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Spirituality, Religion, and Clinical Care*

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Interest in the relationship between spirituality, religion, and clinical care has increased in the last 15 years, but clinicians need more concrete guidance about this topic. This article defines spirituality and religion, identifies the fundamental spiritual issues that serious illness raises for patients, and argues that physicians have a moral obligation to address patients' spiritual concerns. Religions often provide patients with specific moral guidance about a variety of medical issues and prescribe rituals that are important to patients. Religious coping can be both positive and negative, and it can impact patient care. This article provides concrete advice about taking a spiritual history, ethical boundaries, whether to pray with patients, and when to refer patients to chaplains or to their own personal clergy. ***(CHEST 2009; 135:1634–1642)***

Key words: medical ethics; religion; spirituality

Editor's note: *This review addresses the ninth topic in the core curriculum of the ongoing Medical Ethics series.—Constantine A. Manthous, MD, FCCP, Section Editor, Medical Ethics.*

Writing something comprehensive about religion and medicine in a single article is impossible. The world's religions are too many and too diverse, the relevant topics too numerous, and the relationship between medicine and religion too complex. The best one can hope for is a broad treatment of common themes and a few signposts directing readers to the appropriate resources. To narrow the scope a bit, this article focuses on religion and the care of the critically ill and those at the end of life. It also focuses mainly on Jewish and Christian beliefs and practices while touching on multiple other faiths and also considering the needs of those who profess no religion.

Religion is the oldest form of medical practice. The shaman was the traditional tribal healer, whose treatments were religious rituals.[1] Eastern cultures have tended to preserve this link between religion and health care, although the influence of Western medicine and culture has had a significant impact even in Asian nations.[2–7]

In the West, where the Judeo-Christian heritage has been dominant, the relationship between religion and scientific medicine began as a perfect marriage but has grown increasingly strained over the last several centuries. Firm in the belief that only Yahweh could heal, and distrustful of the idolatry associated with the practices of physicians before the Hellenic occupation (2 Chronicles 16:12), ancient Judaism only recognized the moral legitimacy of healing by physicians, rather than priests, with the introduction of "scientific" Hippocratic medicine.[1] Scientific medicine made it possible to reconcile belief in God as healer with the practice of medicine by physicians through an understanding of God as the inspiration and source for the physician's knowledge, and as the Creator of the world's healing resources, such as medicinal herbs (Sirach [Ben Sira] 38:1-15). This Jewish view, in its essential outlines, was later adopted by early Christianity.[8] In the Western world, tensions between medicine and religion can be traced back to the Enlightenment. Only in the last half century, however, has it become common for outspoken critics to castigate religion as either largely irrelevant or sometimes even harmful to medical progress and good clinical care.[9,10] None-

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theless, in the last 15 years, there has been a great resurgence of interest in spirituality, religion, and health care, both among the public and within the healing professions.[11–14]

Spirituality and Religion

Spirituality and religion are related but conceptually different. I define spirituality as the ways in which a person habitually conducts his or her life in relationship to the question of transcendence. A religion, by contrast, is a set of beliefs, texts, rituals, and other practices that a particular community shares regarding its relationship with the transcendent. Spirituality is thus simultaneously a broader concept than religion and a narrower concept than religion. It is broader in the sense that all religious and even nonreligious persons confront the question of transcendence, and so the term is compatible with all forms of religious belief and even the rejection of religion. Spirituality is narrower than religion, however, in the sense that, because only persons can engage questions of transcendence, each relationship with the transcendent will always be unique and spirituality ultimately personal. Even within a given religion, there will be as many spiritualities as there are individuals.

Growing numbers of Americans consider themselves "spiritual but not religious."[15] Although this represents a challenge for organized religion, it is also true that many millions of Americans (more than in most Western nations) are regular practitioners of particular religions and find in their religions sources of meaning and spiritual wisdom.[16] It is important to note that those who consider themselves spiritual but not religious will also have genuine spiritual needs. And it goes without saying that plenty of people who are "religious but not spiritual," for whom religious practice does not foster a genuine relationship with the transcendent, may still need to grow spiritually within their faith traditions.[17]

Religious traditions have a great deal of accumulated wisdom to impart regarding the profound spiritual questions that illness and death raise for patients. Patients who are seriously ill, even if estranged from the religions in which they were raised, may still find comfort in some connection to their religious traditions.

The primary spiritual questions that illness raises are about meaning, value, and relationship.[18] Questions about meaning include the "Why me?" questions; questions about the meaning of suffering, life, death, purpose, and afterlife. Questions about value encompass those that illness raises regarding a person's worth; the value one has (or may not have) when disfigured, dependent, unproductive, or otherwise afflicted in ways that undermine what society typically values. Questions about relationship encompass those that illness raises about a person's relationships, the need for reconciliation with those from whom one might be estranged, and the need to know that despite illness or impending death one is connected in important ways to family, friends, community, and possibly beyond. All these questions engender a series of finite responses that lead one, at the limit, to the brink of transcendence: the lingering meta-question of whether there is a nonfinite answer at the end of each series of finite responses. These questions arise for both patients of all religious persuasions and those who profess no religious beliefs. And these questions are inevitably occasioned by a person's confrontation with serious illness or injury and the looming possibility of death.

Why Should Health-Care Professionals Attend to the Spiritual Concerns of Patients?

The nature of the conditions treated by pulmonary and critical care physicians seems to raise spiritual questions in a particularly acute way.[19] Some clinicians, however, might acknowledge that the spiritual concerns of patients are important but question whether physicians, nurses, or other health-care professionals have any duty to attend to these concerns. Why not leave spirituality to families, clergy, and chaplains?

For several reasons, I would argue that clinicians have a moral obligation to attend to their patients' spiritual needs.[1] First, if physicians and other health-care professionals have sworn to treat patients to the best of their ability and judgment, and the best care treats patients as whole persons, then to treat patients in a way that ignores the fundamental meaning that the patient sees in suffering, healing, life, and death is to treat patients superficially and to fall short of the best ability and judgment. The encounter between physicians and patients is imbued with an interpersonal significance that is itself, in many religious traditions, an encounter with the sacred. Respect for patients ought to entail attention to meaning that the patient assigns to the encounter with illness and the relationship with the clinician. Second, sometimes clinicians are in the best position to elicit the most serious spiritual and religious concerns of patients. Many patients are frightened by their condition and its meaning. They may, for a variety of complex reasons ranging from fear to guilt to the cognitive effects of serious illness, neglect to request a visit from a chaplain. An astute clinician might discover that the patient is in a serious spiri-

Table 1—*Useful Acronyms for Obtaining a Spiritual History*

FICA (Puchalski[20])
F: Faith and beliefs
I: Importance of spirituality in the patient's life
C: Spiritual community of support
A: How does the patient wish spiritual issues to be addressed in his or her care?
SPIRIT (Maugans[21])
S: Spiritual belief system
P: Personal spirituality
I: Integration with a spiritual community
R: Ritualized practices and restrictions
I: Implications for medical care
T: Terminal events planning

tual crisis and make the appropriate referrals. Third, sometimes spiritual issues may be interfering with treatment and patients may not be readily forthcoming about the reasons. For example, a patient with uterine cancer may believe she is being punished by God for an abortion she had as a teenager and might therefore fatalistically refuse treatment. An astute, sensitive clinician can uncover such a problem and make referrals that help patients to cope with the spiritual and religious aspects of their conditions.

For these reasons, all clinicians, regardless of whether they are themselves religious, ought to be able to elicit a spiritual history from a patient and make proper referrals to clergy or others who are experts in the delivery of spiritual care. Several acronyms have been developed to help clinicians to do so, and two are presented in Table 1.[20,21] These serve as reminders of the kinds of spiritual issues that clinicians ought to be able to address with patients. Like many such acronyms, they are often most useful for novice learners.[22] With greater experience, one might find that simpler, open-ended questions, such as "What role does spirituality or religion play in your life?" may prove more natural for beginning these conversations, simply and quickly eliciting the same information as in an acronym.

Religious Observance and Health-Care Outcomes

Multiple well-designed studies (that control for confounding factors such as the fact that religions often proscribe unhealthy behaviors) have demonstrated that patients who attend religious services, independent of denomination, have better long-term health-care outcomes.[23–28] Religiosity and spiritual experiences are especially associated with better mental health outcomes.[29,30]

However, these research findings are not a sufficient moral warrant for any attempt by physicians to encourage religious practice as something "medically indicated" for health. First, this practice tends to trivialize religion, making the transcendent subservient to the mundane rather than vice versa. Second, the psychology of religion has long noted a difference between intrinsic religiosity (by which a religion is practiced for its own sake) and extrinsic religiosity (by which a religion is practiced for some other reason, such as social acceptability).[17] It is unclear whether health benefits would accrue for persons who were not previously religious but began practicing for an extrinsic reason such as the health benefits. The only way to answer this question would be via a trial in which patients were randomly assigned to religious practice or no religious practice, a study that (for obvious moral reasons) ought never to be done. Finally, if religion is free to be religion, then it can, in fact, be very bad for one's health, sometimes even calling for heroic sacrifices. One need not go further than Jesus of Nazareth or Mohandas Gandhi to appreciate this truth.

Accordingly, data on health-care outcomes and religion provide useful prognostic information but ought not be used to justify using the power of the white coat to encourage religious practice by patients.

Spirituality, Religion, and Ethics

Compounding the error of conflating spirituality with religion, many persons, including many religious persons, tend to view religions as primarily groups of people who adhere to a variety of strict moral codes. It is not uncommon, for instance, for house officers who are asked to describe a case in which religious or spiritual issues are at play to present a case of a moral dilemma involving a conflict between the patient's religious beliefs and "scientific" medical advice. Taylor has described how historical forces in the West have succeeded in "taming" religion by reducing its social function to the maintenance of good moral order in the secular state.[31] The primary function of religion, however, is not to provide a moral code but to mediate an encounter with the sacred. Given that encounter, behavior changes. Religious communities interpret together how their shared answers to the foundational spiritual questions of meaning, value, and relationship ought to affect the behavior of adherents to that faith. Subsequently, religions do tend to prescribe and proscribe many behaviors, including, importantly, many medically related behaviors. Spirituality does provide a motivation to act morally, a

Table 2—*Selected Ethical Beliefs of Some Religions Regarding Particular Issues in Care at the End of Life*

Religion	Issue/Practice	Teaching
Orthodox Judaism	Ventilator support	Most Orthodox Jews oppose withdrawing but support may be withheld if the patient is very close to death. Reform and Conservative Jews tend to be more liberal
Roman Catholicism	Foregoing artificial hydration and nutrition	May forgo if it is ineffective, more burdensome than beneficial, or not reasonably available. Stable patients in persistent vegetative state, in the absence of complicating circumstances, are not considered to be dying, and artificial hydration and nutrition cannot be withdrawn in these cases
Jehovah's Witnesses	Blood transfusion	Transfusion violates scriptural ban on "eating blood." Many Jehovah's Witnesses permit purified blood products such as albumin and clotting factors
Islam	Assisted suicide and euthanasia	Strictly forbidden, although the withholding and withdrawing of life-sustaining treatments is permitted
Buddhism	Brain death	Not clearly defined without a central moral authority, and although the notion is accepted by some, it is strongly resisted in many Buddhist communities, especially in Japan
Hinduism	Autopsies	Hindus believe autopsies disturb the still aware soul that has just separated from the body and should therefore be avoided unless required by law
Southern Baptist	Advance directives	Distrustful of living wills: suspect they may be misused to make quality-of-life judgments. Health-care power of attorney is preferred or an alternative document called a *will to live*

context for cultivating a life of virtue, and a perspective by which to view the affective and interpersonal contours of a moral life. Nonetheless, religion and spirituality are far more comprehensive than the moral code with which they are associated.[32] For example, an Orthodox Jew may refuse to authorize discontinuation of ventilator support for his wife not simply because it is part of his moral code, but because he belongs to a community of believers who equate breath with the spirit that Yahweh breathed on the chaos before creation and the life Yahweh breathed into the nostrils of the first human being, Adam. If one is fully to appreciate and respect a patient's religiously motivated moral code, one must understand that the moral code is secondary to the patient's underlying spirituality and religious sense.

Religion and Specific Issues in Medical Ethics

These caveats notwithstanding, most religions do give their adherents specific guidance regarding ethical issues that occur in the course of medical care. Surveys tend to show that attitudes about a number of issues, such as the use of feeding tubes and physician-assisted suicide, vary according to religious denomination, particularly if one selects those members of the denomination who report some behavioral commitment to that religion, such as attendance at worship services or strength of belief.[33–39] Space limitations preclude a fuller discussion, but one should also note that the religious commitments of clinicians are associated with their moral beliefs and attitudes every bit as much as are the religious commitments of patients.[40] Table 2 shows some representative views of a few religious denominations regarding some of these issues. Two important cautions are worth noting, however. First, not all patients fully understand the beliefs of their own denominations about particular ethical issues, and so pastoral care staff or the patient's own clergy can sometimes be of enormous help in clarifying for patients what their own traditions hold to be true. Second, even if a particular patient's religious denomination holds a certain belief as a matter of dogma, this does not automatically mean that the individual patient will hold that particular belief. One must always ask the individual. Sometimes, this will even require interviewing the patient apart from family or clergy or members of a religious community who might be pressuring the patient to profess a belief with serious health consequences.

Religious Practices Regarding Illness and Death

Death is a profound, inevitable, and mysterious aspect of the human condition. It raises the foundational spiritual question of whether there is anything about human existence that transcends the moment of death. The world's religions all attempt to explain the reality of death and prescribe rituals before and after death. Table 3 lists a representative sample of some of these practices. Respect for patients requires respectful attention to their specific religious needs at the time of death. Sometimes this will require, where not otherwise contraindicated, relaxing hospital rules about visiting hours, number of

Table 3—*Selected Specific Religious Practices for Patients Who Are Dying*

Buddhism: Opportunity to chant or to hear others chanting if the patient is unable
Catholicism: Sacrament of the sick (requires a priest); viaticum (communion)
Hinduism: Use of mala (prayer beads); strong preference to die at home
Islam: Opportunity to die facing Mecca; to be surrounded by many loved ones
Judaism: Opportunity to pray Vidui (confessional prayer) and the Shema

visitors, or the disposition of bodies immediately after death. As growing numbers of Muslims, Hindus, and Buddhists immigrate to the United States, some rudimentary knowledge of the customs of these religions becomes increasingly important.

Religious Coping

Spirituality has an impact on patients' ability to cope with illness.[41] For many individuals, spiritual beliefs and practices provide a source of comfort, supply a font of wisdom to help make sense of what seems otherwise senseless, and prescribe a ritual pathway for addressing the basic spiritual questions of meaning, value, and relationship. However, not all religious coping is positive. Some patients view the deity as distant and uncaring. Others, as described earlier, may see God as punishing them for their own transgressions or those of their forebears. Negative religious coping has been associated with worse medical outcomes, and positive religious coping has not been as consistently linked with improved health-care outcomes in the face of specific illnesses.[42–44] Because it may be possible for clergy or others to intervene to help patients who exhibit negative religious coping, it is important to be able to understand and recognize various forms of religious coping and to know where to refer patients who need assistance because of their style of religious coping.

One infrequent but particularly vexing problem is that of the patient (or family) that refuses, on the basis of belief in miracles, to authorize limits on treatment when, from a biomedical perspective, it has been determined that the patient is close to death. Sometimes such a refusal is a form of psychological denial. At other times it is an expression of deep religious faith.[45] Understanding the difference between positive and negative religious coping and having the knowledge to judge between these states may help clinicians to sort their way through these difficult cases. Although research instruments are available to measure a patient's religious coping, the precise clinical usefulness of "diagnosing" patients' religious coping styles is still, at present, a matter of prudential judgment and experience in need of a broader empirical basis.

Patients' Spiritual Needs

It is not always certain what the precise spiritual needs of a patient might be. Some might want help with specific religious rituals. Some might want to talk to members of their own faith communities about the meaning of suffering. Still others might want pastoral counseling regarding their fear of death. Defining the spiritual needs of patients is a matter that is being investigated empirically, but there are, at present, no well-validated research instruments for this purpose. Several early studies have demonstrated that large numbers of patients report a wide spectrum of spiritual needs, and that meeting spiritual needs is correlated with patient satisfaction with care and their ratings of the quality of medical care.[46–48] More investigation is required in this area.

Praying With Patients

Some religious patients actually desire that their physicians pray with them. Interest in this practice varies significantly from 19% for routine office visits in one study to 95% before ophthalmologic surgery in another.[49–51] The clinician's response to a patient request for prayer generally depends on the religious and spiritual beliefs, practices, and circumstances of both the clinician and the patient. If the patient and the physician are both religious (and especially if they are of the same religion), the request can be met with a simple prayer. Even if they are of different religions this may be possible. For example, an Orthodox Jewish physician might be comfortable offering a short prayer in Hebrew or some very broadly worded prayer in English for an evangelical Christian patient. Nonetheless, she might understandably feel offended if asked to lay hands on the patient's head and invoke the Holy Spirit.

Some clinicians are uncomfortable praying with patients.[52] Such physicians can respectfully decline, acknowledging the honor of being trusted enough to be asked but explaining their reasons for not wishing to participate (*eg*, lack of religious conviction, discomfort engaging in a particular style of prayer, worry about the effect of such intimate sharing on the physician-patient relationship). Other clinicians may be willing to do so on a case-by-case basis (*eg*, in

the right setting, with someone of his or her own faith, after some particularly powerful experience they have shared together, in the presence of a chaplain).

Still other clinicians actively seek to pray with patients. Such clinicians should never force prayer on patients. Health-care professionals need to be careful not to prey on the vulnerabilities of patients. For example, it is inappropriate for a surgeon, without prior patient consent, to pray aloud over a patient when that patient is on a stretcher on the way to the operating room, possibly already premedicated. Nonetheless, there should be no objection to patients and clinicians incorporating prayer into practice if they have sought each other out through formal or informal notification, inquiry, and mutual consent.

Addressing the Needs of Patients Who Are Spiritual But Not Religious

Identifying and addressing the spiritual needs of religious patients is difficult enough. Identifying and addressing the spiritual needs of patients who are not religious presents even greater obstacles. Nonetheless, according to the broad definition of the spiritual described earlier, the spiritual needs of patients who profess no religion ought to be just as significant as those of religious patients. Nonreligious persons also grapple with the fundamental spiritual themes of meaning, value, and relationship, especially at those times when serious illness raises profound questions such as whether suffering, death, and even life itself make sense; about whether the individual has any ultimate worth; or about the possibility of reconciliation with those one has wronged or by whom one has been previously hurt. Without immediate recourse to a known set of religious beliefs and traditions or the possibility of referral to the clergy of a specific denomination, clinicians need to have more extensive conversations with nonreligious patients in order to define their needs and understand their sources of spiritual support. Sometimes a nonreligious person who has drifted from the religion in which he or she was raised seeks answers (or at least comfort) in the texts and rituals of his or her religion of origin. Clinicians and chaplains must tread carefully here, not pushing religiosity but exploring the patient's genuine needs. Other patients may have constructed a syncretistic set of beliefs, practices, and texts, often combining elements from the Eastern and Western traditions. If such patients belong to some sort of spiritual community, contacting that community might be of enormous help in mustering resources for the patient. If not, trained chaplains are often skilled in assisting such patients by meeting their eclectic needs with an eclectic set of resources. Still others may have a "closed" or "internal" or "imminent" sense of the transcendent, and they may find solace in poetry, music, or art, or may belong to some sort of humanistic organization.[31] Again, without asking, one might not recognize the spiritual needs of such patients and be unable to assist them in a time of extraordinary need.

Ethics and Boundary Issues

Proselytizing has no place in the physician-patient relationship. The vulnerability of the sick and the power imbalance between clinicians and patients profoundly limit the range of choices available to patients. The characteristics of this relationship never ought to be exploited by clinicians, even for a noble cause. Religious clinicians, especially, must remember that spirituality is about a relationship of mutuality and freedom. Bedside conversions do happen, but if the clinician coerces a spiritual awakening, even subtly, it will not be a conversion based on the free assent of the patient or marked by the mutuality that is characteristic of all genuine relationships between the human and the divine. Contradicting the intentions of the proselytizer, it will be a false conversion.

At the other extreme, however, the fear that their inquiries might be misinterpreted as proselytizing may have led many clinicians to assume that avoiding discussion of spirituality is the safest course. This is also a morally mistaken view. Although the prevalence varies with the setting, between 33% and 77% of patients are interested in having clinicians attend to their spiritual needs.[19,46,49,50] As long as the inquiry is made politely and without presuppositions about the form of the patient's response, a question such as "What role does spirituality or religion play in your life?" is not offensive. In moments of medical crisis, one might say, "This sort of illness often raises very significant questions for patients. How are you dealing with this in a spiritual sense? Is there anything I can do to help? Are there resources here in the hospital or in your community that we can call on to help you?" No one ought to take umbrage at such questions.

How Far Should Physicians Pursue Spiritual Discussions?

One can offer guidance but no formulas concerning spiritual discussions with patients. Algorithmic thinking is inadequate for traversing the ineffable

but deeply human terrain of spirituality. Above all, the safest rule is to follow the patient's lead. If the patient indicates that he or she is neither religious nor spiritual and reports no spiritual needs, the patient should not be harangued with inquiries about these topics. In most cases, clinicians will have paid sufficient attention to the spiritual needs of patients if they have made inquiries about these needs, acknowledged their importance, and made appropriate referrals. Physicians should be careful not to assume that their expertise generalizes to encompass skill in spiritual care. Most physicians have had little or no training in these matters. Hospital chaplains not only have undertaken general theological and pastoral training, but they often have been certified as hospital chaplains through additional, intensive training programs.[53] In most cases, the patient's own clergy or the hospital chaplains, included as valued members of the caregiving team, ought to be the ones who provide the bulk of the spiritual care in the hospital.

Sometimes, however, clinicians may inadvertently uncover profound spiritual concerns and be uncertain about what to do next or how to extricate themselves from the conversation. Basic clinical judgment is as applicable in discussions of spiritual matters as it is in other settings. The clinician can simply say, "It seems that these matters are serious and important. I'm very glad that I asked. Now we need to figure out how best to help you. I think it would be beneficial if a member of our pastoral care staff, Reverend Jones, were to come to see you. If it is OK with you I will let her know that we've had this conversation and let her take it from here."

Concordance and Discordance

A simple (and admittedly, somewhat simplistic) way of examining the issues involved in raising spiritual issues with patients in a pluralistic society such as our own would be to look at four possible patient-clinician dyads.[54]

1. When the health-care professional is religious and the patient is also religious, then both should be able to talk about religion in relationship to healing. Some studies[55] have predicted that such concordance in religiosity (but not necessarily in religion) will be the most common situation. The theoretical problems in such cases are only over differences in denomination and in strength of belief.
2. When neither the health-care professional nor the patient is religious, then things might appear to be at their simplest. If neither party is interested in things spiritual, the issue will simply be irrelevant to both parties. However, if the parties do not consider the question irrelevant despite their lack of belief; if they consider themselves spiritual despite their lack of theism, things may be at their most complex. Without any sense of common language or organizing principle for their beliefs, or even rudimentary understanding of the beliefs of the other as an identifiable and organized religion with an accompanying spirituality, it will be extraordinarily difficult to engage in spiritual conversation. They will have to struggle to find a way to speak to each other about their important spiritual concerns.
3. When the patient is religious and the health-care professional is not, the physician should take the initiative to make inquiries about the patient's religious beliefs and to be supportive and perhaps even to be encouraging of that patient's beliefs. Even an atheist clinician, who rejects the very possibility of transcendent or spiritual meaning, can know something about various religions and their belief systems and engage patients in fruitful discussions about these beliefs.
4. When the health-care professional is religious and the patient is not, a situation that statistics would predict is the least common of the four scenarios, the situation is most risky with respect to proselytizing. As I argued earlier, such clinicians should open up the question of spiritual needs with such patients but then follow the patient's lead in further conversation and inquiry, always respecting the patient's freedom to believe or not to believe.

Conclusion

I have briefly touched on a wide range of religious and spiritual concerns in health care. This is only the beginning of such a discussion, not the end. Much more needs to be studied and much more needs to be taught. But the time has passed when the spiritual concerns of patients can be ignored as irrelevant to good medical care. I hope that this article helps clinicians to understand how attention to the spiritual and religious needs of patients can be incorporated fruitfully into 21st century health care.

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A Practical Approach to the Family That Expects a Miracle*

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When a patient is extremely ill and/or dying, and the family expects a miraculous recovery, this situation can be very challenging to physicians, particularly when there is certainty that the miracle will occur through divine intervention. A practical approach is therefore provided to clinicians for engaging families that anticipate the miraculous healing of a sick patient. This strategy involves exploring the meaning and significance of a miracle, providing a balanced, nonargumentative response and negotiation of patient-centered compromises, while conveying respect for patient spirituality and practicing good medicine. Such an approach, tailored to the specifics of each family, can be effective in helping a family come to a place of acceptance about the impending death of their loved one. ***(CHEST 2009; 135:1643–1647)***

Abbreviation: CPR = cardiopulmonary resuscitation

The word, "miracle," comes from the Latin *miraculum*, a wonder, marvel, or wonderful thing, and the related verb *mirari*, to marvel, or to be amazed or astonished.[1,2] When patients are extremely ill and/or dying, and loved ones expect a marvelous, amazing, or astonishing recovery, this situation can be very challenging. And even more so to physicians, particularly, when there is certainty that this wonderful thing will occur through divine intervention. Outlined below is an approach to engaging families that anticipate the miraculous healing of a sick patient, particularly when spiritual or religious beliefs are the underpinnings of this expectation. The elements of this strategy, exploring the meaning and significance of a miracle, providing a balanced nonargumentative response and negotiation of patient-centered compromises while conveying respect for patient spirituality and practicing good medicine, will be illustrated by walking through a case.

Explore the Meaning and Significance of a Miracle

Mrs. Clark is a 75-year-old woman with a history of hypertension and non-insulin-requiring diabetes, who was admitted to the ICU for ventilatory support because of multilobar pneumonia and respiratory failure. Her clinical course over the last 10 days has been characterized by evolving ARDS, progressive renal failure, uncontrolled sepsis with hypotension, and unresponsiveness. It is the conclusion of the attending physician (Dr. Carr) and the medical team that the likelihood of recovery for someone her age with multisystem organ failure is very small. Therefore, they meet with her children (a daughter and two sons) to advance her level of care to comfort measures only. The family vigorously resists this suggestion, insisting that mechanical ventilation be maintained and cardiopulmonary resuscitation (CPR) be provided in the event of a cardiac arrest because, "We know a miracle will occur."

Before responding, the physician needs to determine the meaning and significance of a miracle to the family.[3] This will not only enable the physician to

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have a full sense of what the physician is "dealing with," and thus help to inform a response to the family, but it also provides an effective, nonconfrontational way of beginning the discussion. Further, when listening to the family first, the care team conveys sincerity about knowing the family's perspectives as well as a respect for their beliefs.

The expectation of miracle may reflect a belief in a divine, supernatural intervention superceding the laws of nature.[2,4,5] Most Christian faiths, and some strains of Orthodox Judaism, accept the possibility of this kind of divine action in which God acts in the present time to contravene the natural order.[6,7] In contrast, non-Orthodox Jews, many liberal Christians, and most Muslims for the most part reject this view.[6–8] For these groups, descriptions of miracles in sacred texts are symbolic and not literal; divinely mediated events may have occurred in the past, but God no longer acts in this way; and/or miracles represent divinely preordained occurrences already built into the scheme of creation by God. There is also the perspective that there is much that God does everyday without contradicting the natural order that is amazing and spectacular (*ie*, "miraculous"), which humans fail to appreciate. These are certainly generalizations, and individual adherents of a specific faith may have their own idiosyncratic views about miracles.

The expectation of divine intervention may be intensified by specific experiences and beliefs.[3] These include previous personal experiences with miracles; the sense that the current situation is a "test of faith"; and the belief that the occurrence of the miracle is dependent on unwavering or unquestioning faith. Identifying these associated beliefs may be as important as confirming that there is an expectation of divine action.

Since the expectation of a miracle may have religious implications, it is important to establish a pattern of clinical practice that conveys respect for and tolerance of the religious and spiritual beliefs of patients and their families, independent of whether there is conflict around the expectation of a miracle.[9–12] Such an approach to care may provide a measure of good will that could prove to be helpful in dealing with the family that subsequently comes to anticipate a divine intervention.

Although the language of miracles is often about divine healing, it may be an expression of at least two other things.[13] First, the family may in fact be expressing hope or optimism about the possibility of recovery, trying to maintain a positive attitude. In its most extreme form, this sense of hope may be a manifestation of denial or avoidance of the seriousness of the patient's grave situation.[14] Assuming that efforts at effective communication have been employed, clinical situations in which the anticipation of a miracle may suggest denial include the following: (1) when the family appears to lack understanding about the patient's diagnosis and prognosis; (2) when the family reaches conclusions about the patient's condition that are very different from those of the care team; and (3) when the family maintains a disproportionate optimism. Second, talk of a miracle may reflect the way in which the family expresses its anger, frustration, disappointment, and/or hurt over some aspect of care. The family may be able to seize some measure of control or even retribution, knowing that talk of a miracle can be an effective method to control the care team or even strike back at them. These two additional meanings to the term *miracle* may also be present in families that hold a belief in divinely mediated healing.

"A miracle can mean different things to different people," Dr. Carr begins. "When people say they expect a miracle, it often is about God, but sometimes it may be about hope or even frustration and disappointment. It would be very helpful to us if you could tell me what a miracle means to you?"

Provide a Balanced, Nonargumentative Response

The family clearly expresses a sincere belief in the ability of God to intervene to fully restore the health of their mother. They are certain that their faith and prayers can move God to act and more than once the experience of an uncle is cited who got better after "the doctors had said there was no hope."

The information learned from the initial discussion with the family about their meaning of a miracle can be used to frame a response. If it is discovered that the anticipation of a miracle is really an expression of hope or optimism, then it might be helpful to suggest that there are always good things, other than recovery, which are attainable, that we can also hope for. It is also helpful in these situations to patiently listen without frustration to their expressions of hope, while continuing to provide consistent information on the poor prognosis of the patient. Or, if the expectation of a miracle is instead about anger or some hurt or disrespect, efforts should be made to reestablish trust by acknowledging the emotions of the family, assuming responsibility and apologizing for any unfortunate events, and putting in place a plan for ensuring good communication and resolving any lingering issues.

However, where the expectation of miracle represents a belief in a divine intervention, little will be gained by trying to directly challenge the family about its belief. In arguing the validity of the family's

belief, the physician is only likely to alienate them.[15] Instead, an approach that is more likely to be effective is one that includes the following, which can be adapted to each family.

- Emphasize nonabandonment. One of the things that patients and their loved ones fear when death approaches is isolation and abandonment.[16] The family therefore needs to know that the care team will be attentive to the needs and comfort of the patient and that the well-being of the family will not be ignored. This is imperative especially in the setting of conflict or disagreement, where physicians may unconsciously withdraw and or distance themselves from either the patient or the family, sending a message of abandonment.
- Cite professional obligations. Just as it is important for the care team to hear the family's perspective, it also necessary for the family to appreciate the motivations and professional obligations of the caregivers.[17,18] When deciding to initiate or continue a particular treatment, the family should understand that the physician is required to determine whether the treatment is medically appropriate or effective. If appropriate or effective, would the treatment be desired by the patient under the current conditions? Or, if the patient's desires are unclear, would the treatment in question be in the patient's best interest? Thus, when death is near, there is no professional requirement that the physician will base treatment plans on the expectation of divine intervention. Rather, when death is close and inevitable, ethical and professional standards of physician conduct require that this reality not be denied or ignored, but that management should instead be focused on the patient's comfort. It is certainly very appropriate to respectfully review these professional obligations with the family.
- Reframe the meaning and manifestation of the miracle. With care about and sensitivity to the family's broader story, the physician can offer the thought that the miracle (*ie*, the amazing, the spectacular, the unbelievable) may have already occurred, or may occur in some other way.[19,20] For example, bitterly estranged family members are brought together because of the patient's illness and/or death, and, to everyone's astonishment, they are able to reconcile. The patient's death motivates a careless or wayward child to put his/her life in order, something that no one thought was possible. Or the grace and dignity with which the patient faces illness and impending death inspires surprising change in the attitude and actions of others. In other words, the amazing, astonishing, and unimaginable may occur with, because of, or after the death of the loved one. The physician might begin this conversation, by asking, "Is there anything that has already happened through all of this that has been amazing or wondrous, like a kind of miracle."
- Suggest that if a miracle is to occur, physician actions will not prevent it. Last, for those families whose worldview includes an all-powerful, sovereign God, and to the physician who is comfortable doing this, it can be suggested that if it is truly God's will that a miraculous healing occur, then there is nothing we as humans can do to prevent the healing from taking place.[19,20] Thus, as the physicians do what is expected of them, the family can go forward with the assurance that God will not allow divine will to be thwarted. This suggestion is a challenge to the family to have faith in the power of their God. Consequently, this perspective may be more skillfully and carefully presented to the family by pastoral care or clergy trusted by the family,[12] who may also be able to help the family reframe the meaning of the miracle.

In responding to the expectation of divine intervention, the goal is not to present arguments that intellectually overwhelm the family, but to provide the family with information and additional perspectives that the family can use to reshape their thinking, understanding, and experience of the current situation. To this end, exercising a little patience and allowing the family the opportunity to process what they have heard can facilitate a change in their expectations. Additionally, although the physicians may be certain of the outcome, it is also important in conversations with the family that physicians maintain a humility that allows them to acknowledge the inherent uncertainty of medicine and the occurrence of inexplicable events.

Dr. Carr continues the discussion by saying, "In responding to what you have said, I want to emphasize that my intent is not to challenge your belief in the possibility of a miracle. In fact, I have been in situations where things have occurred that have made me wonder if a miracle did occur. There are few things, however, I want to share with you, that I would like you to go home and think about and discuss among yourselves . . ." The meeting adjourns with a plan to continue the current level of care and to meet again in a day or two.

Negotiate Patient-Centered Compromises While Practicing Good Medicine

The next afternoon, the three children again meet with Dr. Carr. The previous evening they had spoken with the pastor of their church. He had indicated

that from the perspective of their faith tradition, there was no obligation to preserve life by extraordinary means when death was likely, and that it was important to "put Mom in the hands of God." The patient's two sons had accepted this, acknowledging that their mother probably would not want life-support to continue. Their sister, however, with great emotion asserts that now was not the time to "give up hope," insisting that her mother continue to receive full intensive care. The two brothers are unwilling to challenge their sister.

In many instances, simply understanding the meaning of a miracle to the family, obtained by diligent and careful conversation, will provide an effective approach for respectfully redirecting the focus of the family that is hoping for a miraculous healing. But what should be done when this approach is not successful, and family members still insist on interventions based on an expectation of a miracle? Respect and tolerance for the beliefs of the family does not mean that caregivers should acquiesce to demands for medically inappropriate or medically ineffective treatments.[12] Boundaries, albeit wide ones, do need to be set and maintained, and the care provided ultimately must be patient centered. Therapy may be nonnegotiable, such as the administration of sufficient analgesia and/or sedation to provide for the comfort of the patient. In short, while addressing the demands of the family, the physicians must continue to practice good medicine.[12,18]

However, when there is continued insistence on therapy because a miracle is anticipated, the physician should enter into further discussions with the family to identify a mutually acceptable middle ground between the demands of the family (for full intensive care and CPR) and the recommendations of the physicians (for comfort measures only). Ideally, a consensus is arrived at about the level of care in which the family does not feel marginalized, while the caregivers still have the sense of providing meaningful care. The fact that a failure to come up with a compromise will likely lead to (further) alienation between the caregivers and family members should lead to persistence in seeking some agreement. In those instances in which these types of "negotiation" discussions fail to produce a mutually agreeable outcome, the ethics committee and/or mechanisms for conflict resolution of the institution should be employed.

After additional discussion, Dr. Carr offers, "It is obvious that you are not prepared to accept our recommendation that we focus on your mother's comfort, while we do not believe it is medically appropriate to continue this level of intensive support. We need to move beyond this disagreement and come up with a compromise . . ." Following further conversation, it was agreed by everyone that, going forward, the current level of support would be maintained and not increased. However, if a new or catastrophic event occurred, including a cardiopulmonary arrest, then Mrs. Clark would be allowed to die peacefully. Three days later, Mrs. Clark became progressively bradycardic and died without the initiation of CPR.

Conclusion

The successful application of this or any other approach for redirecting the focus of a family that expects a miracle must occur against a backdrop of continuous physician efforts at establishing, encouraging, and sustaining the trust of the family. The physician does not assume that he or she should be trusted, but instead, diligently and compassionately provides the best care possible, demonstrating over time that the physician is deserving of the family's trust. Trust also thrives when the communication from the physician to the family is goal oriented and patient centered, understandable and jargon-free, truthful and honest, and timely and consistent.

There will certainly be instances in which the resolution of a conflict arising from a family's expectation of a miracle will require some kind of mediation. The ideal, however, should still be that situation in which a consensus about the direction of care is reached at the "bedside," without the intervention of "outsiders." Experience indicates that this ideal can be achieved by patiently employing an approach of genuine respect, careful listening, honest discussion, and thoughtful responses. Such a strategy, tailored to the specifics of each family, and coupled, if necessary, with persistent negotiation toward a compromise, will likely prove successful in helping the family come to a place of acceptance about the impending death of their loved one. This approach can be also be adapted and applied to other situations in which the expectations and demands of patients or their families are inconsistent with professional values or physician recommendations.

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