THE MORAL IMPERATIVE OF ADDRESSING PATIENT RELIGION AND SPIRITUALITY IN MEDICINE

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ABSTRACT

The disconnect between physician religious belief and experience and that of their patients is a growing problem in medicine. As physicians shy away from important discussions of their patients' values, patients begin to drown in the growing medical complexity and feel less respected. Patient ability to drive their own care decisions is reduced when important topics like religious and spiritual beliefs are avoided. In light of the evidence of how religion and spirituality can influence health and medical decision making, physicians have a moral imperative to pursue an understanding of their patients' belief system based on principle and pragmatism. There are easy tools available to help physicians streamline these patient interactions even when a physician is inexperienced in religious topics. For these reasons and more, it is of critical importance for physicians to no longer shy away from uncomfortable conversations but to pursue human flourishing through more deeply understanding their patients. While several objections may exist to this imperative, none are sufficient to outweigh the importance of this, and there are several tools in the toolbox that can make this process targeted, brief, and valuable.

Ultimately, having a basic understanding of the religious views of patients enables physicians to more adequately assess barriers to health, understand key principles at play in medical decision making, and communicate effectively with patients and their families during stressful, life-altering times. Modern medical education allocates very few resources to training medical students to address patient beliefs, resulting in provider avoidance of religious conversations that are fundamental to patient health.

To my wife Hannah

Who has never ceased to support me and care for me

Through all the late nights, long hours, desperate defeats, and ceaseless celebrations,

You deserve this degree more than I do.

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CHAPTER 1: INTRODUCTION

A Brief Vignette

When I was sitting in on an internal medicine resident lecture during my third year of medical school, the palliative care physicians were discussing how to navigate family meetings with adept care and proficiency. At the end of the session, one of the palliative care fellows offhandedly mentioned that any time religion comes into play in family meetings or the family begins to pray, she tries to silently slip out of the meeting unnoticed. Many of the other internal medicine residents in the room began to speak up about how they also felt uncomfortable and unequipped to fully engage with the highly religious patients of North Philadelphia. For me, this highlighted the ever-growing divide between the ivory tower of academic medicine and the daily suffering of many patients in North Philadelphia and elsewhere often navigated with a religious worldview. The shy comment developed into a discussion about how many clinicians felt ill-equipped to adequately engage the predominantly religious patients of the hospital's catchment area. Religious demographics of both providers and patients are changing, and there is little education in medical school designed to address the foundational beliefs of patients that influence decision-making and interactions with healthcare professionals. While the central goal of contemporary medical education is to develop compassionate physicians that practice evidence-based medicine, many of the communities in which physicians practice do not ascribe to the purely naturalistic value system that is foundational to the methodology of scientific inquiry.

The disconnect between physician religious belief and experience and that of their patients is a growing problem in medicine. As physicians shy away from important discussions of their patients' values, patients begin to drown in the growing medical complexity and feel less

respected. Patient ability to drive their own care decisions is reduced when important topics like religious and spiritual beliefs are avoided. There is a moral imperative to address patient religion, many pragmatic reasons to do so, and easy tools available to help physicians streamline these patient interactions even when a physician is inexperienced in religious topics. For these reasons and more, it is of critical importance for physicians to no longer shy away from uncomfortable conversations but to pursue human flourishing through more deeply understanding their patients.

The Problem of Medical Complexity

In a medical landscape of increasing complexity, getting to the bottom of the beliefs of patients is critical—especially religious beliefs. Goals of care discussions and the like are often reduced to simple "yes and no" living will questions. These discussions are often navigated with family present. However, as patients near the end of their lives, their comprehension of complex medical language is often poor (Jacobson et al. 1994; Thorevska et al. 2005). Patient's also rarely suffer through the end of their lives alone but instead do so with their family and communities. There is much stress on patient families near the end of their lives which may cause family interference with the true wishes of the patient. Goals of care should be discussed early in hospital stays, preferably prior to admission to a hospital for a major life-altering event (Gieniusz et al. 2018). However, it ought to be the role of the physician to address both the patient's goals and desires in a way that maximizes the autonomy of the patient. This necessitates an understanding of a patient's worldview that allows them to make informed medical decisions regarding their care.

Increasing complexity places significant onus on the physician to be able to interpret the patient's guiding principles and apply them to known medical interventions. Most patients do not have the advantage of many years of education and training in the etiology of disease and

efficacy of treatment, and therefore depend on their physicians to interpret scientific data and distill this complexity into a simple set of viable medical treatment options. Together, the patient and physician decide on a treatment option that should take into account the patient's goals and values. The benefits of this approach are more evident in discussions surrounding end of life care, but engaging patients in health discussions and giving them power in decision-making is an important aspect of increasing patient adherence to medical therapy (Atreja et al. 2005). Taking stock of a patient's values enables true communication and relationship to occur, which in turn maximizes human flourishing for a patient within the confines of their belief system.

The True End of Medicine

The goal of any medical intervention should be to increase human flourishing. The traditional end of medicine is health, which Leon Kass famously described as "the 'well-working' of the organism as a whole" (Kass 2008). This is in stark contrast to the seemingly more modern goal of medicine, which seeks to eliminate all suffering from the human existence as its primary end. It has turned from a focus on comprehensive human flourishing to a compartmentalized organ based approach that favors medical sub-specialties over generalists. In the traditional approach of restoring health, seeking to relieve a patient's suffering is not an end in itself, but is only pursued insofar as it is seeking to restore the whole person (Curlin 2015). As an example, the approach taken where opioid pain medications are overprescribed in an attempt to eradicate all pain does not appropriately account for the traditional aim of medicine—that of the whole organism, and instead sacrifices the health of the whole organism by promoting opioid dependence (Frush et al. 2018). The appropriate view of the end goal of medicine recognizes that human health is both a scientific and an experiential endeavor. As conversations in medicine

have shifted to focus on psychological and social components of the human experience and health, the spiritual and religious components have not received equal attention.

The Role of Religion and the Physician's Moral Imperative to Pursue Understanding

We have a medical training system in place that increasingly teaches physicians to delve into very personal topics including living situations, recreational substance use, sexual activity, and financial insecurity—all of which have clear implications for health status. However, as depicted in the opening vignette, the importance of patient religion, its impact on health status, and ways to approach this potentially taboo topic have not been adequately conveyed to medical trainees. This has resulted in a woefully inadequate handling of patient religion and often a fear of broaching the topic. Physicians are certainly not pastors, priests, rabbis, or imams; nor do they need to be. In fact, one study at the Mayo Clinic noted that rates of atheism and agnosticism in physicians were significantly higher than the general population, and only approximately 50% of physicians reported themselves as religious, and 25% spiritual (Robinson et al. 2017). The Pew Research Poll in 2012 reported that of the U.S. general population, 81% of respondents had a religious affiliation, with 14% of the remaining 19% having no particular religious affiliation but likely falling into the spiritual category (Pew Research Center 2012; Robinson et al. 2017). While the general U.S. population largely reports Christian affiliation, physicians on the whole consist of a more religiously diverse group than the general population (Curlin, Lantos, et al. 2005). The fact that physicians are less likely to be religious or more likely to have differing religious beliefs from the populations they serve may be a source of hesitancy to broach topics of religion and spirituality in the physician's office. However, the medical literature has demonstrated that religion serves as both a protective and potentially detrimental factor to health, and therefore patient religion should not be an untouchable topic by physicians. Knowing a

patient's religious and spiritual practices may also open up the opportunity to engage the patient in a community of the same religious affiliation with resources to improve health and human flourishing. In light of the evidence of how religion and spirituality can influence health and medical decision making, physicians have a moral imperative to pursue an understanding of their patients' belief system based on principle and pragmatism. While several objections may exist to this imperative, none are sufficient to outweigh the importance of this, and there are several tools in the toolbox that can make this process targeted, brief, and valuable.

CHAPTER 2: RELIGION AND MEDICINE

Shifting Tides—The Importance of Religion in Patients' Lives

Religion and medicine have had a long and storied history, with several time periods throughout the world where religious and medical care were administered by the same individual (Sloan et al. 1999). This is quite obviously not the case in modern medicine in the United States. With the advent of modern scientific methodology, which utilizes methodological naturalism as a foundation, there is little room for miracles and the divine. This belief that all causes are empirical and naturalistic and therefore can be measured, studied, and quantified has driven many scientific and medical advances. From the careful study of the endothelium of arteries and the role it plays in the formation of atherosclerotic disease to revolutionary discoveries in pharmacology like imatinib and its role in treating chronic myelogenous leukemia, the belief that the world behaves in a predictable and repeatable fashion is an attractive and productive one. The result of the influence of naturalism on science is the expectation that religion and science have become separate entities that do not interact or touch, and instead they speak to different problems in different domains. However, in the day to day world, the interaction between medicine and religion is far more complex than a simple siloing of each to their own respective realms. Compared to areas of study like chemistry, where the emphasis is placed on impersonal characteristics such as physical properties, synthesis, and state change, medicine is the realm where science and suffering meet.

Suffering is a universal part of the human experience. It is not uncommon for patients to interpret their medical experiences and suffering through their religious or spiritual worldview. One Christian theologian wrote about his experience with an aortic valve replacement for severe aortic stenosis. Dr. Gene Green, in his book *The Scalpel and the Cross: A Theology of Surgery*,

writes that surgery is a journey that is about "deep life with God in the middle of deep pain" (Green 2015). For Green, surgery is an action of man influencing an inevitable destiny to bring about restoration in a broken world of mortality and imperfection. Surgery is a fight against the persistent decay of our bodies. Far from being futile, surgery is an act—a symbol, even—of God's saving hand in the world, ultimately pointing us to a day when all suffering shall end. For Green, his aortic valve replacement was more than just a second chance at renewed energy to live life and continue competitive cycling, but a sign of ultimate healing and eradication of imperfection which is yet to come in the Christian understanding of redemption and eternal life. Green's story is one that encapsulates the struggle between medicine and death as viewed through his religious worldview. Many people similarly interpret their medical experiences through religious and spiritual lenses, but few do it so vividly and poignantly.

Reflections like Green's and many others like it exhibit the human process of meaning making in illness. Meaning making may take different forms depending on the particular religious or spiritual background of the individual, but it emphasizes an underlying spiritual need—purpose in suffering. The core of spirituality is the framework for the purpose and end of human existence, and for this reason it heavily influences the way patients think and act in the world (Best et al. 2016). Spiritual needs of patients may be diverse and vary based on culture, location, background, and more. As generalizing spiritual needs is complicated, especially in the context of an increasingly diverse patient population in the United States, much prior work has described generic concepts like spirituality and "spiritual well-being" (Astrow et al. 2018). Spiritual needs are not always readily distinguished from emotional and psychological needs, but general themes described by Astrow et al. include finding meaning in one's illness, help finding

hope, help in engaging in prayer and meditation, and help with relationship with God, a higher being, or something beyond oneself (Astrow et al. 2018).

While common themes like suffering may be present across religions, the complexity of religion becomes apparent when interacting with individual patients (Gunderson 2005). Different religions may share common beliefs or themes, common vocabularies with different meanings, or have different beliefs entirely. Even within one particular religious category or sub-category, there is significant particularity that may result in vastly different beliefs that make it challenging for a physician to draw meaningful conclusions from a person's religious affiliation. This inter- and intra- faith variability may make classes or training on specifics of religious belief only marginally useful. Instead, training to adeptly and compassionately approach religious topics with humility and genuineness along with simple tools to gauge a patient's religiousness and the effects that may have on their health needs may be of the most benefit. Indeed, knowledge of patient beliefs should be pursued, especially as inquiry has been shown to be important to patients.

One study by Ehman et al. investigated the importance of asking patients if their religious beliefs would influence their medical decision making if they became gravely ill (Ehman et al. 1999). Of the 177 patients surveyed, they found that while only 51% of patients described themselves as religious, 90% endorsed a belief that prayer may sometimes influence recovery from an illness (Ehman et al. 1999). Overall, 94% of the patients surveyed agreed that physicians should inquire about religious beliefs and how they might influence decision-making if they were gravely ill (Ehman et al. 1999). Interestingly, they also found that 45% of the non-religious respondents agreed that physicians should ask about religious beliefs that may influence medical decision making (Ehman et al. 1999). Despite these high rates of desire for religious inquiry,

only 15% of respondents could recall being asked about religious beliefs that may influence medical decision making in the past.

Further, understanding a patient's values is a critical task of the physician when providing care. Medicine is fraught with value judgments. The question must always be raised, "Whose value judgments are being expressed, implied, and conformed to?" Understanding what values are operative in any particular situation is essential to delineating the appropriate path forward. One unfortunate example of values driving medical care is how many changes in medicine are driven by financial concerns. For example, with the advent of mandatory electronic health records (EHRs) in the United States, standards for documentation and subsequent reimbursement have changed the face of the patient-doctor interaction in the clinic (Campbell et al. 2006). Less time is spent face-to-face with patients and more time is spent face-to-computer in documentation (Campbell et al. 2006). However, by setting a priority on seeking to understand patients, we increase their ability to become primary drivers of their care. This in turn takes back some of the freedom that is so often usurped by a world driven by health executives, insurance companies, and certain government regulation. Understanding a patient's value system is a way to liberate patients from cold algorithms and impersonal EHR information bloat.

However, not everyone wants to discuss religion and spirituality in the physician's office. One systematic literature review noted that some studies revealed that certain patients object to discussions of religion and spirituality with physicians, and these groups tended to consist of those that prefer people other than physicians to have those discussions with them and those that were not gravely ill (Best et al. 2015). Overall, patients still desired inquiry into their spiritual and religious beliefs to promote strong doctor-patient relationships and holistic care (Best et al. 2015). This literature review suggests that engaging patient spirituality can be a significantly

important aspect of patient care, particularly as certain patient characteristics come into play. Specifically, as patient religiosity and severity of illness increases, it becomes more important to initiate religion and spirituality discussions (Best et al. 2015).

Positive Health Effects of Religion and Spirituality

There is extensive literature examining the effects of religion and spirituality on various health domains. While literature exists on the effects of religion and spirituality on both physical and mental health, approximately 80% of the existing literature is concerned with effects on mental health (Koenig 2012). The value of research in this area should not venture into prescriptive territory, but rather focus on descriptive characteristics of populations that engage in religious and spiritual practices apart from their purported health benefits. While addressing both physical and mental health effects of religion and spirituality, some have leveled the criticism that the health effects observed are a result of behavioral differences and not differences of belief. However, this criticism misses the mark, because regardless of the ways in which religion's health effects are mediated, the underlying behavioral differences would be attributed to the patient's underlying belief system. As a brief example, one literature review noted that a significant number of studies have linked religion and spirituality with decreased risk of coronary artery disease and other studies also showed decreased incidence of cigarette smoking in religious patients (Koenig 2012). One might argue that the decreased risk of coronary artery disease may be linked more directly with the decreased rates of smoking in an attempt to discount the role of religion in this association; however, the Christian religious belief that one's body is a temple of the Holy Spirit and therefore one should refrain from activities that shorten lifespan could be driving this observed behavioral difference and the subsequent decrease in coronary artery disease. In this case, the religious belief is related to a behavioral difference that

results in a real effect on health. Ultimately, it does not matter if these studies are able to delineate the effects of religion and spirituality as mediated at a physiological level or a behavioral level, but rather these studies attempt to demonstrate valuable associations that may promote physician encouragement of protective religious and spiritual practices.

Religion has been demonstrated to be associated with less medical burden and greater ability to cope with illness (Koenig 1998; Koenig 2012). The connection between religion and spirituality and mental health has been proposed as a result of positive emotions and ability to cope with adversity through religious practices (Koenig 2012). The research is diverse and varied with respect to religion's positive effects on mental health. Studies have been performed examining these effects in patients with kidney disease, diabetes, cancer, HIV, and more. One study of 450 patients with HIV/AIDS noted that most patients belonged to organized religion in some form or another and were utilizing their religious beliefs to cope with their chronic illness (Cotton et al. 2006). Thirty-two percent of the patients engaged in daily prayer or meditation, and 75% of patients stated that their illness had strengthened their faith (Cotton et al. 2006). Many of the studies in other populations focus on the ability to cope with chronic illness and not necessarily effects on the chronic disease process itself. Religion and spirituality can also have positive effects in persons that are critical in providing care to their ill friends and family members. In one study of 1229 caregivers of persons with dementia, increasing religious attendance, increasing importance of one's religion, and increasing prayer or mediation were associated with decreased depressive symptoms in the caregivers (Hebert et al. 2007). While these are a few selected examples, positive emotional effects that have been demonstrated include increased well-being, hope, optimism, sense of purpose, and other positive characteristics (Koenig 2012).

Positive mental effects of religion are not isolated just to those that are ill. In one robust study of 48,984 US nurses in the Nurses' Health Study, women who had the most frequent religious service attendance were less likely to become depressed, and of the women who self-reported feeling depressed (odds ratio [OR] = 0.71, 95 % confidence interval [CI] 0.62–0.82), they were less likely to attend religious services once or more per week (OR = 0.74, 95 % CI 0.68–0.80) (Li et al. 2016). This is an example of the protective role of religion in the lives of women, however this study consisted of predominantly Christian, white women. It is important to note that this does not mean that physicians should be prescribing religious service attendance as they might prescribe a pill; however, in patients that already consider themselves to be religious, it may be advantageous to encourage attendance. This may be of increased importance in religious patients that are depressed, as it provides an opportunity for interpersonal connection and reconnect with a religious community—particularly as depressed persons tend to isolate themselves. There is great power in community, and in particular religious community. One might argue that the positive effects of religion on health in many of these studies are observed because of the act of rigid religious service attendance and community. These meetings often allow time for participants to engage in self-reflection, perform selfless acts, and receive support from others.

The positive effects of religion and spirituality are also not isolated to mental well-being, but also include some interesting effects on health behaviors. Common studies have looked at the effects of religion and spirituality on substance use, exercise habits, diet, and sexual behavior. To give brief examples of the many studies that exist, one study of high school seniors across seven different time periods demonstrated a consistent negative association between religious commitment and cigarette, alcohol, and marijuana use (Brown et al. 2001). As far as dietary

concerns, another study demonstrated that African American women in an urban environment held beliefs that fruit and vegetable consumption was more important and actively consumed more fruits and vegetables than their less religious counterparts (Holt et al. 2005). This may have been due to beliefs surrounding the importance of caring for one's body, healthy eating initiatives through religious programming, or other undefined mechanisms. When looking at exercise, one study demonstrated an association of increased strenuous exercise with weekly religious service attendance (Hill et al. 2006). Lastly, Nonnemaker et al. utilized data from the National Longitudinal Study of Adolescent Health to demonstrate that among teens, higher levels of religiosity were associated with a lower probability of having sexual intercourse and having never been pregnant (Nonnemaker et al. 2003).

While much less frequent than studies on mental health and health behaviors, studies examining the effects of religion and spirituality on physical health have demonstrated positive effects on common health problems such as coronary artery disease, hypertension, and overall mortality (Koenig 2012). One study by Schnall et al. utilized the Women's Health Initiative Observational Study data and found that after controlling for important variables like patient demographics, socioeconomic status, and preexisting health conditions, women with higher levels of self-reported religious service attendance and affiliation had decreased risk of all -cause mortality (Schnall et al. 2010). Many other health associations have been described, but in summary, the most important takeaway from this discussion is that religion and spirituality may be a significant source of emotional and psychological strength in the midst of suffering. Positive health effects may be associated with religious beliefs and activity through a variety of differing mechanisms, but much data exists to describe these important positive relationships.

Negative Health Effects of Religion and Spirituality

The effects of religion and spirituality on health are not always positive, however. Sometimes, religious beliefs can obstruct quality medical care. In rural Appalachia, religious beliefs sometimes lead patients to seek medical care less aggressively than their urban counterparts, and a diagnosis of cancer may be viewed as a mandate from God (Behringer and Krishnan 2011). Some clinicians have described how religious Appalachian patients are more accepting of their diagnoses, often stemming from a trust of God. This may make them less likely to pursue intense medical treatment and less engaged in understanding the biology of their diagnosis (Behringer and Krishnan 2011). An astute clinician must recognize when spiritual and religious beliefs are in play that are affecting the quality of care. While it is possible that engaging patient belief may not change the beliefs themselves, having a more thorough understanding of patient beliefs may help a clinician explain disease processes and treatments in a way that is perceived as compatible with the framework with which a patient interprets the world.

When disease affects a patient that is a spiritual or religious person, it may raise existential questions that are not readily addressed by modern medicine (Mueller et al. 2001). One longitudinal cohort study demonstrated that religious struggles are associated with increased mortality risk. Using the Religious Struggles Scale, patients in this study with religious and spiritual struggles demonstrated a 6% increase in mortality independent of physical health, social support, and psychologic struggles for every point increase on a religious struggles scale (Pargament et al. 2001). The particularly harmful beliefs explored by this study included themes of abandonment by God, questioning God's love for the individual, punishment by God for a lack of devotion, and demonic influence on the health of the individual (Pargament et al. 2001). While religious beliefs are often a source of comfort and strength for patients, it becomes clear

from this study and others similar to it that when patients encounter uncertainty and feelings of abandonment by the divine, they can experience harmful health outcomes.

The preceding exploration of the positive and negative health effects of the religious and spiritual beliefs and practices of patients is mainly to raise awareness of this fascinating, growing body of literature. Religion and spirituality is an expanding topic that will only increase in importance as the population in the United States becomes more diverse. In order to prepare for these coming changes, the inadequate education in the U.S. medical training curricula must begin to prioritize religion and spirituality as a topic to be explored alongside other social determinants of health.

CHAPTER 3: CURRENT TRAINING AND PRACTICE

Training

Little data exists on the implementation of teaching on spirituality and health in medical school curricula. One such study surveyed the deans of 122 U.S. medical schools accredited by the Liaison committee for Medical Education (LCME). This study found 90% of reporting schools had available courses or content on spirituality and health, while only 7% of schools reported a required course dedicated to this topic (Koenig et al. 2010). Additionally, the quality of such courses may be suspect, as by the broadest definition, "spirituality" classes may include little objective content and may be focused on mediation techniques rather than addressing patient beliefs. Most medical school administrator respondents also stated that it was unimportant to develop methods to evaluate student understanding and competency on these topics through exams or standardized testing (Koenig et al. 2010). Overall the majority of medical school deans surveyed in this study denied a desire to increase the amount of course content surrounding patient spirituality in the United States (Koenig et al. 2010).

Addressing religion and spirituality may have beneficial effects for patient care and also for the medical profession as a whole Balboni et al. propose religion and spirituality as a way to return to the traditional ideals of medicine and professionalism—those of altruism, humanitarianism, and empathy (Balboni et al. 2015). Balboni et al. note that there is a "hidden curriculum" in medical school that may instill selfishness, apathy, and cynicism toward the medical profession that is often most ingrained during the third year of medical school (Balboni et al. 2015). Encouraging future physicians to engage their own religious communities and spiritual practices may have a humanizing effect that will fight the cynicism that is both increasingly common and harmful to patient care. Additionally, they also found that

religious/spiritual respondents gravitated toward the coping mechanisms of prayer, faith, and compassion when faced with difficult situations such as patient death (Balboni et al. 2015). In this way, addressing religious and spiritual topics in the medical school curriculum may serve to improve patient care and medical trainee satisfaction and strength.

When looking at post-medical school education, the amount of training in religion and spiritual care is also quite low. Among surveyed members of the Multinational Association of Supportive Care in Cancer, Best et al. found that 34% of members seldomly provided spiritual care and 26% of members felt incapable of adequately addressing spiritual care. Only 33% of the members reported ever receiving spiritual care training (Best et al. 2016). In a group of highly trained healthcare professionals that frequently address issues such as end of life and weighty treatment decisions, these numbers are troubling. Only a minority of providers have formal training in addressing spiritual care, and non-trained clinicians are less confident to address these issues (Best et al. 2016). Similarly, this study demonstrated a positive association between having received specific training for spiritual care and providers taking responsibility for pursuing spiritual care with patients (Best et al. 2016). Respondents identified several areas they thought were most important to be equipped to offer spiritual care, with the first being basic knowledge to identify when an issue is spiritual in nature and training to understand other world views. Barriers may include things such as provider beliefs conflicting with those of the patient population, which may cause distress in the provider that feels internal conflict about being perceived as promoting beliefs different from ones they hold. In addition, providers that considered themselves to be spiritual people were more likely to have had training to engage patients in spiritual care and were more likely to consider themselves able to perform spiritual care. These findings demonstrate that while religious and spiritual training is currently not a

major focus of medical education, increasing the importance and education of religious and spiritual issues would better equip physicians to navigate spiritual topics, which are often of great value to patients' health and well-being.

Practice

The lack of adequate training in religious and spiritual topics also effects the implementation of religious and spiritual interventions in patient care. In one study by Astrow et al. in New York City, one multi-ethnic and multi-religion study demonstrated some fascinating findings. Across several outpatient hematology/oncology sites from 2013-2014, patients were surveyed using a spiritual needs assessment to evaluate spiritual needs and provider discussions surrounding spirituality. While religious affiliation was reported by 92% of patients, only 25% of those that filled out the survey reported attending religious services once weekly or more (Astrow et al. 2018). In addition, 59% of patients reported being "spiritual but not religious." In the study population half of the patients reported they would feel comfortable with their physician inquiring about their religious belief (Astrow et al. 2018). While half of patients want help with their "relationship with God or something beyond themselves," only 28% of patients desired discussion about "death and dying (Astrow et al. 2018)." This is significant because even in an area as urban as New York City, these numbers are relatively high, though lower than reported in rural and southeastern states. While 52% of patients desired physician inquiry about their religious beliefs, only 3.3% of patients reported that their physician had asked about their religious and spiritual beliefs, and only 2.5% had been asked about their religious and spiritual needs. Deeply seated spiritual needs expressed by patients that were going unaddressed spanned several themes connecting religious and medical experience. These needs included finding meaning in a patient's experience of their illness, finding hope, and help with prayer or

meditation (Astrow et al. 2018). The study above serves several purposes. It demonstrates in a diverse environment that many patients have underlying spiritual needs related to their health. This is to be expected in many patient populations, but it is particularly expected in patients carrying oncologic diagnoses. Secondly, it demonstrates a distressing discovery through the reported figures which showed the abysmal rate at which patients' spiritual needs were inquired about by physicians in this particular group of oncologic practices. While it may be difficult to generalize these findings to other regions of the United States, other studies have demonstrated similar to increased levels of religiosity of the patient population and similar abysmal rates of physician inquiry (Behringer and Krishnan 2011).

Low rates of physician inquiry into spiritual topics has even been observed in a traditionally protestant health system. In a study by Koenig et al. across the Adventist Health System, physicians were less likely to be Christians than mid-level providers and nursing staff at 77.9% compared to 91.1% and 94.2% respectively (Koenig et al. 2017). It is important to note that religious affiliation is not required to work for Adventist, which is the largest Protestant health system in the United States. Physicians were less likely to state that a spiritual history should be taken "quite a bit" or "very much" when compared to mid-level providers and nursing staff 45.2% versus 52.7% and 55.4% respectively (Koenig et al. 2017). Despite the fact, 85-94% of all providers were willing to take a spiritual history in the future, only 10-17% of providers reported often or always doing so presently (Koenig et al. 2017). The study also revealed that family practitioners, those that were religious, and Christian providers were more likely to support taking a spiritual history. What this study highlights is that even within a Protestant Christian health system, a quite small percentage of providers were actively taking spiritual histories in their patient encounters.

Unfortunately, the lack of physician engagement with spiritual and religious issues is a national trend. A cross-sectional national survey study by Curlin et al. demonstrated that only 10% of physicians often inquire about religion and spirituality related issues (Curlin et al. 2006). Lastly, when religious and spiritual topics become most important to patients, such as at the end of life or with a grave diagnosis, physicians address these beliefs at poor rates. In one multi-site study, 94% of oncology patients with advanced cancer had never been given any form of spiritual care from their physicians (Balboni et al. 2012). One review discovered the trend that spiritual histories are more often to be taken at the end-of-life, inpatient, and psychiatric contexts (Koenig et al. 2017). However, even in these contexts, rates of physician engagement with these topics are still poor (Koenig et al. 2017).

CHAPTER 4: ETHICAL RESPONSIBILITY TO ADDRESS PATIENT RELIGION

Principalism

Physician training and practice presently do not value engagement with spiritual and religious topics, despite the exhibited positive and negative effects on health religion and spirituality can exert. In light of these findings, a moral argument must be made that physician practice ought to change. The argument to change physician training and practice is both based on principle and on pragmatic outcomes of such changes. While many principles may make a compelling argument for the inclusion of religion and spirituality in holistic patient care, a cornerstone of modern medical ethics are the four principles described by Beauchamp and Childress in their seminal work on medical ethics. The four principles guiding many modern medical ethical discussions are autonomy, beneficence, non-maleficence, and justice (Beauchamp and Childress 2012). These four principles have become critical in ethical discussions because they both resonate with cultural and moral norms while providing a common framework for people of different belief systems and religions to operate within. While moral conclusions based on these principles may be different for different people, they provide us with a common language based on common agreements and values even when disagreements abound. Interestingly, utilizing the four principles may produce conflicts between the principles themselves and also of interpretation of how each principle applies to a given scenario. In the United States, patient autonomy often seems to take precedence over the other principles when they are in conflict (Varelius 2006). Using the four main principles described by Beauchamp and Childress, it is clear that physicians have a moral responsibility to address patient religion and spirituality. One principle that Beauchamp and Childress do not discuss is that of solidarity, or the act of joining together and unifying persons. The principle of solidarity is not one of

similarity; on the contrary, solidarity is a principle that recognizes deep difference—like that between physicians and their patients—while promoting joining together of persons for a common goal. This principle is increasingly important in modern medical discussions and will also further the argument to address patient spirituality in medicine.

Argument from Patient Autonomy

Patient autonomy is often conceptualized as a right to self-govern. In medicine, self-governance can be a complicated topic, as patients often lack knowledge of the medical interventions available to treat their medical conditions. Therefore, they rely on physicians to understand their principles and desires in their most vulnerable states. While in the past, physicians were more likely to act paternalistically, current practices in medicine require that physicians enter into joint decision-making with the optimal health of the patient as the primary goal. By seeking to understand patient values through their religious and spiritual lenses, physicians enable them to make the most autonomous decisions—essentially allowing them to make decisions that are most in-line with their values. By seeking to understand a patient's value system, physicians are enabling them to make decisions that are more fully informed and therefore more fully free.

One particularly contentious aspect of patient autonomy to discuss is that of a patient's right to refuse medical intervention on religious grounds. Religious objections to medical therapy are not bound by the same scientific evaluation as claims made by empirical treatments. However, in the case of religion, respecting a patient's autonomy does not mean that physicians take a hands-off approach to refusal of medical care, but rather a physician ought to make an active effort to understand the underlying religious grounds for objection and determine if the patient has a full understanding of the implications of their beliefs about particular medical

interventions (Martin 2007). Respecting patient autonomy is not the same as shifting difficult decisions from the physician to the patient in order to skirt responsibility, but instead, physicians should not be afraid to provide recommendations based on their expertise and challenge patient decisions—particularly ones that seem to go against prevailing gold-standard treatment. These challenges should not be manipulative or coercive, but rather should be reasoned responses in an attempt to safeguard against decisions based on incomplete knowledge and rash decisions that are inconsistent with a patient's belief system when considered more fully.

Argument from Beneficence

Beneficence is an interesting principle, because it is often seemingly at odds with self-interest. The recognition of autonomy implies that people act in their own self-interest to drive their own reality forward in an act of self-determination. Beneficence often requires of us self-sacrificing actions for the betterment of others. In doctors, we see beneficence as the requirement to do good. Good, as Beauchamp and Childress see it, is kindness, charity, and altruism (Beauchamp and Childress 2012). It is important to act with the best interest of the patient in mind. From the studies mentioned previously, patients overwhelmingly want to be asked about their religious beliefs and how they might affect their medical care. As also demonstrated earlier, physicians are less religious and more diverse in their religious beliefs than the general population. These differences of belief may lead to a hesitancy to broach topics of religion out of a desire to avoid conversations concerning topics the physician knows little about or a desire to avoid feeling like they are implicitly condoning patient beliefs and behaviors the physician disagrees with. However, in order to do good to patients, physicians are often required to broach topics that may make them uncomfortable. Discomfort alone is not sufficient to avoid topics like religion and spirituality that may carry deep significance for patients and also have implications

for health. This is not to say that physicians should enter the realm of providing religious advice, as this is outside the realm of the modern physician's duty and training. Additionally, this is not suggesting that physicians must ignore their own beliefs. Physicians that are atheist or agnostic can still encourage the prosocial behaviors of religious activity and protective coping mechanisms of mindfulness and meditation without breaching their own conscience by honestly seeking the good of their patients without addressing the veracity of religious claims. If a physician begins to feel like they are approaching the line of breaching their own conscience on issues of faith, it is certainly appropriate to refer a patient to a religion specific chaplain or faith leader to aid in the conversation.

Argument from Non-maleficence

The principle of non-maleficence is encapsulated by the Hippocratic Oath, which states "above all, do no harm." Beauchamp and Childress help elucidate the underlying principle as avoiding doing anything that is unnecessarily or unjustifiably harmful (Beauchamp and Childress 2012). It is clear from simple observation that many things in medicine are, in the strictest sense, harmful. Surgeons cut into the bodies of their patients and inflict pain in hopes to relieve some underlying pathology. Medications are prescribed with extensive lists of side-effects in hopes to stave-off more imminent and severe problems. A physician and patient must together navigate if a particular intervention poses to do proportionate good for the potential corporeal, psychological, and financial harms it may inflict. This decision making is not simple, as often the data from scientific studies on the benefits and harms of a specific intervention are based on populations and not individuals. The result often is a difficult to predict outcome that can lead to frustrated physicians and patients alike. However, patient religious and spiritual beliefs may have

some very practical implications for the principle of non-maleficence and why patient beliefs should be addressed.

In order to avoid doing harm to patients and respect particular religious and spiritual beliefs, it is important to investigate beliefs that may impact medical care. One common example of this would be the Jehovah's Witness objection to receiving of blood products. As this objection is more commonly known in the medical community, it is often asked about specifically. Additionally, Muslim women have a set of religious and cultural needs, including that of modesty in the physician's office (Islam and Patel 2018; Blythe and Curlin 2019). This might require a female examiner for a physical exam, and if preferences of modesty are not explored, spiritual harm could be done to the patient in question if they are too timid to object to the bodily exposure required for some physical exam maneuvers. One other area of discussion that would not necessarily be clear for physicians to discuss with patients unless the physician knew the religious background of their patients is that of animal products in medicine. Porcine and bovine products abound in medicine, from heart valves and other implants to the capsules that contain common medications (Eriksson et al. 2013). As patients of particular faiths may object to consumption or implantation of porcine and bovine products due to religious beliefs, knowing the particular religious association can help prevent physicians from inadvertently breaching the conscience of their patients. While some religions allow for the use of porcine and bovine implants if all other options are exhausted and the intervention is medically necessary to promote health, not all religions have this exception (Eriksson et al. 2013). These examples are merely a few of the applications of addressing patient religion and spirituality in the physician's office, but in keeping with the moral obligation to avoid harm, physicians have a moral responsibility to be aware of the religious implications of common medical interventions.

Argument from Justice

Justice is a necessary principle to consider in any medical ethics discussion. Justice in healthcare can be simply defined as fair distribution of limited resources. We live in a world of scarcity. No matter how hard we try as human kind, there is not enough time, money, or raw materials to produce everything for everyone. Scarcity is a commonly encountered entity in medicine—from limited organs for transplantation, to the number of dialysis machines in a given geographical area, to the amount of time a physician has to meet with a patient in clinic. It is a primary task in medicine to ensure that patients are treated equitably and fairly. Equitably does not necessarily imply equally. For example, it would not be just for a physician to spend five minutes with every patient to discuss smoking cessation if only 20% of the patients in his or her practice smoke. While this would be treating all patients identically, this would not be treating them equitably. This intervention ought to be targeted to the patients that need it the most. Office time is finite, and perhaps the other 80% of the patients would benefit from a nutrition intervention instead. For the sake of argument, here we shall define treating patients with justice as "aiding persons to achieve their optimum health status given the severity of their underlying medical conditions using the resources at hand to the best of the physician's ability."

A failure to address the spiritual needs of patients may disproportionally affect racial and ethnic minorities and further contribute to health disparities—specifically observed in studies surrounding oncologic care, as spirituality plays a large role in minority communities (Smith et al. 2008; Astrow et al. 2018). Using language as a model, while physicians can utilize an interpreter to provide care for patients that speak a primarily different language, certain valuable information is often lost in translation. Similarly, having a physician/patient relationship where fundamental beliefs are shared allows for useful information and nuance to be picked up in

conversation (Blythe and Curlin 2019). It is not necessary for a physician and patient to necessarily share religious beliefs, but simply to be versed in some of the basics such that important details are not "lost in translation." If physicians are not adept at picking up on harmful religious beliefs and addressing them from a position of good-will and humility, poorer and more religious communities may be less likely to undergo the gold-standard of treatment for certain pathologies. Additionally, many resources that promote physical and emotional health may be available within the community for patients of different faiths. In low resource settings, these health resources can be a significant component of the promotion of human flourishing. By seeking to understand patient needs and matters of conscience, a physician seeks to do justice to patients and their faith communities.

One last consideration of justice is the importance to not discriminate based on patient religion and spiritual practice. In the same vein, it is important to not think more or less of a patient that is areligious. Remembering that patients of a particular faith may have significantly variable beliefs about medical intervention and also significant differences in religious behavior requires physicians to treat each patient as an individual. The principle of justice requires careful attention to the particularities of the patient in front of the physician and to avoid making assumptions about religious belief and practice until those assumptions are confirmed with the particular patient.

Argument from Solidarity: A Lesson from Liberation Theology and the Oppressed

Liberation theology is a movement that originated within the Catholic Church in Latin America during the 1950s largely founded by the Peruvian priest Gustavo Gutiérrez. The central belief of proponents of liberation theology is that orthodoxy (right belief) is worthless unless it leads to orthopraxis (right action). Liberation theology grew out of the roots of poverty and

oppression and emphasized the contextualization of religion to social action. This movement highlights that both implicit and explicit beliefs precede practice. Action follows belief. However, religiosity and spirituality can be an asset for resilience or a vice of crippling despair. Patients may have vast physical and emotional resources at their disposal to combat suffering alongside their religious communities, or they may be struggling against the frailty of their bodies while simultaneously in a crisis of belief—rejecting the foundational principles that previously guided them through life.

Increasingly in the medical community, there is discussion of the importance of solidarity with the community in which a physician practices medicine. This terminology is analogous to compassion, defined as suffering alongside the patients and community being served. The calling of a physician is to bring the intense breadth of their ivory-tower education and deliver it to the streets of their community, and even taking the experience gained from engaging their community back to the teachings in the ivory-tower. Doing this requires knowledge of the religious beliefs and spiritual practices of their community, and even an awareness of the religious resources at the disposal of a patient. This need not be an individual endeavor of each physician, but rather health systems can play a role in tailoring lists of possible resources based on particular faiths in the surrounding communities. One other way to make this practical is to consider integration of these resources into the electronic health record system to provide patients with resources tailored to their religious beliefs. While these steps may not be feasible for all, the principle of solidarity ought to drive physician interaction with their communities.

CHAPTER 5: PRAGMATIC RESPONSIBILITY TO ADDRESS PATIENT RELIGION

While it is not the role of the physician in modern day America to assume the role of pastor, priest, rabbi, or imam, it is constructive to conversations of health to include lines of inquiry related to personal faith. Encouraging engagement with a community that can serve as a support network for ill patients can help promote health and personal resilience in difficult times. While moral obligations from principles of autonomy, beneficence, non-maleficence, justice, and solidarity have been argued, several brief and practical reasons to address patient religion must be mentioned.

Encourage Healthy Practices

Firstly, one pragmatic reason to address patient religion is to encourage healthy practices. This applies to both individuals and communities. For example, a Christian patient may be encouraged to improve their dietary practices by encouraging them to care for their body, as the Bible has many verses that value avoiding overeating and keeping healthy (Proverbs 23:2; Philippians 3:19; 1 Corinthians 10:31). Additionally, inviting patients to bring their own religious leaders and community into discussions of their health may help build trust and facilitate productive conversations that result in the edification of hurting and misunderstood patients (Frush et al. 2018). Religious communities could also become the center for a public health intervention such as dietary education and healthy food distribution. This could be an important component of public health efforts against the obesity epidemic in the United States, as particular religious communities may have similar dietary restrictions, allowing for a targeted and tailored intervention.

Uncover Possible Religious Objections to Medical Care

Uncovering possible religious objections to medical care is a matter of the principled approach, but also the pragmatic argument for addressing patient religion. By seeking to understand patients' point of view, difficult disagreements in how to approach medical treatment of disease may be less frustrating for physicians. In line with this, one study reported that when beliefs are widely accepted amongst a particular sect of religious members and the intent and reasoning is clearly explained, these beliefs are less frustrating for physicians. For example, physicians reported refusal of blood products by Jehovah's Witnesses as the least frustrating for physicians because the religious reasoning is clear and as long as the patient understands what will happen medically as a result of the refusal, providers are less troubled by it (Curlin, Roach, et al. 2005). In the case of more ferocious ethical controversy, such as in prenatal and end-of-life decision making, physicians often feel more frustrated. In these situations, it is the patient's religious community or nuanced interpretation that results in fundamental disagreements between providers and patients. Lastly, there are times when physicians encounter patients that delay or refuse treatments based on faith alone, not on any actual objection to the procedure or test. These refusals often seem to be the most frustrating, as there is no clear line of reasoning to debate, and it seems naïve to count on a divine intervention when resources are readily available to alleviate a particular condition or suffering. Having a basic understanding of religious belief, reasoning, and nuance could prove to be helpful in both explanations of treatments and countering objections.

Similarly, it may be important to understand patient beliefs in order to convince patients of certain medical therapies using their own religious worldview. This task must be undertaken with great care as to not unjustly influence patients to do the bidding of the physician in a paternalistic manner. Physicians are often unaware of the ways their own religious or areligious

views influence their practice, as one study also revealed that some physicians are not aware when their own worldview is affecting the care they are providing (Curlin, Roach, et al. 2005). Attempting to plant ideas in a patient's head or subvert their religious beliefs may be perceived as disrespectful by the patient. Many of the physicians in this study claimed they leave their own religious values out of conversations yet attempted to persuade a patient that their beliefs were wrong or misguided. This may be damaging to the patient's autonomy. However, uncovering inconsistencies in a patient's beliefs or misunderstandings of medical therapy may help the patient to realize no true conflict of belief exists. As mentioned previously, physicians have a duty to respect their patients' religious convictions; however, this does not mean that religious beliefs are off limits when objections to medical therapy are raised. Physicians have a responsibility to respectfully challenge refusals of medical care and not assume that religious reasoning is off limits to a physician (Frush et al. 2018). Frush et al. argue that the heart of the issue of addressing religious concerns in the office is whether accommodating a religious belief or conviction compromises the physician's commitment to the patient's health (Frush et al. 2018). The authors also argue that in the context of active inquiry and charity to patient beliefs, it is important for physicians to challenge patient refusals of medical care that are in the best health interest of the patient (Frush et al. 2018). Keeping the best health interest of the patient at the forefront of any disagreement should be the guiding value when addressing patient objections to medical care.

Build Rapport

One particularly pragmatic aspect of inquiring about patient beliefs is that of building rapport. Patients often desire physician inquiry into their religious beliefs, and in some cases like in end of life discussions, they expect questions about guiding beliefs (Behringer and Krishnan

2011). Inquiring about deeply held beliefs allow for an opportunity for the physician to be humanized in the view of the patient, allowing for discussions of similarity and difference in belief in a cordial fashion. Some providers may object and state that it can be a difficult community to serve as an areligous provider or a provider with a religious background different from the majority religion of the patient population. In predominantly religious populations, being able to communicate an understanding of cultural and religious beliefs may be important to the credibility of discussions surrounding disease. Building credibility and rapport with patients helps patients to view their physician as being on their side in dire issues of health.

One major focus of modern medical care is the consumer focused metric of care satisfaction. One study from Maimonides in New York found that higher levels of spiritual need are associated with lower levels of satisfaction and diminished perception of quality of care in a diverse patient population undergoing cancer care. The conclusion of the study was that training clinicians to address patients' spiritual concerns may improve the overall care experience (Astrow et al. 2018). This approach is both patient centered and quality focused. By addressing spiritual needs and religious beliefs, physicians may be able to increase patient satisfaction with the medical care they provide.

Engage the Patient in Resources Available through Local Religious Organizations and Support Systems

Lastly, engaging religious leaders in the area is also an important way to ensure appropriate understanding of specific diagnoses, particularly oncologic diagnoses (Behringer and Krishnan 2011). As religious leaders and family members are often some of the first people approached by a patient with a new diagnosis, building rapport with patients and religious leaders in the community can help prevent the spread of false information and misunderstandings

of medical care. In rural Appalachia, cancer diagnoses are often shared with the community and while families and social networks play a strong role in caregiving, churches are a source of spiritual, psychosocial, and economic support (Behringer and Krishnan 2011). This type of focus within the community should encourage physicians to engage family members or clergy within the patient's religion to increase medical understanding and support (Curlin, Roach, et al. 2005). As mentioned in the section on solidarity, being aware of health resources available through local community religious organizations may also allow patients with poor access to medical care, healthy food, mental health counseling, and more can promote human flourishing in under-resourced communities.

CHAPTER 6: ETHICAL BOUNDARIES

It is important to consider several ethical boundaries when addressing religious and spiritual beliefs. As spiritual and religious training in medical school is minimal, physicians should be careful to not step outside their area of expertise, deferring conversations outside the purview of medical applications to religious professionals. Similarly, it is important for a physician to not claim authority in the realm of spiritual or religious beliefs in the way that they claim authority in a medical context. When addressing spiritual topics, it is wise to admit to patients that physician training at this time is minimal, and that the physician is simply seeking to understand what the patient values and how that may influence their medical decision making. In this way, it allows the patient to become the teacher—not to proselytize their provider, but to help the provider seek understanding. It is also important to emphasize that religious and spiritual information obtained will not be used in a discriminatory fashion.

Physicians must also be careful to avoid using a patient's belief system to manipulate the patient into making medical decisions according to the desires of the physician. With an expansion of social determinants of health to include religious and spiritual topics, certain literature about the role of the chaplain in the medical team may also apply to physicians. For example, one article notes that chaplains should not be a coercive arm of the healthcare team that seek to bend the will of the patient to the medical team's plan, but instead should seek to promote patients' spiritual good (Frush et al. 2018). Paternalistic manipulation of patient decisions should never be the goal of religious discussions, as this could degrade trust and rapport with patients and their religious communities instead of increasing trust. Enabling patients to make decisions most in line with their deeply held convictions and thereby promoting

patient autonomy should still remain balanced with the desire to promote the healthiest state of the patient and the moral principle of beneficence.

Another difficulty and boundary that physicians may encounter is a patient that desires a physician that holds similar religious beliefs. One study of 500 patients from the New York University Hospital for Joint Diseases showed that overwhelmingly the majority of patients have no preference in regard to age, gender, race, or religion. However, patients that did have a preference tended to desire surgeons of similar qualities to themselves (Abghari et al. 2014: 204). Eighty-four percent of patients had no preference for their surgeon's religion, and the remaining patients' preference had a strong correlation between patient and physician religion (Abghari et al. 2014: 204). There is a move in medicine to ensure that all population characteristics are represented in physicians entering medical school, as physicians from different backgrounds enrich the experiences of other physicians and patients (Abghari et al. 2014: 204). However, physicians are not bound to bend to onerous requests for similarity. Reasonable requests based on ethical grounds like that of modesty in the Muslim female should be met with sincere attempts to meet that request; however, requests made out of racist or discriminatory beliefs should not be afforded the same patience. Patients may choose to see a different provider in the future, but requests for concordance of beliefs do not respect the humanity of the physician and are discriminatory.

One last consideration is that of patient privacy. While governed by national health privacy laws like HIPAA, religious and spiritual preferences should be treated with a special level of privacy and care. One particular area of consideration is that of the electronic health record. One article notes that listing a patient's religious preference in their electronic health record may be problematic, as this may cause providers to assume that a patient holds particular

beliefs that may differ based on region, congregation, or sect of faith (Orr 2015). As noted previously, diversity is common even within a faith system. If a patient's religious belief system is noted within the electronic health record similarly to how a language preference is presently documented, this might result in assumptions being made about that patient's beliefs that are false. Additionally, documenting patient beliefs in this way may also open them up to discrimination by health insurance providers, the government, and other parties that have access to patient documentation. Before moving forward with a change in the EHR, appropriate laws need to be in place to protect patients from discrimination.

CHAPTER 7: TOOLS IN THE TOOLBOX

This paper has comprehensively, though not exhaustively explored the importance of religion in patients' lives, the effects of religious and spiritual beliefs on health, and the reasons why physicians ought to address these topics. While there is a severe deficiency in training and practice of current physicians, future funding and prioritization of religious and spiritual topics in medical school may help remedy this situation. One last consideration must be made in the argument to pursue understanding in this way—the lack of time in the patient clinical encounter. Due to the lack of time afforded by insurance companies in medical generalist visits, an intervention must be brief, practical, and easily modified from simple to complex depending on the situation.

Many religious screening tools exist, but few are comprehensive and brief. One study evaluated several screening tools, and found one to be both validated and superior. The tool known as the FICA, which assess faith, importance/influence, community, and address (Puchalski and Romer 2000; Lucchetti et al. 2013). This tool was validated and provides an easy way for both religious and areligious physicians to ask targeted, meaningful questions without consuming an unreasonable amount of time. The four basic questions of this screening tool are as follows (Puchalski and Romer 2000):

F: "What is your **Faith** or belief?"

I: "Is it **Important** in your life?"

C: "Are you part of a spiritual or religious **Community**?"

A: "How would you like me to **Address** these issues in your healthcare?"

Further follow up questions can include questions about things that give meaning to the patient, how their beliefs influence their behavior, how the importance of their beliefs impact their health, and if their community is supportive of them (Puchalski and Romer 2000). The beauty of this intervention is that it can be very brief at the first visit and then be subsequently expanded on in cases of complex medical decision making. It is easily memorable due to its simple pneumonic. It is practical, because it asks the patient to briefly connect their beliefs to their medical decision-making. Finally, it allows for patients that are less religious or more private with their beliefs to ask the physician to not address topics of faith with them in the future through the final question. While future training in topics of specific religious beliefs may be of great benefit, this tool allows physicians that are unfamiliar with religious topics to open-mindedly gather religious and spiritual data simply and straightforwardly.

CHAPTER 8: CONCLUSION

Ultimately, having a basic understanding of the religious views of patients enables physicians to more adequately assess barriers to health, understand key principles at play in medical decision making, and communicate effectively with patients and their families during stressful, life-altering times. Modern medical education allocates very few resources to training medical students to address patient beliefs, resulting in provider avoidance of religious conversations that are fundamental to patient health. Despite this fact, physicians have an ethical obligation and a pragmatic interest to engage with religious and spiritual topics in order to promote human flourishing. There are simple and practical tools available like the FICA that allow for physicians without much training to address difficult topics in a manner that requires little previous religious knowledge.

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