical students with training in how to address the spiritual concerns of patients, especially those with chronic and serious illnesses. Essential to this component is recognizing how to refer to and work with trained spiritual care professionals such as chaplains. In G-TRR, students experience their own spirituality in the context of their professional development as healers, as they reflect on themes of accompaniment and presence.

Table 2. Components of Spirituality and Health Curriculum at GWU

| Patient care |
|---------------------------------------------------------|
| Spiritual history |
| Spiritual distress diagnosis and treatment |
| Biopsychosocial spiritual assessment and treatment plan |
| Compassionate presence to persons' suffering |
| Student/resident/clinician formation |
| Inner life focus |
| Meaning, purpose, call to serve |
| Authenticity |
| Compassionate presence—to self |

Reproduced from C. Puchalski.³¹

Conclusion

Medical educators are increasingly recognizing the need to bring the art of compassionate care back into the curriculum.³² We must move away from asking whether spirituality *should* play a role in health care to examining ways this dominant force already functions in health care today. Given that (1) spirituality is associated with reduced mortality and risk for certain diseases,³³ (2) there is a growing number of patients with chronic conditions and suffering, and (3) physician burnout is increasing,²⁰ addressing spirituality is both relevant and timely. Requiring spirituality as an integral component of medical education would bring medicine closer to the World Health Organization's longstanding definition of health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity,"³⁴ updated with spirituality in the World Health Assembly's palliative care resolution in 2014.¹² We cannot serve our patients well if we only focus on the physical aspects of their illness, and neither can we rely on others on the team to take care of the psychosocial and spiritual issues as ancillary luxuries. The core element of the healing relationship is our ability to adequately address all the concerns of our patients and their families—psychosocial, spiritual, existential, and physical—and to work in partnership with experts in each of these domains. Anything less than this is both inadequate and unethical in meeting our professional obligation to our patients and their families.

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Citation

AMA J Ethics. 2018;20(7):E655-663

DOI

10.1001/amajethics.2018.655

Conflict of Interest Disclosure

The authors had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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ISSN 2376-6980**

AMA Journal of Ethics®

July 2018, Volume 20, Number 7: E664-667

ART OF MEDICINE

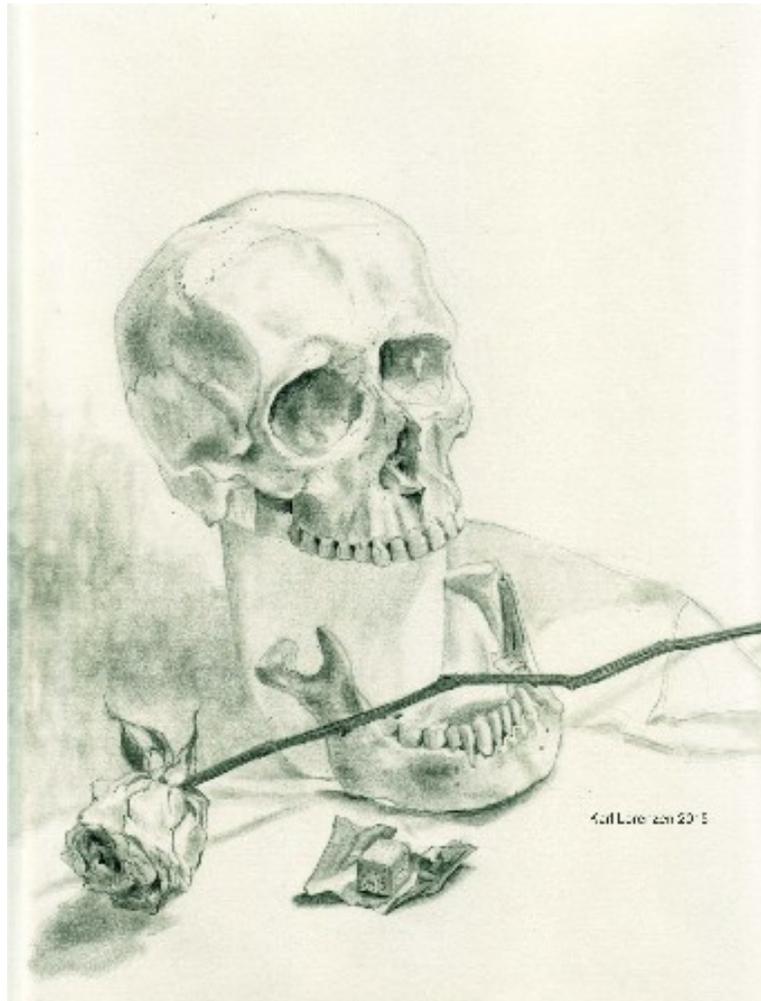
Balance of Principles

Artwork and captions by Karl Lorenzen

Abstract

Each work in this collection explores, from patients' or their loved ones' points of view, balance between patients' experiences and one or more of 4 well-known principles of ethics in health care.

Figure 1. *Portrait*, by Karl Lorenzen



Media

Graphite on paper.

Caption

Patients can be frightened by clinical instruments in close proximity to their faces. The principles of nonmaleficence and beneficence suggest the importance of both minimizing fear as a source of harm and cultivating the hope of good outcomes in specific clinical encounters. Once maxillofacial or dental pain is alleviated, for example, some grateful patients might offer flowers to staff; a rose is a symbol of beauty and impermanence, a reminder of benefits' triumph over the risks and fears endured to achieve good outcomes.

Figure 2. *Some Other Spring*, by Karl Lorenzen



Media

Graphite on paper.

Caption

Chemotherapy is considered treatment in the best interests of a cancer patient. Although a patient might choose chemotherapy autonomously, anti-nausea medication is needed to make the benefits of treatment tolerable. In this drawing, a patient's iatrogenic hair loss meant her curlers were put aside for a while. The wood beads and straw necklace symbolizes body adornment: it is an attempt to salvage the self-esteem lost with the hair.

Figure 3. *At Last*, by Karl Lorenzen



Media

Graphite on paper.

Caption

A justice concern is that patients without insurance or adequate insurance must wait awhile to save enough to have dental work done. When the opportunity arises, at last, they can be relieved of pain or discomfort. Health insurance for a person who is ill is like a pencil sharpener for a pencil: without it, a person needing medical treatment, like an unsharpened pencil, might not function well. The balloon weight is a symbol of festivity; patients “celebrate” obtaining health insurance (“at last!”). And the sprig of baby’s breath signifies purity and freedom from corruption.

Karl Lorenzen is a professional artist who exhibits and teaches at cultural, educational, health, and holistic learning centers in New York State. Formerly a faculty member of the New York Open Center and Anthroposophy NYC, he is currently a teaching artist in residence at the Omega Institute in Rhinebeck, New York. His artwork has been published in numerous sources and was included in exhibitions at the Tokyo Metropolitan Art Museum, the Memorial Sloan-Kettering Cancer Center inFUSION Gallery, and the United Nations headquarters.

Citation

AMA J Ethics. 2018;20(7):E664-667

DOI

10.1001/amajethics.2018.664

Conflict of Interest Disclosure

The author had no conflicts of interest to disclose.

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ISSN 2376-6980**

ART OF MEDICINE

Healing Body and Spirit

Artwork and caption by Ariana Ellis

Figure 1. *Healing*, by Ariana Ellis



Media

Charcoal and gold leaf on paper.

Caption

This drawing considers how achieving balance between allopathic, Western medical practices and spiritual practices can be critical for clinicians hoping to offer compassionate health care. Ethical and clinical challenges of consistently offering compassionate care to patients from all backgrounds requires cultivating and practicing spiritual awareness while maintaining professional boundaries.

Ariana Ellis is a third-year student at Northeast Ohio Medical University in Rootstown, Ohio.

Citation

AMA J Ethics. 2018;20(7):E668-669

DOI

10.1001/amajethics.2018.668

Conflict of Interest Disclosure

The author had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

PERSONAL NARRATIVE

Chaplains' Roles as Mediators in Critical Clinical Decisions

Susan Harris, MHL

Abstract

Chaplains provide spiritual care and support to patients, families, and hospital staff. What may be less familiar is that chaplains also help mediate decisions among patients, family members, and clinical teams. How clinicians, patients, and families formulate and articulate their goals and concerns can be informed either directly or indirectly by religious values. Finding common ground and common language can be helpful for both the medical team and the family. Physicians can use their clinical and social authority to try to ameliorate distress and offer recommendations based on patients' and families' goals and values; conversely, physicians' hesitancy to use their authority in these ways can generate moral distress among patients, families, and caregivers. However, when the medical team engages in conversation with a willingness to be informed by patients' religious worldview, more effective decision making may ensue.

Narrative of a Parental Dilemma

A previously healthy infant, having enjoyed the adoration of his family at home for several months, is rushed to the hospital's emergency department. In short order he is sent to the neonatal intensive care unit (NICU). Soon he is on a ventilator. The baby undergoes a battery of tests. Within days his physicians suspect he has a rare and fatal genetic condition. Within a few more days their suspicions are confirmed; the diagnosis is like a lightning strike, so incalculable are the odds. Death is expected imminently.

The parents are observant Jews. They are active members of their community and have very close ties with their rabbi. He is a source of support and guidance to the entire family. The decisions the parents are facing are daunting, full of unknowns and uncertainties, but all leading ultimately to the same finality. The parents invite their rabbi to meetings at the hospital to help navigate the complexities of medical decision making with respect to the dictates of religious law. Given the diagnosis and prognosis, what treatments should be pursued? In matters of life and death, Jewish law is stringent; it can be complicated to stop what has been started.

At the bedside, medical options are also discussed, albeit with less formality than in the conference room. At the bedside, the parents' hopes, fears, misgivings, and tentative aspirations are voiced to their chaplain. These parents see all too clearly how limited, now, is their baby's future—whatever they decide to do. The wait is excruciating.

This particular family has experienced many challenges and losses in their lives. They have made difficult decisions, although perhaps none of this magnitude, which have been informed by their religious tradition, to be sure. And the family has its own culture based on unique personal experiences and predilections—the entire constellation of traits that make all of us who we are. Given the course of their baby's decline, these parents are not inclined to prolong the suffering with heroic interventions. To them, quantity of days is inversely proportional to quality: in this case, more is much less. This is the narrative a chaplain might hear.

The parents might not express this conviction as explicitly as they could to their rabbi. Their respective goals overlap but do not align. There is an inherent conflict. The rabbi represents law in a tradition that strictly defines life and safeguards its sacredness—including longevity. The rabbi is committed to prolonging life and advocates pursuing and continuing treatment. Disappointment, ambivalence, heartbreak, and spiritual distress are not necessarily admissible factors for this legal decision-making process. To the law, life is more a binary. A person is considered alive until that person is dead. Legal adjudicators feel the same heartache as parents, but their framework is constructed differently. In short, the parents want what they want—release for their child—and they want to adhere to [Jewish law](#) as well. In some circumstances, both may not be entirely achievable.

The medical team, however skilled and sensitive, is in a precarious position in the partnered decision making they seek to elicit. All the medical information is laid out. Treatment choices and possible interventions are shared and then examined to be ruled in or out. The team appears to be acting from a point of neutrality. The family's counsel, the rabbi, is on a predetermined course to choose more rather than less. It might reasonably appear to the medical team that elaborating and prolonging interventions, in line with the rabbi's requests, is also what the parents want. That appearance could be misleading.

What might a chaplain do? In this case, two parallel conversations are happening—one at the bedside and one in the conference room. The chaplain has access to both. In addition, there is a possible third conversation. Parents' goals of care can inform the options the medical team presents in the first place. In this chicken and egg scenario, the chaplain may confer with the team to clarify nuanced religious issues and to elucidate possible strategies. The medical team can use its authority and judgment in choosing and delineating treatment options—to edit them, as it were, with an understanding of

the parents' priorities. The team's recommendations can in turn inform how rabbinic law is applied with the support of the family's chosen counsel. A chaplain can mediate these conversations, helping the medical team members to understand the implications of the choices they offer through the lens of religious law and how asserting their medical authority might benefit achieving the family's goals while still respecting the requirements of religious tradition. Although mediation entails tension, it can be productive tension. The ideal would be for the parents' values, their community's values, and the team's medical and ethical judgment to work together and, together, to refine decision making.

In this instance, the parents empowered their rabbi to become a part of the process. Indeed, that is the ethical way to engage a third party. Here, the chaplain could contribute indirectly to the negotiation by providing deep listening and context to both team and family, thereby helping to inform and suggest limits to their decision-making process. When there is no chaplain involvement, a team may offer such a wide range of options that in the resulting moral and spiritual distress parents or clergy are "blamed" for choosing the "wrong" option. Yet this dynamic is often repeated.

A more difficult scenario, perhaps, is one in which the religious counsel is off site and has no direct contact with the patient. When decisions are seemingly dictated to the team from a remote source—from someone who has not been in the presence of patient or caregivers—the potential for misunderstanding and hard feelings increases dramatically. In extreme situations, this kind of "disjointed" decision making can take on the feel of negotiation between adversaries. Stonewalling, ultimatums, and misunderstandings may undermine direct communication, risk escalation and entrenchment, and increase duress. That the absent advisor is not witness to the patient's experience can corrode the medical team's trust. A chaplain can both empathize with the team while providing cultural context and redirect attention to the relevant religious legal issues.

Consider a similar but different case in which family and religious authority are completely aligned. The patient is being kept alive with aggressive and heroic measures, and there is no possibility of either recovery or consciousness. Religious counsel is effective in advocating for the medical team to continue with a "full court press." Thus the family is spared most of the negotiating and is allowed to experience "only" the tragedy of the patient's plight—but no further existential, religious, or moral distress. The medical team may feel manipulated and at odds with the medical options chosen or, worse, demanded of. There is a significant moral remainder in this unmediated discussion.

How might a chaplain help? It may be helpful for each side to have more nuanced understanding of the other's culture. It may assuage some of the team's [moral distress](#)

to understand what meaning the parents ascribes to their choices. For many reasonable people and in some religious traditions, life itself is the ultimate value and goal. Quality of life of course matters, but it is only one of many variables. Even when team and family are at odds, by creating broader common ground, respect for one another can be cultivated and enhanced. Questions asked determine the answers considered. A chaplain is well situated to help ask questions that illuminate and mediate the exchange between patient, family, clergy, and physician.

The modern hospital is a compelling crucible of the complex, multicultural world in which we live. We are each at the intersection of many more cultures and influences at a given moment than we may be aware of. Even though we each use words we seem to share, in fact we may be speaking entirely different “languages.” The hospital chaplain provides insight into the world of spirituality and religion as well as the world of hospital culture to those who are unfamiliar with it—especially when neither may have been explicitly articulated. Goals of care and medical decision making are constantly evolving in whatever languages we speak.

The Place of Prayer

The Talmud—the major rabbinic compendium of Jewish law and thought redacted approximately fifteen hundred years ago—relates the story (here loosely retold) of the death of Rabbi Judah, a second century sage. After a long, miserable illness, he appears to be on the verge of death. His colleagues declare a public fast to beseech God’s mercy and prolong Rabbi Judah’s life. His students gather in his courtyard, praying that he should live. Rabbi Judah’s handmaiden goes up to the roof and prays, “Those on high (celestial beings) desire Rabbi to join them, and those below (students and sages) desire Rabbi to remain with them. May it be God’s will that those below prevail over those high.” But when she sees how much pain he is in, she changes her prayer. “May it be God’s will that those above prevail over those below.” The students do not stop praying; their prayers continue to keep Rabbi Judah alive. The handmaiden picks up a pottery jar and hurls it from the roof to the ground. As it shatters, the noise startles the students and stops their prayers for just an instant. In that instant Rabbi Judah dies, his soul departs.

In Jewish tradition, the handmaiden’s actions are seen as meritorious. It is a complicated matter for the one who prays to know what to pray for. That has not changed over the centuries. Although [prayer](#) is not the vocabulary of medicine, it articulates challenges each of us—whether patient, family, caregiver, or religious counsel—confronts: how to respond to the ever-changing exigencies of life with skill, wisdom, and compassion.

Susan Harris, MHL, is the director of Chaplaincy at Boston Children’s Hospital. She is a graduate of Brandeis University, Hebrew Union College—Jewish Institute of Religion, and an Association of Professional Chaplains board-certified chaplain.

Citation

AMA J Ethics. 2018;20(7):E670-674

DOI

10.1001/amajethics.2018.670

Conflict of Interest Disclosure

The author had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.