

pennpulse

Spirituality



In
Medicine —

Does It Fit?

How

Who

Why

Where

When

How should physicians address spiritual or religious issues with their patients? What happens when a family's spiritual or religious beliefs stand in opposition to a sound therapeutic decision? Should physicians pray with their patients? How can sensitivity to diverse religious beliefs be encouraged through the medical school curriculum without sacrificing time devoted to clinical skills? How important a factor is spirituality to our overall health?

Photo by Candace diCarlo

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A Publication
for the Faculty,
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Fellows of the
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Spirituality IN Medicine

By Dina Greenberg

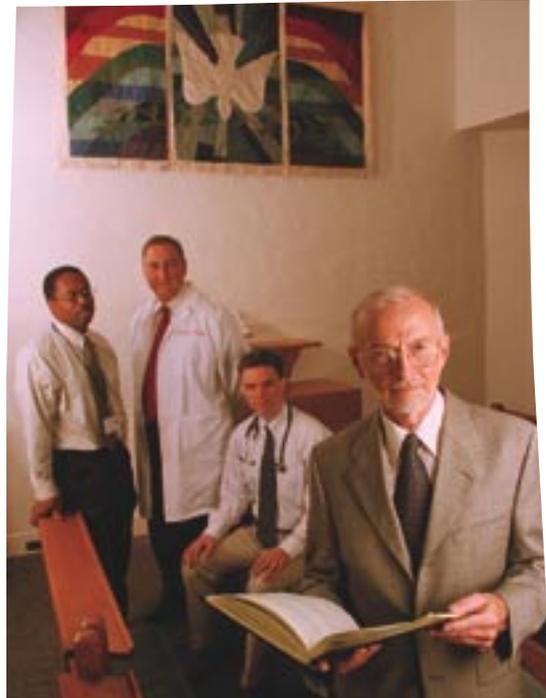
(l.to r.) Horace DeLisser, M.D., John Hansen-Flaschen, M.D., Kevin Fosnocht, M.D., and Ralph Ciampa, S.T.M. in HUP's Interfaith Chapel.

Photo by Candace diCarlo

None of these questions yields particularly easy or succinct answers. Yet for Reverend Ralph Ciampa, S.T.M., director of HUP's Department of Pastoral Care, his experience tells him that these questions deserve a good, hard look. And he is not the only one who thinks so. Harold Koenig, M.D., founder of the Center for the Study of Religion/Spirituality and Health at Duke University Medical Center, estimates that there have been some 1,200 studies "on the healing power of faith and the health effects of spirituality" in recent years.

From clinical applications, to research methodologies, to palliative and hospice care, to medical school training, questions regarding spirituality, religion, and the professional boundaries of physicians are becoming more frequently discussed throughout the halls of academic medicine. According to the University of Kentucky's College of Medicine, there are currently 70 medical schools throughout the country that incorporate formal instruction in issues of spirituality into the medical school curriculum. Many Penn doctors and researchers have joined the discussion. They are listening to what people like Ciampa have to say and increasingly working as collaborative partners with members of the pastoral care staff.

Last May, more than 100 participants turned out for the Sixth Annual Spirituality Research Symposium held at Medical Alumni Hall. Penn's Center for Research on Religion and Urban Civil Society (CRRUCS), along with HUP's Department of Pastoral Care, hosted the event. This year's conference was entitled "The Role of Religion in Understanding Risk and Protective Factors for Adolescents." Byron R. Johnson, Ph.D., director for CRRUCS and senior fellow in the Robert A. Fox Leadership Program at Penn; C. William Schwab, M.D., chief of the division of traumatology and surgical critical care at HUP; Gail Morrison, M.D., vice dean for education; and John Hansen-Flaschen, M.D., professor in the Department of Medicine, were among those on the roster. Ciampa was pleased that so many members of the Penn community — as well as attendees from the broader community, including clergy, physicians, nurses, social workers, and students — had turned out on a clear Friday afternoon, but he didn't seem particularly surprised.



In his view, the intersection of spirituality and health is clear; on the other hand, he acknowledges that melding spirituality and modern health care has proved to be exceedingly complicated. Still, Ciampa is not discouraged. In the past several years, he has paved the way for numerous intersections linking the Department of Pastoral Care with Health System clinical, research, and education initiatives. Along with lead author Reverend John W. Ehman, M. Div., chief chaplain at UPMC – Presbyterian, Ciampa collaborated with Penn colleagues including Hansen-Flaschen, to design and complete a study of patient attitudes concerning physician inquiry about spiritual/religious beliefs. *The Archives of Internal Medicine* published the paper in 1999. In conjunction with staff members from the Institute on Aging, Ciampa and Ehman launched the Penn Spirituality, Religion, and Health Interest Group in March 2000, a monthly meeting that consistently draws a wide range of participants. He continues to both shape and to co-teach, along with Michael Baime, M.D., assistant professor in the Department of Medicine, an elective course for first-year medical students entitled "Spirituality and Medicine."

Amidst recent media attention that focuses on spirituality and religion as prescriptive medicine and frequently aligns spirituality with complementary and alternative medicine (CAM) practices, Ciampa espouses a balanced, respectful stance that eschews controversy from either the medical or religious communities. “The first perspective of spirituality in medicine,” says Ciampa, “is the traditional aspect of bringing comfort to the patient and family members.” As a researcher, he is intrigued by study results that tout the efficacy of intercessionary prayer. On a personal level, he does not need to be convinced that faith can be a powerful healer. “But as a pastor,” Ciampa says, “I have a real problem with the idea of co-opting the tool of spirituality and, in essence, separating it from the larger context. The very nature of spirituality is seeing the entire journey as an end itself, rather than as the means.” Still, in no way is Ciampa discounting or discouraging research that seeks to quantify what he describes as “the operative factor” of spirituality as it affects health outcomes.

Ciampa points to the popular “mindful meditation” course for health-care professionals taught by Michael Baime as an example of a successful adaptation. “We know that meditation works for stress-reduction and that this translates into other physical benefits.” Ciampa notes that while Baime’s philosophy regarding meditation is “deeply rooted in the spiritual tradition of Tibetan Buddhism [See *Penn Medicine*, Winter 2003], he is, none the less, careful to keep this aspect separate from the class instruction.” Ciampa cautions that if Baime were to be “too careless” in separating the spiritual grounding for the modality from the tool, “this wouldn’t be a good thing.”

Ciampa is also familiar with the work of Penn colleague Alfred P. Fishman, M.D. Fishman is professor in the Department of Medicine, senior associate dean for program administration, and director of Penn’s office of Complementary and Alternative Therapies. In 1998, Fishman called upon Ciampa to address a group of Penn physicians — the then-fledgling steering committee for complementary and alternative therapies — at their first Health System retreat; the group was discussing the potential for integrating CAM practices at Penn. Ciampa was pleased and encouraged when Fishman invited him to be a member of the advisory board.

“I think the interest that Dr. Fishman has shown in spirituality and medicine is a relevant part of the big picture here at Penn,” says Ciampa. He points out that the group’s primary focus has been on “research exploring the efficacy of interventions that have spiritual roots or dimensions, and in offering such interventions if they are supported by empirical research.” Yet in his interactions with the group, Ciampa notes he has also found “wide recognition that the attitudes of compassion, dedication, and respect for the whole person — aspects often associated with professionalism and humanism — are basic to *all* good medical care.”

In this regard, Ciampa describes the traditional role of pastoral care as helping patients and family

members to access spirituality as a resource during illness and death. He feels that few physicians would argue against this long-accepted application of faith. He does, however, understand the reluctance of many physicians to blur the line between their agency as doctor and as spiritual counselor. “Historically, in Western cultures there was an overlap of medicine and spirituality; the healer was the same person as the religious leader and their roles were entwined,” Ciampa explains. In recent times, the delineation of roles is much more prevalent than in many other cultures, Ciampa adds. Even so, he stresses, “Physicians are becoming much more attuned to helping patients to access spirituality as a resource in both individual and traditionally communal ways.”

In Ciampa’s view, making physicians familiar with, and training them to determine when it is most appropriate to refer patients to pastoral care services is an ideal place to start. Since 1997, the SOM has offered Spirituality in Medicine, a full-time, four-week summer elective with the express goal of training medical students to appropriately address patients’ spiritual needs. The course accommodates a maximum of five first-year students, who complete 16-hour overnight rotations with chaplain residents, in addition to the 40-hour-per-week schedule. The course also includes a series of didactic sessions led by faculty members such as Paul Root Wolpe, Ph.D., assistant professor in the departments of Medical Ethics and Psychiatry and chief of bioethics for NASA; and David J. Hufford, Ph.D., a fellow at Penn’s Institute on Aging and adjunct professor of folklore and folklife at the University. Hufford, also a professor of humanities and behavioral science at Penn State University and director of the Doctors Kienle Center for Humanistic Medicine, is a frequent contributor to related programs hosted by Ciampa and his colleagues.

In addition to the elective course, the Pastoral Care Department also collaborates with the SOM to facilitate panel discussions on spiritual and religious aspects of medicine for the entire first-year class, a mandatory part of the medical school curriculum. Ciampa, Horace DeLisser, M.D., associate professor in the Department of Medicine, and Paul N. Lanken, M.D., medical director of the medical intensive care unit (ICU) at HUP, associate director of medical education at the SOM, and faculty leader for the

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– *Ralph Ciampa*

Professionalism and Humanism module of Curriculum 2000, were instrumental in designing the coursework as an integral component within the Professionalism and Humanism module. In an effort to provide ongoing support, Ciampa and his colleagues have developed a set of nine guidelines that establishes a framework to help medical students and practicing physicians negotiate the dual roles that may, at times, seem uncomfortably at odds.

Ciampa points out that the medical student group for the elective course is self-selected, and although not all participants consider themselves “religious” they often have fervent reasons for choosing the course and report profound insights both personally and professionally once they have completed it. At a panel discussion following the conclusion of the 2003 summer session, medical student Jennifer

Conroy told Lynn Seng, director of special educational projects at the SOM, “I have an interest in bioethics and I felt that learning about patients’ spiritual needs would help to make me a better doctor. After taking the course,” says Conroy, “I was impressed by how concretely people apply their religious beliefs to health outcomes, both positive and negative.” Seng was moderator for the panel, composed of Conroy and two of her classmates, Steven Crooks and Kara Durand. Members of the Spirituality, Religion, and Health Interest Group made up the audience. They listened intently as the students reflected on their experiences of the past four weeks. As a result of their on-call experience, all three medical students expressed enormous respect for the chaplain’s office and the high caliber of interpersonal skills exhibited by the pastoral residents. Not surprisingly, the medical students rated this segment the most valuable. “We spent a great deal of time in waiting rooms,” says Kara Durand. “One of the important things that I came away with was an understanding of the difference between the perception the doctor might have — speaking with the family in 30-second snippets — compared to the students who saw the families for long stretches of time; doctors don’t get the whole picture.”

After Seng explained to the group that the medical students had been instructed *not* to wear their white coats when they met with patients and their families throughout the course — “We told them they were not to be interacting with patients in a medical capacity.”— she asked the panel if they felt comfortable in a role more closely linked to spiritual counselor than doctor.

“I was attracted to the idea of this kind of patient interaction where I didn’t have to have a medical agenda,” said medical student Steven Crooks. “Reliance on faith is pervasive among people and I found that patients generally appreciated my asking about their beliefs.” Crooks went so far as to join two patients in prayer. In one instance, he described a female patient on the cardiac floor. “She was Catholic and I’m Catholic. We said the Lord’s Prayer together.” On another occasion, Crooks prayed with a woman whose husband had been brought in through the ER trauma bay. “Both of us felt better afterward,” said Crooks affably. “I’m not sure if it was right or wrong, but I felt comfortable with it.” Conroy’s experience was different, though; she ultimately came to the conclusion that her reluctance to pray with patients during the course reflected her ambivalence about her own spiritual beliefs. “I’m not sure how I feel,” said Conroy. “The course forced me to start thinking about how I’m going to communicate with patients about religious or spiritual matters, though.”

While acknowledging that there will always be disagreement on tough questions such as these,



The Interfaith Chapel

The first chapel at HUP (1890), provided by the Board of Women Visitors, was adjacent to the hospital mortuary. In 1993, grants from the Board and individual donors made possible renovations to HUP’s present chapel on Dulles 1, renamed the Interfaith Chapel.

Two tapestries — depicting symbols appearing in both Hebrew and Christian scripture — were gifts from a project designer who consulted with the hospital during the chapel renovation. A Muslim prayer space was later added, with a prayer rug and a tapestry depicting a verse from the Holy Qur’an.





Bringing Spirituality to a PENN Medicine Residency Program

“One of the challenges in delivering high quality graduate medical education is to convey the importance of humanistic issues like spirituality without compromising the hard clinical training,” says Kevin Fosnocht, M.D., assistant professor in the Department of Medicine. As an internist with the Penn Center for Primary Care at UPMS-Presbyterian and the program director of Penn’s Primary Care Internal Medicine Residency Program, Fosnocht places a great deal of emphasis on establishing this delicate balance. Fosnocht believes that, particularly as a general internist, he must have “an openness to his patients’ experience of illness and health that includes an assessment of physical, emotional, and spiritual well being.” He believes that to be a truly exceptional doctor, one must “develop that additional desire to understand the whole person.” This, says Fosnocht, takes time, experience, and maturity.

Directing 150 residents with 24 specialty tracks through the three-year residency program, he is especially aware of the “enormous anxiety” residents experience at this crucial point in physician training, a time when mastering technical skills is paramount. Resident training is delivered in month-long blocks, a short time-frame that does not allow residents to build long-term relationships with their patients. “Much of what patients may reveal about their spirituality depends upon a strong doctor-patient relationship and this is harder to appreciate as a resident,” says Fosnocht.

Fosnocht refers to a small study done by a Florida researcher that maps interest in understanding spirituality as an aspect of patient care — from the point of medical student status, to residency, and on through one’s tenure as a practicing physician. Initially, explains Fosnocht, interest is high. He points, however, to a dramatic drop during the residency years, followed by a rebound once physicians become established in their fields.

Fosnocht contends that the study represents a general national trend and, from a personal perspective, is in line with his own experience throughout *his* medical career. “What attracts many people to medical school,” he says, “is the idea of healing the whole person, of dealing not just with medicine and illness, but also with what it is that makes us human. So, in those early stages, when you’re unfamiliar with the biology, you’re drawn to the humanistic piece of doctoring.”

At the residency stage, however, Fosnocht describes a period when “a premium is put on clinical practice skills.” This is the time when physicians-in-training must effectively synthesize the countless technical skills required in their specialty area. “It’s imperative to know all of the small details that can dramatically affect patient care,” says Fosnocht. “Now is the time to know when to order a thyroid test and to know how to interpret the results, for example.” Therefore, says Fosnocht, making the humanistic aspect of patient care a lower priority during residency “is not entirely inappropriate.” Putting himself in the role of a patient who is given the choice of either a “well-versed clinician” or a “kind and caring person,” Fosnocht says that he would “have to go with the skilled clinician.” He emphasizes, though, “The goal is to combine the two.”

In Fosnocht’s view, once the clinical skills have been mastered, it is not unusual for practicing physicians to explore a more holistic view of patient care, “to ask what more there is to learn” and to delve into what he describes as “the *real* art of medicine.” Fosnocht believes that the way to teach this intangible skill is through modeling.

According to Fosnocht, the Primary Care Internal Residency Program provides a practical means of accomplishing this skill. In 2000-2001, with a grant from the John Templeton Foundation, Fosnocht put into practice some of the heartfelt principles he relies upon as a physician and as a teacher. He developed a year-long, multi-disciplinary course for residents, focusing on spirituality in medicine. Culling input from specialists across the University, the program included a series of lectures, role-playing scenarios, homework, and videotaping sessions. Residents were exposed to several diverse examples of religious beliefs that “call upon physicians’ cultural competency in regard to delivering appropriate and respectful health care.”

The basis for the course, according to Fosnocht, was to illustrate that expressing interest in patients’ spiritual needs often leads to a stronger doctor-patient relationship

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– Kevin Fosnocht

— with the increased potential for better health outcomes. “The physician’s ability to communicate and to show empathy is an essential element in caring for his patient,” says Fosnocht. “Even though I’m not a psychiatrist, I need to be open to the emotional life of my patient. I must be able to respond in a humane *and* therapeutic sense.”

Building upon the prototype course, a similar class offered this year emphasizes training residents to take a spiritual history from patients. Fosnocht likens the spiritual history to a sexual history of a patient; the information gathered helps the physician to have a more complete understanding of the patient and to know better what he or she may be at risk for. “It’s so important not to presume, not to make general assumptions,” says Fosnocht, “so that as a physician, I know how to deal with you as an individual.” To Fosnocht, there is a far-reaching context in which to gather information regarding patients’ spiritual beliefs, what he refers to as “shared humanity — an aspect of being human that doctors need to know in order to provide quality health care.”

Learning this information early in the doctor-patient relationship is advantageous, according to Fosnocht. “Better now than in crisis,” he advises residents. “What is gained from taking a spiritual history, apart from the cultural competency issue and the specifics of religious or spiritual beliefs as they pertain to making health-care decisions, is that the provider is sending the message that he or she is interested in the whole person; conveying that message is fundamental to establishing a therapeutic relationship.”

Fosnocht points out, however, that as a primary-care physician, he faces particular challenges in determining how to make inquiries regarding patients’ religious or spiritual beliefs.

Unlike in critical care settings — where health crises often prompt patients and family members to seek spiritual guidance — it is not always clear when or how the physician should “insert religion or spirituality into the picture” during a routine medical examination. “What we’re really doing here is just putting the question of spiritual matters out there on the table. We’re asking the question in an open-ended, respectful way: ‘Do you have any spiritual or religious beliefs that you would like me to know about?’ — And, mind you, a spiritual history need not be a lengthy theological or philosophical discussion. The answer may simply be ‘No.’” At the other end of the spectrum, Fosnocht points out, “many of our residents spend time in the intensive care unit at HUP, where they have to face hysterical family members who need to make life and death decisions about their loved ones’ care.” At both extremes, Fosnocht believes that acknowledging that spiritual beliefs may play a role in a patient’s health and illness sends a clear message that “you are concerned and open to this information. This, alone, is quite meaningful to the patient and reinforces the doctor-patient relationship.”

For this year’s primary care residents, the spirituality in medicine course will reinforce this humanistic aspect of medicine. In addition to didactic sessions, medical residents will take call along with pastoral care residents. In one session, patients will talk to residents about how spirituality has affected their choices regarding health and illness and about the relationships they have built with their physicians. “We keep raising the bar higher on our expectations of physicians’ ability to put this additional factor on their radar screen,” says Fosnocht. Still, he is not, in any way, suggesting that physicians should be trained as chaplains, as well. From his vantage point, integrating spirituality into the residency program fits neatly within the context of professionalism and humanism modules. “Ultimately, it’s an issue of meaning [of one’s life], of the inexplicable nature of illness, not something that is explicitly religious. I think you would be hard-pressed to find any physician who would dismiss the importance of this issue.”

Ciampa and many of his Penn colleagues suggest that these questions would not continue to crop up in medicine if they were not exceedingly relevant to the doctor-patient relationship. A 1999 Penn study led by Ehman surveyed 177 adult ambulatory patients visiting a pulmonary clinic here. “We were asking the question, ‘In the grand scheme of medical care, is it appropriate to ask patients a question regarding their religious beliefs in the context of taking a medical history?’” says Hansen-Flaschen. Three previous major studies conducted by family practice physicians and published in scientific journals concluded that “an impressive fraction of people were reluctant to discuss their religious affiliation in an outpatient setting,” Hansen-Flaschen explains. He attributes this outcome to two factors: patients’ concern that the physicians interviewing them would take the opportunity to proselytize and/or they would receive a different level of care from the physician, depending upon their religious affiliation.

Hansen-Flaschen and co-investigators in the Penn study hypothesized that a large part of the problem rested upon the way the question was being asked. “Instead of simply asking ‘What is your religion?’ we hoped to present a question that would make clear our goal: to work together with the patient to make decisions that are more closely aligned with his or her beliefs, to deliver care on a more personal level.” Ultimately, the question presented by the investigative group to patients in the study was: “Do you have spiritual or religious beliefs that would influence your medical decisions if you became gravely ill?” The study results — forty five percent of respondents answered yes — lent further relevancy to addressing spirituality in medicine in the SOM curriculum and in patient care.

Ciampa stresses that this study has been replicated with very consistent findings, under the guidance of co-investigator Barbara Ott, R.N., Ph.D., assistant professor of nursing at Villanova University. Elsewhere in the Northeast, a study of six academic medical centers, led by Charles D. MacLean, M.D., and published in the *Journal of General Internal Medicine* this year, reports that one third of patients wanted to be asked about their religious beliefs during routine visits; two thirds felt that physicians should be aware of their spiritual beliefs; and ten per cent of respondents reported a willingness to give up time spent on medical issues in order to address spiritual concerns with their physicians.

Pulmonary specialist Horace DeLisser has understood the close link between spirituality and medicine since he first contemplated entering the ministry as a teen. Instead of entering the seminary, he plunged into medical school and a career as a physician. For DeLisser, however, the two paths are closely entwined. “I’ve had many experiences throughout my residency, fellowships, and in my work now that confirmed that being a physician is *my* ministry.”

DeLisser feels that he is particularly attuned to helping patients who face acute illness. Aside from his medical experience, one crucial skill he draws upon is his ability to establish a strong bond with his patients and to help guide them through frequently difficult medical

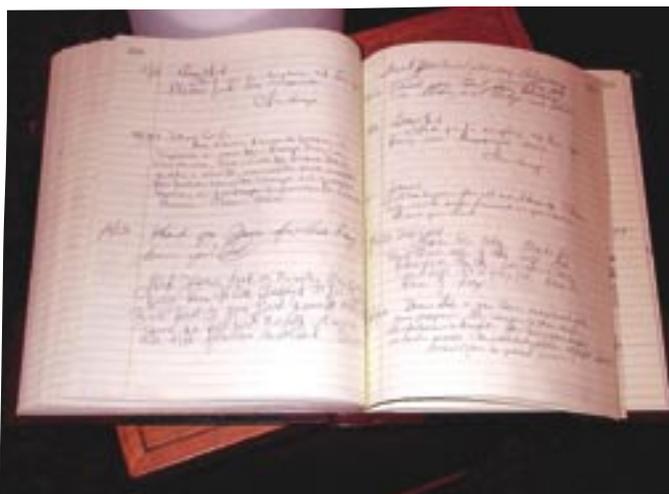
decisions at perhaps the most vulnerable stage in their lives. DeLisser explains that many of his patients are so gravely ill they frequently end up in the ICU. “The mortality rate is 50 percent; that’s a lot of death and dying. Collectively,” says DeLisser, “doctors don’t do well with discussing death and dying openly.” He attributes this failing to “the product of Western science — We don’t emphasize in medical school things that cannot be measured or defined. We’re not trained well to deal with this aspect of the doctor-patient relationship. And this reflects a larger problem: We’re uncomfortable with discussing religion and spirituality with our patients. To my mind, you can’t really discuss death and dying without referring to the religious or the spiritual nature of these experiences.”

Still, DeLisser was encouraged when in 1997 he learned that the Spirituality in Medicine course would be implemented. “We’re trying to change things here,” says DeLisser, in respect to inculcating a more inclusive approach to viewing patients’ spiritual needs as an integral part of patient care. “Ralph [Ciampa] wanted to make clear that the concept of spirituality transcends religious denominations and affiliations. That’s what the course tries to get at.”

DeLisser feels that the course offers medical students interactions with patients they wouldn’t ordinarily have the opportunity to encounter. His role as a mentor in several small interest groups on spirituality in medicine here at Penn has confirmed that there is a growing desire for medical students to explore this aspect of the doctor-patient relationship.

DeLisser also received wider interest from his peers at the American Thoracic Society’s annual meeting in Seattle in May, where he delivered a talk entitled “When the Family Expects a Miracle.” In the presentation, DeLisser related his experience with family members of patients whose religious or spiritual beliefs include divine intervention; they may fervently rely upon “a miracle” to the exclusion of medical intervention. In other instances, family members may demand what DeLisser deems “a futile attempt at treatment” based upon religious beliefs that this intervention “will bring about a miracle.” Balancing respect for the family’s beliefs and an appropriate clinical decision can be complicated.

If there is a conflict “where a deeply held religious belief is intruding into the therapeutic process,” DeLisser says that patience and time are the most effective tools a clinician can use in negotiating a compromise. He stresses that, ideally, the medical decision-making process, involving doctor, patient, and family members “begins up-front, before there is a controversy.” It is advantageous, he adds, to create an environment where religious



Prayer Book

“Chapel visitors are free to write prayers here to express their needs, gratitude, and faith — to be seen and shared by all who pass through the chapel,” says Ciampa. Visitors have filled more than 20 of the 300-page prayer books since 1991.

expression is not discouraged. “Even so,” says DeLisser, “as a clinician, I have my own agenda and my own perception.”

When he is dealing with gravely ill patients and family members DeLisser prefers that his patients turn their religious or spiritual beliefs toward the goal of “something other than straight healing.” In DeLisser’s view, “peace and closure are just as important as healing.” He gives as an example the experience of many terminally ill patients who experience something that is “spectacular, unexpected, or unbelievable” as a result of their illness. “Maybe he or she reconciles with a sibling or a parent — This is something that would not have happened before the illness. Or a family member witnesses the sick person’s acceptance of his illness with dignity and grace. This provides inspiration that he or she may not have experienced otherwise.”

For Ciampa, these experiences are the threads that connect him to the HUP patients he counsels, the students he teaches, and the physicians and researchers with whom he collaborates. At a meeting of the Spirituality in Medicine interest group this past summer Ciampa said simply, “In the world where I live, everything is surrounded by mystery.” He is determined to help his medical colleagues to embrace this notion, not as an alternative to sound therapeutic treatment, but as a complement. He is certain that there is room for spirituality in medicine, and he is even more certain that patients and doctors alike can learn valuable lessons “on the journey from illness to healing” as a result of integrating the two.