Attention to Spiritual/Religious Concerns in Pediatric Practice: What Clinical Situations? What Educational Preparation?

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Many pediatricians believe that spiritual/religious (SR) concerns of patients/families are important in some clinical situations. This project identifies these situations, the educational preparation of pediatricians to respond helpfully to these concerns and their interest in additional education. Pediatricians associated with three academic Midwestern pediatric hospitals responded to a survey by briefly describing clinical situations in which they regarded the SR concerns of patients/families as an important part of the clinical situation as well as curricular experiences that prepared them to respond. They deemed SR concerns important at the end of life, in medical crises and when medical management is impacted by specific religious beliefs. The most frequently sugested seminar topic was how to talk about these concerns with patients and families.

MEDICAL PRACTITIONERS AND RESEARCHERS CONTINUE to explore the association between spiritual/religious (SR) concerns and illness and medical care. Koenig et al. summarize over 1600 publications that describe this relationship.[1]

In a previous publication, we reported the statistically significant web of associations between the personal/professional characteristics of pediatricians and their attention to SR in clinical practice.[2] In summary, we found that older pediatricians who described themselves as religious and spiritual more frequently talked with patients/families about their SR concerns. These pediatricians reported that their own personal SR was important in their clinical practice and that the SR of patients/families was relevant to the care they provided.

This article presents results relative to the following:

- Clinical situations in which pediatricians perceive that the SR of patients/families plays an important role.
- The education pediatricians receive in medical school and residency that prepares them to respond to these concerns.

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- Pediatricians' interest in continuing medical education that addresses the role of SR in clinical medicine.

Literature review

A few studies in the primary care literature suggest clinical situations in which physicians or patients/families find SR to be important. Monroe et al. report results from 476 internists and family physicians concerning their willingness to inquire about or be involved in spiritual behaviors in three clinical settings.[3] Approximately one-third (31 percent) would ask about SR beliefs in the office setting, 39 percent would inquire of hospital patients and 74 percent would ask dying patients.

Results from another study suggest that physicians address SR in the context of death/dying more frequently than in other clinical situations.[4] A third study produced similar results. Primary care residents (N = 247) indicated that they were more likely to incorporate SR into patient encounters as the gravity of the patient's condition increased.[5]

How does medical education prepare physicians to respond to these SR concerns? Some authors focus on how the medical school curriculum can incorporate attention to SR. The Medical School Objectives Project Report-Three includes learning objectives, educational strategies and outcome goals to ensure that graduating medical students recognize the importance and role of SR in healthcare.[6] Puchalski and Larson argue that medical students must learn how SR interfaces with healthcare because it is at the heart of learning how to deliver compassionate care.[7] In another publication, Puchalski traces the increasing attention to spirituality in medicine, reporting that in 2006, 75 percent of medical schools report that they provide curricular attention to spirituality.[8] At least four other reports describe curricular efforts.[9] Additionally, the John Templeton Foundation continues to reward SR curricular efforts in medical schools.[10]

Other authors explore how attention to SR can be included in residency training. King and Crisp describe survey results from 101 family practice residency programs, reporting that 31 percent have a specific SR curriculum.[11] Wolkenstein describes his efforts, opining that "lectures, seminars and presentations alone to the residency cohorts and faculty are not as strategic as seeing their faculty asking questions about the component of spirituality in their precepting encounters with residents."[12] Silverman describes need assessments for an SR curriculum in a family medicine residency program before writing a curriculum.[13] Two additional authors report curricular efforts that involve healthcare chaplains in teaching and/or clinical roles.[14]

Still other reports look at how practicing physicians interact with the SR of their patients/families either positively or negatively. The Working Group on Religious and Spiritual Issues at the End of Life discusses three cases, providing a list of phrases to help elicit the patient's concerns, potential pitfalls in SR discussions and goals of such conversations.[15] Barriers to spiritual care experienced by physicians, the need to respect professional boundaries and the benefits of taking a spiritual history also have been explored.[16] The Anglican Working Group in Bioethics discusses professional grounds for physician inquiries and how they may make inquires appropriately.[17] Todres et al. describe a training program in clinical pastoral education (CPE) adapted for clinicians.[18] Summarizing the first six years of the program, they describe the didactic and reflective processes whereby skills of relating to the spiritual concerns of patients/families are acquired and refined.

In the pediatric literature, only five publications describe clinical situations in which pediatricians believe that SR is important and/or their education/training has prepared them to discuss SR concerns. The American Academy of Pediatrics Committee on Bioethics has published recommendations concerning religious exemptions from child abuse statutes and religious objections to medical care.[19] These recommendations offer guidance to pediatricians as they provide care to the children whose parents espouse beliefs that conflict with prescribed medical care.

Siegel et al. describe six clinical situations of increasing severity, asking which medical conditions would warrant discussions about SR, e.g., health maintenance, birth of a baby, non-life-threatening bad news, emotional crisis, life-threatening bad news, death/dying situations.[20] Respondents (N = 165) reported that they gave increasing attention to SR as the clinical situations became more life threatening, e.g., health maintenance <40 percent, death/dying situations >90 percent.

The Brooks and Chibnall study of pediatricians (N = 61), observed

that "some pediatricians felt ill-trained for religious inquiry."[21] They quote a pediatrician who said, "We were taught not to discuss this kind of thing."[22]

In a study conducted by Armbruster et al., 46 percent of the faculty (N = 46) and 33 percent of the residents (N = 44) who responded agreed with the statement, "I am not adequately trained to address religious/spiritual issues."[23]

The project reported here gathers data from a large sample of pediatricians concerning clinical situations in which the SR of patients/families plays an important role, their educational experiences that prepared them to helpfully respond, and their interest in further training.

Methods

Participants

The authors surveyed all active pediatric medical staff members in three academic Midwestern pediatric hospitals after the institutional review board (IRB) of each hospital approved the study. The aggregate response rate was 58 percent (N = 737). Males constituted a slight majority (53 percent) of respondents. Age was reported in decades; most respondents were between thirty-six and forty-five years of age.

Respondents identified their faith groups as follows: Christian – 72 percent, Jewish – 12 percent, Muslim – 4 percent, Other – 12 percent. Seventy-one percent described themselves as "religious," and 83 percent indicated they were "spiritual." Approximately three-fourths affirmed that their personal SR was important in their medical practice (73 percent) and that the SR of patients/families was relevant to their practice (76 percent).

Instrument

The questionnaire included an item asking pediatricians to write a few words that described clinical situations in which, from their perspective, "the patient's/family's SR played an important role." A dichotomous item asked respondents whether they had received "any formal instruction concerning SR in healthcare" during medical school or residency. If they responded positively, they were asked to write a brief description of it. The second dichotomous item asked if they would "be interested in attending a Category 1 CME workshop on SR in healthcare." The final item asked them to name an SR related topic of special interest to them to be addressed in such a workshop.

Procedure

A cover letter, the survey and a return envelope were mailed to hospital-related pediatricians. After two weeks, a reminder postcard was sent that thanked responders and encouraged nonresponders. After two additional weeks, nonresponders received a revised cover letter, the survey and a return envelope. The authors arranged for the transcription of the narrative materials and analyzed responses to the two dichotomous items utilizing the Statistical Package for the Social Sciences (SPSS). The brief written narratives from the pediatricians were analyzed manually by identifying themes in the material and placing each response within the appropriate theme. Unique responses were grouped into a miscellaneous category.

Results

Sixty-seven percent (N = 494) wrote responses that identified clinical situations in which, from their perspective, the SR of patients/families played an important role (Table 1). One-third (33 percent) identified end-of-life situations, e.g., DNR decisions, removal of life support, the dying process and grief. Responses included the following:

- When the parents are facing life and death situations.
- When I need to discontinue mechanical ventilation in DNR situations.

Eighteen percent identified critical, serious, and severe medical situations:

- Coping with severe injuries, e.g., brain injury, spinal cord.
- Whenever you deal with a critically ill child.

Fourteen percent reported that from their perspective, SR played an important role when patient/family beliefs disallowed standard treatments. These pediatricians frequently cited specific religious groups whose beliefs/practices impinged on clinical practice, e.g., Jehovah's Witnesses, Amish.

Five percent pointed to medical situations that involve chronic conditions:

- When the patient is chronically ill and in much pain.
- When the child has a severe genetic disorder.

Twenty-five percent of the responses were deemed unique and placed in a miscellaneous category. For example, one respondent briefly noted situations in the pediatric outpatient office and another described "the willingness to

Table 1

Pediatricians' identification of clinical situations in which patients/families find their spirituality/religion to be important

Clinical Themes	*N = 494*	*Percent*
Terminal illness, DNR situations, dying, grief	169	34.2
Stressful crises in general	85	17.2
Special care requirements due to religious beliefs	68	13.8
Chronic illness/chronic care	26	5.3
Miscellaneous responses	125	25.3
Did not identify a clinical situation	21	4.2

N = 494 (67 percent of the total sample of 737)

Table 2

Spirituality/religion related educational interest

Educational Topics	*N = 228*	*Percent*
How to talk to patients/families about SR	93	40.8
Information regarding diversity of religions	52	22.8
When appropriate? When helpful? Boundaries?	22	9.6
Miscellaneous	61	2.8

N = 228 (31 percent of total sample of 737)

accept psychiatric treatment." This category also included responses that described patients/families rather than clinical situations. For example, a pediatrician wrote that SR of parents was important "when faith is central to family relationships and day-to-day living." Attempts to find additional themes in the large amount of material in this miscellaneous category were unsuccessful.

Twenty-one pediatricians (5 percent), who wrote a response but did not identify clinical situations in which patient/family SR played an important role, used such words as none, unsure and never.

A second questionnaire item inquired about SR training in medical school and residency. Eleven percent (N = 85) indicated that they had received some formal instruction. The follow-up question asking them to describe the instruction elicited such words as classes, lectures, seminars or talks. Miscellaneous responses noted attendance at a religiously-oriented medical school or participation in the Christian Medical Society.

A third item asked whether they were interested in attending a Category 1 CME concerning the role of SR in healthcare. Sixty-one percent (N = 429) answered "yes." A follow-up question then asked those respondents to suggest specific topics for such a workshop. Fifty-six of these pediatricians, however, while making a response, did not suggest specific topics. They wrote responses such as "not sure," "anything" and "leave it up to you." When these responses are eliminated, the usable responses are reduced to 31 percent (N = 228).

These 228 pediatricians most frequently suggested a workshop that explored how to open a dialogue with patients/families regarding SR concerns (Table 2). They wished to learn the skills related to talking about SR, how to approach it in a sensitive manner, how to address it without offending patients or families and "how to kindly and safely bring up the issue." One pediatrician wrote, "I don't really know where to begin since spirituality/religion or faith tend to be such personal things." Another described the goal of such a workshop as "overcoming physician discomfort in addressing patients' spiritual beliefs."

Twenty-three percent of those who responded to this item suggested that the workshop should provide an overview of diverse religious beliefs and practices and their relevancy to healthcare. One pediatrician suggested an "overview of other religious faiths, specifically case scenarios showing importance

of spiritual aspects in healthcare." A subset (N = 12) of these pediatricians requested a workshop that focused on beliefs of religious groups that impinged on and complicated treatment, e.g., Jehovah's Witnesses.

Nine percent of those who responded to the item suggested a workshop focused on whether addressing SR was appropriate or helpful and whether addressing SR transgressed legal and/or ethical boundaries. Comments included the following:

- When is this appropriate to discuss with families? How to introduce topic?
- Appropriateness in routine care ... how to access this area in the context of caregiving.
- Spiritual assessment—how, when appropriate?

The miscellaneous category (27 percent) contained small groups of responses concerning such topics as the role of faith in healing (5 percent), attention to scientific studies examining whether SR was helpful in healthcare (5 percent), the role of prayer (3 percent), death and dying concerns (2 percent) and other suggestions that could not be classified (12 percent).

Discussion

As the responses make clear, pediatricians in this study believe that SR is important in serious medical situations (Table 1). This is defined as impending death or other highly stressful medical situations for patients and/or their families, including chronic conditions that will require years of attention. It appears that the role of SR increases as the suffering of patients/families increases, presumably because it offers support and comfort. These results suggest that pediatricians, like physicians in other specialties and medical patients, believe that attention to SR is appropriate, perhaps even necessary, in more urgent clinical situations.[24]

Fourteen percent (n = 68) of the respondents indicated that SR is important when beliefs/practices prohibit the use of usual clinical interventions. In such situations, the function of SR is turned on its head; instead of providing support and comfort, it may increase the patient's suffering and the possibility of death. Smaller percentages of respondents identified chronic medical and miscellaneous situations.

In summary, these results are compatible with Siegel's study described above and two qualitative pediatric studies of parents whose children died in a pediatric intensive care unit (PICU).[25] In the latter two studies, parents describe many spiritual needs.

The educational experiences that prepare pediatricians to helpfully interact with SR concerns appear to be limited. In the Armbruster study noted earlier, 46 percent of faculty and 33 percent of residents agree with the statement, "I am not adequately trained to address SR issues." In our study, only 11 percent (85 out of 737 pediatricians) acknowledged any formal training, most of which consisted of lectures, seminars and group discussions. The written responses to the item suggest that SR was briefly considered in the context of broader subject matter such as cultural diversity or biomedical ethics. One respondent summarized educational exposure with one word—"minimal."

Recent publications suggest that attention to the role of SR has increased in medical education. The long-term benefits likely will depend on the nature of these efforts. It is doubtful that lectures and other "talk about it" methods are adequate for learning the necessary skill sets. Like medical skills taught in internship and residency, interpersonal skills are usually learned by practice under supervision. Todres et al. describes such a clinical program that includes the process of actually providing spiritual care.[26] No respondent in this project reported participation in such a supervised program. Pediatricians likely will find it difficult to adopt this supervised approach because it challenges the fast-paced, fact-based and financially-driven practice of medicine.

A majority of respondents (61 percent) in this study expressed interest in attending a Category 1 CME workshop focused on SR and identified a wide range of SR topics (Table 2). While interest in such a workshop may fade in the face of other pressures within clinical practice or the appeal of other workshop topics, many want to learn how to talk to patients/families about SR. It is unclear whether they want to engage more competently in fact-finding concerning SR beliefs and practices that impact their decision making or whether they seek skills to provide spiritual care as clergy understand it.

For example, obtaining religious information is very different from responding to the SR concerns during diagnosis and treatment. The first constitutes fact finding with the goal of acquiring accu-

rate information; the second seeks to provide emotional and spiritual support from within the patient's/family's SR tradition. The first is best carried out with careful and skillful questioning; the second requires intense listening to and interacting with patients/families as they struggle with fear, hope, despair, and regret. The first can be accomplished within a limited time frame; the second should not be rushed and must follow the time frame set by patients/families. If pediatricians—and physicians generally—wish to learn how to provide spiritual care, then a clinical program similar to that described by Todres appears to be necessary.

Almost a quarter of those who suggested a workshop topic want information about the diverse religious beliefs that impact healthcare. While those who want help learning how to talk to patients/families as noted above desire increased clinical skills, the pediatricians in this category want information.

Nine percent want an educational context in which issues of clinical judgment are discussed. When is it appropriate to raise SR issues, to inquire about those issues? In what contexts is it helpful? And what are the professional boundaries? These pediatricians implicitly appear concerned that starting a conversation about SR could be problematic. Perhaps they believe that it may offend patients/families because SR is private or that it may lead to their involvement in discussing matters that go beyond their training.

Response to these educational interests appears to be limited. We found only one brief description of a CME course. Its author, a member of the Christian Medical Association, reports training "more than 6000 healthcare clinicians."[27] We found no further publication describing this or similar efforts.

At least two limitations must be considered when evaluating the results of this study. While a majority responded to the items concerning clinical situations in which SR is important, many did not respond to the educational items. Thus, although these results provide more information on the educational aspect than was previously available, they should not be regarded as representative of the specialty or of physicians generally. Further, while pediatricians identified clinical situations in which they regard SR as important, it is unclear whether they make interventions in these situations, refer the patient/family to the chaplain, or take no action at all.

In conclusion, many pediatricians recognize that SR is important to patients/families in stressful medical situations. Most reported limited educational preparation for responding to these concerns. Further SR continuing medical education focused on SR skills and information is desired, but few opportunities appear to be offered. This merits attention from physicians, chaplains, and other healthcare professionals.

Authors' note

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References

[1] H. G. Koenig, M. E. McCullough, D. B. Larson, *Handbook of Religion and Health* (New York: Oxford University Press, 2001).

[2] D. H. Grossoehme, J. R. Ragsdale, C. L. McHenry, et al., "Pediatrician characteristics associated with attention to spirituality and religion in clinical practice," *Pediatrics* (2007): 119. Available at Pediatrics.org/cgi/content/full/119/1/e117.

[3] M. H. Monroe, D. Bynum, B. Susi, et al, "Primary care physicians preferences regarding spiritual behavior in family medicine," *Archives of Internal Medicine* 163 (2003): 2751-56.

[4] M. R. Ellis, D. C. Vinson, B. Ewigman, "Addressing spiritual concerns of patients: family physicians' attitudes and practices," *Journal of Family Practice* 48, no. 2 (1999): 105-19.

[5] S. E. Luckhaupt, M. S. Yi, C. V. Mueller, et al., "Beliefs of primary care residents regarding spirituality and religion in clinical encounters with patients: a study at a Midwestern U. S. teaching institution," *Academic Medicine* 80, no. 6 (2005): 560-70.

[6] Association of American Medical Colleges, *Contemporary Issues in Medicine: Communication in Medicine, Report III, Medical School Objectives Project* (Washington, DC: Association of American Medical Colleges, 1999). Available at www.aamc.org/meded/MSOP/MSOP3.pdf.

[7] C. M. Puchalski, D. B. Larson, "Developing curricula in spirituality and medicine," *Academic Medicine*, 73 (1998): 970-4.

[8] C. M. Puchalski, "Spirituality and medicine: Curricula in medical education," *Journal of Cancer Education* 21, no. 1 (2006): 14-18.

[9] K. G. Barnett, A. H. Fortin "Spirituality and medicine: A workshop for medical students and residents," *Journal of General Internal Medicine* 21 (2006): 481-85; D. L. Graves, C. K. Shue, L. Arnold, et al., "The role of spirituality in patient care: Incorporating spirituality training into

medical school curriculum," *Academic Medicine* 77, no. 11 (2002): 1167; G. Anandarajah, J. Stumpff, "Integrating spirituality into medical practice: A survey of family medicine clerkship students" *Family Medicine* 36, no. 3, (2004): 160-61; M. J. Kelly, K. E. Olive, L. M. Harvill, et al., "Spiritual and religious issues in clinical care: An elective course for medical students," *Annals of Behavioral Medical Education* 4 (1996): 29-35.

[10] Center for Spirituality, Theology and Health www.dukespiritualityandhealth.org/medical education.

[11] D. E. King, J. Crisp, "Spirituality and healthcare education in family medicine residency programs," *Family Medicine* 37 no. 6, (2005): 399-403.

[12] A. S. Wolkenstein, "Spirituality in residency education: Taking the next step," *Family Medicine* 32, no. 3 (2000):159-60.

[13] H. D. Silverman, "Creating a spirituality curriculum for family practice residents," *Alternative Therapies* 3, no. 6 (1997): 54-61.

[14] M. C. Pettus, "Implementing a medicine-spirituality curriculum in a community-based internal medicine residency program," *Academic Medicine* 77, no. 7 (2002):745; G. Anandarajah, R. Long, M. Smith, "Integrating spirituality into the family medicine residency curriculum," *Academic Medicine* 76, no. 5 (2001): 519-20.

[15] B. Lo, D. Ruston, L. W. Kates, et al., "Discussing religious and spiritual issues at the end of life. *JAMA* 287, no. 6 (2002): 749-54.

[16] J. T. Chibnall, M. L. Bennett, S. D. Videen, et al., "Identifying barriers to psychosocial spiritual care at the end of life: A physician group study," *American Journal of Hospice and Palliative Medicine* 21 (2004): 419-26; S. G. Post, C. M. Puchalski, D. B. Larson, "Physicians and patient spirituality: Professional boundaries, competency, and ethics," *Annals of Internal Medicine* 132 (2000): 578-83; C. M. Puchalski, A. L. Romer, "Taking a spiritual history allows clinicians to understand patients more fully," *Journal of Palliative Medicine* 3 (2000): 129-37.

[17] C. B. Cohen, S. E. Wheeler, D. A. Scott, et al., "Walking a fine line: Physician inquiries into patients' religious and spiritual beliefs," *Hastings Center Report* 31, no. 5 (2001): 29-39.

[18] I. D. Todres, E. A. Catlin, M. M. Thiel, "The intensivist in a spiritual care training program adapted for clinicians," *Critical Care Medicine* 33, no. 12 (2005): 2733-36.

[19] American Association of Pediatrics Committee on Bioethics, "Religious exemption from child abuse statutes," *Pediatrics* 81, no. 1 (1988): 169-71; American Association of Pediatrics Committee on Bioethics, "Religious objections to medical care," *Pediatrics* 99, no. 2 (1997): 279-81.

[20] B. Siegel, A. J. Tenenbaum, A. Jamanka, et al., "Faculty and resident attitudes about spirituality and religion in the provision of pediatric healthcare" *Ambulatory Pediatrics* 2, no. 1 (2002): 5-10.

[21] C. A. Brooks, J. T. Chibnall, "Religion in medicine among Salt Lake City pediatricians," *Utah Medical Association Bulletin* 47 (2000): 10-11.

[22] Ibid.

[23] C. A. Armbruster, J. T. Chibnall, E. Legett, "Pediatrician beliefs about spirituality and religion in medicine: Associations with clinical practice," *Pediatrics* 111, no. 3 (2003). www.Pediatrics.org/cgi/content/full/111/3/e227.

[24] Monroe, "Primary care physicians," *Internal Medicine*; C. D. MacLean, B. Susi, N. Phifer, et al., "Patient preference for physician discussion and practice of spirituality: Results from a multicenter patient survey," *Journal of General Internal Medicine* 18 (2003): 38-43.

[25] K. L. Meert, C. S. Thurston, S. H. Briller, "The spiritual needs of parents at the time of their child's death in the pediatric intensive care unit and during bereavement: A qualitative study," *Pediatric Critical Care Medicine* 6, no. 4 (2005): 420-27; M. R. Robinson, M. M. Thiel, M. M. Backus, et al., "Matters of spirituality at the end of life in the pediatric intensive care unit," *Pediatrics* 118 (2006). www.pediatrics.org/cgi/content/full/118/3/e719-729.

[26] Todres, "Spiritual care training program."

[27] W. L. Larimore, M. Parker, M. Crowther, "Should clinicians incorporate positive spirituality into their practices? What does the evidence say?" *Annals of Behavioral Medicine* 24, no. 1 (2002): 69-73.